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update

A&A's proposal to acquire Reed Stenhouse hits snag

NEW YORK—Alexander & Alexander Services Inc. and Reed Stenhouse Cos. Ltd. may have each failed to meet the conditions of their proposed merger agreement, but discussions pertaining to the merger were still continuing late last week (*BI*, Dec. 10, 1984).

A&A, the nation's second-largest broker, agreed in December to acquire Reed Stenhouse, Canada's larg-

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Pioneers combine comp with group health plans

By CAROL CAIN

A handful of insurers and administrators of self-insured programs are aggressively cultivating hybrid programs that package workers compensation insurance with group health coverage, and others are expected to follow their lead.

By packaging the two coverages in an integrated program, the insurers and administrators say they can coordinate workers compensation and health care claims administration and cost-containment measures, which will save employers money.

However, some major insurers say they are not currently planning to offer a combined workers compensation/group health package—often dubbed "24-hour coverage"—because their current practices "are good enough."

Employers, state insurance regulators and some insurers and brokers have advocated the integration of workers compensation and group health insurance programs in the past as a way of eliminating payment of duplicate claims and streamlining claims processing and other administrative responsibilities.

Some also maintained that such an approach could fuel competition in the market, further enhancing the savings (*BI*, April 16, 1984; May 2, 1983; Aug. 2, 1982).

But the complexities and differences between the two types of coverage, along with state regulations, have stymied development of combined workers compensation/group health packages until only recently.

The two insurers and two administrators of self-insured programs that are now actively marketing combined programs define their parameters differently and are going after a distinct niche in the market.

For instance, Philadelphia-based CIGNA Corp. describes its "24-Hour Coverage" as a comprehensive insurance program combining the administration of workers compensation coverage and group health benefits, although the coverages are written on separate policies. The five employers that have signed up for the coverage, which was scheduled to be marketed nationally late last month after a six-month test period, are all large accounts.

Meanwhile, Blue Cross & Blue Shield of South Carolina and two of its subsidiaries are offering "Protector 24," a package plan that includes separate health care, workers compensation, life and disability coverages. The product is being sold to employers with seven to 49 employees; 15 have signed up since it became available last fall.

Broker Arthur J. Gallagher & Co. in Rolling Meadows, Ill., is offering a single excess insurance policy to self-insurers that includes coverage for workers compensation, employers liability and group health risks. So far two clients have been attracted to the "Gallagher Integrated Employee Security Plan."

And, Waters Insurance Management Corp. in Sarasota, Fla., took what it learned from 25 years of managing a self-insured workers compensation pool for Florida contractors and its recent experience with a similar group health program and combined the two into its "Total Care Program." The plan is now being used by 12 Florida employers (see story, page 6).

None of these markets are yet estimating how much their products can save buyers, noting that the programs are too new to track cost savings. Likewise, employers generally have not yet determined how well the programs will work.

At the heart of most of these workers compensation/group health packages is coordinated claims management, which relies on sophisticated data collection and analysis. Through this type of monitoring,

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Rate hikes are necessary, concede risk managers

By LORRIE GIBSON

Most risk managers hit with insurance rate increases averaging 105%—and some reaching as high as 500%—accept them as reasonable and necessary, according to a recent *Business Insurance* survey.

But, this hasn't stopped them from blaming the current state of the market on the poor management of insurance companies.

Nor is it stopping them from fighting back: They are taking a more aggressive stance in renewal negotiations and are exploring more self-insurance of risks to cut their costs, the latest survey of the *BI* Risk Management Board shows.

The Risk Management Board is composed of 73 risk managers who have volunteered to respond to periodic surveys on risk management topics. The latest survey had a 59% response rate; 74% of the respondents renewed some type of insurance coverage within the last eight months.

Almost half of the risk managers responding to the latest survey said the recent increases in insurance prices are dramatic, but conceded they were acceptable given the bargain-basement prices that preceded the tightening of the market.

Another 23% found the increases to be reasonable given the recent declines in insurers' operating income and reports of inadequate loss reserves. For instance, 25 commercial property/casualty insurers tracked by *Business Insurance* reported a 52.4% aggregate decline in aftertax operating income during 1984 (*BI*, March 25).

