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Update

Iranian state-owned insurer to pay claims from massive earthquakes

LONDON—Claims resulting from two devastating earthquakes in northern Iran last week that destroyed some small towns and killed at least 12,000 people will be paid by Iran's state-owned insurer, Bimeh Iran Insurance Co., said the insurer's London representative.

Iranians "are very aware" of the concept of property insurance and many likely insured their homes and businesses, which collapsed like decks of cards in the quakes, said Barry Hillion, director and principal

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Supreme Court sides with PBGC

Pension plans returned to LTV

By JERRY GEISEL

WASHINGTON—Last week's Supreme Court ruling forcing LTV Corp. to reassume responsibility for three pension plans with $2.3 billion in unfunded liabilities is a victory for the nation's pension insurance system and the employers that finance it.

The decision will reduce the potential of the federal Pension Benefit Guaranty Corp. to be hit with billions of dollars in new liabilities and will help hold down the premiums it charges employers, say federal regulators and pension experts.

After terminating three LTV defined benefit plans in January 1987, the federal agency later that year attempted to return those plans to the company. By that time, LTV had established a new low-cost "follow-on" program to provide benefits that were not guaranteed under the PBGC insurance program.

Federal officials described the LTV follow-on plan as a wrap-around program providing non-PBGC-guaranteed benefits that were lost when the plans were terminated.

Writing for the 8-1 majority, Justice Harry Blackmun said such plans frustrate one objective of the Employee Retirement Income and Security Act of 1974—the continuation and maintenance of voluntary pension plans.

The PBGC was established by ERISA.

Follow-on plans also could increase the PBGC deficit and boost premiums charged to employers, "thereby frustrating another related statutory objective—the maintenance of low premiums," Justice Blackmun wrote.

Federal regulators hail the ruling as a triumph for the pension agency and employers with defined benefit plans that finance its insurance program through mandatory premiums.

That insurance program protects the benefits of more than 40 million people who participate in defined benefit plans.

"This really is a victory for all companies that pay premiums to the PBGC and responsibly fund their pension plans," said PBGC Executive Director James B. Lockhart III.

Observers say the decision affirms the PBGC's role as an insurer of last resort—rather than a dumping ground for pension promises companies no longer want to keep.

"In my view, this is definitely a victory for the defined benefit plan system. It provides greater assurance that the PBGC will be an insurer of true necessity rather than being subject to corporate and/or union financial manipulations and strategies," said Dallas Salisbury, president of the Employee Benefit Research Institute, a business-supported think tank in Washington.

Had LTV prevailed, other finan-

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The PBGC stems the tide of red ink

The Pension Benefit Guaranty Corp.'s deficit has shrunk over the past several years as premium income has risen. All figures in millions of dollars.



*The PBGC assumed responsibility for LTV Corp.'s pension plans in fiscal 1986, but returned the plans to LTV in fiscal 1987.

Source: Pension Benefit Guaranty Corp.

BI/HOLLY SEGUINE

Regulators target work comp abuses in employee leasing

By MEG FLETCHER

State insurance regulators and workers compensation insurers are cracking down on employers' use of illegal and unethical employee leasing arrangements designed to avoid payment of tens of millions of dollars in workers comp insurance premiums annually.

Regulators and insurers are drafting rules to prevent employee leasing arrangements that allow employers with poor workplace safety records to avoid the resulting high premium. Small and medium-sized firms that buy their workers comp coverage through residual markets are the main concern of regulators and insurers.

The premiums workers comp insurers are losing as a result of fraudulent employee leasing arrangements are being passed on to other employers, the National Council on Compensation Insurance points out.

"This shortfall in premium is ultimately paid for by other employers through increases in the overall rate level," the NCCI said.

"Cracking down on fraudulent or unethical employee leasing arrangements is important because they are one of the factors that keep workers compensation rates high for all employers," agreed a spokesman for Aetna Casualty & Surety Co., which is a plaintiff, along with the NCCI, in one of several lawsuits seeking to recover lost premiums from leasing firms.

To solve the problem, the NCCI wants to ensure that a company's true loss experience is reflected in the workers compensation premium for employees at that company, even if the employees are

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Action by entire House still in doubt

McCarran foes push for vote

By ADRIENNE C. LOCKE

WASHINGTON—The House Judiciary Committee's approval last week of legislation that would amend the McCarran-Ferguson Act could set the stage for the first congressional floor vote on overhauling the 45-year-old law.

Consumer groups say they will mount a massive lobbying campaign to win House passage of the legislation, which would strip insurers of their key exemptions from federal antitrust law.

"We are calling on citizens all across the nation to write or call their representatives and express their full support for the passage. . .when it comes before the full House," said Robert M. Brandon, vp of Citizen Action, a consumer group in Washington, D.C.

"There is no doubt in my mind. Rep. Brooks is very serious about this issue" and will push for a vote by the entire House, said J. Robert Hunter, referring to the bill's sponsor, Rep. Jack Brooks, D-Texas. Mr. Hunter is president of the National Insurance Consumer Organization in Alexandria, Va.

Mr. Hunter expects the bill to be overwhelmingly approved by the House this year.

"Who wants to go into an election year saying, 'We want insurance price-fixing?' " he said. "By the time this hits the House floor, Congress will know that this vote goes back home because we will make sure that it does."

But insurance industry observers say the close 19-17 Judiciary Committee vote in favor of the bill makes it unclear whether the bill will be brought up for debate on the House floor this year.

Legislation to amend McCarran-Ferguson would have to be reintroduced next year since the current congressional session ends this year.

The bill, H.R. 1663, introduced by Rep. Brooks, the House Judiciary Committee's chairman, was approved earlier this month by the House Economic and Commercial Law Subcommittee on a 9-6 party line vote with Democrats supporting the proposal (*BI*, June 18).

But the even closer 19-17 vote by the full committee last week is fueling speculation that Democratic support for the proposal could be slipping.

Three Democrats voted against the bill when it was approved by the full committee, including two legislators who had voted in favor of the bill on the subcommittee level. No Republicans voted in favor of the bill.

Roger Levy, vp of federal government affairs in the Washington, D.C., office of Travelers Corp., says the three Democrats that voted against the proposal—Rep. Dan Glickman of Kansas, Rep. Edward F. Feighan of Ohio, and Rep. Bruce A. Morrison of Connecticut—recognize that "there is something troubling" about the bill.

"They are not persuaded that the case has been made" for eliminating the insurance industry's limited exemption from federal antitrust laws, Mr. Levy said.

"We were encouraged by the closeness of the vote" by the full Judiciary Committee, said David M. Farmer, vp-federal affairs at the Alliance of American Insurers in Washington, D.C.

Mr. Farmer said he believes in-

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Amoco plans to appeal award of $126 million for Cadiz spill
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Health claims system saves Caterpillar millions of dollars
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Manufacturer suing insurers for not settling product suit
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Iranian insurer to pay losses

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underwriter for Bimeh Iran Insurance Co. (U.K.) Ltd., a unit of Bimeh Iran in Tehran.

Most of the region devastated by the quakes was residential, he noted. However, Mr. Hillion could not estimate total insured damage Friday, in part because Bimeh Iran was closed that day, which is considered part of the weekend in Iran.

Bimeh Iran is the only insurer doing business in Iran and is the largest insurance company in the Middle East, he said. According to its latest results under its three-year accounting system, Bimeh Iran in 1987 wrote 286 million pounds ($493.1 million) in premiums and had more than 1 billion pounds ($1.72 billion) in assets.

Bimeh Iran places property excess-of-loss reinsurance in London through broker Willis Faber P.L.C., Mr. Hillion confirmed. He did not know the limits of Bimeh Iran's reinsurance.

Willis Faber could not say what the limits are.

Insurance execs indicted

AUSTIN, Texas—Officials of two failed Texas insurers face theft and other charges for allegedly diverting millions of dollars in premiums following an investigation of insurers by the Travis County district attorney's office in Austin over several months.

A grand jury indicted Robert Walker, former chairman of National County Mutual Fire Insurance Co. in Dallas, on one count of theft, 11 counts of misapplication of funds and two counts of filing a false financial statement. Mr. Walker allegedly transferred more than $9 million in premiums to personal accounts.

National County Mutual's demise—the largest insurer failure ever in Texas—triggered a shakeup of the State Board of Insurance. The insurer was insolvent by $54 million when it was placed into receivership in October 1988 (*BI*, Nov. 7, 1988).

Separately, John Gordon, Frances Gordon and W.L. Lasiter, owners of Best Lloyds Insurance Co. in Houston, were indicted on theft and other charges related to the insurer's demise. When placed into receivership in April 1988, Best Lloyds was insolvent by $29.4 million.

Among other things, the Gordons allegedly used premiums to pay more than $1 million in personal debts. Mr. Lasiter was indicted on one count of misapplication of funds.

In addition, R.W. Brayton, a former state regulator, was indicted for allegedly misapplying $1 million in premiums while he was operating an agency—R.W. Brayton & Co. in Austin—in 1987 and 1988. Mr. Brayton was director of conservation of companies with the Texas State Board from 1976 to 1979.

Except for Mr. Walker, who has disappeared, the indicted insurance officials and Mr. Brayton are expected to surrender to authorities this week, an assistant district attorney said.

Unlimited oil spill liability

TRENTON, N.J.—Tanker owners and operators would face unlimited liability for cleanup costs and other damages resulting from oil and hazardous materials spills in New Jersey waters under legislation approved by the Legislature last week and expected to be signed by Gov. James J. Florio.

The measure would amend the state's Oil Spill Compensation Act, which does not now address liability limits.

The same amendment also would establish civil penalties of up to $10 million for any spill as well as daily fines of $50,000 for each violation of the law. Under current law, the state could fine tanker owners and operators up to $50,000 per spill.

A second amendment to the act approved by the Legislature would require tankers to take new protective measures when transferring oil and hazardous materials to other vessels and facilities.

The Legislature also passed a bill that would require pipelines carrying oil and hazardous materials to register with the state.

The legislation is needed because of the numerous oil spills in New Jersey that have caused serious economic and environmental problems in the state, said a spokesman for state Sen. Richard Van Wagner, D-North Monmouth, who sponsored the two amendments to the Oil Spill Compensation Act.

"We wanted to send a strong message to the oil companies that if they don't adopt more prudent means to prevent oil spills, then they will have to pay for it," he said. "You spill, we bill," he said.

Oil cleanup costs top $4 million

GALVESTON, Texas—The cost of cleaning up the light crude oil spilled by the crippled KS Mega Borg II in the Gulf of Mexico reached about $4.2 million late last week, according to an attorney for the ship's owner.

However, much of the 3.9 million gallons of oil spilled by the tanker evaporated or was dispersed, and authorities predict damage will be slight.

Shipowner Mosvolds Rederi AS of Farsund, Norway, though, is paying $275,000 for a study of the spill's environmental impact, according to its attorney, Robert Klawetter of Eastham, Watson, Dale & Forney in Houston.

The Texas Water Commission will conduct the study with the National Oceanic and Atmospheric Administration.

Mosvolds Rederi AS has up to $700 million of pollution liability coverage for cleanup and liability claims: $500 million from Assuranceforeningen Gard Gjensidig, a protection and indemnity club in Arendal, Norway, and the rest from London underwriters (*BI*, June 18).

Meanwhile, salvage crews are examining the crippled oil tanker and authorities are expected to release damage estimates this week, says a lawyer for the ship's owner. Portions of the ship, damaged by June 9 explosions in the Gulf of Mexico, remain inaccessible, Mr. Klawetter said.

The ship's hull is insured for its current market value, an estimated $23 million, with half of the coverage placed with Christianssands Skibassuranse of Kristiansand, Norway, and half with A/S Storebrand-Norden-Gruppen in Oslo.

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If pollution is abrupt, cleanup insured: Court

By STACY ADLER

BOSTON—The cost of responding to a government order to clean up polluted property are covered "damages" under comprehensive general liability insurance policies, but only if the release of pollutants occurred abruptly, according to two rulings by the Massachusetts Supreme Court.

The two rulings—which are viewed both as a victory and a defeat for policyholders—are expected to be influential in pollution coverage litigation nationwide, attorneys say.

In one of the rulings, the court interpreted the pollution exclusion in post-1970 CGL policies, which bars coverage for all pollution that is not "sudden and accidental."

Some courts have sided with policyholders by ruling that the exclusion bars coverage only for pollution that was intentional.

But other courts, including the Massachusetts Supreme Court, have sided with insurers by giving "sudden" a temporal definition.

In its ruling, the Massachusetts high court said the exclusion bars coverage for pollution that is not "abrupt and also accidental."

"For the word 'sudden' to have any significant purpose, and not to be surplusage when used generally in conjunction with the word 'accidental,' it must have a temporal aspect to its meaning and not just the sense of something unexpected," the court ruled.

Meanwhile, the Massachusetts court's ruling that cleanup costs constitute covered "damages" under CGL forms marks the fourth time a state supreme court has ruled in favor of policyholders on this critical issue.

Insurers have argued that government orders to clean hazardous waste sites do not constitute "damages" and thus are not covered.

To date, courts in Minnesota, Washington and North Carolina have held that cleanup costs are covered by CGL forms.

However, the Maine Supreme Court has held that the costs are not covered (*BI*, June 11; April 16; Feb. 19; Jan. 15).

The two June 14 rulings by the Massachusetts high court came in two separate coverage disputes. But, because the two cases involved related issues, they were argued together before the court.

Attorneys say that both rulings will be influential nationwide because Massachusetts is a well-respected jurisdiction. And, they note the decisions are especially important within Massachusetts because the state has significant

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Damages to be appealed in Amoco Cadiz oil spill

By DOUGLAS McLEOD

CHICAGO—Amoco Corp. will appeal a federal judge's order to pay an estimated $126 million in damages stemming from the 1978 wreck of the Amoco Cadiz.

U.S. District Judge Charles R. Norgle last week adopted the recommendations of retired U.S. District Judge Frank J. McGarr, who was "special master" in the case.

Judge McGarr last year recommended that Amoco pay more than $100 million to the French government and scores of other claimants after finding the oil giant liable for the wreck, which spilled 68 million gallons of crude oil off the coast of France (*BI*, Nov. 6, 1989).

Judge Norgle's order, which does not specify damages, directs lawyers for Amoco and the French claimants to submit computations of damages in French francs based on Judge McGarr's findings by July 11. The award is to be officially entered on July 24.

The award will amount to about 710 million French francs including interest (about $126 million) through July 24, said Frank Cicero, a lawyer with Kirkland & Ellis in Chicago representing Amoco.

Amoco will appeal both Judge McGarr's liability ruling and the damage ruling to the 7th U.S. Circuit Court of Appeals, Mr. Cicero said. French claimants also may appeal.

The 1,095-foot Amoco Cadiz ran aground in March 1978 and eventually split apart in heavy weather, spilling its entire cargo. The spill spawned numerous lawsuits—later consolidated in federal court in Chicago—seeking roughly $2.2 billion.

In a 1984 ruling, Judge McGarr found Amoco liable for the spill. The judge also entered a default judgment finding Astilleros Espanoles S.A. of Spain, which built the ship, liable to Amoco. Astilleros has refused to recognize the court's jurisdiction.

After a separate damages trial, Judge McGarr in 1988 ordered Amoco to pay about $85.4 million in damages and prejudgment interest (*BI*, Jan. 18, 1988).

After retiring, Judge McGarr continued to act as a special master on the case, and revised the 1988 damage several times, submitting his final recommendation in October (*BI*, Feb. 27, 1989; Sept. 18, 1989). ■

Excess/surplus listing near

Business Insurance will publish two directories in the Aug. 13 issue, which will contain a spotlight report on the excess and surplus lines insurance markets.

One directory will list underwriting managers, managing general agents and surplus lines brokers. The second will list surplus lines insurers and insurers that specialize in writing excess coverages.

To be listed in the second directory, surplus lines insurers must write at least 50% of their gross premiums on a direct, non-admitted basis; excess insurers must write at least 50%, or $500,000, of gross premiums in excess liability insurance lines.

There is no charge to be included in either directory. However, companies that wish to be listed must fill out and return a questionnaire provided by *Business Insurance*.

Underwriting managers, managing general agents, surplus lines brokers, excess insurers and surplus lines insurers that have not yet received a questionnaire should request one from: Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-649-5279.

The deadline for returning completed questionnaires is July 13.

Inside

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- The public and private sectors must cooperate to ensure that all Americans have adequate health care coverage, experts say at the Group Health Assn. of America's Group Health Institute. **PAGE 10**
- Successfully promoting employer-sponsored savings programs is a key challenge facing employers, says consultant John F. Hammond in Perspectives. **PAGE 23**
- A U.S. Lloyd's of London member must sue Lloyd's in English courts, a U.S. appellate court ruled. **PAGE 29**
- Stock analyst Leonard Wilson addresses several questions raised by the merger of Corroon & Black Corp. and Willis Faber P.L.C. **PAGE 39**

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Employer spots inflated medical bills

By CHRISTINE WOOLSEY

PEORIA, Ill.—A state-of-the-art claims processing system is saving one of the country's largest manufacturers millions of dollars a year by catching inflated doctor bills.

Caterpillar Inc., which self-insures and self-administers its health care plan, is refusing to pay for "unbundled" medical and surgical procedures that are spotted by CodeReview—a computer system jointly created by Caterpillar and Boston-based Health Payment Review Inc.

By reviewing procedure codes on health care claims, CodeReview identifies in seconds cases in which doctors charge separately for each step in a procedure rather than submitting a single lower charge.

Such unbundling can significantly inflate medical charges.

Caterpillar's system is designed to repackage claims using proper codes to assure each claim is paid according to the employer's "usual and customary" fee schedule.

Using CodeReview, the construction machinery and engine manufacturer is consistently trimming physician claims by 10% to 15%, said Dr. Robert D. Hertenstein, medical director of group insurance.

"That's an estimate, but even if you cut that percentage in half, you're still talking about multiple millions of dollars," he says.

Caterpillar, a Peoria, Ill.-based equipment manufacturer, spends about $220 million a year on health care, according to Dr. Hertenstein. About one-fifth of the 2.5 million health care claims it processes each year are for physician care.



The company's health care plan covers about 246,400 people, including nearly 60,000 active and retired employees worldwide, he said.

Caterpillar is one of the employers identified by the National Assn. of Manufacturers as making significant efforts to control health care costs.

Other employers are battling rising health care costs by: implementing comprehensive flexible benefit programs (*BI*, May 21); implementing case management programs (*BI*, May 7); analyzing utilization data (*BI*, April 30); adopting comprehensive health management programs (*BI*, April 16); working closely with labor unions (*BI*, April 2); and operating in-house medical clinics (*BI*, March 5).

Even small employers have developed cost management strategies (*BI*, March 19).

Dr. Hertenstein said CodeReview is more extensive and stringent than any other computer unbundling system.

Last year Blue Cross & Blue Shield of Illinois introduced a computerized system to check procedure codes that was available only to BC/BS plans (*BI*, Dec. 11, 1989).

Five years after joining Caterpillar in 1982, Dr. Hertenstein began developing software to investigate and improve claims payment.

His first step was hiring surgical technicians to manually review each claim submitted to the company.

"Caterpillar wasn't terribly sophisticated about paying claims nine years ago," Dr. Hertenstein said. But as health care costs began to soar, the company "wanted someone to look to see if they were paying those claims correctly."

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Analysts pick top insurance stocks

By JUDY GREENWALD

NEW YORK—Marsh & McLennan Cos. Inc., Chubb Corp., CIGNA Corp. and Fund American Cos. Inc. are among stock analysts' top picks as leading stock market performers.

However, conspicuously absent from the selections by leading analysts are several prominent property/casualty insurers that have been touted by analysts previously.

Analysts this year favor companies well-insulated from the soft property/casualty insurance market, as well as those involved in financial services and life/health insurance.

Insurance stocks continue to lag behind the overall stock market. Page 35

If there is a theme to the selections, it is "ducking and bobbing and weaving away from the property/casualty cycle," commented G. Allen Zimmerman, vp and senior insurance analyst at Smith Barney Harris Upham & Co. in New York.

Nine insurance stock analysts explained their selections during a panel discussion at the Assn. of Insurance & Financial Analysts insurance symposium, held June 10-13 in New York.

Insurers selected by analysts at the AIFA symposium a year ago, but not this year, included American International Group Inc., Continental Corp., Travelers Corp., The Hartford Steam Boiler Inspection & Insurance Co. and W.R. Berkeley Corp. (*BI*, July 10, 1989).

This year, the analysts cited, among others, UNUM Corp. of Portland, Maine, which specializes in long-term disability coverages; Provident Life & Accident Co., a life/health insurer based in Chattanooga, Tenn., that is active in guaranteed investment contracts; and Long Grove, Ill.-based Kemper Corp., which restructured its operations in 1989 to exclude commercial property/casualty activities. These activities are now carried on by mutual insurer members of the Kemper Group, rather than stock companies (*BI*, Jan. 30, 1989).

And the top companies cited by four analysts—M&M, Chubb, CIGNA and Fund American—were selected because the analysts felt they are well-equipped to cope

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Public entity risks

Self-insurers must structure claims process

By MICHAEL SCHACHNER

RENO, Nev.—Risk managers for self-insured cities, states or counties can mitigate liability payouts by using a claims procedure that starts before an accident occurs and extends beyond claims filing, a risk management consultant says.

A well-planned claims handling and management procedure that begins before an accident and proceeds into occurrence and post-occurrence phases will promote expeditious claims handling, he says.



It will also increase a public entity's chances of avoiding expensive settlements and judgments, according to Robert A. Condne, branch manager for Gallagher Bassett Services Inc., a consulting and claims administration firm in Southfield, Mich.

At the 11th annual Public Risk Management Assn. conference, held June 10-13 in Reno, Nev., Mr. Condne said risk managers do not need to be claims experts. Instead, he says, they should concentrate on identifying problem spots and coordinating open communication between a risk management department and its claims administrator.

"The insurance coordinator or risk manager is the most important resource in the claim

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Police procedures needed to reduce liability exposures

By MICHAEL SCHACHNER

RENO, Nev.—Municipalities can avoid many common forms of liability by having strict, well-defined policies and procedures for police officers, says a public entity loss control adviser.

"Many public entities think rules and regulations suffice, but rules and regs only dictate behavior. Policy and procedures are different," says Donald J. Walter, risk control department manager for Governmental Risk Managers Inc. of Plymouth, Mich., a public entity pool manager.

"Municipalities expose themselves to liability by not having written policies and procedures. It is essential today to have them," Mr. Walter said during a session at the Public Risk Management Assn. conference June 10-13 in Reno, Nev.

Without carefully defined policies, "line officers will set them themselves," he said. In cases of alleged negligence, the courts will only be able to look at history from other cases to form a judgment, he contends.

Mr. Walter said spelling out such policies and procedures can protect municipalities from several liabilities associated with police forces: negligent hiring, negligent employee retention, negligent assignment, negligent entrustment, failure to train, failure to supervise and failure to direct.

Thirty-nine percent of all government losses

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Insurers sued for failure to settle

By DOUGLAS McLEOD

KANSAS CITY, Mo.—A paint manufacturer facing a $20 million product liability judgment is suing several of its liability insurers for failing to settle the case for a fraction of that amount.

Cook Paint & Varnish Co. of North Kansas City, Mo., filed suit against the insurers earlier this month after a jury awarded $20 million in compensatory damages in a lawsuit filed by one of its customers.

Although the customer had offered to settle the case for $6.5 million before trial, Cook Paint's insurers failed to settle and have reserved their rights to deny coverage under the policies, according to Thomas W. Wagstaff, a Kansas City lawyer representing the paint manufacturer.

In addition to seeking a declaratory judgment that the insurers are liable for the $20 million award plus defense costs, Cook Paint's lawsuit also seeks $50 million in punitive damages for bad faith.

Cook Paint was sued by the customer, Allied Tank Services Inc., in Bexar County District Court in San Antonio, Texas, in March 1989. San Antonio-based Allied, a manufacturer of drinking water tanks, charged that paint it bought from Cook to coat the inside of hundreds of water tanks had blistered, contaminating drinking water. The actions that led to the lawsuit occurred between 1983 and 1986, Mr. Wagstaff said.

Allied amended its complaint several times, filing a fourth amended petition on May 1, 1990. The suit went to trial that month, and a jury rendered a $20 million judgment against Cook Paint on June 7.

Once a final order is entered, Cook Paint will ask the judge to throw out or reduce the award or grant a new trial, said Mr. Wagstaff, a lawyer with the Kansas City firm of Blackwell, Sanders, Matheny, Weary & Lombardi.

If these motions are denied, Cook will appeal the award, he said.

Cook Paint filed its own suit in Clay County Circuit Court in Kansas City earlier this month against several insurers that wrote occurrence-based product liability coverage for the company between 1983 and 1986. Insurers named in the complaint are:

- The Missouri Insurance Guaranty Assn., on behalf of the defunct Ideal Mutual Insurance Co. of New York, which wrote primary completed operations and product liability coverage with a limit of $500,000 and a $3,000 per occurrence deductible for the 1983-84 policy year.
- Safety Mutual Casualty Co. of St. Louis, which wrote $9.5 million of completed operations and product liability coverage excess of $500,000 for the 1983-84 policy year.
- Transport Indemnity Co. of Los Angeles, later known as Mission American Insurance Co., which wrote primary coverage with a $500,000 limit over a $25,000 per claim self-insured retention for the 1984-85 policy year.

Mission American's business has since been assumed by by North American Insurance Co. of California.

- Fremont Indemnity Co. of Los Angeles, which which wrote $9.5 million of coverage excess of $500,000 for the 1984-85 policy year.
- Columbia Casualty Co. of Chi-

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ISO changes to raise insurer costs: Panel

By JOANNE WOJCIK

NEW YORK—The Insurance Services Office Inc.'s decision to provide only prospective loss cost information—not advisory rates—will mean more work for insurers, agents and regulators, experts say.

And, the cost of the support services—like actuarial advice—that will be required by insurers to develop their own rates will likely be passed on to insurance buyers, the experts predict.

"Operationally, getting loss costs instead of rates means insurers will have to do more work," said Michael Fusco, executive vp of ISO, during a teleconference earlier this month sponsored by the Society of Chartered Property & Casualty Underwriters and produced by the Insurance Television Network.

"It is one thing to build rates from loss costs for a couple of lines of business in a few states. It's another to have to do this for every line of business in every state," said Victor D. Lincoln, executive vp of New York Casualty Insurance Co. in Watertown, N.Y.

"The flow of paper alone is sufficient to add costs to an already burdened state regulatory system dealing with financial and market conduct questions," added Michael A. Walters, vp and principal at the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in New York.

ISO decided to stop providing fully developed advisory rates in response to assaults on the insurance industry, such as the antitrust suit filed by 19 state attorneys general and "congressional assaults" on the McCarran-Ferguson Act, explained ISO President Fred R. Marcon (see story, page 1).

"Our goal, which I believe we've achieved, was to make advisory rates a non-issue—and let the property/casualty industry get on with its job," he said.

Prospective loss costs are estimates of the amounts insurers will pay for future claims and related claims adjustment expenses, including legal defense costs.

"This information is the basic information companies need to price their product accurately and competitively," explained ISO's Mr. Fusco.

Currently, ISO provides rates that consist of prospective loss costs plus selected provisions for marketing and overhead expenses for profit and contingencies.

But without ISO advisory rates, insurers will now have to:

- Evaluate whether their loss costs are significantly different from ISO's average loss costs.
- Determine their own expense needs.
- Determine their own profit and contingency requirements.
- Combine these elements into a gross rate.

Developing rates individually will be costly, the panelists agreed.

"The additional staff required to accomplish the increased size of the task is probably the greatest immediate expense," said Mr. Lincoln.

"The clerical personnel represent a cost, but are obtainable. But I wonder about the skilled underwriters and technicians who will be needed to evaluate rate levels? These people are in short supply," he added.

Small insurers will be particularly affected by ISO's move to loss costs because they do not have the staff necessary to develop rates, he said.

"No doubt, some carriers will find it necessary to secure some level of actuarial services at some point. This will add to expenses," he said.

However, the change to loss costs does not mean the demise of small insurers, Mr. Lincoln asserted.

"Advisory rates were discontinued in favor of projected loss costs for the homeowners and personal auto lines in about a dozen states several years ago. The small companies in those states seem to be doing as well today as they were when advisory rates were available to them," he said.

However, "commercial lines may be another matter. Obviously, if the small carriers write principally personal insurance coverages, their data bases with respect to their commercial writings are, indeed, very small," Mr. Lincoln said.

ISO's change to loss costs also will put a significant burden on insurance regulators, who will be hit with rate filings from every insurer for every line of business, others participating in the teleconference agreed.

"In particular, those states operating under so-called prior approval laws may face a 'culture shock' of vast magnitude," said Mr. Lincoln.

"When companies can't use an advisory organization to evaluate the changes, whether it be in coverages or rating procedures, that could also put great stress on the regulatory filing system," said Tillinghast's Mr. Walters.

Premium taxes may have to be increased to generate the funds necessary to support the increased workload at state insurance departments, he suggested.

However, Robert A. Miller, deputy commissioner in the Virginia Bureau of Insurance in Richmond, said the National Assn. of Insurance Commissioners has equipped regulators with loss cost reference filing forms that will make it easier to process rates.

"These forms allow an insurer to file rates by referencing the prospective loss costs filed by an advisory organization and indicating the multiplier which should be used to adjust the referenced prospective loss costs to determine the ultimate rate," he explained.

In addition, most states have either implemented loss cost procedures or are in the process of doing so, he pointed out.

Agents also will be affected by ISO's decision since it will be difficult for them to compare rates from several insurers when all they have to work with is raw loss cost data, pointed out Tom W. Clark, president of Clark Insurance Services, an independent agency in Miles City, Mont.

John M. Purple, vp and actuary at Aetna Life & Casualty Co. in Hartford, Conn., agreed.

"They may have to take the ISO loss cost and multiply it by the loss cost multiplier and deviation factor that the insurer has provided. Only after doing the calculations will the agent be able to see which rate is better," Mr. Purple said.

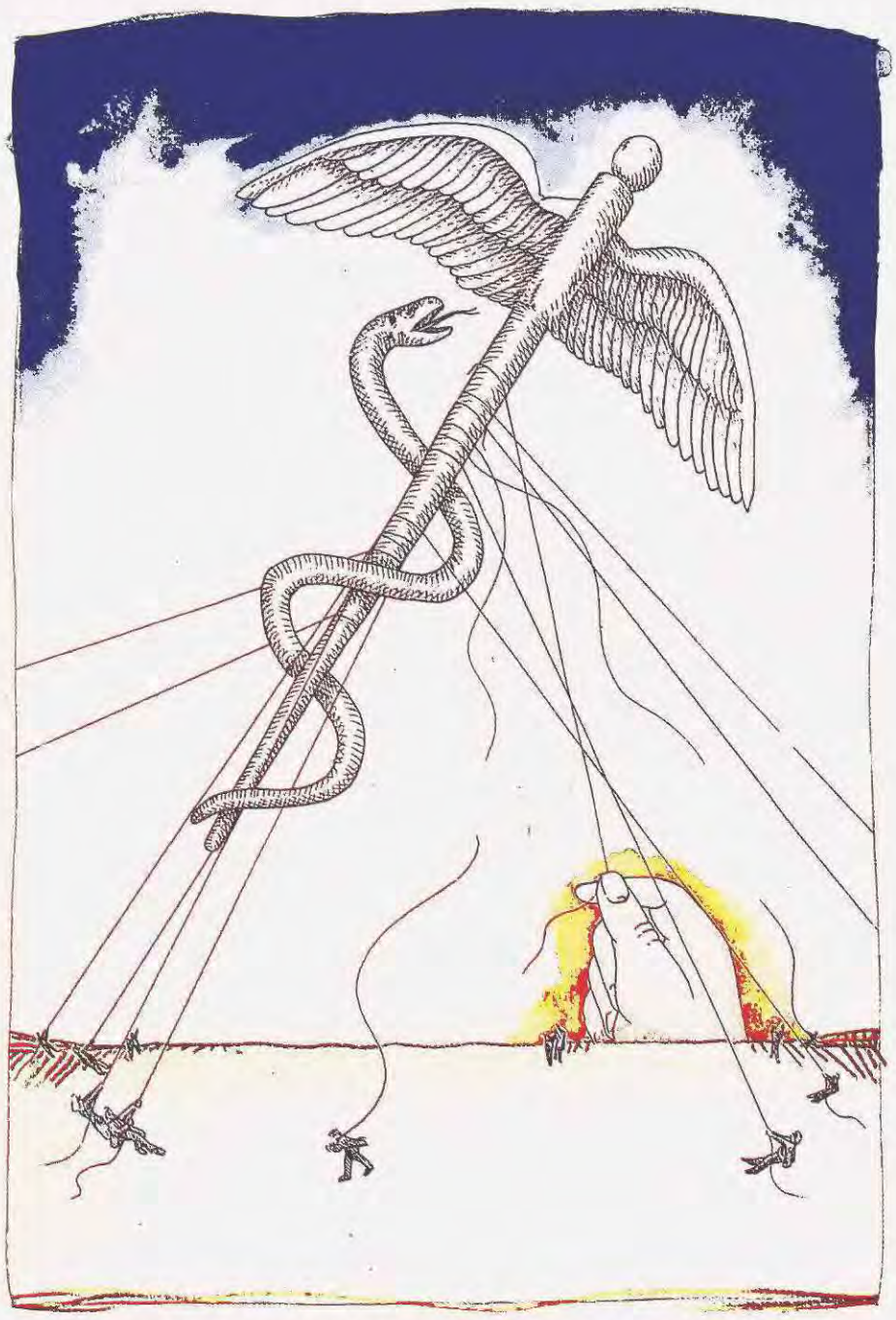
Loss costs will be phased in to coincide with ISO's normal experience review schedule for each line of insurance serviced, ISO's Mr. Fusco explained.

Loss cost filings for personal auto began in April. Commercial auto filing begun this month, while loss costs for general liability insurance will be filed beginning in October. Homeowners filings are scheduled for February 1991 and commercial fire and allied lines filings are scheduled for October 1991. Loss cost filings for all remaining lines will begin during 1991 and 1992, he said.

However, ISO will continue to file advisory rates for 1990 for all lines of business that are not scheduled to be converted to prospective loss costs until later, Mr. Fusco stressed.

The panel was moderated by Richard L. Katten, president of the Society of CPCU and executive vp of Ferd Marks Insurance Agency Ltd. in New Orleans. ■

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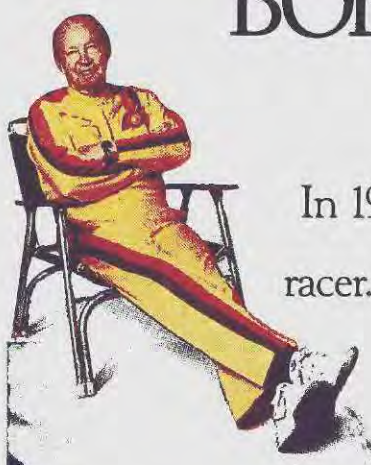


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GM execs' pension hike angers union

By MICHAEL SCHACHNER

Many top General Motors Corp. executives will receive additional supplemental retirement benefits following overwhelming approval by GM stockholders of a new pension calculation formula.

But, the boost to executive pensions has drawn intense criticism from the United Auto Workers union, which vows to fight for increased pension benefits for its members during contract negotiations later this year.

The new calculation formula could boost executive pensions under the automaker's non-qualified defined benefit pension plan by up to $41.6 million in 1990, GM said.

For example, under the new formula, Chairman Roger B. Smith's supplemental pension plan benefit would rise to more than $1.2 million from about $750,000 annually, a GM spokesman said.

The spokesman could not say how many of the more than 3,300 top-level executives are eligible for the richer pension benefit.

The new formula was outlined in GM's proxy statement and approved by 83% of shareholders.

Under the new pension calculation formula, GM executives who are at least 62 years old, have 10 years of service with GM and retire after Nov. 1, 1989, will have the option of receiving pension benefits based on their total direct annual compensation—including incentive bonuses—rather than just salary.

Benefit beat

The pension benefits of eligible executives will be calculated using an average of their highest annual total direct compensation, including bonuses, for five of the 10 years ending on Dec. 31 of the year before the executive retires. This figure then is multiplied by years of service and 1.5%.

Benefits had been calculated using an average of the highest annual direct compensation, excluding bonuses, for five of 10 years immediately preceding top executives' retirement. This figure then was multiplied by the number of years of service and 2%.

This option is still open to GM executives. Those with low bonuses would receive a higher pension benefit under this formula.

GM proposed the modified pension benefit calculation to be consistent with other large companies throughout the country, the spokesman said.

In its proxy statement, GM said pensions for its executive group ranked in the bottom 21st percentile among a group of large companies it surveyed.

And, "surveys over the last several years of other industrial companies have shown that many companies based the pensions of executives on the total direct compensation package rather than on just the base salary, as has been the case under the current GM Salaried Program," GM said.

However, the UAW calls the pension increases "unjustifiable," saying GM executives were "already overpaid."

"General Motors is unable to find any justification for this outrageous move because there just isn't any way to justify it," said UAW Vp Stephen P. Yokich.

"Everyone realizes GM is confronting numerous competitive issues, but we'd be surprised to learn that competitive pensions for over 3,000 extremely well-compensated executives is one of them," he said.

"We didn't win this fight, but we have served notice that the days when GM could talk out of both sides of its mouth about sacrifices and restraint in the face of global challenges are coming to an end," Mr. Yokich said.

"Later this year, we'll be bargaining with the corporation for hundreds of thousands of retired auto workers, many of whom are facing a real income squeeze and all of whom are hard-pressed in comparison with the privileged manager group," Mr. Yokich said.

"In view of the company's largesse to its executives, there will be no excuse for the corporation to be less than fully responsible to the needs of our older members and retirees," he said.

Benefits survey

Approximately 85% of U.S. workers are satisfied with their health care benefits, and 32% would pay up to $25 more per month to maintain their current benefit plan, according to a survey commissioned by Northwestern National Life Insurance Co. of Minneapolis.

However, 39% of workers would object to paying even a dollar more to maintain those benefits, according to the survey of 606 full-time employees throughout the country, which was conducted by Winona Market Research Bureau Inc. of Minneapolis.

Seventy percent of respondents said the amount their employer currently contributes toward their health insurance is "about right."

However, 43% said they do not know what portion of the cost their employer pays.

Many respondents also did not know all of what their health care plans cover. For example, 53% said they did not know whether catastrophic claims were covered.

Half said they receive first-dollar health care coverage from their employers and are not required to contribute to coverage costs.

Respondents also were asked what changes they would most like in their health care plans:

- 32% said lower costs.
- 25% said broader coverage, especially for routine doctor visits, dental care and prescriptions.
- 9% said freedom to choose providers as well as fewer restrictions on access to providers, such as precertification.
- 21% said they would make no changes.

The survey also found that many employees view health benefits as an entitlement.

For example, 80% said employers have an obligation to provide health care benefits to workers; 70% said that obligation extends to providing health care coverage to dependents; and 70% said that employers should extend health benefits to retirees.

Survey results are contained in NWNL's "Employee Satisfaction with Health Benefits" report. A free copy can be obtained by writing to Marsha Johnson, Northwestern National Life Insurance Co., P.O. Box 20, Minneapolis, Minn. 55440; 612-342-7137. ■



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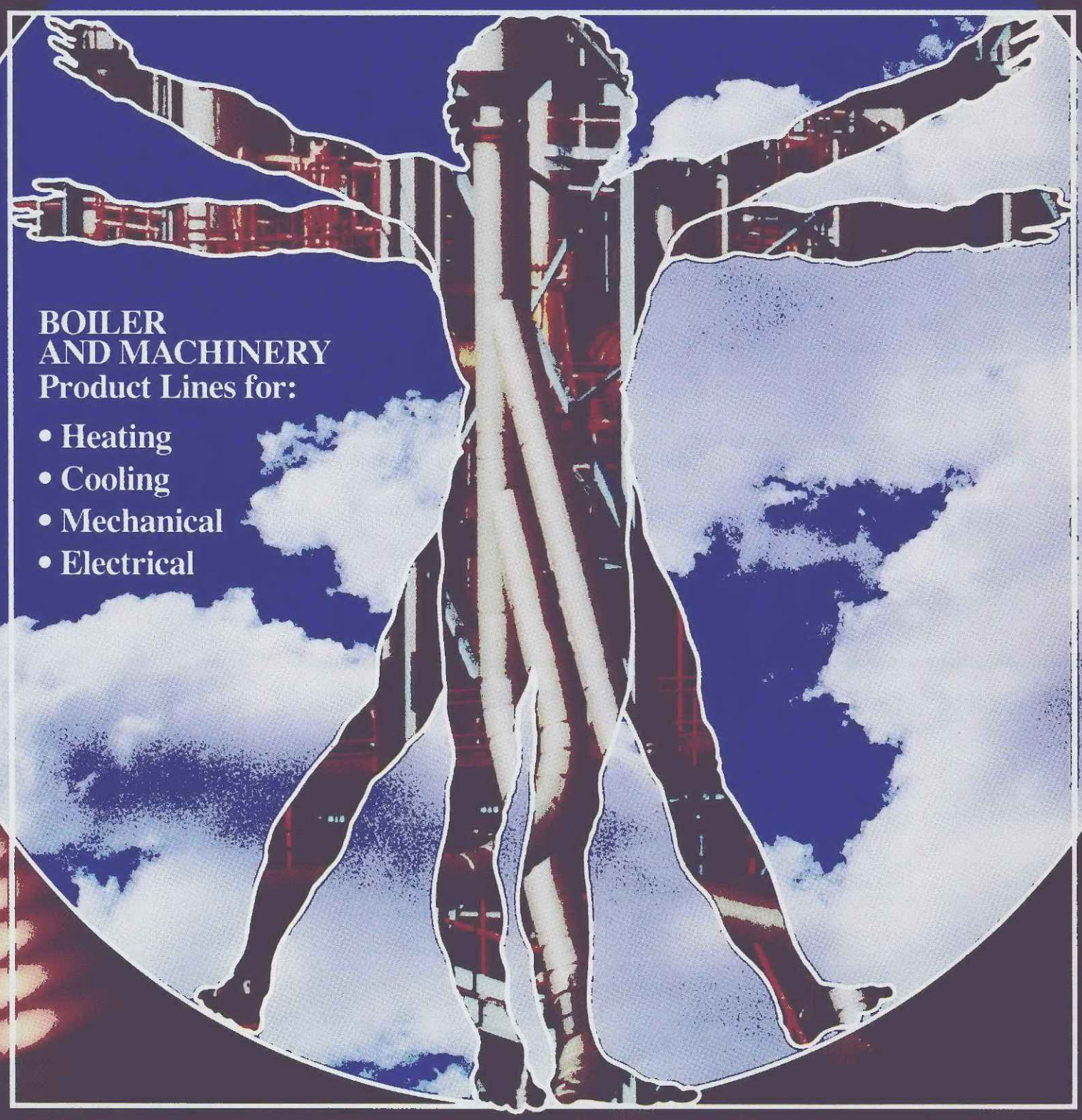
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Opinions

Don't dodge oil spill threat

WHILE AVOIDING RISK is one of the key principles of risk management, simply dodging a risk sometimes is not the best way to go.

Case in point: the decision by the Royal Dutch Shell Group of Companies earlier this month to halt shipments of crude oil on its own tankers to and from U.S. ports other than a Louisiana offshore oil terminal (*BI*, June 18).

The decision was made two days after the tanker KS Mega Borg II caught fire in the Gulf of Mexico and threatened to spill its entire 38-million-gallon cargo. Environmental damage from the Mega Borg catastrophe appears to be limited.

Shell says it decided to use chartered tankers, rather than its own fleet, to carry oil to and from U.S. ports partly because the United States refuses to sign international conventions limiting the oil spill liability of ship and cargo owners. As a result, a shipowner involved in an oil spill "may face largely uninsurable exposure to claims which far outweigh the potential commercial reward for such trade," Shell says.

But we wonder if Shell is really saying that operating oil tankers in U.S. waters is not worth the public relations black eye that oil spills can cause. Witness the experience of Exxon Corp. following the Exxon Valdez disaster a year ago. And, we wonder if, in this case, Shell's efforts to avoid risk is really good risk management. While protecting its own bottom line, is Shell protecting our coastlines?

Shell is not alone: Industry analysts say that other oil companies are considering using only chartered tankers to carry oil to U.S. ports.

If a huge company like Shell, the world's ninth-largest in terms of sales, concedes that it cannot adequately prevent oil spills, we doubt that smaller shipping companies without comparable resources or risk management expertise can do any better.

So, instead of dodging this risk, Shell and other large oil companies—which profit handsomely from the oil that flows into the United States by tanker—should strive to find ways to reduce the risk of an oil spill and the subsequent contamination of the environment and huge liability claims. To us, that's real oil spill risk management.

Some oil companies are doing just that.

ARCO Marine Inc., a subsidiary of Atlantic Richfield Co., is adopting a tactic 180-degrees from Shell's strategy: Oil it owns will be transported whenever possible on ARCO-owned ships, rather than on chartered vessels, despite the primary liability that befalls a tanker owner when an oil spill does occur.



The company says that it feels it can control the risk of an oil spill better than another party, thus giving it more control over its liability exposures.

Of course, oil companies without extensive fleets must still use chartered tankers. However, companies that do charter other ships should make sure that the tanker owner has adequate pollution liability insurance to ensure complete and responsible cleanup following a spill.

Despite our previous remarks, we salute Shell, which in February said that it would contract only with shipowners that purchase the full $700 million in pollution liability insurance now available through protection and indemnity clubs worldwide (*BI*, March 5).

The problem of spilled oil polluting our water, fouling our beaches and harming animal life will not go away. Oil companies, which profit from our society's thirst for oil-generated energy and other petroleum products, should not turn their backs.

Letters

"Tax penalty" on B.C. captives misleading

To the editor: I have recently reviewed your April 30 issue and would like an opportunity to clarify certain comments in the article entitled "Tax Hurts British Columbia." In particular, I believe the article leaves a false impression that there is a tax penalty on incorporating a B.C. captive.

I am not a tax expert and do not intend to provide tax advice. I do, however, have some understanding of the Canadian tax rules.

The vast majority of captive business relates to writing related company risks. For Canadian companies writing predominantly Canadian-domiciled risks (some foreign risk would be OK), the Foreign Accrued Property Income rules would tax the profits of the captive no matter where it was domiciled. Indeed, any onshore jurisdiction will tax the profits of the captive, Vermont included.

For those situations where the FAPI rules do not apply—i.e., non-related business—an offshore jurisdiction may provide certain advantages. It is, however, misleading to make the blanket statement contained in the article's headline. Each case would have to be judged on its merits. In fact, the deductibility of the premium and the ability to claim loss reserves may be significant improvements over the U.S. situation.

Another issue raises the acceptance of B.C. captives by the other provinces. What is the difference between a B.C. captive and a Bermuda captive in the eyes of the other nine provinces? None. They are both considered unlicensed insurers.

Indeed, if the other provinces did accept a B.C. captive as a licensed insurer, there would be a distinct advantage to forming a B.C. captive as the program could be written direct, avoiding fronting fees altogether.

In the meantime, this issue should have absolutely no bearing on the decision as to which captive domicile to consider. The captive program will simply have to be fronted, no matter where the captive is domiciled.

In conclusion, for any Canadian parent company that is considering a captive program for predominantly Canadian-domiciled related-party risks, British Columbia is an attractive alternative.

Unlike Bermuda, we have not been plagued by increases in operating costs and do offer a cost-effective alternative. Travel costs, accommodation costs and operating expenses are considerably reduced.

Another major benefit for those companies that plan on reinsuring some of the risk offshore is that the federal excise tax of 10% would not be applicable to any reinsurance premium paid by a B.C. captive.

I would like to correct some other common misconceptions about British Columbia as a captive jurisdiction. I believe the lack of captive activity in British Columbia is due to the soft market and, based on all the other reports in the April 30 issue, this lack of activity is happening all over.

Unfortunately for British Columbia, the soft market hit just when the captive legislation was enacted. I expect to see considerably more interest in British Columbia when the inevitable market turn occurs. In fact, we currently are working on two new prospects that are very interested in setting up in British Columbia.

And, finally, there was a factual error regarding new B.C. captive formations. Pengins International Corp.'s parent company is UMA Group Ltd.

William J. Morgan
Vp
Alexander Insurance Managers
(Canada) Ltd.
Vancouver, B.C.

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HMOs seek to improve health care accessibility

By JOANNE WOJCIK

LOS ANGELES—The public and private sectors must cooperate to ensure that all Americans have adequate health care coverage, health care experts say.

But, the health care industry—including health maintenance organizations—should make the first move in this cooperative effort if it is to have any control over its own destiny, they add.

GHAA

"We cannot assume an ostrich-like stance," said James Walworth, chairman of the Group Health Assn. of America, an HMO trade group, in a keynote address at its annual Group Health Institute June 10-13.

"We have a responsibility to work on the real issues which plague us today. We must participate in programs designed to alleviate the plight of the uninsured fairly and fully with all payers and providers," said Mr. Walworth, who also is president of the Health Alliance Plan of Michigan, a Detroit-area HMO.

Other experts at the conference said a universal health care system should combine the best elements of the U.S. and Canadian health care systems: the quality assurance and cost control innovations of managed care developed in the United States and the universal accessibility to health care under the Canadian health system.

However, if the HMO industry takes a passive role, it may be forced to succumb to state-mandated benefits, proposals to establish a national socialized health care system and stepped-up regulatory pressures on underwriting practices, others at the GHAA conference said.

"If a competitive system is going to survive and be part of the solution, insurers will have to stop the practice of selective underwriting," said George Halverson, president and chief executive officer of Group Health Inc., a Minneapolis-based health maintenance organization.

"We believe that medical underwriting of employed groups is wrong and that efforts must be made to offer care—prepaid and fee-for-service—to small groups," agreed Mr. Walworth.

Mr. Walworth believes rates should be spread more evenly among large and small groups regardless of experience rating.

John Ramey, deputy secretary for program and fiscal affairs in the California Health and Welfare Agency in Sacramento, concurred: "There has to be, at least in the small group market, insurance reform" to provide "guaranteed issuance, guaranteed renewability and rate banding for like groups with the band not having a disparity of more than 30%."

In fact, insurance underwriting reforms already are being considered by the California Legislature, Mr. Ramey said.

And, in Minnesota, lawmakers have formed the Minnesota Comprehensive Health Assn. to provide coverage to individuals who have been rejected by one or more insurers, according to Mr. Halverson.

A couple of states are confronting the problem of uninsured Americans by passing legislation mandating employers to provide a minimum level of health care benefits to workers.

Continued on page 11

At issue

Should the federal government or individual states require health plans to cover certain procedures?



Gary P. Yeaw
Director-group insurance
Allied Signal Inc.,
Morristown, N.J.

A national mandated benefits standard would certainly be more consistent and less administratively complex. It may also be less vulnerable to influence by special interest groups. However, under either scenario, one must be concerned about how mandated benefits may affect the competitive position of companies within different industries.



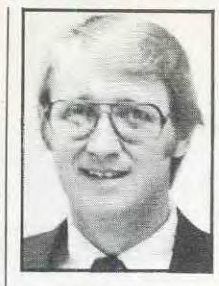
Cathryn C. Lewis
Employee benefits director
Globe Newspaper Co.,
Boston

A national minimum benefit package would allow employers with multistate locations to standardize their health benefits program. It would reduce the competitive disadvantage faced by companies in states with many mandated benefits. And, companies would have more control in designing a program that best meets their employees' needs.



Janet McCullough
Vp-human resources
Wilson Sporting Goods Inc.,
River Grove, Ill.

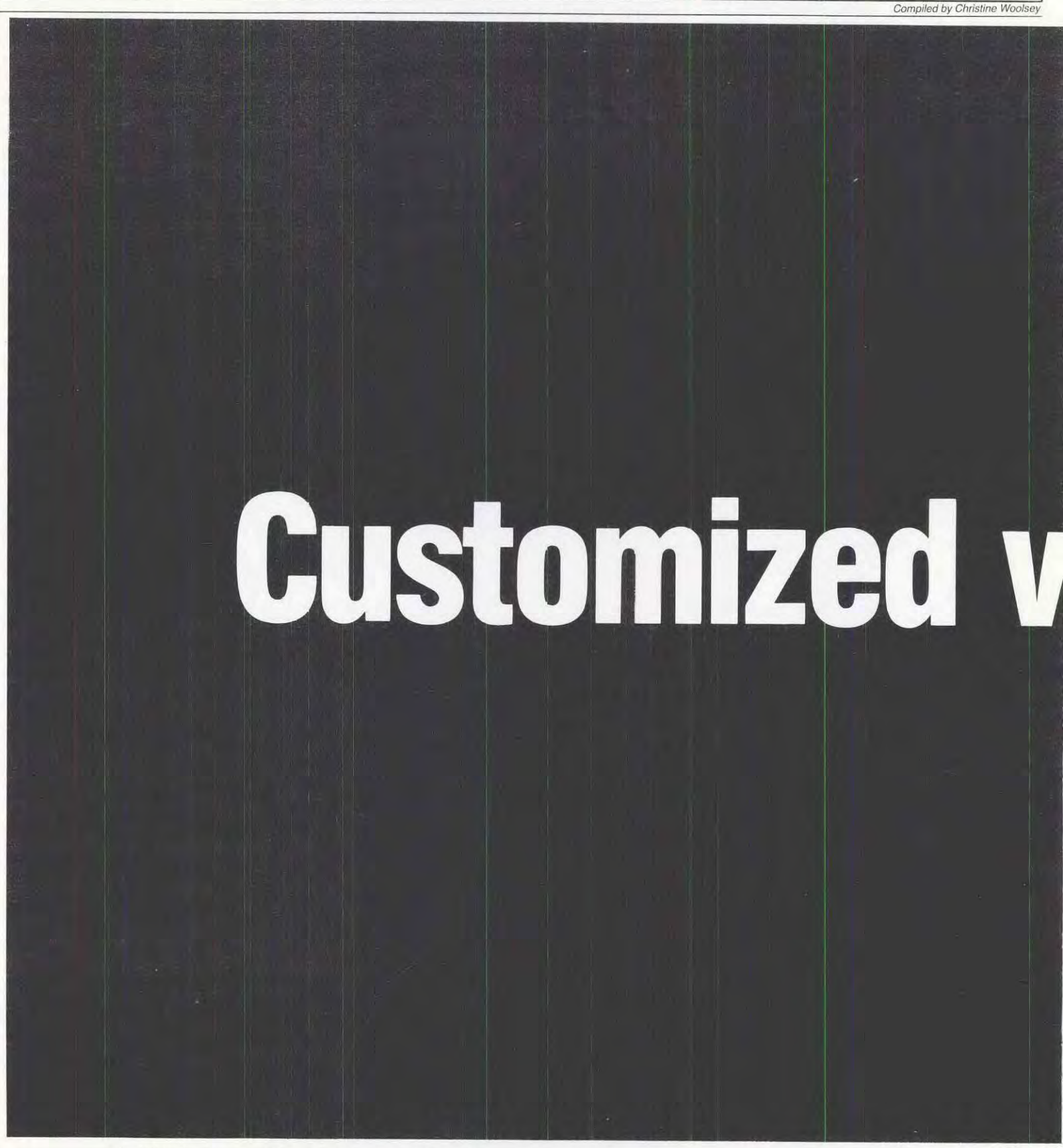
As a company that regularly relocates employees throughout the United States, my preference would be to have consistent, basic guidelines. I can just imagine the complexity of managing benefits for employees scattered around the nation if each state set its own basic level. Isn't benefit life complicated enough?



Robert C. Penzkover
Director-employee benefits
The Quaker Oats Co.,
Chicago

As a company that does business in virtually every state, I'd have to favor a federal standard. We've found the state mandates that currently exist are a nuisance. Quaker complies with the state mandates and our health benefits generally exceed state standards. But each time a state institutes a new standard, we have to adjust our plans.

Compiled by Christine Woolsey



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Health care access

Continued from page 10

For example, a universal health care law in Massachusetts imposes a $1,680 tax on employers that do not provide at least $1,680 of health care benefits to employees. However, a legislative battle may be brewing in the state over the future of the law (*BI*, May 28).

In Oregon, all employers could be forced to offer their workers health care coverage by 1994 unless employers in the state voluntarily offer coverage to an additional 100,000 employees.

And in Hawaii, employers with 20 or more employees have been required to provide a minimum health care plan since 1974.

To ward off further mandates, which could be prohibitively expensive for some small employers, the GHAA advocates that the public and private sector cooperate in developing a universal health care system.

"We will cooperate with our colleagues in other organizations" to eliminate "state-mandated benefits which emanate from the power of state lobbying organizations rather than from soundly reasoned policy," said the GHAA's Mr. Walworth.

The GHAA already has undertaken such initiatives in the Medicaid area, having developed a set of recommendations to make HMO membership more accessible to those on public aid, Mr. Walworth said.

Other approaches touted at the conference include a cooperative effort between Washington state and the Group Health Cooperative of Puget Sound and the Social HMO pilot long-term and acute care insurance program, which combines the managed care aspects of HMOs with public and private financing (see story, page 16).

While the Seattle-area project, launched in 1987, is providing acute care coverage to only 25,000 of the state's estimated 500,000 working poor, it is a step in the right direction, according to James Dinan, special account executive for the Seattle-based Group Health Cooperative, an HMO.

In addition to Group Health, other participating HMOs are Group Health Northwest in Spokane, Wash., Pacific Health in Seattle and Good Health Plan of Washington in Settle.

We shouldn't have to pay for a 'health care system gone haywire,' says Ms. Novotny.

Several Seattle-area preferred provider organizations also participate, including Pierce County Medical/Blue Shield, Callam County Physicians, and Columbia Health Services (Blue Cross/Blue Shield of Oregon).

The program, called "The Washington Basic Health Plan," is 18% funded with premiums paid by participants, with the remainder coming from the state's general fund, Mr. Dinan said.

Under the program, physician office visits are paid 100% after a $5 copayment.

Other services for which a copayment is required are hospital stays, which require a $50 per-stay copayment, and emergency room visits, which call for a $25 copayment.

The program emphasizes preventive care by paying 100% of fees for lab services, X-rays and other preventive medical services, Mr. Dinan said.

Assuring coverage for preventive health care services is one of the goals of the federal Health Resources and Services Administration in Rockville, Md., according to Ron Carlson, association administrator for plan evaluation and legislation.

Mr. Carlson outlined a five-point plan to provide all Americans with health care coverage:

- Establish cooperative agreements between federal and state governments to finance and provide health care services.
- Identify federally qualified health centers, which would be reimbursed based on "reasonable cost," such as the diagnosis-related groups formula used by Medicare and Medicaid.
- Increase the number of health care professionals administering care at those centers.
- Offer medical education training programs to communities through the health centers.
- Assure preventive care services throughout the country's health care delivery system by the year 2000.

Mr. Carlson urged private sector involvement in publicly administered plans because many of the uninsured will not use federally qualified health care centers if they believe the centers' chief goal is to provide care for the poor.

"Having a primary care organization as part of a delivery system that is essentially a privately acceptable way of delivering care is a very important psychology to have working in a community," he said.

But while the current U.S. health care system is flawed, the Canadian system is not necessarily the answer, many health care experts at the conference concurred.

For example, although the Canadian system provides universal access to health care, it has not made the strides toward controlling costs that the private U.S. system has, the GHAA says in a position paper handed out at the conference.

The managed care system in the U.S. "is based on an integrated system which rewards cost-effective delivery of quality care (with) a total set of comprehensive benefits," the paper states. "Organized delivery systems use savings achieved from prudent hospital and ambulatory utilization to fund expanded benefit packages which are appealing to consumers."

However, "in Canada, this system of integrated private sector incentives is lacking," the paper notes. "Instead, the Canadian system relies on a variety of regulatory provider controls with no focus on the appropriateness of the overall allocation of resources or service mix."

While the idea that a health care system could be formed combining the best of all possible worlds seems utopian at best, many health care experts at this year's GHAA conference believe it is worth a try.

"It's important to establish a beneficial relationship with government," said California's Mr. Ramey. "The government is willing to be responsive to a fair argument."

Even the Communication Workers of America, after having won its long, hard fight over benefits by striking numerous telecommunications companies across the country last summer (*BI*, Aug. 14, 1989), has passed a resolution calling for a national health care policy administered by the federal government and funded by individual and corporate income taxes, said Louise Novotny, CWI's health policy adviser.

"We spend more on health care than other countries, but 25% more Americans had no access to health care by the end of the 1980s than at the beginning," Ms. Novotny asserted.

Employers and individuals "should not have to pay for a health care system gone haywire," she said. "Someday, somewhere down the line, something will have to give," Ms. Novotny said. "It's a national problem that requires national solutions." ■



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Health plans urged to assess liability

By JOANNE WOJCIK

LOS ANGELES—Recent court rulings holding managed care plans liable for patients' injuries make it easier for health maintenance organizations, preferred provider organizations and employers that self-fund their health care plans to assess their liabilities, an attorney says.

However, managed care providers and payers shouldn't sit back and take whatever the courts hand them, says Sally Spong, a health law specialist with Michaels & Wishner of Washington, D.C.

HMOs, PPOs and self-funded employers should step up quality assurance efforts, regularly check physician credentials and spell out in plan documents the relationships between those doctors and the plan, Ms. Spong advises.

She also urged health care providers and payers to back legislation to limit some liabilities associated with managed care.

GHAA

The recent legal developments "give plans some ability to determine their liabilities and take appropriate actions to protect themselves," Ms. Spong said at a health law session at the Group Health Institute. The conference, held June 10-13 in Los Angeles, was sponsored by the Group Health Assn. of America, an HMO trade group in Washington, D.C.

Among the areas in which courts have expanded managed care provider and payer liability are:

- Liability for patient injuries resulting from a plan's utilization review decisions.
- Vicarious liability for malpractice committed by contracted providers.
- Malpractice liability involving physician incentive arrangements.
- Corporate negligence if the managed care firm fails to check physician credentials, review care and monitor provider performance.

"Although this phenomenon may be more pronounced in the HMO context, it also extends to other payers," such as employers, "who have adopted the utilization and case management controls typically employed by HMOs, and particularly where financial incentives exist for the insured to secure services from a contracted network of providers," Ms. Spong said.

A decision holding a payer liable for an injury resulting from a UR decision has been overturned (*BI*, Oct. 23, 1989; Sept. 19, 1988).

But that landmark 1986 ruling—in *Wickline vs. California*—should still stand as a warning to managed care plans, Ms. Spong said.

The trial court ruled that if defects in a UR process result in inappropriate decisions, the payer can be held liable for resulting injuries, she said.

A plan enrollee alleged that the state of California negligently discontinued her eligibility for Medi-Cal, the state's Medicaid program, by denying her physician's request for a hospitalization extension.

As a result, Lois Wickline suffered post-operative complications that necessitated the amputation of her leg. She was awarded $500,000.

However, an appellate court reversed the decision in 1989, saying that the physician was ultimately responsible.

Managed care plan sponsors also must be careful that their UR criteria are not too restrictive, Ms. Spong said.

For example, in *Hughes vs. Blue Cross of Northern California*, a California court in 1988 found that a UR decision, based on standards of medical necessity that were significantly more restrictive than community standards, constituted bad faith, she said.

Plan sponsors can even be held liable if they fail to evaluate thoroughly all medical information before making a UR decision, Ms. Spong pointed out.

In the 1987 Alabama decision in *Aetna Life Insurance Co. vs. Lavoie*, a payer's decision to limit or deny treatment for the enrollee, which was made prior to complete review, was found to constitute bad faith, Ms. Spong said.

"That kind of case emphasizes the importance of reviewing all pertinent medical information when conducting UR," she says.

HMOs also are increasingly being held liable for the actions of doctors with whom they contract, even though these physicians are not HMO employees, Ms. Spong pointed out.

In *Boyd vs. Albert Einstein Medical Center*, a Pennsylvania court in 1988 found that an independent practice association model HMO could be held vicariously liable for the malpractice of an independent contractor physician. According to the court, marketing materials, credentialing activities and referral practices of the HMO could lead an enrollee to perceive the HMO as his health care provider and the doctors as its agents, Ms. Spong explained.

Financial incentives for controlling patient use of specialists and referral services also can pose risks for managed care plans, she pointed out.

In *Schleier vs. Kaiser Foundation Health Plan*, a District of Columbia court in 1989 found the HMO liable for the malpractice of an outside consultant physician to whom a primary care physician in the plan had referred a patient.

The court said the plan had "some ability" to control the referral physician through the primary care physician, she explained.

No appellate court has ruled that a managed care plan may be held liable for the malpractice of a participating physician based on payment arrangements, Ms. Spong said. But at least one trial court permitted such a malpractice claim to be submitted to a jury.

In *Bush vs. Dake*—a 1989 case in Saginaw County, Mich.—the plaintiff alleged that the HMO's capitation and risk pool arrangement delayed her referral to a specialist for a pap smear test.

"She claimed that if she had received the referral and tests on a timely basis, her cancer would have been diagnosed at an earlier stage," Ms. Spong said.

The doctrine of corporate negligence also has been expanded to include HMOs in a 1989 Missouri appellate decision, according to Ms. Spong.

In *Harrell vs. Total Health Care Inc.*, the court found that an IPA model could be held liable under the doctrine of corporate negligence for the alleged malpractice of a referral physician used by the plan on the basis that the plan had a duty to adequately check the credentials of its physicians and failed to make any investigation into the physician's background.

Erling Hansen, GHAA general counsel, moderated the session.

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HMOs moving into claims administration

By LOUISE KERTESZ

LOS ANGELES—Health maintenance organizations are increasingly offering claims administration services to employers that self-fund their group health care indemnity plans as a way to entice employers to contract with the HMO.

HMOs that offer third-party administration services to self-funded employers can tout their experience as managed care vendors to attract clients, HMO experts say.

However, HMOs that decide to enter the TPA business must make difficult organizational changes and expand their capabilities and services, HMO executives say.

But that challenge has not deterred many HMOs, hungry for market share, from adding TPA services.

"More than 30 HMOs already offer TPA administrative services of various levels of sophistication (and) more are entering the market this year," said David E. Kelleher, president of Healthcare Options Inc., a consulting firm in Indianapolis.

GHAA

Mr. Kelleher spoke at a session entitled "Is There a TPA in Your Future?" at the Group Health Institute earlier this month in Los Angeles. The conference, which attracted HMO executives and others interested in managed care, was sponsored by the Group Health Assn. of America.

When an HMO offers TPA services, it may "use its cost-conscious delivery system" to develop products for indemnity plan clients, like preferred provider organizations, "that broaden its appeal to employers," Mr. Kelleher said.