Still, one-third of the respondents said current insurance prices were "outrageous and intolerable" because the price increases are more than insurers need to make a profit on the coverage offered.

And, 79% of the risk managers criticized the insurance industry when asked to pinpoint the cause of insurance cycles of hot competition and cheap prices followed by periods of tight capacity and dramatic price increases.

Fifty-one percent said the dramatic swings in cycles are the result of poor management of insurance companies; another 28% said the cycles are intolerable because modern data processing should provide insurers with the statistics they need to properly price their products and avoid such dramatic swings.

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Former self-insured client wins $2.2 million from GAB

By MEG FLETCHER

LOS ANGELES—A former client of GAB Business Services Inc. is entitled to $2.2 million from the third-party claims administrator for GAB's failure to adequately administer and pay its third-party liability claims, a federal district court judge has ruled.

Judge Robert J. Kelleher of the U.S. Central District Court of California ruled March 20 that GAB, which is based in Parsippany, N.J., should pay $2.2 million in compensatory damages for breaching the terms of its contract with the Southern California Rapid Transit District.

At issue was GAB's handling of RTD claims under a three-year contract that was in force for 21 months from Aug. 1, 1978, to April 15, 1980.

The RTD notified GAB it was canceling the contract in February 1980. Shortly thereafter it sued GAB to recover the additional expenses the RTD incurred when it says it was forced to replace GAB's services and to recover losses from excessive payment of claims. RTD also had sought punitive damages, charging that GAB had breached its fiduciary responsibilities.

This may be the first suit against a TPA alleging mishandling of a large number of claims over a long period of time. It is more common for a TPA to be sued over its handling of one particular claim.

The GAB case also may be the first time a major TPA has been successfully sued.

The RTD, which operates the public bus service in Los Angeles and surrounding counties, also is suing GAB over its handling of claims from Aug. 1, 1975, to July 31, 1978. That suit, covering an earlier period than the suit that RTD has won, was filed while the first case was in litigation and is pending before Judge Kelleher.

Meanwhile, GAB has been named as a defendant in a lawsuit filed by its current errors and omissions insurer against its former errors and omissions insurer over which underwriter is responsible for paying the RTD judgment (see story, page 40).

"We are elated with the results," said RTD General Counsel Richard T. Powers of the $2.2 million award. But GAB's attorney in the case, David J. Prager of Fisher & Prager of Los Angeles, said the RTD was "excessively compensated."

"I think it is quite likely that we will appeal," said GAB's Chairman Irvine E. Williamson.

The 100-year-old GAB, which is owned by UAL Inc. in Elk Grove Village, Ill., is the third-largest property/casualty claims administrator for self-insurers, according to a recent *Business Insurance* ranking (*BI*, Jan. 28).

In 1984, GAB paid out $400 million in claims on behalf of 1,000 self-insured clients.

The relationship between RTD and GAB began Aug. 1, 1974, when GAB took over the administration of RTD's liability claims from Transit Casualty Insurance

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A&A acquisition hits snag

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est broker, in a $345 million transaction. But A&A now says it will not meet certain conditions of the agreement because of its recent decision to add to underwriting subsidiaries' loss reserves as well as its decision to dispose of some of the subsidiaries (*BI*, March 11).

At the same time, A&A says that based on its review of Reed Stenhouse's business operations, it believes Reed Stenhouse may not have met certain conditions of the agreement as well.

Peter Densen, A&A's chief financial officer, said he could not provide details on how either A&A or Reed Stenhouse may have failed to meet the agreement's conditions. He added, however, that discussions between the two sides continues.

Dana unit stops underwriting

HAMILTON, Bermuda—Fairway Bermuda Ltd., a Bermuda-based underwriting management subsidiary of Dana Corp., says it has stopped accepting new and renewal treaty reinsurance on behalf of Solar Insurance Co. Ltd. of Bermuda and Summit Fidelity & Surety Co. of Ohio, two Dana insurance subsidiaries.