HMOs can also use "the expertise that they've developed in managing care and contracting with physicians to reduce (an employer's) total health care costs," Mr. Kelleher said.

However, when an HMO offers TPA services to its employer clients, employers can expect a new kind of relationship with the HMO, Mr. Kelleher said.

For instance, the HMO acting as a TPA advises the client on how to structure its indemnity plan in addition to offering its own health plan option, Mr. Kelleher said.

HMOs need to develop special skills and capabilities to offer TPA services to employers, said Nancy Leaming, senior vp and chief operating officer at Tufts Associated Health Plan in Waltham, Mass., who also spoke at the session.

Ms. Leaming explained that Tufts Associated Health Plan is a holding company that is composed of an HMO, a PPO, a managed workers compensation program and an insurance brokerage. The HMO and PPO share the same provider network.

Tufts "got into the TPA business because we wanted to be a diversified managed care corporation. Developing a TPA was the first major initiative toward that goal," she said.

As a TPA, Tufts signed on its first indemnity plan client, the Roman Catholic Archdiocese of Boston, in October 1986. "We have been very successful in reducing their health care costs, which had been increasing at exponential rates," Ms. Leaming asserted.

Tufts' experience in establishing itself as a TPA illustrates "the financial and operational issues you will face if you form a TPA," she said.

For example, HMOs seeking to offer TPA services must convince employers "that paying a little more for truly managed care will reap rewards."

The HMO's sales staff will need to become "knowledgeable and confident enough. . .to enter into discussions about risk, reinsurance, underwriting techniques and the impact of utilization review on claims experience," Ms. Leaming said.

The HMO might consider marketing its TPA services through a broker, "but not until your systems and product are well-defined and working very efficiently," she cautioned.

The HMO also can consider offering ancillary products, like life insurance and disability insurance, "to provide the benefit of one-stop shopping for the employer," Ms. Leaming said.

HMOs can 'provide the benefit of one-stop shopping for the employer,' Ms. Leaming says.

"Since your administrative fees will very likely be higher than the essentially unmanaged TPA that is competing against you, you will need to emphasize to your prospective client what this premium price will do for the employer over the long run," Ms. Leaming emphasized.

The HMO that offers TPA services to employers must also evaluate whether the size and location of its provider network "has adequate market appeal," and whether the providers are flexible enough to accommodate multiple-option benefit packages.

The HMO must then adapt its management information systems to provide the kinds of reports employers expect of their TPAs. "Self-insured accounts are interested in tracking information differently than the employer that contracts with an HMO" she explained.

For instance, an employer offering a PPO option to its indemnity plan will want the TPA to be able to report on the dollars and number of services generated through preferred providers as compared with other providers.

An HMO offering TPA services to an employer must also address banking and funding arrangements.

The HMO should establish a funding arrangement that will give it "as much control as possible over the timing of payments to providers," she cautioned.

Customer service issues also require considerable planning, she said. To provide good customer service, the HMO must limit the design of benefit packages or implement a computerized customer service system to help its support staff.

Offering a TPA may help an HMO gain market share, Ms. Leaming concluded. But as with any new product offering, it should not be considered lightly because "it will be a drain on your resources." ■

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'Social HMO' project touted for savings

By JOANNE WOJCIK

LOS ANGELES—A hybrid long-term care insurance program combining the managed care aspects of health maintenance organizations with public and private financing can reduce the cost of the coverage, experts say.

GHAA

A pilot project of this type of program, called a "Social HMO," has successfully controlled long-term care costs for employers and individuals in four communities, according to Jeanne Ripley, director of the Minneapolis site.

The pilot project, which is sponsored by Brandeis University, operates under a strong case management system in which case managers perform home assessments, develop care plans and provide a link between home and clinics, Ms. Ripley said at the Group Health Institute sponsored by the Washington, D.C.-based Group Health Assn. of America in Los Angeles June 10-13.

Because spending for long-term care is expected to nearly triple in the next 30 years to $120 billion annually from $42 billion currently, providers of these services must find ways to control costs, said Joshua M. Wiener, an economist at the Brookings Institution in Washington, D.C.

"By joining acute care and long-term care into one system, we offer the possibility of getting greater savings on the acute care side that we can plow into the long-term care side, therefore reducing the incremental cost of providing these new long-term care benefits," Mr. Wiener said.

"Case management makes for a more efficient and coordinated level of care," he said.

'We offer the possibility of getting greater savings on the acute care side that we can plow into the long-term care side, therefore reducing the incremental cost of' new long-term benefits, says Joshua M. Wiener.

And, a joint financing arrangement that incorporates both private and public sector insurance programs would be the best way to finance long-term care coverage, Mr. Wiener said.

The pilot program sponsored by Brandeis University combines all of these elements and has succeeded in controlled long-term care costs for the elderly, according to Ms. Ripley.

The "Social HMOs" created by the five-year demonstration project are similar to those recently called for by the 15-member Pepper Commission, she said.

The Pepper Commission proposed a social insurance program financed through payroll taxes that would coordinate both acute and long-term care needs of elderly Americans, noted Robert B. Friedland, a professional staff member of the commission.

Under the Pepper Commission's proposals, individuals requiring long-term care would not have to prove indigence to be eligible for a federally financed and state-run program. Individuals would be eligible for care if they cannot perform three of five activities considered necessary for daily living.

The Brandeis University project was set up with a capitated financial structure that pools funds from Medicare, Medicaid and premiums paid by enrollees, Ms. Ripley said.

Similar to HMOs formed under the Tax Equity and Fiscal Responsibility Act of 1982, which encourages HMOs to participate in the federal Medicare program, Social HMOs provide a broad range of acute care and ancillary services including those covered by Medicare parts A and B.

"However, the Social HMO picks up where the TEFRA programs stop," Ms. Ripley said. Social HMOs provide "coverage for chronic home-based services as well as short-stay, custodial nursing home care."

Among the home-based services covered are personal care services, adult day care, medical equipment and Lifeline, an electronic device that an elderly person can use to signal for help.

Under the demonstration project, the HMOs provided benefits ranging from $6,500 to $12,000 annually, depending on the site.

Four sites are being used in the project. They are:

- Portland, Ore. The plan there, called Medicare Plus II, is available through Kaiser Foundation Health Plan Inc.
- Long Beach, Calif. The plan there, called SCAN Health Plan, is available through the Senior Care Action Network, a community case management brokerage agency in Long Beach.
- Minneapolis. The plan there, called Seniors Plus, is available through Group Health Inc. and the Ebenezer Society, a Minneapolis-based non-profit organization that provides long-term care services to the elderly.
- Brooklyn, N.Y. The plan there, called Elderplan Inc., is available through the Metropolitan Jewish Geriatric Center in Brooklyn.

There are between 3,000 and 6,000 members enrolled at each site.

Premiums range from nothing in Long Beach to $75 at the Portland site.

So far, service and management costs for the HMOs have averaged $35 per member per month, Ms. Ripley pointed out.

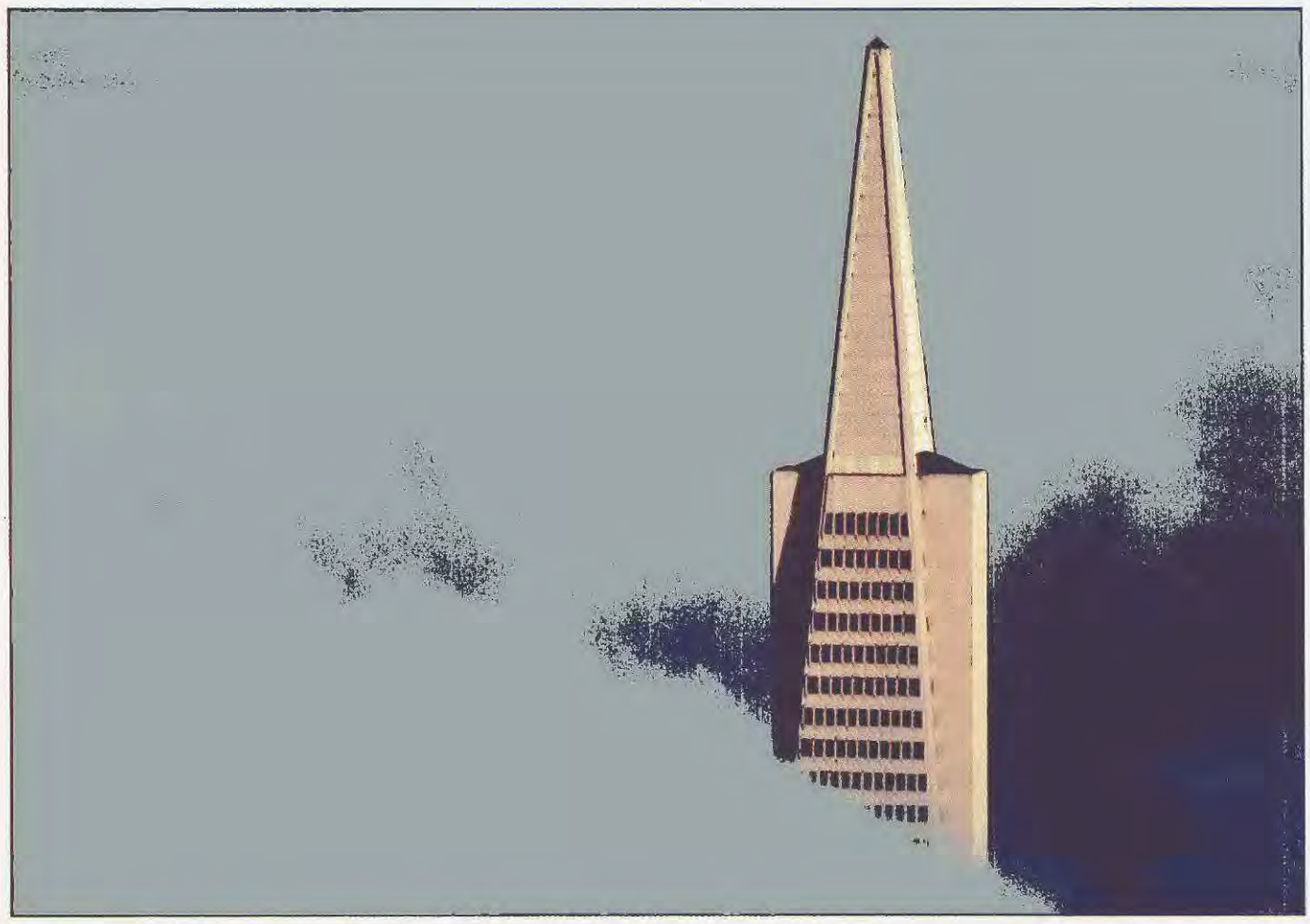
"The results of the last five years of experience by the Social HMOs suggest that this model deserves serious consideration by policymakers who are looking for joint public and private solutions to the delivery and financing of long-term care services to the elderly," she said.

While Mr. Wiener praised the Pepper Commission's recommendations as a step in the right direction, he said Medicare and Medicaid should not be left holding the entire bag.

And the cost of long-term care would be too high if it is financed solely by the elderly population, he said.

The session was moderated by Rick J. Carlson, an attorney with Epstein, Becker & Green P.C. in Washington, D.C. ■

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At long last, doctor finds health care's 'prince'

By LOUISE KERTESZ

LOS ANGELES—A new system of quality management must be adopted by managed care firms if they are to maintain quality care while holding down costs, a doctor contends.

Such a system of "total quality management" has proven successful in Japanese and American manufacturing, noted Dr. Donald M. Berwick, vp of quality of care measurement at Harvard Community Health Plan in Brookline, Mass.

GHAA

In an attempt to hold costs down without sacrificing quality, "health care has been searching for romance for a number of years now," said Dr. Berwick at the Group Health Institute in Los Angeles June 10-13. The institute was sponsored by the Group Health Assn. of America, an HMO trade group in Washington, D.C.

"But so far, no prince. Costs soar, trust continues to erode, and basic quality and value remain unchanged. The frogs keep turning into frogs," he said.

Demand for quality is very loud, but ideas about quality in health care remain vague, Dr. Berwick said. "For managed care, the promise remains unrealized."

American manufacturers in the 1970s and 1980s faced "a set of problems no less severe," as their share of global markets eroded, he noted. American manufacturers realized that their foe was the Japanese achievement of quality, Dr. Berwick explained.

"Through innovative forms of management and organizational activity, the Japanese were systematically improving the reliability, the performance, the durability and the production efficiency of their companies" far beyond levels reached at U.S. firms, he said.

But in a dramatic turnaround, American manufacturing companies have begun the slow process of emulating the Japanese achievement by implementing "techniques of total quality management," according to Dr. Berwick.

Those techniques involve management and production methods "rooted deeply in research and experience, in statistics, engineering, human resource management, psychology and measurement sciences," he said.

"TQM is not a vague set of beliefs, a rhetoric or a religion. It is a collection of disciplined, theoretically informed management sciences and activities, proven in other industries," Dr. Berwick asserted.

Health care managers and leaders are now wondering if these same total quality management methods can also "produce breakthroughs in the area of medical care—or is this just another frog?" he said.

"The managed care industry may be in the early phase of exploring TQM, but leaders are confused about what it is," said Dr. Berwick, citing results of a recent survey of 200 HMO medical directors, 451 physicians affiliated with HMOs and 550 corporate employee benefit executives.

The survey, sponsored by pharmaceutical manufacturer Burroughs Wellcome Co. of Research Triangle Park, N.C., was intended to assess attitudes toward and use of TQM methods in HMOs around the country, Dr. Berwick explained.

The survey's questions were based on a model of "a hypothetical new organization," that would be managed using TQM methods, he said.

The new HMO's attributes, according to Dr. Berwick, include:

- A focus on improving quality and value as the central operating strategy.
- Leadership commitment to that focus.
- A "constant movement" toward meeting customer needs.
- The active involvement of employees in training and implementation of quality improvement activities.
- A focus on the improvement of work processes.
- Use of modern statistical methods of quality control and improvement.
- A commitment to continuous improvement instead of meeting finite standards.
- Active involvement with regulators and policymakers.

"The survey revealed very widespread interest in TQM as a promising strategy for health care," Dr. Berwick said. Respondents believed TQM would "improve care and service and clinical outcomes" at the hypothetical organization, he said.

In addition, respondents predicted TQM would boost staff retention by raising the morale of the HMO organization as it has in manufacturing companies, he added.

Total quality management is a breakthrough, not 'just another frog,' says Donald Berwick.

But the respondents "showed less confidence in the ability of TQM to control costs, utilization or malpractice risk," Dr. Berwick said. This response was "rather odd," he said, noting that TQM has achieved cost control in manufacturing.

As for using TQM methods in their own organizations, HMO medical directors "overwhelmingly" say their companies are placing "a great deal of emphasis" on TQM, Dr. Berwick noted.

When the HMO medical directors were asked which specific aspects of TQM were present in their organizations, their responses indicated that while they were committed to quality management, there was little actual use of the technical and procedural steps in place at the hypothetical organization, he said.

For example, less than 25% of the responding HMO directors identified improving work processes as an essential element of their organization's TQM efforts, Dr. Berwick said.

"This last issue is rather telling," he said, because "no aspect of modern quality management in other industries is more central to its effectiveness than a reorganization of managerial effort toward improving the process through which work is accomplished, rather than (focusing on) individual workers' performance," Dr. Berwick said.

HMO medical directors "part company severely with the doctors and the payers" when it comes to estimating what part TQM is playing at HMOs, Dr. Berwick noted. While medical directors say they are putting a great deal of emphasis on the management of qual-

Continued on next page

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Alaska Bulletins and Orders
Alaska Selected Attorney General Opinions
Arizona Circular Letters
Arizona Selected Attorney General Opinions
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California Bulletins
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'Total quality'

Continued from previous page

ity at HMOs, "the other two groups, simply put, disagree," he said.

"The good news" in the survey is that TQM "has reached the consciousness of the American managed care industry. The vast majority of medical directors and benefits officers who contract with HMOs feel that those management methods do offer substantial promise in health care as they do in other industries," he says.

Another speaker at the GHAA institute agreed that new systems, like TQM, will help HMOs improve their quality.

Implementing new systems and programs and working with various groups dedicated to quality care will help improve quality at HMOs, said James Walworth, president of Health Alliance Plan of Michigan in Detroit, at the institute's keynote session.

Apart from the emphasis on TQM, HMOs can further their quest for quality improvement by working with groups such as the National Committee for Quality Assurance, an independent quality review agency, said Mr. Walworth, who is the incoming chairman of the GHAA.

"No other industry or industry association has ever to my knowledge set up an independent agency to review its own conduct," he said.

In addition, the American Medical Assn. is developing practice standards or guidelines that it is hoped will lead to "reasonable standards geared to our systems and uniform requirements throughout the entire medical care system in the United States," he said.

Concern for quality at HMOs will result in "the institution of quality review programs unheard and unthought of a decade ago," Mr. Walworth predicted. ■

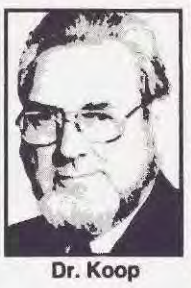
Dr. Koop seeks care for teens to prevent future health woes

LOS ANGELES—Money put toward health problems of teenagers today will prevent them from becoming unhealthy adults tomorrow, says former U.S. Surgeon General C. Everett Koop.

"Unless we respond correctly to the current crisis in adolescent health with compassion, urgency and skill, the problems of our society will not only add up, they will multiply," he said at the Group Health Institute. That conference, held June 10-13 in Los Angeles, was sponsored by the Group Health Assn. of America, an HMO trade group in Washington, D.C.

GHAA

Adolescents are the one age group in U.S. society whose health has not improved over the past 70 years, according to Dr. Koop, a pediatrician who was surgeon general from 1981 to 1989.



Dr. Koop

"All in all, 42 million adolescents in this country suffer from severe health problems," he said.

These problems include:

- One of every 10 teen-age girls becomes pregnant—the highest rate among industrialized nations.
- 3.5 million people between the ages of 12 and 17 have used marijuana, and more than a half-million have used cocaine.
- More than 50% of all high school seniors become drunk at least once a month, resulting in 10 alcohol-related teen traffic fatalities every day.
- More than 2 million teen-agers suffer from abuse or neglect that is reported each year. Another 2 million cases go unreported.

He notes that health problems are not confined to poor, crime-ridden areas. "Affluence is no protection" from this crisis, he said. "It's in all communities and every neighborhood across the country."

As an example, Dr. Koop cites high rates of bulimia, anorexia nervosa and similar disorders among "overly driven children of demanding middle-class parents," said Dr. Koop.

'Affluence is no protection' from the adolescent health crisis, warns C. Everett Koop.

And the high cost of treating adolescent health problems is adding to the growing problem of uninsured Americans, according to Dr. Koop, since many young adults who had health problems as adolescents find themselves blacklisted by health insurers.

"I think it is time to re-examine the ways in which we look at adolescents and their special health problems," said Dr. Koop.

It is time "to reallocate resources and to redesign delivery systems in ways that help all of our young people and their families cope with the challenges associated with becoming well-educated and healthy citizens," he said.

All efforts toward this goal should be "family-centered, community-based, culturally sensitive, coordinated, confidential and, of course, adequately financed," Dr. Koop stressed.

And the business community should exert the greatest pressure, not government, he said.

—By Joanne Wojcik

GHAA selects new chairman

LOS ANGELES—James Walworth, president of Health Alliance Plan of Michigan in Detroit, was elected chairman of the board of the Group Health Assn. of America at the GHAA's 40th annual Group Health Institute in Los Angeles June 10-13.

Mr. Walworth replaces Wayne Moon, who on July 1 will become president of Kaiser Foundation Health Plan Inc. in Oakland, Calif. Mr. Moon currently is executive vp and manager of operations.

A total of 2,200 managed care executives, exhibitors and speakers attended this year's conference.

Next year's conference is scheduled for June 23-26 in New York.

For more information, contact Leah Lough, director of education, Group Health Assn. of America Inc., 1129 20th St. N.W., Suite 600, Washington, D.C. 20036; 202-778-3200.

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Mar 12	Feb 27	International Captive & Reinsurance Forum	Bermuda
Apr 16	Apr 4	Insurance Marketing Services	Orlando, FL
Apr 30	Apr 17	Risk & Insurance Management Society	Boston
May 28	May 15	National Assn. of Insurance Brokers	Sea Island, GA
Jun 4	May 22	National Assn. of Insurance Commissioners	Baltimore
Jun 11	May 30	Group Health Assn. of America/GHI	Los Angeles
Jun 11	May 30	Public Risk Management Assn.	Reno, NV
Jun 18	Jun 5	National Assn. of Insurance Women	Denver
Aug 13	Jul 31	American Risk & Insurance Assn.	Orlando, FL
Sep 3	Aug 21	Monte Carlo Rendez-Vous de Septembre	Monte Carlo
Sep 10	Aug 28	Independent Insurance Agents of America	Chicago
Sep 10	Aug 28	Intl. Assn. of Industrial Accident Boards & Commissions	New York
Oct 8	Sep 25	Self-Insurance Institute of America	Washington, DC
Oct 8	Sep 25	National Assn. of Casualty & Surety Agents & Executives	Greenbrier, WV
Oct 8	Sep 25	Chartered Property & Casualty Underwriters	Washington, DC
Oct 22	Oct 9	Baden-Baden Conference	Baden-Baden, W. Germany
Oct 22	Oct 9	RIMS Singapore	Singapore
Nov 12	Oct 30	National Assn. of Professional Insurance Agents	Atlanta
Nov 12	Oct 30	National Assn. of Independent Insurers	Los Angeles
Dec 3	Nov 19	National Assn. of Insurance Commissioners	Louisville, KY

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HMO competition cuts costs for Xerox

By LOUISE KERTESZ

LOS ANGELES—Xerox Corp. is attempting to control its health care costs by promoting competition among its health maintenance organizations.

"I'm convinced the program we've implemented was the right one," said Patricia Nazemetz, director of benefits at Xerox Corp. in Stamford, Conn.

GHAA

Ms. Nazemetz spoke at the Group Health Institute earlier this month in Los Angeles, sponsored by the Washington, D.C.-based Group Health Assn. of America, an HMO trade group.

In 1986, Xerox focused on promoting competition among HMOs to control rising health care costs after rejecting other options, she explained.

For instance, the company viewed shifting health care costs to employees as a short-term solution. Another option, utilization management, which involved "controlling big-dollar claims," entailed "no real buy-in from the providers," she asserted.

However, in addition to focusing on promoting competition among its HMOs, Xerox has joined other employers and organizations "in working to determine what the employer role should be in helping to effect a national solution to the health care problem," she said.

But until a national solution is achieved, Xerox's corporate solution for purchasing health care is "the managed competition strategy," she said.

Dubbed "HealthLink," the strategy involves "intelligent purchasing" of health care following competitive bidding by the HMOs serving Xerox's employees so that the company offers only HMOs that provide the most efficient, highest-quality care.

HealthLink, she noted, also involves "a local delivery mechanism. You can't really manage health care via an office in Stamford, Conn., and a few telephone lines," she stressed, noting that HealthLink HMOs are managed locally rather than centrally.

The goal of HealthLink is to allow Xerox "to purchase health benefit programs that meet our customer requirements," Ms. Nazemetz said.

"We are really using the corporate purchasing model in developing and implementing this program. We're taking the lessons we have learned in the quality efforts in managing our own business and we've begun to apply them to the purchase and development of health benefits for our own employees," she explained.

A company spending hundreds of millions of dollars for health care "has the right to act like a customer and demand to be treated like a customer," she asserted.

The HMOs—or "partners"—that Xerox selects as HealthLink HMOs must be committed to customer satisfaction, Ms. Nazemetz said.

Another way of looking at it is that "quality, in very simple definition, is 100% satisfaction of the customer's requirements."

Xerox wants to select HMOs on a long-term basis, not on the basis of a one-year or two-year contract, she stressed. And "we're not going after cost initially, we're going after quality first." And the providers must be committed to continuous improvement, she said.

When selecting HMOs, Xerox is seeking plans that can:

- Improve employees' and their dependents' health, incorporating preventive care and wellness principles.
- Assess and reduce health and environmental risks. By reviewing data, the HMOs can identify health problems affecting a certain class of Xerox workers and take remedial action.
- Ensure access "to appropriate health services delivered by efficient providers."
- Maintain and improve employee satisfaction with the HMO.
- Minimize administrative efforts and expenses.

Xerox currently has six HealthLink HMO partners, selected through competitive bidding, and they include a total of 94 network local plans. Several of the partners compete in the same local markets, she said.

While employees are encouraged to enroll in a HealthLink HMO, Xerox also allows employees to enroll in a self-insured indemnity plan.

The company also offers 78 non-HealthLink plans. The plans include HMOs in areas in which there is no HealthLink HMO.

An employer has the right to 'demand to be treated like a customer,' says Ms. Nazemetz.

"We decided to take the slow—voluntary—approach," so that employees would view HealthLink positively, Ms. Nazemetz said. However, several of the non-HealthLink plans will be included in the HealthLink system in 1991 and 1992, and some of the non-HealthLink HMOs will be dropped over time, she said.

While 97% of Xerox employees are eligible to participate in a HealthLink HMO in 1990, 31% of eligible employees actually participate, and 21% participate in a non-HealthLink HMO. "Our goal is to move as many employees into HealthLink as possible," Ms. Nazemetz said.

As the HealthLink program matures, Xerox plans to give employees financial incentives for joining the most efficient HMOs, she said.

In addition, "we need to focus on health management as opposed to sickness care," Ms. Nazemetz said.

"We also need to integrate mental health benefits more efficiently into our program and focus on disability and workers comp" treatment in partnerships with providers, Ms. Nazemetz said.

Although it is too early to offer details on HealthLink's cost savings, the program has created "a strong cost advantage for Xerox," she asserted.

As the HealthLink partnerships develop, Xerox wants to identify "quality plans and quality standards, and that will be useful for other companies" in developing common standards and measurements for HMOs, she said.

"We have put all of our eggs in this basket and we hope that most of you out there in this (HMO) industry will work with us to prove that. . .the key to successfully managing health care issues in this country lies with the HMO industry," she concluded. ■

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Self-monitoring urged to let UR mature

By JOANNE WOJCIK

LOS ANGELES—State regulation of utilization review could inhibit the development of this new and evolving industry, warns an insurer executive.

Utilization review instead ought to be regulated by the industry itself, argues Robert A. Picarillo, vp-government affairs at CIGNA Corp. in Bloomfield, Conn.

GHAA

Utilization review "is a relatively new methodology that's still evolving, and we think it should be permitted latitude to improve and gain sophistication," says the CIGNA executive.

"Anti-UR proposals will inhibit this desirable development and could result in the demise of an effective check and balance" in the health care system, contends Mr. Picarillo.

Utilization review has evolved in response to the explosion of health care costs during the last decade, Mr. Picarillo said at the Group Health Institute in Los Angeles. The conference, held June 10-13, was sponsored by the Group Health Assn. of America, an HMO trade group based in Washington, D.C.

"Virtually all insurers and third-party administrators, as well as HMOs and PPOs, now provide utilization management services," and at least half of all large employers include it in their health benefit programs, up from 5% in 1984, he said.

As the industry grows, more than 20 states are considering legislation that would allow monitoring utilization review. But only one of those states—South Carolina—currently is attempting to regulate provider review activities, according to Mr. Picarillo.

One reason for the lack of regulatory action is lack of funding. Few state agencies have the resources to adequately regulate utilization review, which is constantly adapting to developments in medicine, Mr. Picarillo explained.

Also, some bills that would exempt pharmaceutical programs and programs set up in-house by hospitals and other providers have been viewed as unfair, he said. If regulation is necessary, all individuals and entities conducting utilization review services should be regulated, according to Mr. Picarillo.

While "there may be a case for regulation," as a way to weed out unscrupulous or inadequate review organizations, the argument against regulation is stronger, he said.

The utilization review industry is "a moving object. We don't know what or how to regulate until the industry matures," Mr. Picarillo said.

"It's one thing to identify the problem and another to impose a satisfactory solution," Mr. Picarillo said.

"The UR industry is so dynamic that it is difficult to formulate meaningful rules to fit the activities of a variety of organizations through different structures and different incentives."

And ill-conceived regulation could damage irreparably this emerging industry, Mr. Picarillo warned.

"Poor regulatory approaches could lead to premature rejection of UR and I think this would be unfortunate," he said. "UR is viewed by many as the cornerstone of managed care, and as one of the few viable strategies that help control costs in a way that examines individual patient situations.

"Without utilization review more stringent cost containment methods are likely, such as coverage restrictions and economic incentives that take less recognition of the needs of patients on an individual basis," he says.

Mr. Picarillo also asserted that there is no documented evidence that utilization review harms patients

He maintained that many of the proposed regulatory measures, especially those that restrict who can conduct reviews prior to treatment, "look more like professional protectionism than efforts to save patients from harm and physicians from unreasonable administrative burdens."

Rather than state regulation, the utilization review industry should regulate itself, Mr. Picarillo suggested.

He praised both efforts by the joint task force of the American Medical Assn., the American Hospital Assn., the Blue Cross & Blue Shield Assn. and the Health Insurance Assn. of America to set up uniform UR practice guidelines and the establishment of the Utilization Review Accreditation Commission (*BI*, Feb. 19; Jan. 22).

URAC is a new coalition of UR companies promoting voluntary standards of practice that will lead to professional accreditation for UR firms.

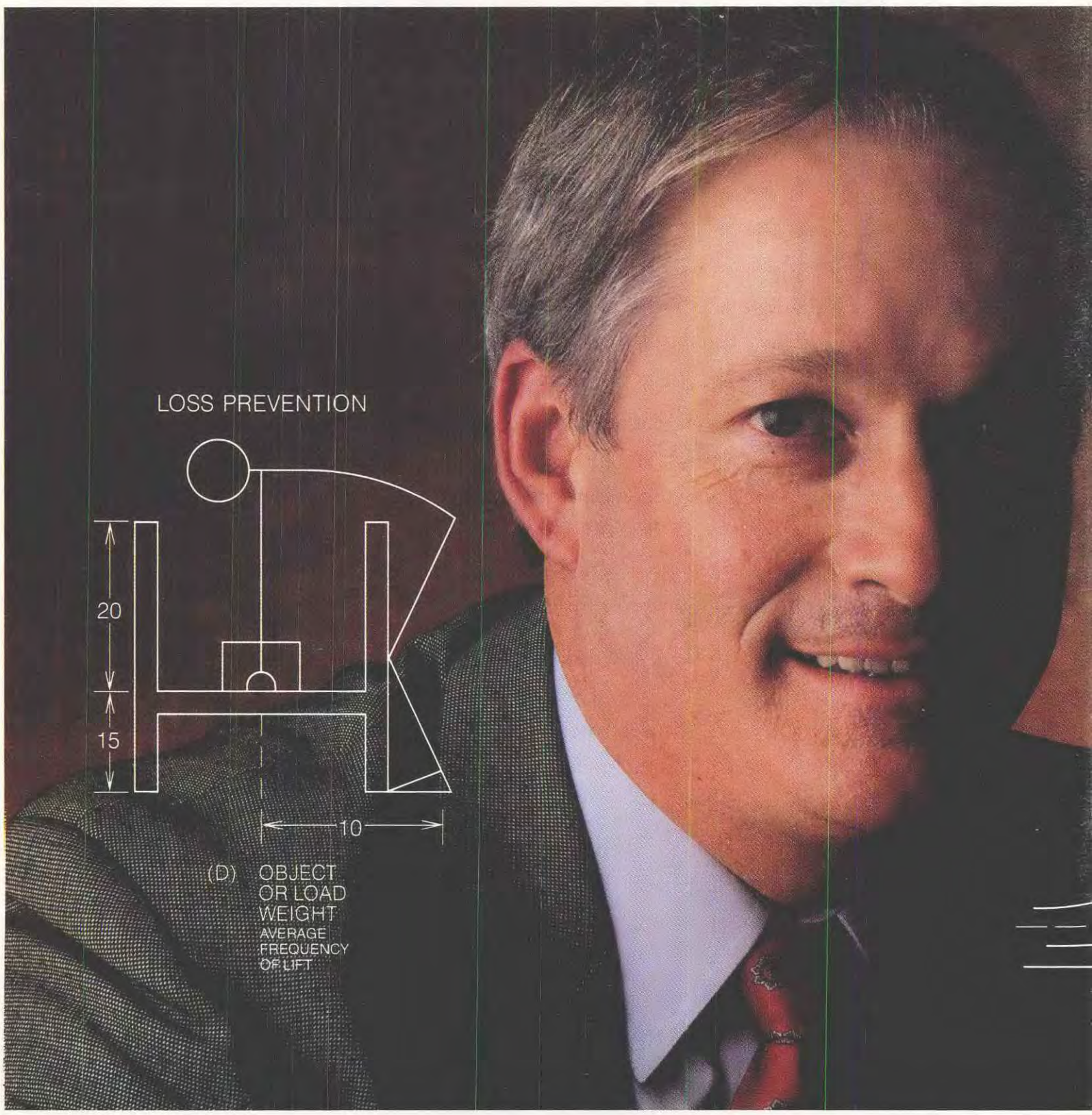
"URAC has developed a set of comprehensive national standards for utilization review that some say are more exacting and rigorous than any legislation introduced," Mr. Picarillo pointed out.

"URAC's mission is to create a credentialing program for review companies based on the premise that the forces of competition are the best regulator of company behavior," he said.

He also says that he hopes that URAC certification "will become a matter of competitive necessity" just as hospitals seek credentials from the Joint Commission for Accreditation of Hospitals.