"The decision to withdraw. . .does not reflect upon the viability of the Bermuda market nor upon the financial integrity of Solar and Summit Fidelity," says a statement released by the company.

Fairway expected to write only about $2 million in unrelated premiums, specializing in property and short-tail treaty reinsurance, *Business Insurance* learned. Fairway wrote its first business in January 1982.

Another Dana insurance unit, Cherokee Insurance Co., is in rehabilitation in Tennessee. Bermuda-based brokers said they viewed the Cherokee rehabilitation as unrelated to the Bermuda underwriting operation and had continued to offer business to Fairway.

Fairways Intermediaries Ltd., a reinsurance broker, and Fairway (Captive Services) Ltd., a captive manager, are not affected by the underwriting decision, the company announcement said.

Illinois paper loses libel suit

BELLEVILLE, Ill.—A state court judge last week ordered the Belleville News-Democrat and a former editorial writer to pay $1.05 million in compensatory and punitive damages to a county official who had sued the paper for libel.

Associate Judge Roger M. Scrivner ruled the paper and editorial writer Richard Hargraves were guilty of vicious and reckless conduct in publishing an editorial on Dec. 31, 1980, that accused St. Clair County Board Chairman Jerry Costello of breaking a campaign promise.

The judge awarded Mr. Costello, who was re-elected last year to a second term, $450,000 to compensate him for the loss of his "good name and reputation." Mr. Costello also was awarded $600,000 in punitive damages.

Publisher Darwin C. Wile and Mr. Hargraves, who now works for The St. Louis Globe-Democrat, said the decision will be appealed.

If the judgment stands, it will be paid by Capital Cities Communications Inc. of New York, which owns the News-Democrat.

Capital Cities has a $10,000 self-insured retention and $5 million in libel insurance through Employers Reinsurance Corp. of Overland Park, Kan., that will cover the award, according to plaintiff's attorney Amiel Cueto of Cueto, Daley, Williams & Moore in Belleville.

The punitive damage award probably is not insurable under either Illinois or New York law.

Officials at the News-Democrat would not comment on the paper's insurance coverage. Capital Cities officials could not be reached for comment.

Nuclear insurers to raise limits

FARMINGTON, Conn.—American Nuclear Insurers and Mutual Atomic Energy Liability Underwriters, two nuclear insurance pools, will increase the limits available under their primary liability program to $200 million from $160 million this year.

The $160 million limit has been in place since 1980 when it was raised from $140 million.

ANI writes 77.5% of the $200 million primary layer, while MAELU writes 22.5%.

Court rules on premium taxes

WASHINGTON—Promoting local companies and encouraging local investment are not "legitimate state purposes" for imposing higher premium taxes on out-of-state insurers than domestic insurers, the Supreme Court ruled last week.

The 5-4 ruling last week involved an Alabama statute, challenged

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Senate proposals threaten federal product liability bill

By JERRY GEISEL

WASHINGTON—Despite the newly announced support of a key House committee chairman, moves in the Senate to liberalize the a federal product liability reform bill threaten the measure.

Rep. John Dingell, D-Mich., chairman of the House Energy and Commerce Committee, said last month that he will work for passage of a uniform federal product liability law to pre-empt varying state product liability statutes.

"I am hopeful that product liability legislation will not fall victim to the legislative clock in the 99th Congress and pledge. . .to make my best effort to have such legislation addressed in the House in a timely fashion," Rep. Dingell said.

But, while Rep. Dingell announced his support for a federal product liability bill, a movement surfaced in the Senate to broaden the product liability reform legislation, S. 100, sponsored by Sen. Robert Kasten, R-Wis.

Several senators, including Sen. Slade Gorton, R-Wash., and Sen. Chris Dodd, D-Conn., said they want Sen. Kasten's bill liberalized to make it easier for victims to receive payment for damages in cases where it is difficult to prove whether the manufacturer or consumer is at fault.

For example, Sen. Gorton, who had signed onto the Kasten bill last year, now says the Kasten bill cannot pass unless it includes an "alternative compensation" system. Under such a system, which would be similar to no-fault, an accident victim would be entitled to compensation in cases where it would be difficult to establish fault.