Robert L. Hughes, executive director of the Massachusetts Assn. of HMOs in Boston, moderated the panel. ■

THE HOM



OLD PROS ON

Florida law opens settlement records

TALLAHASSEE, Fla.—Court-ordered secrecy agreements covering discovery and settlement negotiations in public hazard cases will be prohibited in Florida as of July 1.

The Sunshine in Litigation Act, signed into law earlier this month, also will allow information from such cases filed after July 1 to be used in related proceedings.

The law will apply to litigation involving any device, instrument, person, procedure or product that has caused and is likely to cause injury.

Car and drug companies lobbied hard against the legislation, but found few legislators willing to oppose the bill, said Glinda Woods, spokeswoman for the Academy of Florida Trial Lawyers, which helped draft the bill.

Around the states

Opponents say the act encourages frivolous suits. Some people could try to beef up invalid claims with information from other cases, says Jim Brainerd, a state Chamber of Commerce lobbyist.

However, making more information available will protect the public and improve compensation to victims of similar accidents, a process which has been "frustrated by secrecy agreements" that block adequate details about accidents, said Linda Lipsen, a counsel at Consumers Union in Washington, D.C.

Allowing the sharing of information on public hazards "should save people's lives," says Ms. Woods.

Business groups also argue that legal fees will be inflated by the new law because more companies will litigate rather than settle. If discovery information "is going to be made public anyway, then some companies will think 'why settle?' " says Mr. Brainerd.

But Ms. Woods maintains that the law will reduce legal bills by lowering research costs for information used in previous cases.

—By Adrienne C. Locke

Work comp fund revived

HELENA, Mont.—Montana's debt-ridden State Compensation Mutual Insurance Fund will get a fresh start under a bill passed in a special session late last month.

The law, signed by Gov. Stan Stephens, would authorize a complex accounting procedure that would separate the fund's current unfunded liability of about $200 million from the funds ongoing operations beginning July 1.

The bill also would allow the unfunded liability to be paid off over a number of years through the extension of a payroll tax and loans.

Jim Murphy, executive vp of the fund, said the competitive state work comp fund would then continue to operate with a balance of $27 million, including $15 million in deposits by policyholders.

Under the law, "premium rates must be set at least annually at a level sufficient to ensure the adequate funding of the insurance program. . ."

All Montana employers would help pay off the unfunded liability through an extension of a payroll tax that was to expire next year. However, the tax was reduced from 0.3% to 0.28%, effective July 1.

The law was passed at the end of a one-week special session of the Montana Legislature in late May.

—By Michael Bradford

Georgia auto rate order

ATLANTA—Auto insurers in Georgia will soon have to document for state regulators the effect of auto safety advances, tort reform measures and other factors on private passenger auto rates.

Insurers have until July 1 to comply with the order from Commissioner Warren Evans to demonstrate the effect on rates of, among other things:

- Tort reform measures Georgia has adopted since 1987.
- Drops in claim frequency that have outpaced increases in claim severity.
- Auto safety advances such as air bags, anti-lock brakes, cage construction and passive restraint systems.
- Georgia's mandatory seat belt law.
- Improved insurer financial ratios and trends, particularly related to auto physical damage.

A Fulton County Superior Court ruled March 19 that Mr. Evans had exceeded his authority by freezing private passenger auto rates in the state.

Eleven auto insurers sued the commissioner over that order, which was later rescinded (*BI*, March 26).

—By Linda J. Collins

Warwick rehabilitator

MORRISTOWN, N.J.—The former director of the New York Insurance Department's liquidation bureau will oversee the rehabilitation of Warwick Insurance Co. of Morristown-N.J., a small business insurer declared insolvent by $250,000 in April.

Andrew Alberti was appointed deputy rehabilitator in charge of Warwick, which was placed under state control by State Superior Court Judge Kenneth MacKenzie on June 6.

As of March 31, it was insolvent by about $250,000, with total assets of $84.6 million and total liabilities of nearly $84.9 million.

Existing claims will begin to be paid at their full value beginning July 6. Warwick will continue to service existing business but will not be permitted to issue new policies for an undetermined time.

Warwick wrote $88.3 million in direct premiums in 1989, primarily for small New Jersey businesses.

—By Michael Schachner

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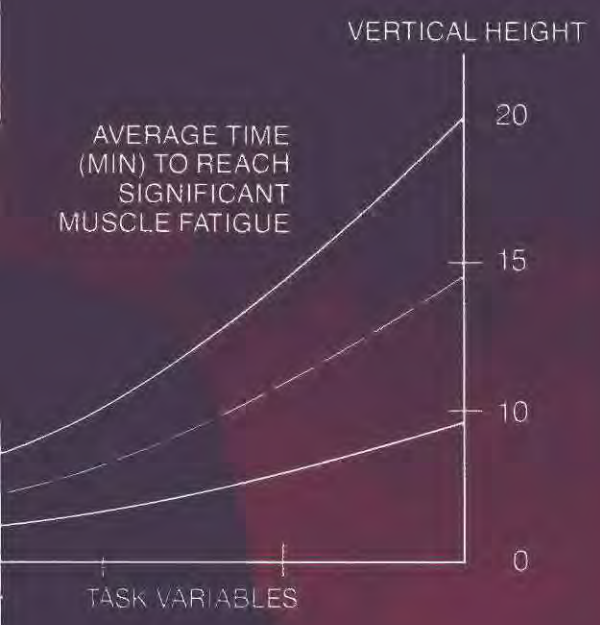
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SHOW	TITLE	DATE	TIME
1	MECHANISM OF INSURANCE I	Tuesday 5/29/90 Saturday 6/02/90 Sunday 6/03/90	10:30 AM 7:00 AM 7:00 AM
2	MECHANISM OF INSURANCE II	Monday 6/04/90 Saturday 6/09/90 Sunday 6/10/90	10:30 AM 7:00 AM 6:30 AM
3	RATE ADJUSTMENT	Tuesday 6/12/90 Saturday 6/16/90 Sunday 6/17/90	10:30 AM 7:00 AM 7:30 AM
4	WHERE DOES THE PREMIUM DOLLAR GO?	Tuesday 6/19/90 Saturday 6/23/90 Sunday 6/24/90	10:30 AM 7:00 AM 7:30 AM
5	CIVIL JUSTICE	Tuesday 6/26/90 Saturday 6/30/90 Sunday 7/01/90	10:30 AM 7:00 AM 7:30 AM
6	LEGAL PROFESSION	Tuesday 7/03/90 Saturday 7/07/90 Sunday 7/08/90	10:30 AM 7:00 AM 7:00 AM
7	TORT REFORM	Tuesday 7/10/90 Saturday 7/14/90 Sunday 7/15/90	10:30 AM 7:00 AM 7:00 AM
8	CONSUMER REVOLT	Tuesday 7/17/90 Saturday 7/21/90 Sunday 7/22/90	10:30 AM 7:00 AM 7:00 AM
9	PERSONAL LINES — AUTO	Tuesday 7/24/90 Saturday 7/28/90 Sunday 7/29/90	10:30 AM 7:00 AM 7:00 AM
10	NO FAULT	Tuesday 7/31/90 Saturday 8/04/90 Sunday 8/05/90	10:30 AM 7:00 AM 7:00 AM
11	PERSONAL LINES — LIFE & HEALTH	Tuesday 8/07/90 Saturday 8/11/90 Sunday 8/12/90	10:30 AM 7:00 AM 7:00 AM
12	LOSS CONTROL	Tuesday 8/14/90 Saturday 8/18/90 Sunday 8/19/90	10:30 AM 7:00 AM 7:00 AM
13	CLAIMS	Tuesday 8/21/90 Saturday 8/25/90 Sunday 8/26/90	10:30 AM 7:00 AM 7:00 AM
14	ACTIVE VS. PASSIVE	Tuesday 8/28/90 Saturday 9/01/90 Sunday 9/02/90	10:30 AM 7:00 AM 7:00 AM
15	ACTUARIAL	Tuesday 9/04/90 Saturday 9/08/90 Sunday 9/09/90	10:30 AM 7:00 AM 7:00 AM
16	CAREERS IN INSURANCE	Tuesday 9/11/90 Saturday 9/15/90 Sunday 9/16/90	10:30 AM 7:00 AM 7:00 AM
17	FUTURE I	Tuesday 9/18/90 Saturday 9/22/90 Sunday 9/23/90	10:30 AM 7:00 AM 7:00 AM
18	FUTURE II	Tuesday 9/25/90 Saturday 9/29/90 Sunday 9/30/90	10:30 AM 7:00 AM 7:00 AM

Communicating 401(k)s

Employees must evaluate benefits, pitfalls of participation

By John F. Hammond

JOHN AND JANE DOE must be puzzled these days about Uncle Sam's position on savings for the future. Ten years ago, the old gentleman truly acted the part of a kindly generous uncle, urging us to rely more on personal savings and less on Social Security, and dutifully dipping into his own pockets to get us started. Tax-deductible individual retirement accounts and employer-sponsored pretax 401(k) plans soared in popularity.

But lately Uncle Sam appears more and more concerned with filling his pockets today, rather than tomorrow. The apparent message to taxpayers? You are on your own! And those whose role it is to encourage retirement planning and promote employer-sponsored savings plans are left to explain why—and to continue stressing the urgency of saving.

While benefits legislation at the start of the '80s spelled "tax incentives" for the future, the regulatory environment toward the end of the decade had changed dramatically. Tax reform and ensuing regulations restricted access to tax-advantaged savings during employment, imposed penalties on most remaining early withdrawal opportunities and narrowed tax-deferral opportunities for higher wage earners.

By the time we heard the news of a "kinder, gentler nation," we were already sobered by a leaner, meaner federal policy on deferred taxation. Yet the tax news in the '80s wasn't all bad. Lower individual income tax rates also became a reality for most people.

The result, as we enter the '90s, is an increasingly complicated retirement planning picture.

On the one hand, we have wavering financial encouragement from the federal government, which ostensibly backs retirement savings but continues to bleed away the incentives that give the policy life.

Still, for some, potentially valuable long-term tax-deferral opportunities still exist.

On the other hand, for many people, lower individual tax rates have diluted the appeal of deferring taxes. Why lock away pretax dollars in a 401(k) plan—to be taxed later in a potentially higher tax bracket—when logic appears to favor paying taxes now, and having reasonable access to your aftertax savings in a 401(a) plan or regular savings account.

Yet such a view may be oversimplified. How high will taxes rise and when? Will the increase(s) be sharp or gradual? No one knows. And doesn't adding deferred taxes to 401(k) savings increase earnings potential? Studies show significantly different outcomes based on a range of differing assumptions. Further complications arise when matching employer contributions are a factor—sometimes offered only on 401(k) savings.

For many people, the clear-cut advantages of saving in a 401(k) plan have been replaced by perplexing trade-offs. Tax-deferral opportunities have become costly, especially for those who joined early, planning on withdrawals for home purchase and educational expenses.

Nevertheless, the need to save for a financially secure future has never been more urgent. Factors that raise the stakes are continuing inflation, gradually increasing longevity after retirement and the hopes of some to retire early.

But human nature being what it is, we generally don't do what is good for us without some incentive.

Successfully promoting employer-sponsored savings programs, then, is one of the key challenges facing today's employee benefit communicators, especially given the ambiguity surrounding traditional 401(k) advantages. Not only have 401(k) plans become more complicated to communicate, but yesterday's blanket endorsement of 401(k) as the alternative for everyone is no longer appropriate. Today, one plan does *not* fit all.

For many people, the clear-cut advantages of saving in a 401(k) plan have been replaced by perplexing trade-offs. Tax-deferral opportunities have become costly, especially for those who joined early, planning on withdrawals for home purchase and educational expenses.

Let's take a look at the pros and cons of 401(k) savings. The advantages include:

- Although individual tax rates have been lowered for most people, deferring taxes on savings over the long term remains an advantage if taxes are deferred until after age 59½.
- Because pretax contributions reduce taxable income, an employee's take-home pay will be higher when making 401(k) contributions than it will be when making 401(a) contributions. Thus the employee can afford to save more in 401(k) contributions (or can pocket the difference).
- An employee's savings will generally be available at retirement since access for active employees is so restrictive.
- Loans on 401(k) savings, though now subject to tighter limits, allow some access to savings, while repayment restores the account for retirement.
- Some employers sponsoring 401(k) plans as the voluntary savings component of their retirement programs will match 401(k) contributions, but are philosophically opposed to matching 401(a) contributions because of access during employment.

Special tax treatment generally is available on final payment at or near retirement.

Among the disadvantages of 401(k) plans are:

- 401(k) contribution amounts are restricted in a variety of ways, such as a $7,979 limit in 1990. Hardest hit by the restrictions are highly paid employees—generally those earning more than $54,480 in 1989—who are also among those taxed in the 28% or 33% tax brackets.
- Lower-paid employees currently taxed in the 15% bracket, who defer taxes now, may fall into a higher tax bracket when payment is received. In fact, tax rates may be higher for everyone in the future.
- Access to 401(k) savings before age 59½ is severely restricted, and a 10% additional income tax generally is charged.
- Hardship withdrawals before age 59½ generally are subject to the 10% penalty tax. In addition, the one-year suspension on contributions is further punishment, as is a limit on the following year's contributions, which may extend the penalty for another year.
- Loans may be forced on employees requesting a hardship withdrawal for a financial crisis.
- Ten-year averaging on final payments has been replaced, in most cases, with five-year averaging, which offers considerably less of a tax advantage at payment time.

Before taxpayer confusion translates into low participation and more lost ground in employees' retirement savings efforts, benefit communicators must find a way to balance promotion with education. We must continue to convey the urgency of saving—*and* the idea of putting those savings to work by starting early. An early start means our savings have time to earn investment income. Otherwise, we'll have to contribute more.

But, we must caution employees to evaluate their savings alternatives. The essential message becomes: "Do it, but think about your options."

Encourage employees to consider:

- Their age, level of income and tax bracket.
- Alternative savings approaches, given potential restrictions that may narrow their options such as limits on deductible IRA contributions.
- Other available retirement income sources, such as a defined benefit plan.
- Short-term financial needs and their resources to meet those needs.
- The specific advantages of the available 401(k) or 401(a) plan, such as employer-matched contributions, opportunity to borrow, etc.
- The specific disadvantages, such as limits on 401(k) contributions by the highly paid, and restrictions on 401(k) hardship withdrawals, along with associated penalties.

When a combination plan allowing both 401(k) and 401(a) contributions is available, such a plan clearly offers the best of both worlds, allowing employees to structure their own savings programs to meet both long- and short-term needs.

But the pattern of employee elections in such plans frequently runs counter to a company's retirement philosophy/objectives. In addition, participation patterns can frustrate recently legislated discrimination testing, designed to prevent such plans from favoring highly paid employees. Experience shows that the highly paid favor 401(k) contributions. The lower paid, who are least able to save for retirement, and middle-income participants feel more comfortable having access to their aftertax savings.

Of course, the employer-sponsored savings opportunities available may not be as broad for some employees as for others. Add in other variables represented by personal circumstances and individual savings objectives, and an employee's range of choices beyond the employer's 401(k) plan may be severely limited.

As benefit communicators working on behalf of an employer, we do not want to discourage participation in an employer-sponsored plan. Nor do we want to force-feed a particular savings option as appropriate for all, and mislead employees in matters of personal finances. A thoughtful approach, an appropriate level of savings and an early start are the recommended goals.

Most employers can easily understand the dangers of overdoing promotion and setting the stage for negative reactions in the future. Clearly, an organization's communication strategy should be addressed early in the planning process—during the plan design stage—to help head off potential communication problems.

The benefit communicator's role is to raise employee awareness of the issues and encourage employees to accept responsibility for personal retirement savings and planning. Promotional goals aside, communication should clarify, not confuse. ■



John F. Hammond is a senior communication consultant with The Wyatt Co. in Wellesley Hills, Mass.

Assessing a company's RMIS needs

By David A. Tweedy

RMIS commentary

OVER THE LAST FEW MONTHS, I have been discussing risk management information systems from a developmental and theoretical perspective. Recent columns have covered such aspects as cost-control techniques and the merger of risk and employee benefit management systems (*BI*, May 21) and new RMIS developments evident at the Risk & Insurance Management Society conference (*BI*, April 16).

However, it is time to look at more practical matters. Over the next few months, I would like to spend time addressing such basic questions as:

- "How do I best design or modify a system?"
- "What does an RMIS really save me in terms of dollars and hours?"

This month, I would like to focus on identifying and determining an organization's RMIS needs. The need determination phase is the most critical in the RMIS design process. If it is improperly conducted, an expensive investment may be made in the wrong system, thus impairing the risk manager's credibility with senior management. More importantly, the system will not assist the risk manager to better perform his or her job.

It is the risk management professional's job to ensure that the system is responsive to the needs of the organization. There may be bits of information the risk manager may wish to have, but are not essential to the performance of his or her job or to the organization.

On the other hand, there are those bits of information essential to the organization that must be identified in the needs identification process before investing in a system.

A well-defined and conducted interview process is an essential element of the needs identification phase. In it, the organization's needs are quantified from both internal and external perspectives. In other words, interviews of key department heads of the organization are conducted and evaluated for incorporating their needs into the RMIS specifications. Also, data sources from outside the corporation (insurance company, broker, regulatory commission, etc.) are also identified and included within the system design.

The interview process involves key departmental personnel and executive staff in RMIS selection. With their commitment, the project becomes more tangible. After all, a well-designed, comprehensive RMIS, with access to many departments within an organization, must have the continued and enthusiastic support of line and staff management for it to be successful. This interaction of executive and middle management personnel tends to reduce potential interdepartmental bickering or jealousy after a system is designed.

A key factor in the success of the need determination phase, including the interview process, is the active support of senior management. A memo by the CEO to each department head, with instructions to cooperate in the internal RMIS needs identification process, is critical in getting the valuable information the risk manager needs in scoping out system requirements.

To gain senior management's support, the risk manager should develop a proposal stating the expected benefits and estimated costs of such a system. In the past several months, I have listed a number of benefits derived from a risk management information system. Briefly stated, they are:

- Increased efficiency. An RMIS reduces manual handwritten analyses, file reviews, etc., and also increases the risk manager's ability to spend time on more analytical decision making.
- Cost reduction. An RMIS leads to fewer errors by reducing manual operations as well as the size of the labor force needed to perform these manual tasks. It also leads to quicker reactions to problems identified by the system.
- Productivity increase. With less time invested in manual compilation of data, the risk manager can spend more time in analysis and decision making.
- Increase in synergy. Through the interaction of the RMIS with other departments and outside organizations, the risk management department can make better decisions, based on better information, and gain a better understanding of risks facing the organization.
- Cost of risk reduction. Better information presented to underwriters and a better control over the risk of an organization and its self-insured programs gives the risk manager a greater opportunity to project a lowered cost of risk due to the efficiency and analytical capabilities of his system.
- Senior management communication tool. Through the summarizing ability of the RMIS to present vast quantities of data in a single table or graph, senior management will have a faster and better understanding of how the cost of risk is affecting the organization.

These are just some of the benefits the risk manager can document in his proposal to senior management. This presentation's objective should be to gain approval and support by executive management to perform the needs determination/feasibility phase.

As I will show in next month's column, the end result of the needs identification process will produce a tangible cost benefit analysis and an accurate assessment of the information flows and needs of the organization to help the risk manager design an effective and comprehensive RMIS. ■

David A. Tweedy is a senior consultant for Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.



Safely evacuating a burning theater

By The Insurance Institute of America

A.R.M. excercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the types of questions asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from a recent national examination in A.R.M. 55—Essentials of Risk Control, focuses on ways of promoting the safe, prompt evacuation of the public from a place of assembly—such as a burning theater—when practice evacuations often are not practical.

Q: When its administrative headquarters burned and some of its employees were injured because they could not leave the burning structure promptly, a major theater chain determined that it should do more to prepare its employees to manage the evacuation of persons from any burning theater.

- For each of the three life-safety factors listed below, describe two actions the chain might reasonably take to improve the ability of its employees to manage evacuations of theaters:
  - ✔ Personal mobility.
  - ✔ Density (crowding).
  - ✔ Awareness of the fire.
- Describe two measures, other than fire drills, through which the chain could periodically monitor this aspect of its risk control program.
- Describe five specific tests by which the chain properly could determine whether the employees injured in the fire at its headquarters are receiving appropriate physical and vocational rehabilitation.

A:

- For completeness, the following answers describe more than the two actions specified in the question; other answers also earned national examination credit.

✔ Patrons' mobility in leaving a burning theater may be increased by providing a greater number of wider aisles and more foot room between rows as well as by increasing the visibility of exit signs. Better emergency lighting and careful training of theater employees in evacuation procedures also are likely to reduce panic and increase evacuation speed.

Another measure—reducing the size of theaters—also lessens the average distance patrons must travel to reach safety. Finally, handicapped patrons may be seated near exits, but not in locations where their presence may impede others from quickly exiting.

✔ Dangerous levels of crowding can be controlled by limiting the capacity of theaters or reducing their size so that any given patron is surrounded by fewer people. Widening aisles and increasing foot room between rows has the same effect. Similarly, increasing the number and/or width of exits reduces the number of people who must pass through any given exit.

✔ The most critical means of alerting theater patrons to any fire is a properly designed fire protection and signaling system for the entire premises that provides both auditory and visual alarms, ideally supplemented by a public address system, together with appropriate messaging systems for the deaf. To make patrons aware of any fire, theater employees should be properly trained to deal efficiently, yet calmly, with fire emergencies.

- Without endangering or frightening patrons through actual surprise fire drills, the movie theater chain should develop an inspection checklist that requires each of its facilities to be tested for the adequacy of its fire detection and signaling systems, and the soundness and other design features of its exits, emergency lighting and exit signs. Moreover, the personnel operating these facilities should be regularly trained and tested in emergency procedures.
- Physical and vocational rehabilitation rests on five points. They are: a clear diagnosis of each patient's disabilities and needs to prepare for returning to the fullest attainable productive life; an appropriate treatment plan to meet the patient's needs through unified medical guidance; guidance that generates a positive attitude of the patient toward his or her treatment; measurement of the patient's progress by objective medical and social signposts of recovery; and signposts targeted on specific plans and dates for hospital discharge and return to work.

These positive standards or tests for effective rehabilitation can be supplemented by any number of specific negative tests for failure to meet one or more of these standards. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Analysts' picks

Continued from page 3

with the vagaries of the property/casualty insurance cycle for a variety of reasons.

Joan Zief, vp of Merrill Lynch Capital Markets, picked Marsh & McLennan, explaining that while "one never knows" when the cycle will turn, New York-based M&M is well-positioned to take advantage of a hard market once it does appear.

In addition, Ms. Zief said she expects good growth in consulting, which now produces about 30% of M&M's revenues.

She also said M&M's position as the "premier" broker for multinational firms has been strengthened because its major competitor in that sector, privately held Johnson & Higgins, is ending its long association with Willis Faber P.L.C., which recently agreed to merge with Corroon & Black Corp. (*BI*, June 18; June 11).

M&M stock was trading at $75.75 per share on June 19.

Norman L. Rosenthal, a Morgan Stanley & Co. principal, said he picked Chubb Corp. because two-thirds of its premiums are generated by specialty lines, which he believes is the highest percentage among U.S. underwriters.

This means the Warren, N.J.-based insurer is "able to sell a value-added approach," which makes it "somewhat price-insulated" and able to charge higher rates than its competitors.

Mr. Rosenthal also said he thinks investors do not "really appreciate" the company's international franchise.

Including Canadian operations, 10% of Chubb's premiums are generated outside the United States. Without Canada, the total is about 8.5%. And Chubb is "very ambitious" in this area, he said.

Chubb is also well-positioned in the asset accumulation area, Mr. Rosenthal said, citing its life insurance subsidiaries.

Other positive factors about Chubb, according to Mr. Rosenthal, include:

- "Demonstrated marketing skills."
- Adequate loss reserves and no reinsurance recoverable problems, which "very, very, very few insurance companies can claim."
- "Very aggressive personnel policies" which have created an "extremely loyal" staff with low turnover.
- An expanded branch office system, which allows it to get closer to customers.

Chubb's real estate holdings are almost all on an equity basis and it holds practically no mortgages, Mr. Rosenthal added.

Chubb stock was trading at $47.13 per share on June 19.

Denis J. Callaghan, managing director of Alex. Brown & Sons Inc. in Baltimore, stressed CIGNA Corp.'s group health insurance operations, rather than its property/casualty business, in explaining why he made CIGNA his top pick.

Mr. Callaghan predicts that CIGNA will convert a large number of its group health clients to managed care over the next five years, which will result in increased growth and profit margins and will make CIGNA less vulnerable to the property/casualty insurance cycle.

CIGNA's acquisition of EQUICOR Inc. in January was a "good strategic fit" with the Philadelphia-based insurer's managed health care operations, Mr. Callaghan also noted (*BI*, Jan. 22).

CIGNA's experience in health insurance should prevent the type of integration problems that arose when Connecticut General Insurance Co. and Insurance Co. of North America merged in 1982 to form CIGNA, he says.

There is also "good synergy" between EQUICOR and CIGNA because both focus on large-case business.

CIGNA stock was trading at $51.13 per share on June 19.

A. Michael Frinquelli, a Salomon Bros. managing director, said he made Fund American, formerly Fireman's Fund Corp., his top pick for, among other reasons, its strong reserves position.

Fund American's reserves-to-earned premium ratio is second only to that of General Re Corp. and a "touch ahead" of that of The St. Paul Cos., according to Mr. Frinquelli. Fund American, however, has only half the long-tail liability business these other insurers do, he noted.

In addition, Mr. Frinquelli said Fund American has a "uniquely high-quality" bond portfolio, with an average maturity of less than four years, compared with an industry average of 12 years.

Fund American's stock was trading at $34 per share on June 19.

The panel was moderated by Mr. Zimmerman. Amy de Rham, vp of Massachusetts Financial Services, was co-moderator of the panel. ■

BI model portfolio

Stock	No. of shares	July 25, 1986 purchase price	Total	June 28, 1989 price	Total	% change	June 19, 1990 price	Total	% change
Chubb	74[1]	$72.13	$2,668.63	$70.38	$2,604.06	-2.4%	$47.13	$3,487.62	30.7%
General Re	33	61.88	2,041.88	67.50	2,227.50	9.1	85.00	2,805.00	37.4
AIG	30[2]	134.25	2,013.75	84.88	2,546.40	26.5	99.75	2,992.50	48.6
Fund American	28	38.13	1,067.50	34.50	966.00	-9.5	34.00	952.00	-10.8
USF&G	15	40.00	600.00	32.13	481.95	-19.7	27.50	412.50	-31.3
Ohio Casualty	14[3]	81.00	567.00	45.75	640.50	13.0	43.25	605.50	6.8
American General	13	41.63	541.13	36.75	477.75	-11.7	47.63	619.19	14.4
CNA	8	55.00	440.00	75.00	600.00	36.4	76.75	614.00	39.5
Cash[4]			56.11		616.66	999.0		982.33	1,650.7
Total			10,000.00		11,160.82	11.6		13,470.64	34.7
S&P 500			240.22		325.11	35.6		358.47	49.2
BI stock index			513.10		547.20	6.6		598.10	16.6

[1]Shares after 2-1 split on May 7, 1990 [2]Shares after 2-1 split on Nov. 17, 1986 [3]Shares after 2-1 split on Jan. 23, 1987 [4]Includes divend payments

BI/HOLLY SEGUINE

BI random portfolio

Stock	No. of shares	July 25, 1986 purchase price	Total	June 28, 1989 price	Total	% change	June 19, 1990 price	Total	% change
CIGNA	40	$62.50	$2,500.50	$56.88	$2,275.20	-9.0%	$51.13	$2,045.20	-18.2%
CNA	40	55.50	2,220.00	75.00	3,000.00	35.1	76.75	3,070.00	38.3
Aetna	35	60.50	2,117.50	55.63	1,947.05	-8.1	52.88	1,850.80	-12.6
Continental	40	46.63	1,865.00	34.63	1,385.20	-25.7	30.25	1,210.00	-35.1
AmBase	40	23.75	950.00	13.75	550.00	-42.1	6.38	225.20	-73.1
Cash[1]			347.50		1,314.66	278.3		1,739.06	400.4
Total			10,000.00		10,472.11	4.7		10,170.26	1.7
S&P 500			240.22		325.81	35.6		358.47	49.2
BI stock index			513.10		547.20	6.6		598.10	16.6

[1]Includes dividend payments

BI/HOLLY SEGUINE

Insurer stock values increase, but still trail other industries

Despite a 35% gain in four years, a portfolio of commercial property/casualty stocks picked by stock analysts continues to lag behind the stock market as a whole.

But the portfolio selected on the basis of analysts' recommendations continues to outperform an assortment of randomly selected insurance stocks.

The value of the *Business Insurance* Model Portfolio, created in July 1986 with a hypothetical $10,000, rose 34.7% to $13,470.64 on June 19.

That figure reflects changes in the value of the stocks, dividends paid since the portfolio was established and interest earned on collected dividends and leftover cash.

The Model Portfolio has done especially well in the past year: Its value has increased 20.6% since June 28, 1989, when it was worth $11,160.82.

And the portfolio has rebounded 53.1% since the October 1987 crash. On Oct. 26, 1987, its value was only $8,800.13.

Still, it has not performed as well as the S&P 500 stock index, which has increased 49.2% since July 1986. That index reflects only the change in stock prices.

The Model Portfolio, however, has performed better than the *BI* Random Portfolio, which was formed with a hypothetical $10,000 by picking names of companies out of a hat.

The value of the Random Portfolio has increased by only 1.7% since it was established to $10,170.26. Its value has actually declined 2.8% since June 1989.

The Model Portfolio also has outpaced the 16.6% increase posted by the entire *Business Insurance* stock index, which includes the stocks of 78 brokers, insurers, reinsurers and insurance-related conglomerates and holding companies.

●

Business Insurance does not recommend the stocks in the BI Model Portfolio or the BI Random Portfolio. BI reporters and editors do not invest in insurance industry stocks. Readers should contact a licensed stockbroker or investment adviser before making any investments.

Ruoff warns next market turn will be severe

By JUDY GREENWALD

NEW YORK—Commercial property/casualty rates will not turn until at least late next year and perhaps 1992, says a brokerage executive.

And, warned Charles Ruoff, a senior vp at Sedgwick James Inc., the longer it takes the market to turn, the more severe that turn will be.

"The further you dig the hole, the bigger the ladder you need to get out," he said at a panel discussion on the underwriting cycle at an Assn. of Insurance & Financial Analysts insurance symposium earlier this month in New York.

Mr. Ruoff said the "Three Rs" to consider when discussing a market turn are reserves, reinsurance and regulation.

Reserves determine net income, said Mr. Ruoff, noting that setting reserves "is an art, rather than a science" and demands a great deal of judgment. Often, he said, reserve levels are determined by prices rather than by claims, as they should be.

Meanwhile, said Mr. Ruoff, the issue of reinsurance recoverables "is still significant in terms of industry surplus."

It will take years to determine finally whether particular reinsurance is collectible or should be written off. Also, he said, the number of disputes over non-performing reinsurance is increasing.

Mr. Ruoff noted also that many reinsurance contracts written in 1985 and 1986 had sunset clauses, which limited the period during which claims could be made. "We're now getting late in the afternoon."

The popularity of financial reinsurance is a problem, Mr. Ruoff said, because it does not transfer risk, but gives the false appearance of improving financial results.

Another issue to be considered in assessing a market turn is the pressure state regulators face from consumers on auto insurance and from the federal government on solvency, said Mr. Ruoff. "Neither problem, as far as we can see, is near solution."

Solvency regulation, he said, is often complicated by the "creative accounting" insurers use to disguise their true financial condition.

The way reinsurance is reported on financial reports also is a problem, Mr. Ruoff said. Regulators very nearly have to read individual agreements, rather than just know who the reinsurers are, he said.

Another severe problem for solvency regulation: the lack of qualified auditors. Mr. Ruoff recommends regulators focus their attention on problem companies rather then examining every company every three years.

Mr. Ruoff also discussed the direction in which the market is moving.

He noted that a $20 billion underwriting loss in 1984 was followed by a market turn in 1985. After another $20 billion underwriting loss in 1989, people thought that "surely 1990 would look like 1985," he said. It does not, though, says Mr. Ruoff, because 1989 differed from 1984 in other respects:

- In 1989, $30 billion in investment income more than offset $20 billion in underwriting losses, leaving an operating profit. But 1984 investment income was only $17 billion, leaving an operating loss.
- Many of the losses generated in 1989 were caused by catastrophes, which were regarded by the industry as one-time situations. By contrast, in 1984, the industry situation was characterized by widespread uncertainty over the tort system.
- The industry had a $15 billion surplus increase in 1989, including $8 billion in unrealized capital gains. But in 1984, there was a surplus decline, with $2 billion in unrealized capital losses.

Discussing the market in 1990, Mr. Ruoff said rates seemed to level off in the first quarter. But price competition "heated up again" in April and May.

Meanwhile, he noted, investment operations still support price cutting on the underwriting side, and will continue to do so until underwriting losses overshadow investment income.

Also speaking at the session were James F. Billett Jr., chairman and chief executive officer of the Trenwick Group of Stamford, Conn., and Joseph R. Wiedemann, president of American Home Assurance Co., a unit of American International Group Inc. in New York.

Michael A. Lewis, first vp of Dean Witter Reynolds, and Brian Posner, portfolio manager for Fidelity Management & Research, moderated the session. ■

Meeting draws 185 analysts, insurers

NEW YORK—About 185 securities analysts and insurance company officials attended the Assn. of Insurance & Financial Analysts' 15th annual insurance symposium in New York June 12-14.

Attendance this year was about the same as in 1989. But Russell K. Mason, symposium director of the New York-based Investment Management Institute, who organizes the meeting each year, said he was pleased with the figure because many financial services firms have cut or eliminated research staffs.

"I think more people are coming back to learn," he said.

Next year's conference has been set for June 11-13.

For more information, contact Mr. Mason at the Investment Management Institute, 50 E. 42nd St., Suite 1505, New York, N.Y. 10017; 212-370-1518.

California reflects industry woes: Reinsurer

By SAM CHRISTY

NEW YORK—California is a microcosm for everything that is wrong in the property/casualty insurance industry, a reinsurance company executive says.

However, it is not unreasonable for California consumers to be upset with high insurance rates. "Insurance is too expensive out there," said Donald Kramer, chairman of Greenwich, Conn.-based NAC Re Corp.

Mr. Kramer spoke about the fallout from California's Proposition 103 and other problems facing the insurance industry to more than 200 insurance stock analysts during the Assn. of Insurance & Financial Analysts' 15th annual insurance symposium earlier this month.

NAC Re Corp., while primarily a reinsurer, wrote $8.8 million in direct property/casualty insurance premiums in California in 1988, according to A.M. Best Co.

Proposition 103, which was approved by California voters in November 1988, requires insurers to—among other things—roll back rates for most types of property/casualty insurance written between November 1988 and November 1989 to 20% below November 1987 rates.

In addition, insurers now must receive Insurance Department approval for rate changes.

While Proposition 103 has caused disruptions in the California insurance marketplace, the market could be stabilized if insurers are allowed to make a fair rate of return, Mr. Kramer said, just hours before California Insurance Commissioner Roxani Gillespie announced that insurers should be allowed a return on equity of between 11.2% and 19% when future rates are determined.

In addition, Ms. Gillespie ruled that insurers must roll back rates in accordance with Proposition 103 if they exceeded an 11.2% rate of return on the combined business between November 1988 and November 1989 (*BI*, June 18).

The 20% rate rollback has caused insurers to attempt to leave the California insurance market, especially the personal auto insurance market, Mr. Kramer said, noting a state senator has proposed the state fine insurers that pull out of the market.

"Its like the old Berlin Wall. You didn't build it to prevent people from getting in, you built it to prevent people from getting out," he said of proposed exit prohibitions. "To keep them in is going to be difficult."

The exit prohibitions only compound the problem, since insurers will be hesitant to invest in lines of business like auto insurance if they are not able to stop writing that line if profits decline, Mr. Kramer said.

"The regulators, if they were smart right now, would be trying to lock the capital into this industry rather than chasing it away," he said. "The anti-cancellation bills that they pass on this stuff only make people unwilling to commit their capital to insurance."

Mr. Kramer explained that encouraging insurers to increase levels of capital actually lowers the price of insurance, since insurers use additional capital to write more premium volume, which in turn increases competition among insurers.

Mr. Kramer also lashed out at the provision of Proposition 103 that makes the insurance commissioner post an elective rather than an appointed office.

"The truth is that the election process corrupts the intellectually honest candidate, since he has to follow essentially a populist platform," he said.

"Could you imagine extending the elected process to all professional jobs? I mean, think about it. Would you go to an elected neurosurgeon?" he chided.

He compared California's recent primary election to an "evening at the Improv," criticizing one candidate who proposed to form a fraud bureau in the state Insurance Department, even though the department already has such a bureau.

"Instead of selecting the best and the brightest, what we get with an elected insurance commissioner is someone who panders to the voters and consumers with promises that he can hardly fulfill," he said.

However, Proposition 103 is not the only source of insurers' grief. The rising cost of doing business is also hurting insurers nationwide, he said.

"The amount available for actual (claims) payments is about 50% to 55% of premium, and the balance is eaten up by agents' commissions, it's eaten up by company overhead and it's eaten up by both defense and plaintiffs' attorneys' costs," Mr. Kramer said.

While administrative costs as a percentage of claim payments has been decreasing, legal costs as a percentage of total claim payments has increased, he said.

"This is one of the major areas that we have to attack because legal costs account for some 27% of the total cost of claims for all lines," he said.

And, Mr. Kramer said, he sees no end to the continued increase in litigation and its costs to the industry.

"The industry is probably sadly underreserved with regard to legal expenses," he said. "Controlling legal fees ought to be a major item for the '90s."

Even worse than the rising costs of litigation are attorneys who advise insurers to continue to litigate when it is not profitable to do so, according to Mr. Kramer.

"The truth is that the defense attorneys are more friendly with the plaintiffs' attorneys than they are—either one—with their clients."

Regulators who demand extensive and needless reports from insurers also are partly responsible for insurers' rising costs, Mr. Kramer said.

"Regulators have to take responsibility for the costs associated with this business, too," he said.

Instead of assessing ways in which insurers' costs could be cut, regulators are focusing on last year's problems, Mr. Kramer said.

"The regulatory agenda for the current year is really designed to punish the innocent for all the things that the guilty did in the last generation," he said.

For example, a report by a House subcommittee chaired by Rep. John Dingell, D-Mich., earlier this year charged that state regulation of the insurance industry was deficient and that the parallels between insurer insolvencies and the early stages of the savings and loan crisis were "distrubing" (*BI*, Feb. 26).

But Mr. Kramer disagrees. "Dingell is looking at last year's problems," he said.

"We have already seen a flight to quality in the insurance business. We have already seen MGAs (managing general agents) discredited.

"And, the analogy to the savings and loan industry is absolutely ridiculous. How can an industry that is suffering from excessive competition and gross overcapitalization be on the brink of failure?" he asked.

There are problems in the insurance industry, Mr. Kramer admitted, but they cannot be solved in an irrational atmosphere of hostility toward insurers.

"The public and political hostility directed toward this industry seems to be the single largest impediment toward a rational attack on the genuine problems that have to be solved," he said.

"This industry needs a real boost in image," he said. "Then, perhaps, we will get some results." ■

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Analysts told to gauge investment risk

By JUDY GREENWALD

NEW YORK—Stock analysts can help prevent further erosion of insurers' asset quality by reporting on the degree to which they risk their capital in investments rather than focusing solely on investment income, an investment manager says.

Every investment has an income and a capital risk component, but analysts tend to ignore the latter, charged Robert W. Bruce III, managing partner at Steamboat Group, an investment management firm in Greenwich, Conn.

"We haven't been paying enough attention to those," said Mr. Bruce, a former chief investment officer of Fund American Cos. Inc.

"It's time we did," he said at an Assn. of Insurance & Financial Analysts insurance symposium earlier this month in New York.

Securities analysts have concentrated on insurers' investment income and have been blind to the capital risks insurers are taking, Mr. Bruce contended. "You should be focusing on the economics of the industry you're following" and not just on investment income, he said.

Looking at the asset side of the balance sheet is both "timely and worthy of a great deal of attention," Mr. Bruce said. Concerns about assets are well-founded, although "to some extent, the horse is already out of the barn," he said. "There are real problems in the industry."

Investors, regulators and other industry observers have become increasingly concerned with insurers' asset quality in recent months, with their attention focused on junk bond and real estate investments (*BI*, March 26).

Analysts ought to more closely examine balance sheets, because when balance sheets do not reflect a company's true financial condition, the income statement "does not have much meaning" and insurance is inadequately priced, he said.

Mr. Bruce said that when he was chief investment officer for Fund American, he attended meetings of an organization called Insurance Investment Officers at which investment officers were "almost crying" about being pressured by managers to make investments they knew would be uneconomical, risky and made "no sense."

One way insurance stock analysts can isolate insurers with potential problems in how they invest capital is to determine where the investment officer fits in the corporate hierarchy. According to Mr. Bruce, there is an "amazing correlation" between successful investing and high-ranking investment officers.

Stressing that insurers' investments have both an investment income and a capital risk component, Mr. Bruce said: "I accuse all of you of being blind to that second fact, of disregarding something that's very important."

He also criticized analysts for systematically excluding capital gains and losses when discussing insurer results based on the premise that those gains and losses are unpredictable and non-recurring.

The "punchline" is that total return on investment should be considered, Mr. Bruce said. "You have to be on the lookout for companies making investments on the basis of reported earnings and disregarding the capital risk."

Analysts must distinguish between insurers that minimize capital risk and those that do not and are active in real estate loans and junk bonds, he said.

Continuing erosion of insurer asset quality is not inevitable, Mr. Bruce said. But to curb it, analysts must ask tough questions and focus on economics, not accounting. "Do not rely on regulators or accountants," he said. "The burden is on you."

John B. Chesson, counsel to the Subcommittee on Oversight and Investigation for the House Committee on Energy and Commerce, pointed out that "some states don't even have an actuary on their own staffs."

The subcommittee, chaired by Rep. John D. Dingell, D-Mich., released a report early this year called "Failed Promises: Insurance Company Insolvencies" (*BI*, Feb. 26).

The panel—which is now investigating junk bonds and insurer involvement in that market—concluded that state regulation must be improved vastly to protect policyholders from the kind of mismanagement, incompetence and fraud that produced a string of large insurer insolvencies in the 1980s.

Mr. Chesson said a current "hot topic" for the subcommittee is financial reinsurance. "What it amounts to is trying to reinsure your own surplus," he said.

Myron Picoult, senior vp of Oppenheimer & Co. Inc., and Alice L. Cornish, a managing director of Northington Partners Inc., moderated the session. ■

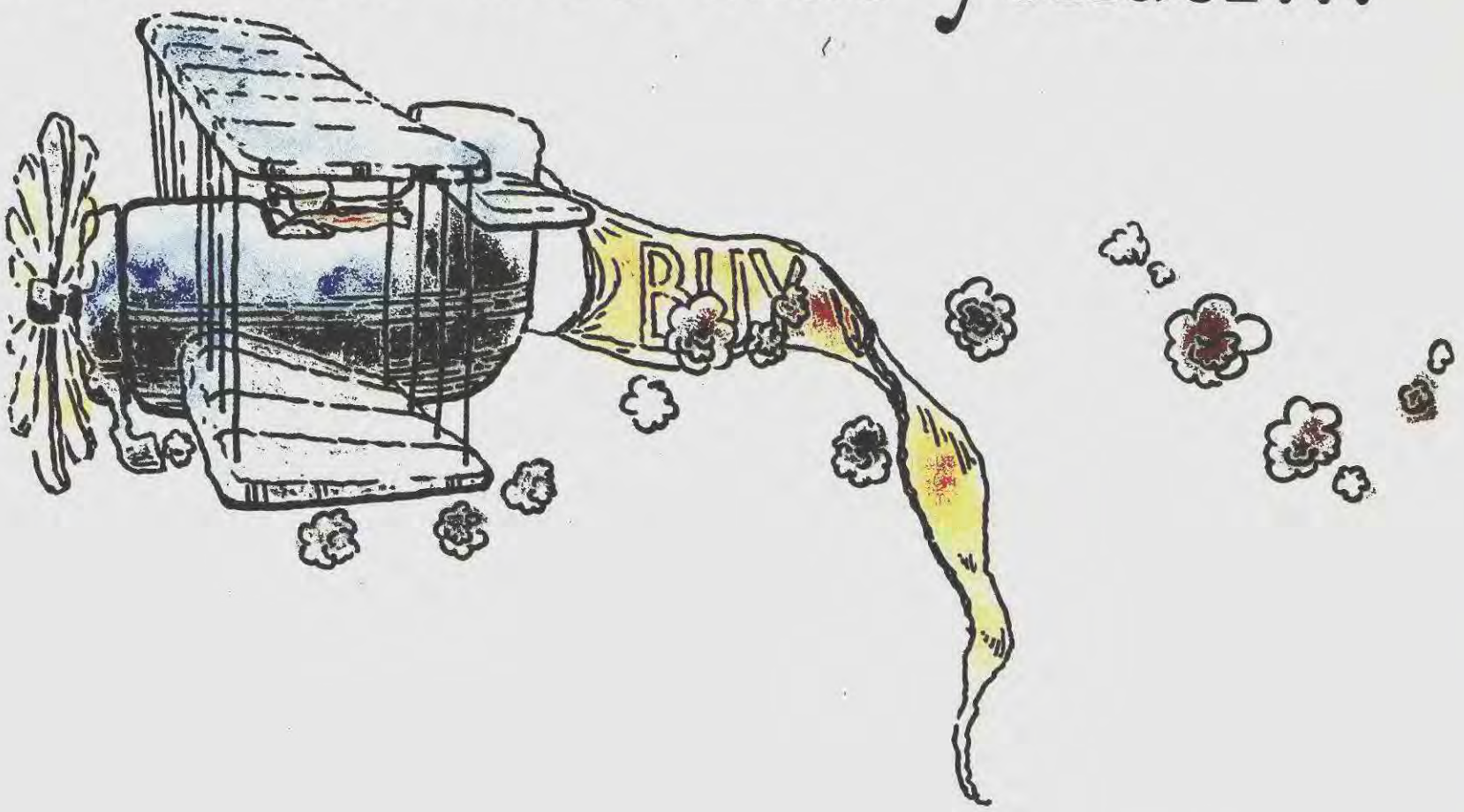
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Caterpillar

Continued from page 3

What the technicians found was that most abuse resulted from physicians' manipulation of Current Procedural Terminology codes. CPT codes were modeled after the California Relative Value Scale, a system developed in 1966 by the California Medical Society to help Blue Cross & Blue Shield plans determine what to pay for thousands of medical procedures, Dr. Hertenstein explained.

For example, CPT code 42820 represents a tonsillectomy performed on a child younger than 12.

CPT codes are now endorsed by the American Medical Assn. and Medicare, and most private insurers now require physicians to use the codes on all bills.

However, CPT codes do not establish prices, Dr. Hertenstein pointed out. Caterpillar pays doctors according to a "usual and customary rate" based on its calculations of what two-thirds of the doctors in a geographic area charge.

Caterpillar researchers found that some physicians used separate billing codes for each step of a procedure as though each step were an individual procedure.

A hysterectomy, for example, could be coded separately as: exploration of the abdomen, removal of the ovaries, removal of the Fallopian tubes and removal of scar tissue.

Some doctors also "upcode"—list a procedure on a claim that is more complex and expensive than the one actually performed.

Unbundling, upcoding and other "gaming" tactics can increase the cost of a single procedure by thousands of dollars.

"A tremendous amount of money was being wasted" at Caterpillar, said Dr. Hertenstein. "But because claims were being processed by people without medical knowledge, they didn't realize this was happening."

Only a small percentage of doctors consistently engage in this practice, Dr. Hertenstein said. But "it's human nature to try something another guy gets away with."

After the surgical technicians identified the miscoding and subsequent overpayment of claims, they looked at how insurance companies payed doctor bills.

Dr. Hertenstein said they found most insurers weren't looking at CPT codes as closely as "they should be," either.

He presented his findings in 1987 to the Pew Group, a coalition of employee benefit managers, executives and medical directors from 50 Fortune 500 employers who met semi-annually to discuss health care problems.

Dr. Hertenstein showed how some physicians were unbundling charges and explained how those excessive charges could be repackaged to produce lower physician expenses—using the appropriate CPT codes.

"The Pew fellows asked us to look at their claims that had already been processed" by insurance companies or third-party administrators, he said.

"We ran those claims through our manual system and found consistently they could save 10%" on physician charges.

Pew Group members were so pleased with the results that they asked Caterpillar to process all their health care claims.

While Caterpillar was not interested in branching into the claims administration business, it did decide to develop and market a computerized system to accomplish the task.

Prominent physicians and computer engineers from Boston University's Health Policy Institute helped design the program.

Although that think tank was "involved in the idea and the concept," CodeReview "was far too complex to conduct as part of a university function," said Dr. Richard Egdahl, director of HPI and Boston University Medical Center.

So the institute created Health Payment Review Inc. to develop the system. With financial assistance from Caterpillar and technical aid from Dr. Hertenstein, HPR developed CodeReview and is responsible for upgrading and marketing the system.

Caterpillar financed half the project in exchange for use of the computer program and a percentage of royalties, Dr. Hertenstein said.

From his manual review of claims, Dr. Hertenstein was familiar with many ways physicians could overcharge by manipulating the CPT codes.

As a result, the system contains 50,000 "rules" to help determine whether a procedure is coded appropriately.

For example, the system "knows" that primary vascular procedures, like scraping arteries, include many minor procedures. When a claim for removing artery deposits is submitted containing the "global" code for that operation but also listing separate codes for the minor procedures, CodeReview "rebundles" the claim, rejecting charges for the minor procedures, he said.

In addition, CodeReview knows that all procedural charges should include charges for pre-operation physicals and post-operation hospital care "but often times physicians try to charge separately for these, too," he said.

Dr. Hertenstein consulted extensively with outside medical experts to determine whether the "rules" were fair.

"We took the rules to the American College of Surgeons and physicians from the Health Policy Institute, who reviewed it and made sure we weren't out in left field with the rules we had in the system," he said.

"I was impressed and knew it was accurate and potentially a good system," said Dr. Oliver Beahrs, then-president of the American College of Surgeons and now professor emeritus of surgery at the Mayo Clinic in Rochester, Minn.

Caterpillar installed a personal computer version of CodeReview early in 1989, though it plans to incorporate the program into its mainframe data base.

CodeReview currently only reviews the most complex physician claims from its indemnity plan, Dr. Hertenstein said.

However, Caterpillar eventually will run every employee claim through the system, he said.

And as the system is upgraded, it should be able to verify the accuracy of lab and radiology fees and prescription drug costs, among other things, Dr. Hertenstein said.

Using CodeReview is extremely simple; claims processors do not need extensive medical knowledge, according to Dr. Hertenstein. "It's like having a doctor looking over your shoulder" as claims are processed, he said.

'It's human nature to try something another guy gets away with,' says Dr. Hertenstein.

But because the system does not catch all coding errors, employers that want to catch every suspicious claim should have someone with medical knowledge oversee the system, Dr. Hertenstein said.

Caterpillar currently employs two surgical technicians who operate the system. Surgical technicians "have a better knowledge of what goes on in the operating room," Dr. Hertenstein said. "We found most registered nurses aren't as qualified or knowledgeable about procedures because not many RNs go into the OR."

Claims processors using the CodeReview system first enter the employee's or dependent's Social Security number into the computer. The system then displays health plan eligibility information, health claims history and other pertinent information.

Caterpillar's self-insured indemnity plan covers 100% of hospital charges, surgical procedures and lab work for Caterpillar employees and retirees and their dependents. The company does not require employee or retiree contributions toward the cost of the plan.

However, the plan does not pay for doctor's office visits.

Caterpillar's prescription drug program pays for all but $2 per patient prescription.

A claims processor next punches in the CPT codes submitted by physicians. Within seconds, CodeReview analyzes the codes and either agrees with them or suggests a "recommended code" instead of the originals.

For example, one claim submitted by a physician contained eight different codes for a heart procedure performed on a Caterpillar employee. The bill totalled $3,650.

CodeReview analyzed that claim and recommended one code for the entire procedure. Based on Caterpillar's UCR for that procedure, the physician was paid only $1,200, a 67% savings.

Reports explaining why Caterpillar is rejecting some codes are generated by CodeReview and sent to physicians along with payment.

"Eighty percent of the health care claims that come in here are paid 100% and go out the door," Dr. Hertenstein said. "If a hysterectomy comes in billed at $1,800, we'll send a check for $1,800. But if the bill comes in for $5,000, we contact the physician and tell him we'll only pay $1,800.

"If a doctor doesn't agree with our usual and customary rates and sues the patient, we'll go to court." Caterpillar defends employees in physician suits about 10 to 12 times a year, he said.

"Sometimes if the patient sees the extra amount that he owes is very little, he'll go ahead and pay it because he doesn't want any conflict," he said.

Dr. Hertenstein said Caterpillar has very few problems with physician charges in Peoria, but "problems with unbundling in other areas of the United States are fairly uniform."

When it cannot process a claim based on the information provided, CodeReview asks claims processors to obtain further information. For example, the system would question a claim that it believes contains upcoding and would suspend the claim until the needed information is added.

In addition to explanatory reports for doctors, the system could generate reports on physicians who often unbundle procedures, he said.

And the reports can also "give you a picture of savings by showing what you would have paid if the charges remained unbundled," he said.

According to Caterpillar, physicians most frequently unbundle obstetric and gynecological claims. And there is a lot of 'gaming' connected with invasive cardiology procedures "because it is so complex it is very difficult to train someone to look at a claim and tell there is unbundling," he said.

However, unbundling is rarely seen in neurosurgery claims, according to the manufacturer.

Caterpillar is the first major self-insured employer using CodeReview, which has been available since early 1989.

Dr. Hertenstein said any employer that spends $4 million to $5 million on health care annually could benefit from CodeReview.

Employers with smaller health care budgets or those using outside claims administrators should "hope their TPAs or insurers are using CodeReview," he said.

Using this type of system throughout the country "would eliminate a lot of headaches" caused by disagreements over medical charges, Dr. Hertenstein said. Insurance companies, TPAs and even Medicare almost always go along with billed charges, he said.

He predicts that scrutinizing CPT codes will become widespread within the next three to four years.

Several large insurance companies are expressing interest in the mainframe version of CodeReview when it is completed, he said.

Employers can either process claims in-house or utilize the program on a service bureau basis, said Peter Polachi, vp of marketing at HPR.

Mr. Polachi would not disclose the price, saying it varies based on factors including the hardware the system runs on and the number of lives covered by a health care plan.

HPR charges clients a one-time licensing fee and an annual user fee.

If a client uses CodeReview on a service bureau basis, HPR typically charges on a per claim or per record basis, Mr. Polachi said.

The system is obviously "expensive because we have several million dollars in the research and development of it," Dr. Hertenstein said.

However, "our experience with it shows it saves as much as $20 per $1 invested in the first year," he said.

Clients can have the system tailored to a certain degree, Dr. Hertenstein pointed out. For example, an employer can obtain a program that rejects claims for "cosmetic" procedures.

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For more information about CodeReview, contact Dr. Dave Rullo, Health Payment Review Inc., 472 Commonwealth Ave., Boston, Mass. 02115; 800-522-6780.

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Companies (Winding-Up) No. 182 of 1985

IN THE MATTER OF THE COMPANIES ACT 1981

and

IN THE MATTER OF
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INTERNATIONAL

U.S. Lloyd's names must sue in U.K.

By CAROLYN ALDRED

NEW ORLEANS—A U.S. Lloyd's of London member seeking to sue Lloyd's must file suit in English courts, a U.S. appellate court says.

The judgment is good news for the Corporation of Lloyd's, which has been threatened with litigation from dozens of U.S. members facing huge underwriting losses.

Lloyd's would not comment on the ruling.

The 5th U.S. Circuit Court of Appeals in New Orleans ruled last month that a U.S. name's membership with Lloyd's is based on a contract "executed in London and designated to be performed in London."

As a result, the court rejected an application by Jay D. Hirsch to sue the Society of Lloyd's in Texas courts over losses arising from Mr. Hirsch's participation on syndicates managed by Oakeley Vaughan (Underwriting) Ltd.

The appellate decision upheld an earlier ruling by the U.S. District Court for the Southern District of Texas.

Mr. Hirsch, a partner of the Houston law firm of Hirsch, Glover, Robinson & Sheineff, initially filed litigation in a Texas state court against Lloyd's, Oakeley Vaughan and Oakeley Vaughan directors Edward St. George and Charles St. George, alleging mismanagement, negligence and violations of the Texas Deceptive Trade Practices Act and the Texas Insurance Code (*BI*, Feb. 15, 1988).

Members of syndicates managed by Oakeley Vaughan face tens of millions of dollars in underwriting losses (*BI*, Feb. 26).

In the suit, Mr. Hirsch "asserted that Lloyd's knew or should have known of mismanagement within the Oakeley Vaughan syndicates at the time he joined them," according to the appellate judgment.

Mr. Hirsch also refused to pay cash calls made by Lloyd's and the Oakeley Vaughan syndicates to pay for losses the syndicates had sustained. Mr. Hirsch obtained an injunction from a state court barring Lloyd's from drawing down a letter of credit. However, the injunction later was overturned.

In October 1987, the Lloyd's defendants removed the case to U.S. District Court, where all defendants moved to dismiss the suit, arguing that the court had no jurisdiction over them personally and that the forum was not appropriate.

"The district court agreed that Texas is not a convenient forum for litigating the parties' claims, and it accordingly dismissed" the case, it explained.

"The district court properly found that Hirsch's contract with Lloyd's was executed in London and designated to be performed in England and that Hirsch traveled to England for purposes of his transaction," the judgment stated.

"Insofar as Hirsch attacks the method by which Lloyd's oversaw the performance of underwriting agents such as Oakeley Vaughan, the documentation and witnesses

Continued on next page

Lloyd's, Sun Alliance join to offer cover in E.C. nations

By CAROLYN ALDRED

LONDON—Lloyd's of London is joining forces with Sun Alliance Insurance Group P.L.C. and four Lloyd's brokers to offer property/casualty insurance coverage for corporations throughout the European Community.

The new venture—dubbed Eurosure—will provide large European corporations with up to $250 million of property and business interruptions coverage. It also will provide general and product liability insurance and marine cargo coverage, but with lower limits.

The facility will be marketed by Lloyd's brokers Alexander Howden Ltd.; C.T. Bowring & Co. (Insurance) Ltd.; Sedgwick Broking Services Ltd.; and Willis Faber & Dumas Ltd.

The formation of Eurosure was announced last week by senior representatives of Sun Alliance, Lloyd's and the four brokerages.

The venture represents one of the first initiatives between Lloyd's and a major British insurance company to together tackle the forthcoming single European market to "help reinforce confidence in the London market," said Roger Neville, group chief executive of Sun Alliance.

LONDON

The joint venture "will create an extremely large facility for brokers to market in Europe," noted David Coleridge, chairman of Lloyd's underwriting agency Sturge Holdings P.L.C.

Access to the facility will be through the four Lloyd's brokers, which together have dozens of offices throughout Europe, he said.

The Eurosure facility, which is 50% underwritten by Lloyd's syndicates and 50% by Sun Alliance, provides:

- Property damage and business interruption cover up to 145 million pounds ($250 million) per occurrence with unlimited aggregate cover.

The property and business interruption policies are jointly led by Sun Alliance; Lloyd's syndicate 190, underwritten by Richard Hazell and managed by Three Quays Underwriting Management Ltd.; and syndicate 210, underwritten by Patrick Plaisted and managed by R.W. Sturge & Co.

- General liability and product liability coverage of up to 10 million pounds ($17.2 million), which is underwritten 50% by Sun Alliance and 50% by syndicate 386, underwritten by Michael Payne and managed by Janson Payne Management Ltd.

The liability business is written mainly on an occurrence basis, said Mr. Payne.

- Marine cargo risks with limits of up to 15 million pounds ($25.9 million), led jointly by Sun Alliance and syndicate 206, underwritten by Michael Maughan and managed by R.W. Sturge.

Eurosure was designed to take advantage of the impending removal of trade barriers for large commercial insurance risks in the European Community. As of July 1, certain large companies in eight of the 12 E.C. nations will be able to buy coverage from insurers authorized in any of the eight countries.

To qualify, a company must meet at least two of the following criteria:

- Have 500 or more employees.
- Have minimum annual revenues of 24 million European Currency Units ($29.5 million).
- Have a minimum balance sheet total of 12.4 million ECUs ($15.2

Continued on next page

West German insurers poised to cross border

By DON LEWIS KIRK

BERLIN—When the West and East Germany unite their currencies next week, West German insurers will, for the first time, be able to expand into East Germany.

Western insurers and industry observers are at once eager to tap the potentially huge, though undeveloped, market but also uneasy about potential pitfalls, like potentially huge pollution liabilities.

Exact values of East German industrial property are unknown, but rapid growth in the need for insurance in East Germany is inevitable, predicts Wilhelm Alms, a market analyst with Mummert & Partner, a consulting firm in Hamburg. "Companies in East Germany are going to need just the same coverage as their West German competitors," he said.

East German industrial conglomerates known as "kombinates"—which control some 95% of the nation's production—are expected to seek commercial insurance coverage they could not previously obtain in the East German market, like coverage for product liability, business interruption and other risks (*BI*, June 11).

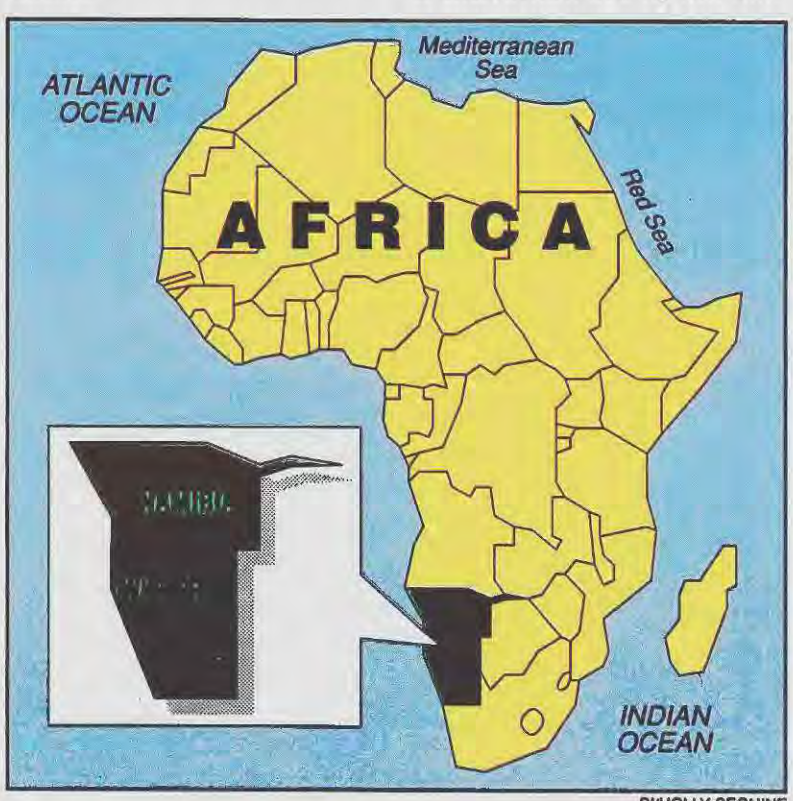
And, at least one West German insurer—Alter Leipziger Lebensversicherung A.G. of Taunus—expects pension plans and life insurance to be a big market.

"East Germans are concerned about their pensions, particularly young people. The pension system only extends to 2010. Most young people don't get their pensions until 2020," says Hanns-Jurgen Weigel, chief executive officer of Alter Leipziger.

Another West German insurer is more cautious, saying radical change is unlikely when East Germany opens its market on July 2.

"You can't enter a market like this with computer insurance or electronic insurance," says a spokesman for Colonia Versicherung A.G. in Cologne. "We'll slim down our policies to fit the market. But

Continued on next page



BI/HOLLY SEGUINE

Namibia considers insurance code

New nation drafts rules

By MARIA KIELMAS and STACY SHAPIRO

WINDHOEK, Namibia—The new African nation of Namibia, declared independent from South Africa earlier this year, already is considering its own insurance legislation.

As early as next month, the newly formed government is expected to consider and possibly adopt the second and final draft of the Namibian General Insurance Act of 1990.

The government is also expected to approve the Long Term Insurance Act of 1990, which deals with life insurance regulation.

The two new acts will replace the South African Insurance Act of 1943, inherited from its old colonial ruler.

"We want to make sure the law is workable and sensible," said David Rush, director of Public Finance at the Ministry of Finance in Windhoek, the Namibian capital.

The Namibian general insurance market is set to expand because the purchase of insurance has become affordable for more people since the end of hostilities with South Africa, he said.

"Companies have been putting rates down in the absence of civil commotions and riots," he said. Mr. Rush said there was no real infrastructure or legislation yet for a local insurance market to develop, "but we are hopeful there will be one in the future."

The new Namibian government and a new constitution was installed on March 21. Formerly known as South West Africa, the country was declared a German colony in 1884. In 1915, it came under the control of South Africa, which was then a British colony.

However, the South West African Peoples Organization, the present party in power in Namibia, had been fighting a guerrilla war for independence from South Africa from the 1960s until last year, when a cease-fire was reached and free elections were held.

Gross premium income in the Namibian market last year was 74 million South African rand ($29 million, at year-end commercial exchange rate) for general insurance business and 150 million South African rand ($58.7 million) for life business, according to insurance sources.

There were 11 insurance companies operating in Namibia before independence last year, but sources expect that there will be about seven by the end of 1990 due to mergers and political

Continued on page 31

INTERNATIONAL

Germany

Continued from previous page
you can't expect a lot in the beginning. You can't offer theft policies if there's nothing to steal," said the spokesman.

To some insurers, regulation could prove crucial.

West German regulators must approve East German operations for all registered insurers, says a spokeswoman for the Federal Insurance Supervisory Authority in Berlin.

In addition, West Germany's insurance supervisory law—known as VAG—will regulate the East German market, the spokeswoman commented.

The Federal Insurance Supervisory Authority spokeswoman noted, though, that policies sold in East Germany would be subject to that country's civil code.

Nevertheless, strict West German liability rules will apply to East Germany after the economic and monetary union.

This has dampened most West German insurers' interest in providing coverage for East German environmental risks.

The insurers fear they could be held to Western pollution liability standards while saddled with the cleanup of numerous hazardous waste sites.