And, Sen. Dodd already has drafted an alternative compensation bill, which he is considering proposing as an amendment to the Kasten bill.

However, insurers and other groups currently lobbying for the bill may drop their support if manufacturers' liability for damages is expanded.

"We feel very strongly about this," said Tom O'Day, assistant vp in the Washington office of the Alliance of American Insurers, an industry trade group. Mr. O'Day says the Alliance not only could withdraw its support, but could become an active opponent if the Kasten bill is liberalized in this manner.

"This is a very serious development," Mr. O'Day said.

Under the Dodd bill, which was published in the March 19 issue of the Congressional Record, an accident victim would have a choice of legal remedies to recover damages from a product manufacturer.

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Rhode Island is studying comp reform

By MEG FLETCHER

PROVIDENCE, R.I.—The Rhode Island Legislature is considering two bills aimed at establishing a Cabinet-level department to administer the state's workers compensation system.

And, in a related matter, the Legislature has extended to next year the deadline for completion of a study on the feasibility of an exclusive state workers compensation fund.

The two bills are among about 70 workers compensation measures already before the Legislature.

H.B. 6432, drafted by Republican Gov. Edward DiPrete and contained in his budget address March 12, is backed by the Rhode Island Chamber of Commerce Federation, said the federation's executive vp, Francis Holbrook. The Business and Industry Council, a Chamber offshoot of larger employers concerned about compensation issues, also favors it.

H.B. 7162, introduced by co-sponsors Rep. Henry R. Boeniger,

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FASB makes new changes in pension accounting draft

STAMFORD, Conn.—An employer with one underfunded and another overfunded pension plan will have to list separately the assets and liabilities for each plan on its balance sheet, the Financial Accounting Standards Board says.

In an exposure draft released last month, FASB proposes that an employer with several plans generally could not aggregate the assets and liabilities of the plans on its balance sheet.

For example, a firm with a $100 million surplus in a salaried employees' pension plan and a $50 million unfunded liability in a union plan couldn't merge the amounts to show a $50 million surplus.

FASB, though, would allow the merger of assets and liabilties if the employer has a clear right to use the assets of one plan to provide benefits to another.

As reported earlier, the FASB has dropped a proposal that would have required employers who base pension benefits on employees' salaries to estimate future salary increases when they calculate their pension liabilities (*BI*, Feb, 11).

Instead, employers generally will have to list as pension liabilities only the difference between the market value of its pension assets and its accumulated vested and non-vested benefits.

However, an employer that promised to increase benefits over a certain number of years, such as from $9 per month per year of service to $10, would have to include this increase in calculating accumulated benefit obligations.

Employers with underfunded plans would have to begin listing liabilities on their balance sheets in 1989, FASB proposes.

Employers that want to comment on the FASB proposal, which retains many provisions first proposed in November 1982, should write to FASB, File Reference 1032, High Ridge Park, P.O. Box 3821, Stamford, Conn. 06905-0821. The deadline for comments is June 21. FASB will conduct hearings July 22-24 in New York.

N.Y. department investigating malpractice mutual's reserves

By DOUGLAS McLEOD

NEW YORK—Medical Liability Mutual Insurance Co. and the New York Insurance Department are discussing ways to raise new capital for the insurer to address potential reserve deficiencies.

The Insurance Department is apparently concerned about actuarial studies that indicate the company's reserves for long-tail medical malpractice claims may be deficient by several hundred million dollars.

The department is completing a report on MLMIC following closed hearings on the company's financial position.

MLMIC, the largest medical malpractice insurer in New York and the second-largest in the nation—with more than 16,000 policies in force—reported earned premiums of $166 million and loss reserves of about $1 billion at the end of 1983.

While the company's ability to pay current claims is not in doubt, MLMIC's own actuaries projected an eventual reserve deficiency of $600 million on business it had written through the end of 1983.

Despite the actuaries' findings, MLMIC's management says that actual loss development may be better than projected and, coupled with rate increases, may eliminate any reserve deficiency.