Other West German insurance underwriters say that they are wary of insuring outdated production facilities.

Frank Golinski, executive director of Gerling Konzern Insurance A.G. in Cologne, the nation's leading underwriter for chemical companies, says he doubts many facilities aged 50 years or older can be insured.

"We'll see what East German industry does, of course, and we'll have to pioneer a lot of risk coverage," he says.

"But when it really comes down to the question of insuring outdated machinery and facilities, why do it?" Mr. Golinski said.

Such concerns aside, many other western companies remain interested.

In Berlin, the Federal Insurance Supervisory Authority began licensing procedures last week for at least 350 insurers it expects will operate in East Germany.

A state monopoly—Staatliche Versicherung der DDR—long controlled insurance in East Germany and a rush of foreign insurers into its former domain could cut substantially into its business.

However, a joint venture between Staatliche and Allianz A.G. of Munich, Europe's largest insurance company, could soften that fall (*BI*, April 16). ■

Lloyd's ruling

Continued from previous page
must be in England. The logistical scale tips strongly toward England," it noted.

In addition, "Hirsch's argument in this court that he could enforce a Texas judgment against the defendants is. . .highly dubious," according to the judgment.

The appellate court also dismissed Mr. Hirsch's argument that "he would be severely disadvantaged by being forced to litigate against these defendants in England."

The appellate court noted that "approximately 40 of Hirsch's fellow underwriting members, including U.S. citizens, are presently pursuing a lawsuit in the High Court of Justice in London against these defendants."

"Hirsch has not shown that he is unable to join that lawsuit or to commence his own lawsuit in England."

Moreover, "the district court concluded that English statutory laws would be applied and that English courts have a significant 'local interest' in resolving the disputes internal to the operation of Lloyd's. Despite Hirsch's insistence that his claims are governed by Texas law, we agree with the district court's decision to the contrary," the appellate judges ruled.

"This lawsuit aims at the heart of the unique self-regulatory mechanism within Lloyd's, which is a product of complex English legislation," the judges declared.

The judgment likely could be used by defendants in other suits brought in U.S. courts by U.S. members of Lloyd's.

For example, U.S. members of syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., who face huge losses from the syndicate's 1982 underwriting year, are considering suing Lloyd's, the Outhwaite agency and their members' agencies in the United States. ■

LONDON

Continued from previous page
million).

Sun Alliance and Lloyd's spent more than 12 months working with the brokerage to formulate standardized core policy form wordings, which have since been translated into the principal European languages.

Each policy can be adapted to cater to the needs of individual clients varying from country to country, according to Sun Alliance's Mr. Taylor.

E&A buys U.S. insurer

London-based English & American Group P.L.C. is making its first foray into North America by buying for an undisclosed sum The New Zealand Reinsurance Co. of America from General Accident Fire & Life Assurance Corp. P.L.C. of Perth, Scotland.

Although the name "English & American" has been around for 61 years, the purchase represents the first time that the company will actually underwrite from a U.S. office, according to E&A Director Ian Daish.

General Accident, which acquired NZ Re in 1989 when it bought New Zealand Insurance Corp., agreed last week to sell the company to a consortium of buyers headed by E&A. The sale, which was made for cash, is subject to regulatory approval in the United Kingdom and the United States.

E&A plans to continue the mainly non-marine property reinsurance underwriting of Chatham, N.J.-based NZ Re and to introduce aviation underwriting, for which E&A is well known worldwide, said Managing Director Tony Taylor. With a premium volume of $30 million last year and a staff of 14 people, NZ Re will continue to be headed by President and Chief Executive Officer Jeremy Wallis.

The purchase is part of an overall strategy to develop E&A's underwriting expertise in North America, according Mr. Taylor.

Lloyd's brokers abroad

A "handful" of brokers from France and Spain have approached Lloyd's of London about becoming Lloyd's brokers, says Lloyd's Chief Executive Alan Lord.

For some time, Lloyd's has encouraged European Community-based brokers to become Lloyd's brokers to increase the market's retail presence in the European Community as trade barriers in those nations begin to fall.

Lloyd's announced this month that it extended the scope of its broker regulations to allow non-E.C. intermediaries to become Lloyd's brokers. However, Mr. Lord stressed that non-British brokers will still have to meet the same financial and professional standards laid down in Lloyd's 1988 broker regulations.

Meanwhile, in a separate initiative to encourage broker-driven marketing, the market introduced a new broker logo, modeled on the atrium of its famous London headquarters. Any Lloyd's broker can use the market logo. Officials called the new logo "a clear visual sign linking them to Lloyd's."

In a letter to brokers, Chairman Murray Lawrence said that "use of the symbol as a mark of quality will demonstrate Lloyd's brokers' status, identifying them as able to meet the highest standards. It will also do much to spread the Lloyd's name wherever Lloyd's brokers are active, working for the good of the Society as a whole."

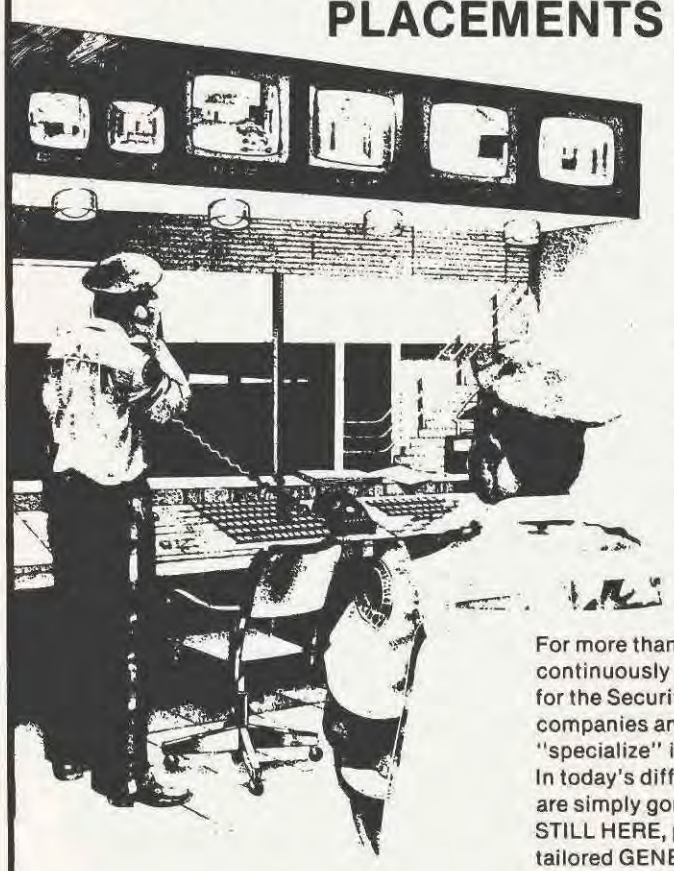
Sturge profits

Sturge Holdings P.L.C., parent company of Lloyd's of London's largest underwriting agency, anticipates lower profits for 1991 and 1992 and cites what it predicts will be "disappointing" results from Lloyd's for the 1988 and 1989 underwriting years.

Sturge this month reported pretax profits of 4.7 million pounds ($7.9 million) for the six months ended March 31, up 24% from 3.8 million pounds ($6.1 million) for the same period last year.

The company says it expects profits for the year ending Sept. 30 to be similar to 1989's pretax profits of 31.2 million pounds ($50.2 million). Under Lloyd's three-year accounting system, the 1987 accounting year closed in 1989. ■

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Business Insurance

INTERNATIONAL

Namibia

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pressure, since all of the insurers are based in South Africa.

The largest insurer last year was Santam Insurance Co. Ltd. of Cape Town, South Africa, a subsidiary of Sentinel Insurance Corp. Ltd., with annual premiums of 26 million rand ($10.2 million) last year.

According to African sources, the nation's next largest insurers, based on 1989 premiums written, are:

- Mutual & Federal Insurance Co. Ltd. of Johannesburg, South Africa, 18 million rand ($7 million).
- Incorporated General Insurance Ltd. of Johannesburg, 15.5 million rand ($6.1 million).
- Allianz Insurance Ltd., a Johannesburg-based unit of West German insurer Allianz A.G. Holdings; Aegis Insurance Co. Ltd. of Johannesburg, a unit of British insurers Norwich Winterthur Overseas Ltd. and Legal & General International Ltd.; and Commercial Union Assurance Co. of South Africa Ltd., a Johannesburg-based unit of Commercial Union Assurance P.L.C., which each wrote 2.5 million rand ($979,000).
- Guardian National Insurance Co. of Johannesburg, 1.9 million rand ($744,040).
- Building Society Business of Johannesburg, 1.5 million rand ($587,400).
- Sentraboer (Cooperative) Ltd. of Johannesburg, South Africa, 1.4 million rand ($548,240).
- Fedgen Insurance Ltd. of Johannesburg, 1.3 million rand ($509,080).

"We will try to get the subsidiaries of South African companies (underwriting in Namibia) incorporated as Namibian companies," said Mr. Rush. They must all comply with the new Namibian insurance regulations "or they can get lost," he said.

Risks from large corporations such as the mining conglomerates in Namibia are too large for the local market and are channeled into the international market via offshore captives, says Mr. Rush.

The insurance legislation will allow foreign reinsurers to directly reinsureNamibian insurers, rather than force all reinsurance to pass through a state-owned company as is done in several other African nations.

"They (the foreign reinsurers) will be virtually unrestricted and we think that is a good thing," he said.

"We have been sitting here all these years battling with (edicts) from across the border. Now that we have a breath of fresh air we want to do something. This is a very self-sufficient country."

European insurers and reinsurers such as Lloyd's of London, Swiss Reinsurance Co. and Munich Reinsurance Co. have expressed interest in the new Namibian market. Only Munich Re has a local office.

Mr. Rush says he would like reinsurers to open representative offices "so we can keep an eye on them."

He says South African law was chaotic. "Since 1943 it has been amended and amended and no one has a clue what applies to whom. But Clause 140 of the Namibian Constitution states that we will take over the act temporarily until new legislation is approved.

"We don't agree with over 60% of what goes on in" in insurance in South Africa," said Mr. Rush. "And we are switching our sights to Europe. We have been assisted by London and especially by Bonn."

However, Mr. Rush said that some of the attitudes of the European insurers were rather "paternalistic."

Under the first draft of the General Insurance Act of 1990, the country's Minister of Finance will appoint a commissioner of general insurance for Namibia who will be in charge of supervising the insurance market, including reinsurers and brokers.

Ideally, the ministry would like to have two insurance commissioners, one in charge of general insurance and one in charge of life insurance.

"But we don't have enough money to pay for two people at the moment," said Mr. Rush. "We cannot compete for people in the (world) market, so we may ask the IMF (International Monetary Fund) to give us someone."

All companies that plan to write all classes of general insurance or reinsurance in Namibia must be registered with the Ministry of Finance and approved by the commissioner.

All insurers that were registered under the South African law must notify the commissioner that they intend to continue underwriting in Namibia within 30 days after a fixed date after the new act is passed, says the draft law.

Within 60 days after that, all the documents for re-registration have to be filed to the commissioner.

To register, each insurer must pay a fee to be set by the commissioner.

The company must:

- Have capital of at least 500,000 rand ($187,600 at current commercial exchange rate) to write one class of business and 1 million rand ($375,200) for more than one class.
- Deposit with the commissioner either cash or approved securities worth 50,000 rand ($18,760) for one class of business or 100,000 rand ($37,520) for more than one class.
- Deliver to the commissioner a business plan with the company name, directors and types of insurance to be underwritten.
- Maintain its principal office and name a principal officer in Namibia.
- Maintain a margin of solvency of 15% of gross written premium for the previous year or 1 million rand, whichever is the greater amount.
- Submit accounts each year checked by an approved auditor.
- Manage its affairs in "the utmost good faith."

The insurance legislation also has a section dealing with "associations of underwriters," which primarily applies to Lloyd's of London.

Under this section, Lloyd's syndicates writing in Namibia would have to be audited annually and be approved by the commissioner. Lloyd's must also furnish annually to the commissioner a certified copy of the market's global results and a certificate signed by the Lloyd's chairman and the British Department of Trade and Industry "that the members of the association (Lloyd's) have. . .complied with the insurance law relating to (British law)," says the draft.

Meanwhile, any company or person who wishes to carry on reinsurance business in Namibia as a foreign reinsurer must also be registered as a foreign reinsurer, according to the draft.

The foreign reinsurer must:

- Comply with the laws of the country where it is domiciled.
- Maintain capital exclusively for reinsurance of 3 million rand ($1.1 million) or the equivalent in foreign currency for one class of reinsurance and 5 million rand ($1.9 million) to write more than one class.
- Deposit with the commissioner 100,000 rand ($37,520) to write one class and 150,000 rand ($56,280) for more than one class of business.

The commissioner, however "shall not register a foreign reinsurer if it appears to him that. . .(the representative of the company) is not a fit and proper person to hold the position held by him," says the law.

The Namibian government is expected to include regulations for insurance brokers in its second draft of the legislation.

In order to be registered, insurance brokers will have to, among other things, submit annual returns; maintain investments in approved securities of not less than 25,000 rand ($9,380); and buy professional liability insurance of not less than 500,000 rand ($187,600) or 50% of brokerage income, whichever is greater. ■

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PBGC victory

Continued from page 1

cially troubled companies, federal regulators say, also would have abandoned pension programs, dumping billions of dollars in liabilities onto the federal agency and then establishing new low-cost programs.

"Other companies were waiting to do what LTV did: tank up at the PBGC's and premium payers' expense. If that had been allowed to happen, there would have been no way to protect the PBGC," says Kathleen P. Utgoff, a former executive director of the pension agency and now an economist with Groom & Nordberg, a Washington, D.C., law firm.

Had other companies followed the LTV course of action the PBGC —already straining under a $1 billion deficit—would have had to seek a sharp hike in premiums to fund its new liabilities.

Employers' annual premiums increased during the 1980s from a flat $2.60 per participant to a variable rate of $16 to $50 per participant, depending upon how well a plan is funded.

Ultimately, some employers with well-funded defined benefit plans would have terminated those plans to avoid paying higher premiums, observers say. That would have dried up funding for the PBGC, probably prompting its collapse or a federal bailout.

"The PBGC is the last best hope for defined benefit plans. If the PBGC goes down, so does the nation's pension system," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans, a lobbying group in Washington, D.C.

"By winning this decision, the PBGC's discretion to deal with abuses has been greatly strengthened," said Gary Ford, a Groom & Nordberg partner and former PBGC general counsel.

"The decision preserves the PBGC's resources for where they really are needed. It keeps the cost of defined benefit plans and PBGC premiums under control. That is in the long-term interest of employers and workers," Mr. Ford said.

"This was a critical decision to the PBGC and its future financial exposure to pension liabilities," said John Erlenborn, a partner with Seyfarth, Shaw, Fairweather & Geraldson, a Washington, D.C., law firm. Mr. Erlenborn, a former U.S. representative from Illinois, played a leading role in drafting ERISA in the early 1970s.

Hailed as a boon to the private pension system, the Supreme Court ruling poses grave problems for LTV, a Dallas-based aerospace company and steel manufacturer which has been operating under Chapter 11 of the Federal Bankruptcy Code since July 1986.

By reassuming responsibility for the pension plans—which have about 100,000 participants—LTV again is liable for annual contributions of more than $200 million.

In 1986, the company asked the PBGC to terminate the plans, saying it could not afford them.

"The situation has not changed. We still cannot afford the plans. The company's objective is to continue to seek a resolution that recognizes that fact," said an LTV statement.

Company officials last week were discussing strategy in the wake of the Supreme Court decision. A spokesman said LTV is contemplating a range of options, including trying again to terminate the plans.

Pension agency officials, though, said they would resist such a move.

Mr. Lockhart, the PBGC's executive director, said LTV can afford to fund the plans, noting the company's positive cash flow and reported net profits of $264.9 million in 1989.

According to the LTV spokesman, the profit figure is misleading because some payments the company would normally make were suspended while the company is in Chapter 11 reorganization.

If LTV were to terminate its plans, it would have to do so under tough rules in the Pension Protection Act of 1987—passed after the LTV plans were terminated.

To qualify for a "distress" termination, a company must now, among other things, prove that it would face liquidation if the plan is not terminated.

"We don't think LTV meets the criteria for a distress termination," said PBGC General Counsel Carol Connor Flowe.

The LTV pension case began in early 1987 when the three LTV plans were terminated by the PBGC after the company said it could no longer afford to make contributions.

But in September 1987, in a step unprecedented in its history, the PBGC ordered LTV to reassume responsibility for the plans, which at the time had about $3 billion in liabilities and about $1 billion in assets (*BI*, Sept. 28, 1987).

The PBGC acted after LTV, as part of a collective bargaining agreement with the United Steel Workers union, established new pension plans that restored to union members certain benefits, not guaranteed by the PBGC, lost when the old plans were terminated.

New follow-on plans, the pension agency charged, were in effect an illegal continuation of the terminated plans for which it, rather than the company, was paying the bulk of the benefits.

Allowing LTV to proceed would have made terminations virtually "irresistible" to financially troubled companies, Ms. Utgoff, then the executive director, said when the pension agency tried to make LTV take back the plans.

PBGC officials estimate that LTV's follow-on program costs $75 million to $90 million a year, compared with more than $200 million annual cost of funding the disputed plans.

Workers and retirees did not complain about the new arrangements. Their combined benefits from the PBGC and from the follow-on plans are close to or equal to what they were promised before the original plans were terminated.

While the PBGC described the follow-on plans as an abuse of the pension insurance program, LTV attorneys defended them as legal and financially necessary.

During the first two rounds of a nearly three-year legal battle, federal courts accepted LTV arguments.

U.S. District Court Judge Robert Sweet in New York ruled in June 1988 that the PBGC had acted in an "arbitrary and capricious" manner in returning the plans to LTV. He said that the PBGC did not show a "factual or legal" basis for restoring the plans (*BI*, June 27, 1988).

In 1989, the 2nd U.S. Circuit Court of Appeals in New York affirmed Judge Sweet's decision, saying that the legislative history of ERISA reveals no indication that Congress ever intended the establishment of successive benefit plans to be grounds for restoration (*BI*, May 22, 1989).

But the Supreme Court disagreed. In its June 18 decision, the court said Section 4047 of ERISA gives the federal agency power to restore terminated plans where it determines restoration is "appropriate and consistent with its duties" as spelled out in Title IV of ERISA.

Under that section, the federal agency's statutory duties include continuation and maintenance of voluntary private pension plans for the benefit of participants and keeping PBGC premiums as low as possible.

'Other companies were waiting to do what LTV did: tank up at the PBGC's and premium payers' expense. If that had been allowed to happen, there would have been no way to protect the PBGC,' says Ms. Utgoff, a former head of the agency.

The court said the PBGC policy against follow-on plans is based on the belief that employees would object more strenuously to termination of a pension plan if the company cannot form new plans to pay benefits not guaranteed by the PBGC.

"The availability of a follow-on plan thus would remove a significant check—employee resistance—against termination of a pension plan," Justice Blackmun wrote.

"Consequently, follow-on plans may tend to frustrate one of the objectives of ERISA—that the PBGC is supposed to accomplish the 'continuation and maintenance of voluntary private pension plans,' " the opinion said.

Follow-on plans also tend "to increase the PBGC's deficit and increase the insurance premiums all employers must pay, thereby frustrating another related statutory objective—the maintenance of low premiums," Justice Blackmun said.

"In short, the PBGC's construction based upon its conclusion that the existence of follow-on plans will lead to more plan terminations and increased PBGC liabilities is assuredly a permissible one," he observed.

In addition, the justices said the PBGC is in a better position than the courts to make a decision on the protection of the program.

"Indeed, the judgments about the way the real world works that have gone into the PBGC's anti-follow-on policy are precisely the kind that agencies are better equipped to make than are courts," the justices said.

In his dissent, Justice John Paul Stevens said as long as a company uses its best efforts to complete bankruptcy reorganization, the PBGC has no reason to interfere with managerial decisions.

"Whether the company's resources are dedicated to current expenditures or capital investments and whether the package of employee benefits that is provided to the workforce is composed entirely of wages, vacation pay and health insurance, on the one hand, or includes additional pension benefits, on the other, should be matters of indifference to the PBGC," Justice Stevens said.

Restoration of LTV's plans, he added, "constitutes punishment of both labor and management for the imprudence of their predecessors."

While the Supreme Court's decision removes the immediate threat of the PBGC being hit with billions of dollars in liabilities from LTV and other companies pursuing follow-on strategies, no one suggests that the PBGC's financial worries are over.

Indeed, the very nature of the PBGC—insuring all defined benefit plans—makes the agency vulnerable to big claims when companies collapse, leaving insufficient assets in their pension plans to pay guaranteed benefits.

The agency "always will be exposed to large unfunded liabilities if a major company goes under," said Robert Nagle, a former PBGC executive director and now a Washington pension attorney.

While the LTV decision does not eliminate future difficulties for the PBGC, it does strengthen the pension insurance program, said EBRI's Mr. Salisbury.

And, over the long haul, tougher pension funding rules laid down by the 1987 Pension Protection Act should improve funding of corporate pension plans, reducing the likelihood of big claims against the PBGC, benefit experts say. ■

Cook Paint lawsuit

Continued from page 3

cago, a CNA Financial Corp. unit, which wrote primary completed operations and product liability coverage with a $500,000 limit over a $100,000 per claim retention for the 1985-86 policy year.

- International Surplus Lines Insurance Co. of Chicago, a Crum & Forster Inc. unit, which wrote $1.5 million of coverage excess of $500,000 for the 1985-86 policy year.
- Granite State Insurance Co. of Manchester, N.H., an American International Group Inc. unit, which wrote $3 million of limits excess of $2 million in 1985-86.
- Constitution State Insurance Co. of Hartford, Conn., a Travelers Corp. unit, which wrote $5 million of coverage excess of $5 million in 1985-86.
- International Insurance Co. of Chicago, another Crum & Forster unit, which wrote umbrella coverage with limits of $10 million excess of $10 million for the 1983-84 and 1984-85 policy years.
- Union Insurance Co. of Lincoln, Neb., a W.R. Berkley Corp. unit, which wrote $10 million of umbrella limits excess of $10 million in 1985-86.

After Allied Tank filed its lawsuit against Cook Paint in 1989, the paint producer asked its broker, Alexander & Alexander Inc., to notify all of its insurers, according to the Cook Paint lawsuit.

A&A notified the Missouri guaranty fund, Columbia Casualty and Transport Indemnity, but none of the three has paid any of the costs of defending the paint company in the Allied Tank suit, Cook said.

Cook, though, hired defense lawyers recommended by Columbia, Mr. Wagstaff said.

The paint company also discovered in May—at about the same time the Allied Tank suit was ready to go to trial—that A&A had not told any of its other insurance companies about the litigation, according to Cook Paint's complaint.

The paint manufacturer immediately notified the other insurers itself and demanded that they contribute to a settlement of the Allied Tank claims, the complaint says.

Mr. Wagstaff said attorneys for Allied Tank offered to settle the case for $6.5 million about a week before trial and subsequently made settlement offers of $6.9 million and $7 million.

Cook repeatedly demanded that its insurers settle the Allied Tank action, but the insurers failed to settle the case "even though the consequences of such failure to settle could be devastating to Cook," the complaint alleges.

All of the insurers have sent Cook letters reserving their rights to deny coverage under their policies, according to Mr. Wagstaff. Several of these letters cited a failure to give timely notice of the claim as one possible basis for denying liability, he said.

Several other coverage issues also exist, including whether the Columbia Casualty policy includes defense cost coverage and the number of occurrences under each policy, Mr. Wagstaff said.

Cook Paint's lawsuit seeks a declaratory judgment that the insurers must cover defense costs and indemnify Cook Paint for the jury award.

The complaint also charges that the insurers breached fiduciary obligations and duties of good faith in wrongfully refusing to settle the action.

The complaint does not name A&A, and Cook Paint is not currently suing its broker over the alleged failure to notify several of the insurers, Mr. Wagstaff said. However, "we are keeping our options open" regarding a future action against the broker, he added.

An A&A spokeswoman in New York declined to comment.

None of the insurers named in Cook Paint's lawsuit has filed an answer.

Tom Alleman, a lawyer with Niewald, Waldeck & Brown in Kansas City, representing ISLIC, declined to comment.

Lawyers for the other insurance company defendants could not be reached. ■

Accountants absolved of company's failure

WASHINGTON—A bankrupt company must prove that an accounting firm—not the company's own management—caused the financial problems that led to the company's bankruptcy in order for the accountant to be held liable for the company's failure, a federal appellate court ruled.

The June 15 decision by the U.S. Court of Appeals for the District of Columbia reverses an $11 million award by a District of Columbia jury.

"What's important about this case is having the court of appeal recognize that accounting firms can't be held accountable when the accountants' work wasn't the cause of those business losses," said Kathryn Oberly, an attorney in the Washington office of the Chicago law firm Mayer, Brown & Platt.

The decision "recognizes that management was running the company, not the outside auditors," she added.

Ms. Oberly represented Chicago-based accounting firm Grant Thornton in an appeal of a 1985 jury verdict that awarded $11 million to the trustee of bankrupt Auto-Train Co. (*BI*, July 29, 1985).

The lower court jury found Grant Thornton liable for breach of contract, negligence and fraud in connection with audits for Auto-Train in 1978 and 1979. Auto-Train, which carried cars and passengers by rail between suburban Washington and Florida, ceased operations in 1981.

Auto-Train's trustee charged that Grant Thornton had overestimated the value of Auto-Train's assets and did not point out that Auto-Train used money withheld for federal payroll taxes to meet cash needs.

However, in a unanimous June 15 decision, a three-judge panel of the U.S. Court of Appeals for the District of Columbia threw out the lower court verdict.

In the decision, Judge Stephen Williams wrote that the evidence on which the 1985 jury had made the award failed to show the Grant Thornton had caused or contributed to Auto-Train's financial woes.

The appellate court also noted the audits contained qualified opinions of Auto-Train's financial stability.

Ms. Oberly said the decision is significant because "cases against accountants are growing at an alarming rate, and the crucial issue in virtually all of them is causation."

Counsel for Auto-Train's trustee was unavailable for comment.

—By Mark A. Hofmann

Claims program

Continued from page 3

process. Success will be dependent upon the strength of mutual communication between yourselves and your claims administrator," he said.

He recommends beginning a claims handling program by setting up pre-occurrence procedures like a hazard recognition and loss control program.

Mr. Condne also suggested that public entities work to obtain certificates of insurance from vendors, contractors and any other users of public property.

"It also helps to be named as an additional insured on all certificates of insurance and even a named insured if possible," he said.

Municipalities should also strive to incorporate hold-harmless agreements into all public contracts. "This way, you can bring additional defendants into a claim litigation situation," he said.

The final part of pre-occurrence planning includes hiring in-house claims handling personnel, third-party administrators and lawyers.

"Get references and talk with local attorneys about TPAs," Mr. Condne recommended.

And too often, he said, governments hire corporate lawyers who they feel can also handle claims litigation for municipalities. Mr. Condne recommends seeking out specialists. "Check them out. Interview them and put firms up against each other. Some competition usually makes them do a better job," he added.

"Also, if you have an excess or stop-loss carrier, make sure they approve of your counsel, because in essence your lawyers represent them, too," said Mr. Condne.

After an accident that could lead to a liability claim, a public employee should never admit to being fully or partially at fault, liable or responsible, according to Mr. Condne.

"So often risk managers get to a claim only to find out that their maintenance man has already promised the claimant money. This puts you, as the risk manager, in an awkward situation," he explained.

Conversely, public employees should always:

- Check for injuries and call an ambulance.
- Obtain the name, address and telephone number of those injured.
- Obtain names, addresses and phone numbers for all witnesses.

"They can possibly testify on your behalf and their statements could go a long way toward disproving a false claim. Also, their testimony can bring other things to the forefront that weren't otherwise known," Mr. Condne said.

- Call the police and make a report in cases of vehicle accidents and do not move vehicles until the police have made reports.
- Take photographs.

"Pictures speak 1,000 words. Take several shots from all directions. One of our clients has even put a disposable camera in every one of its buildings and in the glove compartment of all its vehicles," Mr. Condne said.

- Sketch the scene of the accident showing measurements and placement of objects.

"You want to identify things that won't change, like trees, bushes and telephone poles," he said.

- Barricade the area to prevent future accidents, if required.
- Take physical control of the object that caused the accident, even if it is a banana peel.
- Get a written statement because many times people will make a direct claim or indicate that they will present a claim. Give the person a piece of paper and ask him to write down his name, address and phone number and provide a description of what happened. This document then can act as a written statement.
- Report the claim as soon as possible to enable the claims administrator to begin investigation.

After a claim has been filed, the risk manager should communicate any additional information to the claims administrator even if there has been a significant amount of time between when the claim was filed and when the new information was learned.

"Unless the claim has been terminated, it's never too late to react. Even if it's closed, you may still have subrogation possibilities," Mr. Condne said.

Lastly, all claimants and their representatives, as well as insurance company personnel, should be directed to the risk manager or another appropriate person to avoid the release of misinformation.

Robert S. Coker, risk manager for the city of Coral Springs, Fla., moderated the session. ■

Use goals to evaluate public safety programs

By MICHAEL SCHACHNER

RENO, Nev.—A risk or safety manager must take three initial steps when evaluating a public entity's safety program, says the risk manager for a Southern California air quality management district.

A risk manager must clarify the safety program's goals, identify indicators of performance and determine the program's objectives, said Gregory F. Hidden, risk manager for the South Coast Air Quality Management District in Diamond Bar, Calif.

By spelling out these expectations, risk and safety managers can establish a firm base for organizing safety activities and defining who is accountable for safety, Mr. Hidden said at a session on evaluating safety programs at the 11th annual Public Risk Management Assn. conference held June 10-13 in Reno, Nev.

A complete safety program evaluation is a means by which risk and safety managers can assess and monitor the impact of their ongoing safety operations on a public entity's safety record, Mr. Hidden explained.

The safety program evaluation "is part of the control function and is intended to provide management with information to determine if effective (safety) services are being provided," he asserted.

Risk and safety managers should begin the safety program evaluation process by establishing broad goals of the overall safety program, Mr. Hidden said.

"This should be wide-reaching. It should be able to be attempted, but not necessarily reached," Mr. Hidden said.

Risk and safety managers should then clarify how they will measure the impact of their safety program, he said.

Risk and safety managers should identify performance indicators, which are units of measure that provide an indication of the positive or negative results or impact of the safety program, according to Mr. Hidden.

"This can help assist in developing the objectives for the programs and services," said Mr. Hidden.

Lastly, a safety program's objective should be a specific statement of intent that is measurable, includes a time frame and clarifies any costs that are associated with achieving the objective, he explained.

After these three steps have been taken, the risk manager and safety department must then develop a plan of action for the safety program, he said.

This involves determining how the program's objectives are going to be reached and by whom, said Mr. Hidden.

Mr. Hidden provided an example of how a risk manager and safety department might go about trying to improve driving safety.

Establish a base for 'defining who is accountable for safety,' says Mr. Hidden.

"Let's say the goal of the safety department is to improve safe-driving activities throughout the county, and thus reduce the cost of collision-related expenses," Mr. Hidden said.

In this example, some performance indicators would include:

- The frequency of motor vehicle collisions by type of vehicle.
- The percentage of departments conducting accident investigations by supervisors, including a written report, within 24 hours of a collision.
- The percentage of departments reviewing vehicle accident statistics during supervisory meetings.
- The cost of vehicle collisions by department.

Corresponding objectives might include:

- Reducing the frequency of collisions by a certain percentage over a set period of time, and for a set cost.
- Having all departments review collision reports at a supervisory meeting on a monthly basis.
- Reducing the cost of collision-related damage expenses by a set percentage over a one-year period.

Mr. Hidden advised that risk and safety managers concentrate their efforts on reducing frequency of accidents because "severity is random. There isn't much you can do about that."

Other methods those in charge of public safety can employ to improve their safety program include reading articles in the trade press and exploring what other public agencies are doing, he advised.

Risk and safety managers can also look at usage trends within their domain.

"Determine how many people are using your parks, swimming pools and other public facilities, and decide whether the safety programs fit the usage level," Mr. Hidden urged.

Lastly, he advocated that accident review boards function within all public entities and that risk and safety managers check the driving records of anyone behind the wheel of a public vehicle.

"You don't want to be found liable for the retention of unfit personnel," he pointed out.

Tom Marshall, risk manager for the Washoe County School District in Reno, moderated the session. ■

PRIMA elects directors

RENO, Nev.-More than 1,300 people attended the 11th annual Public Risk Management Assn. conference, held June 10-13 in Reno, Nev.

Attendance was up about 30% from 1,000 last year, according to PRIMA. Also, 96 exhibitors displayed their wares in the exhibit hall at Bally's Reno hotel, up from the 79 exhibitors a year ago.

During the conference, PRIMA announced its 1990-92 board of directors.

Tom Phillips, risk manager for the city of Santa Monica, Calif., was elected president, succeeding Dave Randall, risk manager of the city of Wilmington, Del.

Jim Garrison, risk management administrator for the city of Phoenix, will take over as vp of PRIMA's Region 1, which is composed of Western states. He replaces Mr. Phillips.

Fred Marshall, risk administrator for the city of Winston-Salem, N.C., will take over as vp of Region 5, the Southern states. He replaces David Amason, risk manager for the city of Deerfield Beach, Fla.

Mary Wheeler, risk manager for he Albuquerque (N.M.) Public School District, takes over as vp of Region 6, the Southwestern states. She replaces Mark Wilson, risk manager for the city of Plano, Texas.

Remaining on the board as vps are: Mike Burch, risk manager for Larimer County, Calif., representing Region 2; Stanley Fayne, director of risk management and safety for Oakland County, Mich., representing Region 3; Corey Stein, risk manager for the city of Harrisburg, Pa., representing Region 4; and Rita Costantino, business manager for the Oxford Public School District in Oxford, Conn., who is an at-large vp.

Dubravka Romano, associate executive director of the Texas School Services Foundation in Austin was named the new president of the PRIMA Pooling Section. She replaces Bryce McEuen, executive director for the Utah Risk Management Mutual Assn. Richard K. Maddalena, administrator for the Special Districts Risk Management Authority in Sacramento, Calif., takes over for Ms. Romano as vp of the pooling section.

Next year's PRIMA conference will be held May 12-15 in Atlanta.

For more information, contact the Public Risk Management Assn., 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

Legal Notice

INSURANCE COMPANIES ACT 1982
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Application has been made under Section 51 of the Insurance Companies Act 1982 to the Secretary of State for Trade and Industry by Federation General Insurance Company Limited ("FGI") (formerly known as Anglo-French Insurance Company Limited) to transfer the rights and obligations under all contracts of the insurance and reinsurance portfolio underwritten and accepted prior to 31st December 1975 by the Anglo-French Insurance Company Limited.

Copies of the statement setting out the particulars of the transfer are available for inspection at the offices of FGI at Federation House, Linkfield Lane, Redhill, Surrey or at the offices of Scor (UK) Reinsurance Company Limited ("SCOR") at 52 Lime Street, London from Monday to Friday, between 9:00 AM and 5:00 PM on any usual business day. Particulars may be inspected until 27th July 1990. Any person wishing to inspect the same is requested to give prior notification to Mr. Peter Wyeth at FGI (Telephone No. Redhill 768577) or Mr. Roger Day at SCOR (Telephone No. 071-528 7550).

Written representations concerning the transfer may be sent to the Secretary of State for Trade and Industry, Department of Trade and Industry, Insurance Division, 10-18 Victoria Street, London SW1H ONN before 24th August 1990. The Secretary of State for Trade and Industry will not determine the application until after considering any representations made to him before that date.

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GASB rules stiffen for public risk pools

By MICHAEL SCHACHNER

RENO, Nev.—Public entity risk sharing pools are now required to report losses and premium deficiencies in the year in which they occur as well as provide a 10-year loss history on their financial statements.

The changes were mandated under provisions of the Governmental Accounting Standards Board's Statement No. 10, which is now effective for all pools with financial statements covering periods beginning after June 15.

Pools that fail to comply with the GASB accounting requirements will receive qualified opinions from their auditors, which could hurt a pool's ability to attract members, according to risk management consultants and accountants.

In issuing Statement No. 10 in January, GASB asserted that common pay-as-you-go accounting practices, under which a public entity pool accounts only for a loss when the loss is paid, gives pool members and other observers a false impression of a pool's future liabilities and overall financial status (*BI*, Jan. 15).

GASB issued Statement 10—which mirrors standards spelled out for private entities in the Financial Accounting Standards Board's Statement No. 60—because it is seeking consistency in loss reporting, said Edward P. Chait, senior technical consultant for state and local governments in the Bethesda, Md., office of Price Waterhouse.

Mr. Chait spoke at the 11th annual Public Risk Management Assn. conference, held June 10-13 in Reno, Nev.

"GASB wants consistency so readers of annual financial statements have a common base for analysis," Mr. Chait explained.

"The area of public risk financing is relatively young. It's only about 15 years old and there has been no consistency in financial reporting up to now," he said.

GASB's requirements for pools are relatively simple, according to Mr. Chait.

Under the rules, he said, pools must:

- Perform annual accrual accounting of losses, which must include all incurred-but-not-reported losses.
- Disclose all notes from accountants.

'You now must know what is required of you,' says senior technical consultant Edward P. Chait.

- Use enterprise funds—also known as general business funds—to reserve for losses.
- Compile and disclose a 10-year history of losses.

"So, what does this all mean?" asked Mr. Chait.

"It means risk managers will be working much more closely with their accountants and auditors," he said. "You now must know what is required of you."

While most larger public entity pools have traditionally complied with the standards contained in FASB No. 60, and therefore, will not have to change their practices with the adoption of GASB No. 10, smaller pools will be affected by the change, said Mr. Chait.

Small pools, which operate with a lower fund balance than their larger counterparts, have predominantly used pay-as-you-go accounting methods, he added.

The Wyatt Co., in a January memorandum on risk management issues that was distributed at the session, recommend that pools that were not then in compliance with GASB No. 10 should:

- Examine how liabilities, premium income, acquisition costs and unallocated claims expenses are shown in financial statements.
- Review how any surplus or deficit in program funding is distributed among members, and how such equity is reported to members.
- Estimate the amount of liability that is likely to be recognized to determine the potential effect on the pool's financial results.
- Weigh the potential costs of non-compliance with GASB Statement No. 10 and determine whether or not qualified opinions from auditors would adversely affect pool results.

Within the scope of Statement No. 10 are those liabilities that may result from the risk of loss from such events as:

- Torts.
- Theft of, damage to or destruction of assets.
- Business interruption.
- Errors or omissions.
- Job-related illnesses or injuries to employees.
- Acts of God.
- Provision of accident and health benefits to active employees or retirees.

Beginning in June 1993, self-insured state and local government entities, other than risk-sharing pools, will be required to perform annual accrual accounting for these losses and expenses (*BI*, July 17, 1989).

Thomas S. Norsworthy, senior manager-insurance services group with Price Waterhouse in Hartford, Conn., and Roberta McCreary, a consultant with The Wyatt Co. in San Francisco, also spoke at the session.

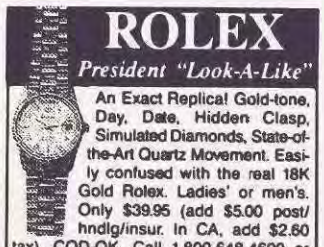
Richard K. Maddalena, administrator of the Special Districts Risk Management Authority in Sacramento, Calif., moderated the session. ■

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Commercial Consumers

Administrative:	
CEO's Presidents, and Owners	3,291
Vice-Presidents, General Managers and Other Administrative Personnel	3,847
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,382
Secretaries, Treasurers, contollers and other Financial Personnel	3,562
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	11,566
Sub-total	**24,648**
Associations	539
Government, Unions and Educational Institutions	1,389
Commercial Consumers	
Sub-total	**26,576**
Insurance Agents and Brokers	10,223
Insurance Companies	7,713
Accountants, Actuaries, Attorneys & Consultants	3,353
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,115
Others Allied to the Field	2,149
TOTAL	**51,129**

* Source Business/Occupational breakdown of qualified circulation, November 27, 1989 issue, as submitted to BPA for December 1989 BPA Publisher's Statement.

Police liability

Continued from page 3
last year stemmed from police activity, according to Mr. Walter.

"Cops without policies and procedures don't know where they live. I urge that you develop policies and procedures, and distribute them throughout the force because you must be able to prove that the officers knew them," he says.

He defines policy as a "goal statement" or "what you want to accomplish." Procedures, which are "how things are done," provide "steps and guidelines to achieve policy," he said.

Without policy, Mr. Walter says, "procedure looks like nothing more than a mandate."

Written guidelines and goals improve consistency among officers and "provide direction in the absence of supervision and a basis for defense in cases of litigation," he added.

They also build a foundation for police orientation and training as well as a foundation for performance evaluation, says Mr. Walter.

In such written materials, he says, officials can also define nebulous buzzwords like negligence, minimal force, reasonable action and deliberate indifference.

One very common source of policies and procedures is the standard guidelines from the Committee of Accreditation for Law Enforcement in Washington, D.C. "The committee's policies provide good standards," said Mr. Walter.

Departments wishing to draw up their own set should begin by having officers log their daily experiences. A list of common occurrences and responses then can be analyzed and standards formulated, he suggests.

Mr. Walter advises having specialists within the department define some standards, but cautions that line officers also should be involved because "they know the day-to-day aspect of the job and will be more cooperative down the line if they had input."

Lawyers and outside law enforcement experts also should be consulted early on, he said.

Mr. Walter said a police department's policies and procedures should be printed in a manual to be distributed to every officer.

"The manual should also be adaptable in case changes are necessary," he said. "I suggest a three-ring binder that includes an index."

Robert Grist, insurance and risk manager for Atlantic County, N.J., moderated the session. ■

Risk managers must 'sell' goals to bosses: Consultant

By MICHAEL SCHACHNER

RENO, Nev.—Public risk managers that must "sell" risk management goals to superiors or other public officials must define the "buying" audience and its needs before making a sales pitch, a consultant says.

M. Roberta McCreary, a consultant in the San Francisco office of The Wyatt Co., says a risk manager must follow four clear-cut steps when explaining the objectives of a specific risk management program: the approach, the presentation, the solution and the close.

Risk managers should begin the process by carefully planning their approach, which consists of defining the audience and the message that is to be delivered.

"You need to uncover your audience's needs and you do this by questioning and listening, after which you can match your message to those needs," said Ms. McCreary during a session at the 11th annual Public Risk Management Assn. conference held earlier this month in Reno, Nev.

"You want to qualify who the buyer is so you don't spend time making a lengthy presentation to the wrong person."



Secondly, Ms. McCreary suggested that risk managers place the good of the public entity they represent ahead of their own personal gains when attempting to sell someone on a risk management idea.

"You must consider political strategies and ask yourself if you can accomplish more if you're not concerned with getting all the credit," she said.

When making the actual presentation, public risk managers must make certain to separate the features of the program from the benefits the public entity will realize if the plan is approved. Some presenters mix them together, which takes away from the effectiveness of the sales pitch. "Always keep your mind in tune with the differences between features and benefits," advised Ms. McCreary.

The risk manager also must prepare for the inevitable obstacles that will be cited by superiors as reasons for not adopting the program.

"A budget is the most common obstacle you'll run into," said Ms. McCreary. "Very often buyers say they don't have the money. Be prepared to display the program's positive results and the gains to the buyer that will make the expenditure worthwhile."

Ms. McCreary equated the solution step of the process to how the risk manager should go about his or her presentation.

"When you begin your presentation, don't be too concerned with the sale," she recommended. Instead, risk managers should pay special interest to the buyer's responses, she added.

"Listen to their objections and try to understand their point of view. Clarify concerns and restate things in order to verify facts. Objections are very often unanswered questions," Ms. McCreary said.

"Sellers" should also be ready to vault over communications obstacles.

One common communication snag that arises during the presentation process is selective listening on the part of the buyer. "Often the buyer tries to filter out what you're saying," Ms. McCreary pointed out. "They're just not in touch with what you're talking about. Just be calm and persistent, but not overbearing."

Ms. McCreary also said poor verbal communication on the part of either party can stall a "sale." "Avoid overtalking," she warned.

When it's time to close the "sale," much of the responsibility falls back to the seller.

"You are responsible for asking for the order," said Ms. McCreary. "Give them all the information they could ask for, but tell them what you want to do. Don't procrastinate."

She recommended that risk managers pay attention to the physical and verbal signs a superior may give off when he or she is ready to accept the plan. When these signs are apparent, the risk manager should push for a commitment, she said.

However, not all sales campaigns end with success. Ms. McCreary cited six steps for dealing with failure:

- Don't overreact.
- Examine situations objectively. Don't blame others; look introspectively for solutions.
- Analyze how and why the sale fell through.
- Concentrate on what has been learned and forget about the setback.
- Plan a course of action for the next time a similar situation arises.
- Undertake new actions so as to achieve future success.

Donald E. Richard, safety officer with the Lafayette Parish government in Lafayette, La., moderated the session. ■

Pollution litigation

Continued from page 2
pollution problems.

"The two decisions of the Massachusetts Supreme Court continue a checkerboard pattern of decisions on environmental coverage," said insurer attorney Roger Warin of Steptoe & Johnson in Washington, D.C.

"There is a checkerboard in the sense that the law is inconsistent from one jurisdiction to another," he said. "This is why more of these cases do not settle."

"Even more recent decisions that favor the policyholder on whether cleanup costs are insurable damages invite additional litigation in terms of the costs spent on-site vs. off-site," he said. Courts generally have held that only the cost to clean up pollution on property not owned by the policyholder is covered, he explained.

Similarly, there will be more litigation to determine how much of cleanup costs are spent to prevent future damage, which generally is not insured, he said.

Insurer attorney Timothy C. Russell agreed: "Insurers, policyholders and the courts will give more scrutiny to the precise nature of the pollution and the cleanup."

For example, the court ruled on the pollution exclusion that it is the release of pollutants that must be "sudden and accidental," not the damage caused.

The court disagreed with policyholder arguments that the policyholder is entitled to coverage if it was aware it was releasing chemicals but unaware the chemicals would harm the environment.

"This ruling makes it clear that the focal point in the pollution exclusion inquiry is on the initial release of pollutants," said Mr. Russell of Sonneschein, Nath & Rosenthal in Washington, D.C., who represented Lumbermen's Mutual Casualty Co. in one of the cases.

"The court undercut the argument of policyholders that the property damage must be unexpected or unintended," he said.

However, policyholder attorney Bill Greaney of Covington & Burling in Washington, D.C., noted that the court's ruling does not bar coverage for policyholders with pre-1970 policies, which did not contain the pollution exclusion.

"Even if the pollution exclusion is ultimately held to bar coverage for cleanup costs, this would only bar coverage for post-1970 policy years," Mr. Greaney said.

If the court later holds that the policyholder's pre-1970 policies must respond to the pollution incident, the policyholder would be able to allocate the entire loss to pre-1970 policies, he said.

"This ruling does not foreclose coverage for my client," said attorney David A. McLaughlin of McLaughlin & Folan in New Bedford, Mass., who represented Belleville Industries Inc. in the case involving the pollution exclusion.

Lumbermen's, a unit of Kemper Corp., sued Belleville in U.S. District Court in Boston seeking a declaration that it did not owe coverage for claims asserted against Belleville by the U.S. Environmental Protection Agency and the state of Massachusetts stemming from the release of polychlorinate biphenyls—or PCBs—into the Acushnett River, which flows into New Bedford Harbor.

Belleville and another New Bedford-based corporation, Aerovox Inc., owned an electrical capacitor manufacturing plant. One byproduct of the system was PCBs.

Belleville and Aerovox have reached a tentative $12.1 million settlement with the state and federal governments for the costs of cleaning up the PCB pollution.

Belleville's share of the settlement is approximately $4 million.

Long Grove, Ill.-based Lumbermen's wrote primary and umbrella liability insurance for Belleville from 1973 to 1977. Annual limits of coverage were not revealed, but the total coverage for the four years was about $30 million, lawyers said.

The federal court hearing the coverage dispute between Lumbermen's and Belleville certified questions regarding the pollution exclusion to the Massachusetts Supreme Court, seeking a definitive ruling on Massachusetts law.

The case will now return to the federal court for a trial, scheduled to begin later this year.

In its other ruling, the state supreme court interpreted wording in most CGL policies that the insurer "will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages." It found that government-mandated cleanup costs are "damages" within this language.

"When pollution has occurred, cleanup costs are damages within the policy language because in that circumstance the word 'damages' which is not defined in the policy is ambiguous," the court said. "If there are two rational interpretations of policy language, the insured is entitled to the benefit of the one that is more favorable to it."

Further, "a reasonable policyholder reading the language would expect that the policy cover amounts he must spend to correct pollution damage for which the law holds him responsible," the court ruled.

"This is another strong statement by a state supreme court that statutory cleanup costs are within standard CGL policies," said policyholder attorney Mr. Greaney.

"The law had done a complete about-face," he said, noting that while two federal appellate courts in early 1988 held that cleanup costs were not damages and therefore not covered by CGL policies, four state supreme courts and the 2nd U.S. Circuit Court of Appeals in the past year have held that cleanup costs are covered.

He predicted litigation on this issue will continue until all 50 state supreme courts have spoken.

"It is wildly premature to declare that this issue is dead," agreed Mr. Russell.

The case relating to the damages issue involved a dispute between Hazen Paper Co. of Holyoke, Mass., and its liability insurer, United States Fidelity & Guaranty Co. of Baltimore, over coverage for a $40 million cleanup of pollution at a hazardous waste facility in North Dartmouth, Mass.

Hazen sued USF&G in 1986 in Massachusetts state court. In 1989, a trial court judge held that USF&G was obligated to defend and indemnify Hazen for its share of the cost of complying with the government order to clean up the hazardous waste site.

The insurer, which wrote $1 million in primary liability coverage for Hazen from 1976 to 1983, was allowed to appeal directly to the state Supreme Court, which ruled in favor of Hazen.

However, because there has been no determination as to whether any coverage for the cleanup would be barred by the pollution exclusion, the high court remanded the case to the trial court for further findings.

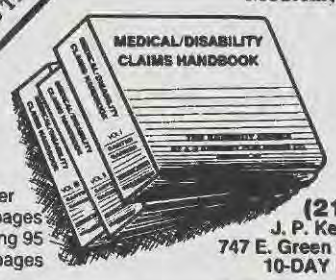
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Lumbermen's Mutual Casualty Co. vs. Belleville Industries Inc., Massachusetts Supreme Judicial Court; No S-5285. Hazen Paper Co. vs. United States Fidelity and Guaranty Co.; No. Hd-5231.

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JULY

JULY 2-6. Advanced Law of Pensions and Deferred Compensation course in Boston, sponsored by the American Law Institute-American Bar Assn.'s Committee on Continuing Professional Education; $725. Alexander Hart, American Law Institute-American Bar Assn., 4025 Chestnut St., Philadelphia, Pa. 19104; 800-253-6397; 215-243-1630.

JULY 8-10. Annual Insurance Regulatory Examiners Society Meeting and Career Development Seminar in Kansas City, Mo.; $50 for IRES members; $75 for non-members. Insurance Regulatory Examiners Society, 6811 W. 63rd St., Suite 208, Overland Park, Kansas 66202; 913-831-0080.

JULY 8-12. 26th Annual International Insurance Seminar in Paris, sponsored by the International Insurance Society Inc.; $1,000; $500 for academics and government officials; $400 for spouses and guests. Mary B. Silberberg, Executive Director, International Insurance Society, P.O. Box 870224, Tuscaloosa, Ala. 35487-0224; 205-348-8974.

JULY 9. Infectious Material Management seminar in Orlando, Fla., sponsored by the Environmental Resource Center; $300. Environmental Resource Center, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 919-822-1172.

JULY 9-10. Underground Storage Tank Management Course in Chicago, sponsored by Executive Enterprises Inc.; $1,045. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JULY 9-11. 1990 Investments Institute in Monterey, Calif., sponsored by the International Foundation of Employee Benefit Plans; $525 for IFEBP members; $600 for non-members; after May 25 add $45. Registration Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JULY 10. Hazardous Waste Management seminar in Orlando, Fla., sponsored by the Environmental Resource Center; $350. **Also July 17** in Charlotte, N.C., **July 19** in Houston, **July 24** in Cleveland and **July 26** in Chicago. Environmental Resource Center, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 919-822-1172.

JULY 10-12. Environmental Regulation Course in Chicago, sponsored by Executive Enterprises Inc.; $1,045. **Also July 10-12 in Washington, D.C.; July 16-18 in Albuquerque, N.M.; and July 30-Aug. 1 in San Diego.** Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JULY 11. SARA/OSHA Right-To-Know seminar in Orlando, Fla., sponsored by the Environmental Resource Center; $350. **Also July 18** in Charlotte, N.C., **July 20** in Houston, **July 25** in Cleveland, and **July 27** in Chicago. Environmental Resource Center, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 919-822-1172.

JULY 11-12. Reinsurance in the '90s-Changing the State of the Art symposium in Princeton, N.J., sponsored by The Society of Chartered Property & Casualty Underwriters; $320 for Society of CPCU members; $395 for non-members. Mari Jennings, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, CB No. 9, Malvern, Pa. 19355; 215-251-2741.

JULY 12-13. Defending a Personal Injury Case seminar in New York City, sponsored by the Practising Law Institute; $295. Practising Law Institute, Dept. 8A-105. 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Ext. 271.

JULY 12-13. Understanding ERISA: An Introduction to Basic Employee Benefits seminar New York City, sponsored by the Practising Law Institute; $450. Practising Law Institute, Dept. 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Ext. 271.

JULY 13-14. Loss Prevention Seminar in Chicago, sponsored by The Assn. of Engineering Firms Practicing in the Geosciences; $245 for ASFE members; $315 for non-members. **Also Aug. 3-4** in Boston. Assn. of Engineering Firms Practicing in the Geosciences, 8811 Colesville Road, Suite G106, Silver Spring, Md. 20910; 301-565- 2733.

JULY 15-17. Financial Aspects of Premium Rate Development conference in San Francisco, sponsored by the Group Health Assn. of America Inc.; $490 for GHAA members; $590 for non-members. Group Health Assn. of America, 1129 20th St. N.W., Suite 600, Washington, D.C. 20073; 202-778-3228.

JULY 16. Underground Storage Tanks seminar in Charlotte, N.C., sponsored by the Environmental Resource Center; $200. **Also July 23** in Cleveland. Environmental Resource Center, 3679 Rosehill Road, Fayetteville, N.C. 28311-6634; 919-822-1172.

JULY 16-17. Basic Product Liability and Toxic Tort Litigation seminar in New York City, sponsored by the Practising Law Institute; $295. Practising Law Institute, Department 8A-105, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700, Extension No. 271.

JULY 16-20. Health Risk Assessment course in Santa Barbara, Calif., sponsored by the University of California at Santa Barbara; $345. UCSB Extension, Santa Barbara, Calif. 93106; 805-961-4143.

JULY 17-18. Property Claims Handling Seminar in Rosemont, Ill., sponsored by the National Assn. of Mutual Insurance Companies; $199 for NAMIC members; $219 for non-members. Dawne Smith, Education Department, National Assn. of Mutual Insurance Companies, 3707 Woodview Trace, P.O. Box 68700, Indianapolis, Ind. 46268; 317-875-5250.

JULY 17-20. National Conference of Insurance Legislators Seminar in Washington, D.C.; $150 for legislators and staff; $25 for spouses; no charge for state insurance department personnel. National Conference of Insurance Legislators, P.O. Box 217, Brookfield, Wis. 53008; 414-782-6669.

JULY 17-20. Reinsurance Claims-Including Insolvency & Liquidation seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,545. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 212-677-5974.

JULY 18-19. 10th Annual Symposium on Directors and Officers Liability in Chicago, sponsored by The Wyatt Co.; $725; $625 each for multiple registrants from the same organization. Connie Johnston, The Wyatt Co., 303 W. Madison St., Suite 2400, Chicago, Ill. 60606; 312-704-2719.

JULY 18-20. Sixth Annual Maritime Law Seminar in London, England, sponsored by Lloyd's of London Press Ltd.; 1,110 pounds ($1,870). Conference Department, Lloyd's of London Press Ltd., 1 Singer St., London EC2A 4LQ; 71-250-1500.

JULY 19-20. Leaking Underground Storage Tanks: Corrective Action Alternatives workshop in Atlanta, sponsored by Georgia Institute of Technology Research Institute; $295. Education Extension-R, Georgia Institute of Technology, Atlanta, Ga. 30332-0385; 404-894-2400.

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Leasing firms

Continued from page 1

leased and the leasing company pays the premium.

Employee leasing arrangements that result in fraudulently lower workers comp premiums are occurring nationwide, according to regulators and others.

"We have what we see as a serious rate fraud problem," according to Maine Superintendent of Insurance Joseph Edwards, who chairs the National Assn. of Insurance Commissioners' Workers Compensation Task Force.

This has become "a major problem" in California, a spokesman for the State Compensation Insurance Fund of the State of California in responding to a survey conducted by the NAIC the International Assn. of Industrial Accident Boards & Commissions, which represents workers compensation system administrators.

"Employee leasing is rapidly becoming a significant issue in workers compensation," said Allyn C. Tatum, a commissioner with the Arkansas Workers' Compensation Commission and vp of the IAIABC.

The abuses have cost workers compensation systems tens of millions of dollars annually, Mr. Tatum estimated.

Mr. Edwards called that estimate "conservative."

Fraudulent or unethical employee leasing arrangements designed to lower employers' workers comp costs also reduce the employer's incentive to provide a safe workplace, observers note.

Under a typical employee leasing arrangement, the leasing company claims the present and future employees of many different client companies as its own employees.

For a fee, a typical leasing company handles payroll and tax reports and obtains workers comp insurance for the employees of client companies, explains the NCCI, which represents workers comp insurers and administers residual markets in more than 30 states.

Some leasing companies also administer employee benefit programs and provide risk management services.

Currently, there are about 250 to 325 employee leasing companies nationwide that lease between 500,000 and 600,000 employees, estimated L. Morgan Hall III, president of the National Staff Leasing Assn. and president of Atlanta-based TFE Inc., an employee leasing company.

About 125 employee leasing companies are members of the NSLA, which requires members to adhere to ethical guidelines.

"Many leasing firms are sound business ventures," emphasized Maureen Ramert, the NCCI's director of national affairs. "Those firms provide a valuable service to employers.

"Our problems are not with those firms, but with firms that unscrupulously manipulate the system to avoid paying the proper workers compensation premium," she said.

Many of these "unscrupulous" leasing companies have misrepresented to employers with poor workplace safety records that employee leasing arrangements can legitimately lower the employers' workers comp insurance costs, the NCCI says.

Those leasing companies then misrepresent to a work comp insurer that the employees of its client company—which often has a relatively high work comp experience modification factor—are actually employees of the leasing company, which may have a much lower modification factor (see related story).

Some unscrupulous leasing companies also misclassify the workers' occupations as a low-risk group to obtain lower premiums. For example, some of these firms classify truckers as clerical workers.

In addition, some leasing companies may misrepresent where workers are based geographically to obtain lower premiums.

For example, a firm that leases truck drivers may tell its insurer that the drivers are based in Indiana, where workers comp rates for firms with drivers are relatively low, when the drivers actually operate primarily in other states where rates are higher.

The problem is compounded by the fact that injured drivers typically try to apply for compensation in states offering the highest benefits, regardless of where their employer pays the premium.

While these problems have existed long before the emergence of the employee leasing industry, "the number of unscrupulous employee leasing firms has given new appeal to these schemes," the NCCI's Ms. Ramert said.

Workers comp insurers in assigned risk plans are bearing the brunt of the lost premiums as a result of problem employee leasing arrangements.

Leasing companies typically seek coverage in assigned risk plans for a variety of reasons. For example, many of these firms are new and the employees they lease to other firms work in such high-risk categories as construction and trucking.

"This is a horrible problem now in trucking, and it is beginning to show up in construction and other industries," said a spokesman for State Fund Mutual Insurance Co., Minnesota's competitive state work comp fund, in responding to the IAIABC/NAIC survey.

Mr. Tatum of Arkansas and Mr. Edwards of Maine, who co-chair a joint IAIABC/NAIC committee on workers compensation, held a hearing on employee leasing problems at the NAIC summer meeting in Baltimore earlier this month.

Members of both groups have shown a "tremendous" interest in the problem and are nearly unanimous in their support for developing a uniform regulatory approach to curbing abuses by employee leasing firms, Mr. Tatum said.

Currently, there are no specific statutes or regulations in most states that apply to employee leasing companies, according to the IAIABC/NAIC survey.

But, some states—including Maine and Washington—are developing comprehensive regulations.

For example, Mr. Edwards held a public hearing in Augusta earlier this month on a draft proposal that would require an employer or employee group to retain its own experience modification factor despite any leasing arrangement.

However, the proposal is likely to be amended following additional comments from the NCCI and the NSLA, he said.

Also, the Maine Insurance Bureau has adopted a rule that requires an employer to keep its experience modification factor regardless of a sale, change in ownership or change in management of the firm.

In Washington, the state monopolistic workers compensation fund is proposing legislation requiring employee leasing firms to establish separate accounts for each client for which they supply workers comp insurance. Then, the client's past loss experience and its experience since it entered into the lease would be combined to formulate an experience rating.

Meanwhile, the NCCI plans to ask states to adopt a rule that essentially would prohibit insurers from considering employee leasing arrangements when calculating an individual employer's premium.

Ideally, a workers comp insurance policy would be issued in the name of the client company of employee leasing firms, according to the NCCI.

Members of the IAIABC and the NAIC hope that they will be able to develop a uniform approach to handling employee leasing problems soon. That could entail a new NAIC model law, which could be ready as early as September, Mr. Edwards said.

However, states may be able to implement a uniform approach without the promulgation of a model law, the IAIABC's Mr. Tatum said.

Besides drafting proposed regulations, the NCCI has made a "strong" commitment to litigate employee leasing abuses, said Lynn Szymoniak, the NCCI's senior counsel.

The NCCI is seeking millions of dollars in damages in five lawsuits against employee leasing companies and their officers, their insurance agents and agencies.

Some of the lawsuits allege violations of the Racketeer Influenced and Corrupt Organizations act.

Although employers are not named as defendants in any of the lawsuits, the NCCI would consider naming employers when the facts of a case warrant it, Ms. Szymoniak said.

"Such litigation is complex—almost always involving several states and carriers," she said. "It presents a lawyer with perhaps the two greatest challenges of a career: one, convincing a judge or jury that the insurance system is deserving of protection and, two, just explaining experience rating and modification factors to anyone outside of the industry."

Under a recent settlement of one RICO lawsuit against two employee leasing companies, a Florida insurance agency and various individuals associated with the firms, the defendants paid more than $2 million to the leasing companies' workers comp insurers.

The defendants also paid $705,000 to the NCCI, which administers the National Workers Compensation Reinsurance Pool, a pooling mechanism that reinsures assigned risk plans in more than 30 states.

The NCCI also is revising residual market applications to improve identification of employers and leasing companies and is revising its rules for underwriting such arrangements.

In addition, the NCCI is recommending that assigned risk plan insurers perform early on-site audits of employee leasing companies to verify information on the insurance application. These steps are needed because almost all of the disreputable practices occur in the assigned risk plans, Mr. Tatum said.

"It suggests to me that there was not sufficient monitoring of assigned risk plans," he said in an interview.

In addition, regulators point out that employers that use fraudulent or unethical leasing arrangements to reduce their workers comp premiums may be opening themselves up to unanticipated liabilities.

For example:

- Employers could be held legally liable in 32 states to provide workers comp benefits to injured employees if the leasing company cannot, according to the IAIABC/NAIC survey.

The survey also found that officials in 14 states and Washington D.C., were aware of situations in which leasing companies did not obtain workers comp insurance.

"The workers compensation administrators will always find someone to pay the claims, and that may be the employer who thought he had transferred the risk," Ms. Ramert said.

"The leasing company can close up shop in a flash because all their assets are liquid," said Ms. Szymoniak. "The employer, which has a plant, machinery and assets that can be attached, will still be there and be available as a source of recovery for disgruntled employees."

- Employers could lose their immunity to tort suits by employees.

While most states now extend to both the leasing company and the client employer immunity from lawsuits by injured workers under the exclusive remedy doctrine, some states do not grant this immunity to employers that enter into employee leasing arrangements, Ms. Szymoniak said.

New Hampshire is one of those states.

In New Hampshire, "it makes sense for an injured leased employee to accept the workers compensation benefits provided by the leasing company (employer) and to sue the business owner" at whose worksite he was injured, said a respondent to the NAIC/IAIABC survey.

- Having to assemble payroll and injury data for several years to help an insurer re-create the employer's individual experience modification factor.

About 200 employers in Georgia faced this problem when a leasing company gave them less than 30 days' notice that it no longer would provide workers compensation insurance, Ms. Szymoniak noted.

"When someone can offer to save an employer a huge percentage of their workers compensation cost, employers should be wary," Mr. Tatum said. "If a deal is too good to be true, it probably is." ■

How to mask a bad 'mod'

By MEG FLETCHER

Fraudulent or unethical practices by employee leasing firms are helping some employers with poor workplace safety records avoid paying hefty workers compensation insurance premiums, the National Council on Compensation Insurance says.

The NCCI illustrated the problem in a hypothetical example.

Golf bag manufacturer Able Bag Co. employs approximately 200 people, 170 of whom are assembly line workers, and has a $4.2 million annual payroll. Because of its poor loss history, ABC has a high experience rating modification factor of 3.0, which results in a total premium of about $460,000.

ABC then decides to enter into an employee leasing contract with a new employee leasing company, XYZ Cos., under which XYZ only administers ABC's payroll.

"In the typical employee leasing operation, the leasing company would not have the right to direct and control the leased employees, nor would the leased employees work primarily for the economic benefit of the leasing company," the NCCI said. Therefore, most jurisdictions would not allow the leasing company to represent itself to the workers comp insurer as the actual employer, the NCCI said.

However, XYZ represents to workers comp insurers that the ABC workers are actually XYZ employees.

Because XYZ is a new company, the NCCI has not developed an experience rating modification factor for the company. Therefore, the NCCI would give XYZ a "unity" experience "mod" of 1.0.

As a result, the total annual workers comp premium for XYZ would be approximately $155,000, instead of the $460,000 premium ABC would have been assessed.

If XYZ also misclassifies ABC's employees as "clerical," even greater premium reductions would result.

But, "if ABC only changes its payroll administration, it is likely to have the same poor loss experience that caused it to have a 3.0 experience mod. The poor loss experience will not be attributed to ABC, however, because ABC's payroll and losses are being claimed by (XYZ) as its own," the NCCI said.

While XYZ's experience modifier may rise over time, XYZ can escape it by incorporating under a new name—thereby getting another 1.0 experience mod, the NCCI says.

Or, ABC can contract with a new leasing company with a 1.0 experience mod.

If, after several years, ABC no longer can find leasing companies with which to contract, it may be able to get a 1.0 experience mod on its own because the NCCI no longer will have information on ABC's loss experience prior to the leasing arrangements.

"By procuring its compensation coverage through leasing companies over a five-year period, ABC would have failed to pay approximately $1.5 million in premium and would have prevented its payroll and loss information from being reported so that future insurers could properly evaluate ABC as a risk for underwriting purposes," the NCCI said.

Markets

Benefit consultants merge

Noble Lowndes Group Ltd. will increase its presence in the U.S. employee benefit consulting marketplace through its acquisition of The Johnson Cos., a Newton, Pa.-based consultant. Terms of the purchase were not disclosed.

The acquisition will double the number of Noble Lowndes employees in the United States, bringing the total U.S. staff to about 660, said Stephen Singer, president and chief executive officer of Noble Lowndes U.S. in East Orange, N.J.

In addition, the acquisition will add approximately $20 million in gross revenues to Noble Lowndes U.S. operations, bringing the total to $50 million, he said.

However, the acquisition may not be large enough to push Noble Lowndes into the ranks of the nation's 10 largest benefit consultants. Godwins International Holdings Inc., a unit of Frank B. Hall & Co. Inc., is currently the 10th-largest U.S. benefit consultant based on estimated 1989 revenues of $59 million (*BI*, Dec. 18, 1989).

Noble Lowndes employs approximately 2,800 staffers worldwide and has global revenues of about $160 million, including revenues from benefit consulting, compensation consulting and claims administration, Mr. Singer added.

Noble Lowndes, headquartered in Croyden, England, approached The Johnson Cos. last year with an offer to purchase the company, but at that time Johnson Cos. declined, Mr. Singer said.

Ed Johnson, president of The Johnson Cos., explained that "when we reviewed our extraordinary growth and considered its implications for the next five years, we agreed that to sustain our development we would need considerable resources and a wider national and international presence if we were to continue" to remain competitive.

In addition to its Newton headquarters, The Johnson Cos. has offices in Boston; Washington, D.C.; and Dover, Del. Noble Lowndes has offices in New York and on Long Island, N.Y.; Chicago; San Francisco and Philadelphia. In addition, Noble Lowndes operates offices in Ireland, Germany, France, Spain, Holland, Belgium, Switzerland, Hong Kong, Australia and New Zealand.

The Johnson Cos. will operate under the name Noble Lowndes/Johnson until the transition is complete, Mr. Johnson said. ■

McCarran

Continued from page 1

surers have been making progress in educating the members of Congress on how the modification of McCarran-Ferguson will hurt both consumers and the insurance industry.

"Our argument on the impact of those changes seems to sway members' views on the legislation," he said.

David J. Pratt, vp-federal affairs at the American Insurance Assn., in Washington, D.C., says the close vote indicates that some representatives are not completely convinced that the bill will do what its proponents say it would: reduce insurance premiums and increase insurance availability.

In addition, the growing concern by small insurers over whether they would be able to collect the joint data they need to make loss projections, has motivated them to actively lobby their representatives, Mr. Pratt said, adding that "I think it had an effect on the final vote."

Insurers say the vague language in Rep. Brooks' proposal—the Insurance Competitive Pricing Act of 1989—throws into question whether a wide range of insurance industry activities might be considered violations of federal antitrust law.

For instance, while the bill would specifically eliminate any antitrust exemption for "price fixing," it does not elaborate on what actions might be considered price fixing.

Under the bill, insurers would be allowed to continue to jointly "collect, compile or disseminate historical loss data." They also would be allowed to "determine a loss development factor applicable to historical loss data."

Yet, experts are unclear whether the bill would allow insurers or advisory organizations to jointly "trend" loss data—or adjust historical loss data to reflect inflationary and other future trends.

Thus, they say, it's not known whether the Insurance Services Office Inc. will still be able to issue prospective loss costs to property/casualty insurers without running afoul of antitrust laws.

ISO announced last year it would no longer issue fully developed advisory rates and instead offer only prospective loss costs, partly in response to the drive to amend or repeal McCarran-Ferguson (*BI*, April 17, 1989).

Unlike fully developed advisory rates, prospective loss costs do not include provisions for insurers' marketing and overhead expenses or underwriting profit and contingencies.

In addition to subjecting price fixing to federal antitrust law, Rep. Brooks' legislation also would eliminate insurers' antitrust exemptions for:

'From a political standpoint, it is a tough vote,' says Peter A. Lefkin of Fireman's Fund.

- Tying the purchase of insurance to another type of insurance or any other product of service.
- Allocating specific geographical areas or customers among insurers.
- Activities that would force competitors out of specific markets.
- Monopolizing or attempting to monopolize "any part of the business of insurance."

While supporters of Rep. Brooks' bill say they have the votes to pass the legislation in the House, a vote by the full chamber on the McCarran-Ferguson amendments, if taken, would be close, said Peter A. Lefkin, assistant vp and director of federal affairs in the Washington, D.C., office of Fireman's Fund Insurance Co.

"From a political standpoint, it is a tough vote," he said. "Congress has come to the realization" that it is not easy "making decisions that will affect a multibillion-dollar industry."

Observers agree that while a House vote on Rep. Brooks' proposal may be possible this year, the Senate will not vote this year on a proposal to amend McCarran-Ferguson.

"It may come up on the House floor this year, but it won't make it to the Senate," if it is approved, said Howard Greene, director of governmental affairs at the Risk & Insurance Management Society Inc. in New York, which opposes changes to McCarran-Ferguson.

No Senate action has been taken on a somewhat different McCarran-Ferguson proposal introduced by Sen. Howard Metzenbaum, D-Ohio (*BI*, Jan. 30, 1989).

During the House Judiciary Committee's markup of Rep. Brooks' bill last week, committee members defeated an amendment proposal by Rep. Glickman that would have specifically allowed insurers to jointly trend loss data.

Although the amendment was targeted to help smaller insurance companies, it would have applied to all insurers, Rep. Glickman said.

This amendment only "clarifies the chairman's commitment that trending will be allowed" and that smaller insurance companies have access to the data that they need to properly calculate rates, he said.

However, Rep. Brooks called Rep. Glickman's amendment "confusing," noting that the intent of his legislation is to move away from joint insurer data collection and analysis.

While the Glickman approach to the data collection issue seemed to be responsible, "both in concept and execution," it did not solve the other problems with the legislation, noted Craig Berrington, general counsel of the American Insurance Assn.

For instance, insurers charge that the bill could make insurers reluctant to form pools, such as the property and liability insurance pools currently serving the nuclear power industry, for fear that this would be construed as "monopolizing the business of insurance."

In addition, insurers say the legislation could be construed to prohibit joint underwriting associations and assigned risk pools, and the development of common policy forms. ■

Fraud alleged in Keating company bond sales

Law firm settles for $20 million

By LOUISE KERTESZ

NEW YORK—A law firm representing insolvent American Continental Corp. and its failed Lincoln Savings & Loan unit has agreed to a multimillion-dollar settlement in a suit filed by American Continental bondholders.

Kaye, Scholer, Fierman, Hays & Handler, American Continental's general counsel since 1977, settled for $20 million. In a letter to its attorneys and staff, the New York firm denied any wrongdoing and said the amount "is fully covered by insurance policies," though it would not provide details of the coverage.

Of the three law firms named in the suit, Kaye, Scholer is the second to settle. A Los Angeles firm agreed in March to pay a smaller amount.

The bondholders' suit charges Chairman Charles H. Keating Jr. and about 15 other executives of the Phoenix-based financial services and development holding company; the three law firms; and three major accounting firms with making or assisting in misrepresentations in the sale of American Continental debentures, or unsecured bonds (*BI*, June 11).

Bond purchasers—including retirees—were told "the debentures were like savings accounts or certificates of deposit, insured by the federal government, when they were not," says the suit, which charges the defendants with racketeering and fraud.

And when American Continental was declared insolvent, up to 23,000 bondholders were "cheated out of almost $400 million," the suit alleges.

Kaye, Scholer "actively participated in the design and structure of the debentures because it knowingly assisted defendants in making the debentures appear as though they were or were closely related to federally insured CDs," the plaintiffs allege.

According to the suit, the firm also "knew that Lincoln's underwriting practices were deficient and violated federal regulatory standards, and that Lincoln was being operated in an unsafe and unsound manner."

Kaye, Scholer partners, the suit charges, used forged documents to cover up unsound practices at Lincoln—now one of the nation's largest savings and loan collapses.

By permitting "its name to be used in connection with the public offering of ACC debentures," the law firm also lent "credibility" to the bonds, the suit charges.

In its letter to employees, Kaye, Scholer admits no wrongdoing and says that defending the suit caused "a substantial drain" on resources.

Rejecting the settlement offer, the letter said, would have been "imprudent." The letter cites "the potentially sympathetic position of the class members, the extraordinary publicity accorded their plight and Lincoln's receivership, the unpredictability of juries and the reluctance of courts to grant summary judgment or overturn jury verdicts."

Because both settlements are from class-action suits, they must be approved by a court, said Leonard Simon of Milberg Weiss Bershad Spechthrie & Lerach of San Diego, co-lead counsel for the plaintiffs.

In its letter, Kaye, Scholer said the $20 million represented "less than 2%" of the amount bondholders sought. Mr. Simon said it was "more like 7%."

Parker, Milliken, Clark, O'Hara & Samuelian, a Los Angeles law firm representing American Continental and another defendant in the suit, settled in March. The settlement calls for payment of $4.3 million by Parker, Milliken's insurers, plus another $10 million if that amount is not recouped from other defendants.

Parker, Milliken, which would not provide details of its insurance coverage, also denies wrongdoing.

Also named in the suit is the Chicago-based law firm Sidley & Austin.

The three accounting firms named as defendants are Arthur Young & Co. and its legal successor by merger, Ernst & Young; Arthur Andersen & Co.; and Touche Ross & Co. and its legal successor by merger, Deloitte & Touche.

As American Continental's auditors, the firms certified financial statements that violated generally accepted accounting standards, the suit charges. ■

Update

COMSAT buys launch coverage

LONDON—Communications Satellite Corp. has launch insurance for its share of a satellite worth an estimated $200 million that was to be launched at Cape Canaveral, Fla., last weekend.

COMSAT is insured for $66 million should the International Telecommunications Satellite Organization's F-4 communications satellite fail to reach proper orbit after launch on a rocket owned by Martin Marietta Corp., said Richard Rankin, manager of investments and insurance for COMSAT in Washington, D.C.

COMSAT is the U.S. representative on the board of governors of the international communications organization INTELSAT. Unlike COMSAT, other INTELSAT members do not insure their share of a satellite's value or launch costs.

The F-4 is the second of the INTELSAT VI series to be launched this year on a Titan III rocket. A $250 million F-3 satellite, launched in March, failed to reach proper orbit.

One insurance program covers both satellites, but the program has a one-loss deductible, so COMSAT was unable to file a claim for the F-3 loss.

INTELSAT is attempting to arrange with NASA to have astronauts aboard a space shuttle repair and redeploy the F-3, said Mr. Rankin.

COMSAT's program, led by Lloyd's of London underwriter Michael Marchant, is placed by Corroon & Black Inspace Inc. in Bethesda, Md., and Crawley Warren & Co. Ltd. in London, he said.

California rate rollback hearings

SAN FRANCISCO—Five property/casualty insurers must appear at California Insurance Department hearings to determine whether they must issue refunds to policyholders to comply with Proposition 103's insurance "charge" rollback provision.

Commissioner Roxani Gillespie last week ordered Allstate Insurance Co., California State Automobile Assn., Progressive Casualty Insurance Co., SAFECO Insurance Co. and United Services Automobile Assn. to appear at the hearings beginning July 18.

The five are the first summoned since Ms. Gillespie's June 13 decision requiring policyholder refunds if insurers exceeded a 11.2% rate of return on their combined business between November 1988 and November 1989 (*BI*, June 18).

The department will not consider at those hearings whether the insurers' rates after November 1989 were excessive.

None of the insurers would comment.

The five insurers also were among the first seven insurers ordered last August to refund policyholders $305 million to comply with Proposition 103's insurance "charge" rollback provision (*BI*, Aug. 7, 1989).

At that time, Ms. Gillespie said the insurers were selected because the department considered them some of the state's most efficient property/casualty insurers.

But Ms. Gillespie's August 1989 order was put on hold during the department hearings on what constitutes an adequate rate of return for insurers. Those hearings were necessitated by a California Supreme Court ruling exempting insurers from the Proposition 103 rollback provision if the rollback would deprive them of a fair rate of return (*BI*, May 8, 1988).

Crew's survivors sue Pan Am

BROOKLYN, N.Y.—Families of the flight crew of Pan Am World Airways Flight 103, which exploded over Scotland in December 1988, are suing Pan Am and insurer U.S. Aviation Underwriters for allegedly breaching an agreement to pay the families a total of $2.6 million in employment compensation benefits.

The families agreed to a settlement proposal from Pan Am on June 6, but the airline later altered the language of the agreement to require the families to release the airline from all liability related to intentional acts or wrongdoing, said Read K. McCaffrey, managing partner in the Washington, D.C., office of Whiteford, Taylor & Preston. The firm represents survivors of the 13 crew members killed in the crash.

Mr. McCaffrey said the compensation benefits—similar to workers compensation death benefits—are payable regardless of the cause of death under negotiated contracts between the three unions representing the flight crew and Pan Am.

The lawsuit, filed June 18 in U.S. District Court in Brooklyn, seeks to force Pan Am and New York-based USAU to pay the benefits regardless of other claims stemming from the crash.

"We want to be able to pursue an intentional act lawsuit if it is found later this year that the airline was negligent in any way," Mr. McCaffrey said.

"These compensation benefits are separate from what caused the plane to go down. It could have happened for any reason, and these benefits would still have to be paid," he said.

Pan Am and USAU declined to comment on the lawsuit.

Briefly noted

The California Court of Appeal refused to review a lower court ruling that allows Mission Insurance Group Inc.'s liquidator to demand immediate reinsurance payments for incurred-but-not-reported claims from **Underwriters Reinsurance Co.** (*BI*, May 7). Underwriters Re attorneys say they now will challenge the liquidator's demand in a lawsuit. . . .Elizabeth P. Wright has been named **Kentucky insurance commissioner.** A former deputy commissioner, Ms. Wright replaces Leroy Morgan, who resigned due to health reasons and returns to his former job as director of the Insurance Department's Division of State Risk & Insurance Services. . . .Connie R. Morton, a retired banker and former newspaper executive, was elected chairman of the seven-member **South Carolina Insurance Commission** last week. The commission oversees the operation of the Insurance Department. . . .Wind, hail, tornadoes and flooding caused an estimated **$50 million in insured property damage** June 6-8 in portions of Colorado, Kansas, Kentucky, Indiana and Missouri, reports the Property Claim Services division of the American Insurance Services Group.

Willis-C&B combination makes sense in today's 'smaller' world

By LEONARD M. WILSON

Special to Business Insurance

THE PROPOSED MERGER of Corroon & Black Corp. and Willis Faber P.L.C. is this month's surprise event. The intended linkup merely extends the long-running consolidation of the insurance brokerage industry. The sequence of industry change over a 30-year period has run the gamut from local to regional to national to multinational broker. Below we address some questions on the merger that we have encountered recently.



Mr. Wilson

What's in it for Corroon & Black? Corroon & Black needed a partner if it was to compete for multinational business in a world where national borders are increasingly transcended by commercial and industrial enterprise. Foreign companies are acquiring U.S. companies, and the insurance brokerage is up for grabs. To be international is to be in the running for the brokerage of the acquired and possibly the acquiring company. Market share for an alphabet broker will largely depend in the future on successful execution of a multinational strategy.

What's in it for Willis Faber? When Marsh & McLennan Cos. Inc. acquired C.T. Bowring P.L.C. about 10 years ago, the pluralistic relationship between the U.S.-based retail broker and the London wholesale marketplace was irretrievably shattered. London brokers could no longer count upon a flow of wholesale or reinsurance business from their U.S. brokerage client base. Vertical integration encompassing all stages in the brokerage process from retail to wholesale became a matter of necessity for the biggest players. Thus, M&M's precedent was in a real sense the pivotal antecedent of Willis' anticipated merger with Corroon.

Why didn't Willis Faber merge with Johnson & Higgins, given their long-standing relationship at a variety of levels? No one can be sure, except the directors of Johnson & Higgins. But Willis is a publicly owned firm, and J&H is privately owned. The culture of the private firm is typically different in a host of areas. In effect, a merger would have meant that J&H was going public, a status that the firm has resisted for many years. Call the stumbling block a case of financial incompatibility.

Won't the loss of business from Johnson & Higgins hurt Willis Faber? It is doubtless true that Corroon & Black cannot replace volume from J&H. Most likely, in line with public comments, the shift of J&H from Willis actually will be gradual. Moreover, the growth of the combined firm will at least mitigate the impact of J&H's inevitable and eventual defection. This kind of shift has occurred as a result of other trans-Atlantic links without major dislocation. Besides, the gains from the merger are to be measured over decades, whereas the transitional effects will last several years.

Isn't there a potential clash of cultures between the entrepreneurial Corroon & Black Corp. and the august Willis Faber? Corroon & Black would probably find the description a flattering one. But Willis is also regarded as quite aggressive and innovative. We would guess that the melding of operations will occur slowly. Managements will give themselves ample opportunity to get to know one another. And, given the geography, neither firm has to alter its personality anyway.

How will the management responsibilities be doled out so as to make both firms happy? The link has been billed as a merger of equals. Willis Faber Chairman Roger Elliott continues as chairman of the combined firms, while C&B Chairman and Chief Executive Richard M. Miller is to become chief executive officer. Doubtless, committees composed of representatives of each firm will be constituted to accomplish the human and professional benefits of the merger. Since there is a learning curve in managing a global insurance broker, deliberation is likely to be a watchword.

How would you characterize the lineup of alphabet brokers now? Marsh & McLennan Cos., Alexander & Alexander Services, Sedgwick Group P.L.C. and Johnson & Higgins are currently the major factors in global insurance brokerage. The smaller alphabets have some measure of penetration in the international scene. But for sheer geographical mass, the four—along with the proposed Willis Corroon P.L.C.—are the dominant factors. They have varying degrees of strength in reinsurance brokerage. But they all possess the ability to seek multinational business with credible international networks, and can claim the advantages of vertical integration.

Will there be additional mergers between U.S. retail brokers and London brokers? The list of participants on both sides has been narrowed appreciably. Most observers know which are left without alliances of consequence. The odds are that another deal or two will ensue. But the structure of the industry seems now to be in place for the 1990s and beyond.

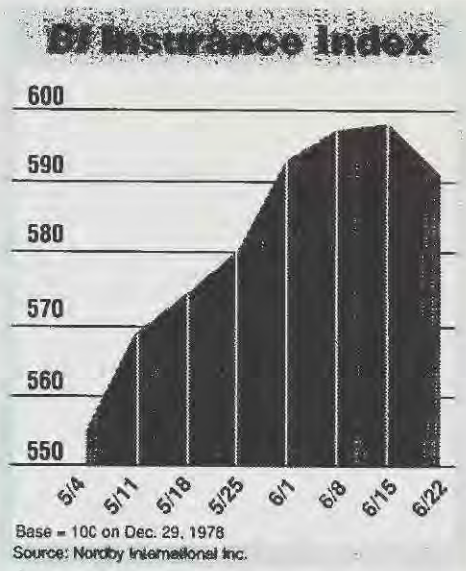
Does competition get tougher as a result of the industry consolidation? The profit margins of both Willis Faber and Corroon & Black have declined over the past several years. This reflects the soft market, and it could also be a function of the competitive environment in insurance brokerage. The consolidation of the industry at all stages has tended to elevate professional demands upon the broker, and in that way lift the cost of doing business as well as the intensity of competition.

Will merger benefits expand the profit margins of the combined firm? Our intuitive opinion is no. Few staff changes are likely, since there is little overlap. Both firms have sophisticated data processing systems. Economies of scale seem not to be relevant.

How will increased retail penetration, an avowed goal, be achieved? Acquisitions are likely to be a major strategic initiative. Corroon & Black has pursued acquisitions more actively than other leading U.S. brokers over the past several years. That experience, coupled with Willis' relationships, should fuel a fertile program of acquisition in retail brokerage.

How will the merger affect the Willis Corroon stock market valuation? The market's initial response to the announcement was anything but resounding. Investors will adopt a wait-and-see attitude which could restrain the market price to earnings ratio. Over a period of time, though, the valuation might rise from the current level if the merged firm is perceived as having made it through the transition period without any material check on operating progress.

We take a constructive view of the merger. It seems like a sensible long-term step for both firms in a world that gets steadily smaller. The closing will not occur for several months, given the array of mandated regulatory approvals. In the meantime, investor attitudes will be in the formative stage. ■



Insurance industry stocks dropped last week, as the *Business Insurance Index* fell 6.8 points to 591.3 on June 22, from 598.1 on June 15. Advancing issues were led by Phoenix Re Corp., up 7.7%; United Healthcare Corp., up 7.4%; and Belvedere Corp., up 6.9%. Declining issues followed Protective Life Corp., down 7.2%; Tokio Marine & Fire Insurance Co. Ltd., down 7.1%; and The NWNL Cos. Inc., down 7.0%. The most active issue during the week was Sears, Roebuck & Co. (Allstate) 4.2 million shares traded. The *BI Index* lost 1.1% for the period; the Dow Jones 30 Industrials dropped 2.7%; the Standard & Poor's 500 fell 2.1%; and the New York Stock Exchange Composite lost 1.8%.

British Issues

June 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	521	24.0	28.7	5.5	525—	521
Genl Accident	1110	17.0	66.7	6.0	1133—	1110
Gdn Royal Exch	241	21.0	15.3	6.3	246—	241
Royal	508	27.4	34.0	6.7	508—	495
Sun Alliance	329	12.0	16.7	5.1	339—	329
Brokers						
Bradstock	256	18.0	10.0	3.9	263—	256
CE Heath	547	16.2	34.5	6.3	548—	543
Hogg Group	176	11.6	9.7	5.5	176—	174
Lloyd Thompson	295	18.4	9.7	3.3	295—	295
PWS Holdings	78	12.4	3.3	4.2	78—	75
Sedgwick Grp	250	18.7	16.0	6.4	256—	250
Steel Brri Jones	291	17.7	14.7	5.0	292—	291
Willis Faber	253	16.0	16.0	6.3	263—	250

Source: Philip Olsen, Insurance Industry Specialist London

BI Industry Stock Report

JUNE 18, 1990 THROUGH JUNE 22, 1990

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	24.63	-4.83	-21.83	34.00	23.25	324	1.00	4.06	19	9.18	2.68
Corroon & Black	NYS	31.00	-5.34	-18.95	41.00	26.50	209	1.36	4.39	16	12.73	2.44
Gallagher Arthur J & Co	NYS	23.13	1.65	-6.57	26.50	19.75	18	0.60	2.59	18	5.33	4.34
Frank B. Hall	NYS	3.00	-7.69	0.00	4.38	2.50	52	0.00	0.00	-2	-2.80	-1.07
Hilb, Rogal & Hamilton	OTC	13.75	-1.79	-26.17	20.63	11.63	15	0.28	2.04	19	4.60	2.99
Marsh & McLennan	NYS	74.75	-3.55	-4.17	89.75	62.50	451	2.60	3.48	18	10.56	7.08
Poe & Associates	OTC	12.00	6.67	-9.43	13.00	8.00	4	0.40	3.33	15	1.93	6.22
BROKERS	AVERAGE		-2.1	-12.4					2.8	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	41.75	-2.34	0.30	46.50	30.75	161	0.44	1.05	9	25.06	1.67
Berkshire Hathaway Inc	NYS	7050.00	-2.08	-18.26	8900.00	5675.00	0	0.00	0.00	-23	2869.00	2.46
ITT (Hartford Group)	NYS	58.38	-0.64	-2.51	64.50	51.38	1367	1.60	2.74	8	56.33	1.04
Sears (Allstate)	NYS	36.38	-1.69	-6.13	47.25	34.75	4242	2.00	5.50	0	37.75	0.96
CONGLOMERATES	AVERAGE		-1.7	-6.6					2.3	1		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	52.00	-1.89	-10.34	62.50	45.25	827	2.76	5.31	9	58.11	0.89
AmBase Corp	NYS	6.75	5.88	-46.53	16.38	5.75	414	0.00	0.00	8	29.08	0.23
American General	NYS	47.13	-2.08	43.89	50.63	28.13	2552	3.20	6.79	14	34.68	1.36
American Heritage	NYS	21.88	0.57	-23.25	24.63	19.50	3	1.00	4.57	11	22.60	0.97
American Indemnity/Fin'l	OTC	5.50	0.00	-31.25	12.75	4.25	2	0.08	1.45	-1	17.38	0.32
American International	NYS	99.00	-1.37	-6.16	112.00	81.50	1021	0.52	0.53	12	41.92	2.36
Aon Corp	NYS	40.00	-2.44	-5.60	43.25	33.38	398	1.52	3.80	11	19.62	2.04
Argonaut Group	OTC	76.50	0.00	11.07	77.25	54.25	44	1.60	2.09	9	36.83	2.08
AVEMCO Corp	NYS	27.75	2.78	13.85	27.50	20.38	47	0.40	1.44	19	9.52	2.91
Baldwin & Lyons Inc	OTC	21.50	1.18	0.00	24.00	17.88	2	0.28	1.30	7	20.80	1.03
Belvedere Corp	ASE	3.88	6.90	-29.55	5.63	3.38	1	0.04	1.03	-5	8.03	0.48
Chandler Insurance	OTC	8.50	-4.23	-27.66	13.25	7.63	135	0.00	0.00	4	9.53	0.89
Chubb Corp (s)	NYS	45.75	-4.19	-52.28	51.38	34.13	1217	1.32	2.89	9	55.49	0.82
CIGNA Corp	NYS	50.75	-3.10	-15.77	66.75	45.25	580	3.04	5.99	11	66.64	0.76
CNA Financial Corp	NYS	74.63	-3.55	-25.38	108.75	68.25	127	0.00	0.00	9	54.87	1.36
Continental Corp	NYS	29.75	-1.65	-5.18	38.63	25.75	384	2.60	8.74	12	41.36	0.72
Durham Corp	OTC	28.13	-2.17	-8.54	34.75	28.00	21	0.92	3.27	13	26.32	1.07
Fireman's Fund	NYS	34.25	0.74	-2.84	40.75	29.50	397	0.68	1.99	51	32.74	1.05
Fremont General Corp	OTC	15.75	-4.55	-21.74	22.50	14.38	384	0.80	5.08	7	19.09	0.83
Frontier Insurance Group	NYS	23.00	-1.08	24.32	23.75	15.50	31	0.00	0.00	9	7.29	3.16
General RE Corp	NYS	85.25	-0.44	-5.28	96.25	64.63	652	1.52	1.78	13	29.04	2.94
Hanover Insurance Co	OTC	26.13	-0.48	-14.34	33.00	22.75	315	0.44	1.68	8	32.03	0.82
Harleysville Group	OTC	25.63	1.49	-6.82	28.75	19.50	56	0.60	2.34	8	18.94	1.35
Hartford Steam Boiler	NYS	59.50	-0.42	9.68	60.75	41.00	75	1.60	2.69	16	18.94	3.14
Kansas City Life Ins	OTC	36.00	-0.69	0.35	36.25	34.50	0	1.12	3.11	10	39.22	0.92
Kemper Corp	NYS	41.25	-2.37	-12.70	51.88	34.00	275	0.92	2.23	10	29.97	1.38
Lawrence Insurance Group	ASE	8.50	-1.45	19.30	9.13	6.50	0	0.36	4.24	15	4.30	1.93
Liberty Corp	NYS	47.00	-1.05	10.59	50.25	34.50	17	0.92	1.96	16	31.32	1.48
Lincoln National	NYS	54.75	-1.35	-10.25	62.88	50.25	299	2.60	4.75	10	49.19	1.11
NAC Re Corp	OTC	33.00	-4.35	-8.97	41.00	24.75	339	0.20	0.61	14	22.81	1.45
Navigators Group	OTC	32.00	3.23	16.36	31.75	25.25	4	0.00	0.00	11	15.22	2.10
Nobel Insurance LTD	OTC	3.31	-5.34	65.65	3.75	1.50	60	0.00	0.00	-2	7.76	0.43
NWNL Companies	OTC	30.00	-6.98	-24.05	44.13	26.50	264	1.32	4.40	6	37.50	0.80
Ohio Casualty Corp	OTC	42.00	-5.08	-12.04	52.50	34.75	194	2.32	5.52	11	33.33	1.26
Old Republic Int'l	OTC	25.75	0.98	0.49	29.00	21.13	216	0.72	2.80	6	30.73	0.84
Orion Capital Corp	NYS	21.50	-4.44	-7.53	28.50	18.38	67	0.92	4.28	6	19.72	1.09
Phoenix RE Corp	OTC	10.50	7.69	-19.23	15.50	8.75	38	0.20	1.90	-15	12.69	0.8
Protective Life Corp	OTC	12.88	-7.21	-9.65	16.00	10.88	405	0.68	5.28	8	14.54	0.89
Provident Life	OTC	24.13	-3.50	-6.76	30.13	19.00	246	0.80	3.32	7	33.24	1.04
Re Capital Corp.	ASE	13.50	-3.57	-6.90	15.25	11.00	12	0.00	0.00	11	14.43	0.94
RLI Insurance Corp	NYS	12.88	-2.83	45.07	14.75	6.88	26	0.40	3.11	7	12.42	1.04
St Paul Companies	OTC	58.25	-4.51	-2.92	63.50	51.50	883	2.40	4.12	7	13.47	1.34
SAFECO Corp.	OTC	35.63	-3.39	-10.38	42.38	29.25	1098	1.36	3.82	8	24.87	1.43
SCOR U.S. Corp	NYS	9.88	-4.82	-30.70	14.50	8.38	13	0.20	2.03	13	0.67	0.93
Seibels Bruce Group	OTC	9.88	-1.25	-9.20	13.63	8.75	14	0.80	8.10	-2	3.75	0.72
Selective Ins. Group	OTC	16.88	-2.17	-11.76	20.25	16.00	120	1.04	6.16	6	5.72	1.07
Statesman Group Inc	OTC	1.94	-3.10	-29.53	3.50	1.88	34	0.16	8.26	4	4.19	0.46
Tokio Marine & Fire	OTC	44.38	-7.07	-41.13	78.13	40.88	10	1.04	2.34	-	70.93	0.63
Torchmark Corp.	NYS	45.25	-1.36	-20.96	58.75	37.88	418	1.40	3.09	11	13.23	3.42
Transamerica	NYS	38.63	-1.90	-13.45	48.00	33.75	420	1.92	4.97	9	34.63	1.12
Travelers Corp.	NYS	30.00	-3.61	-18.64	45.00	29.25	1127	2.40	8.00	8	44.85	
Trenwick Group Inc	OTC	25.00	4.17	2.56	26.88	16.13	60	0.48	1.92	12	16.91	1.48
United Fire & Casualty	OTC	34.25	-1.44	3.79	34.75	30.50	1	1.20	3.50	10	22.56	1.52
USF&G Corp	NYS	27.13	-4.82	-8.44	33.88	26.88	848	2.92	10.76	20	22.87	1.19
UNUM Corp	NYS	50.88	-1.21	6.54	51.63	33.00	221	0.80	1.57	12	31.20	1.63
USLIFE Corp	NYS	37.63	-2.59	-16.85	48.13	34.75	201	1.48	3.93	8	54.34	0.69
Washington National	NYS	21.50	1.18	-23.89	29.13	19.50	186	1.08	5.02	80	32.90	0.65
USLICO Corp	NYS	21.25	-2.30	-10.53	25.38	21.00	163	1.00	4.71	8	27.75	0.77
Zenith National Ins.	NYS	15.00	0.00	-20.00	21.50	13.50	17	0.88	5.87	8	13.87	1.09
INSURERS/REINSURERS	AVERAGE		-1.6	-7.9					3.5	10.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	18.00	0.00	-15.29	26.38	12.88	229	0.00	0.00	15	3.54	5.08
HMO America Inc	OTC	6.25	2.04	-19.35	10.63	4.38	132	0.00	0.00	7	1.2	5.58
Pacificare Health Sys.	OTC	24.00	-1.03	-7.69	30.38	13.25	112	0.00	0.00	19	6.35	3.78
Safeguard Health Enter	OTC	6.88	3.77	-19.12	12.50	5.13	29	0.00	0.00	11	2.99	2.30
Sierra Health Services	ASE	6.63	-3.64	-25.35	9.63	4.50	87	0.00	0.00	11	4.62	10.69
United Healthcare Corp.	OTC	16.38	7.38	33.67	15.88	7.88	1667	0.00	0.00	21	0.34	48.16
United Medical Corp	ASE	9.88	1.26	64.58	10.00	5.63	15	0.20	2.03	18	5.70	1.73
U.S. Healthcare	OTC	18.25	-5.19	28.07	19.50	9.63	0	0.36	1.97	25	3.07	5.94
HMOs	AVERAGE		0.6	4.9					0.5	16		
ALL COMPANIES	AVERAGE		-1.4	-6.7					3.0	11		

System design: Nordby International Inc.

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