MLMIC is also investigating ways of raising additional capital to alleviate the potential reserve problem, though several observers expressed skepticism about the company's ability to come up with additional funds.

If regulators conclude that the projected inadequacies cannot be cured, the Insurance Department could move to take over the company.

The department, however, has made no such plans so far, a department spokesman said.

"We will have to see what the hearing officer has to say. We will have to look at it at that time," the spokesman said. "No war plans are being drawn up. We

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errors & omissions

- The data collection project of the Health Actior. Council of Northeastern Ohio is administered by Commonwealth Clinical Systems Inc. of Charlottesville, Va. (*BI*, March 18).

- Although Insurance Corp. of Ireland stopped underwriting from its Chicago office earlier this year, the office has not been closed as reported in the March 25 issue.

Andersen to contest $22 million award in Drysdale lawsuit

By STEPHEN TARNOFF

NEW YORK—Accountant Arthur Andersen & Co. may have to pay more than $22 million to Manufacturers Hanover Trust Co. for losses suffered after the collapse of Drysdale Government Securities Inc.

A federal court jury in New York last month ordered the Chicago-based accounting firm to pay Manufacturers Hanover $17 million in damages for Andersen's role in an alleged scheme to defraud Manufacturers Hanover.

Andersen also will have to pay more than $5 million in prejudgment interest and costs if the verdict is upheld on appeal, an attorney for Manufacturers says.

In addition, Andersen has paid more than $10 million in defense costs arising from the Manufacturers Hanover suit, another suit brought by Chase Manhattan Corp. after the Drysdale collapse and related litigation, one attorney says.

The Chase Manhattan suit was settled last October for $48 million (*BI*, Oct. 22, 1984).

A source knowledgeable about the Manufacturers Hanover suit said that Andersen could have settled for $9 million.

An Andersen attorney said the firm will attempt to have the Manufacturers Hanover verdict overturned or will try to obtain a new trial.

Andersen would not comment on its professional liability insurance; however, it is believed to have adequate coverage for the award.

A Lloyd's of London syndicate managed by Merrett Syndicates P.L.C. with Robin A. Jackson as underwriter is the lead underwriter on Andersen's primary professional indemnity coverage.

In 1970-71, Andersen had $50 million in professional liability coverage and in 1974-75 it had $101 million. Lloyd's underwriters also were Andersen's primary insurers during those policy periods (*BI*, Nov. 12, 1984).

Andersen, the nation's largest accounting firm, recently revealed in documents filed with the Securities and Exchange Commission that it has paid $137 million in settlements and verdicts in lawsuits since 1980.

According to the figures, which do not include the $17 million award in the Manufacturers Hanover case, the amount Andersen has paid out due to professional liability lawsuits is more than six times the amount reported by any of the other "Big Eight" accounting firms.

In the Manufacturers Hanover case, the jury found that Andersen violated three sections of federal securities laws and was guilty of common law fraud and negligence.

The suit arose out of the 1982 collapse of Drysdale Government Securities Inc., a unit of Drysdale Securities Corp. which was involved in the sale and purchase of government securities known as repurchase agreements. Andersen was the auditor of Drysdale.

In 1982, Drysdale Government Securities failed to meet approximately $300 million in interest payments that were due various securities dealers including Chase Manhattan and Manufacturers Hanover.

Both companies sued Andersen in the fall of 1982.

According to Manufacturers Hanover, Andersen, through one of its partners, prepared and then issued an unqualified opinion on a false financial statement. That financial statement said Drysdale Government Securities was worth more than $20 million when it was really bankrupt and had debts of $190 million.

Manufacturers Hanover claimed it lost more than $20 million because it relied on Andersen's statement.

Two top officers of Drysdale Securities have been sentenced in connection with Chase's and Manufacturers Hanover's losses.

Andersen, however, claimed that it did everything it was required to do when it audited Drysdale. It also contended that Manufacturers disregarded fundamental business principles, acted recklessly and was the real cause of the losses.

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Insurers, consultants oppose bill forcing well-child coverage

By DIANE LYNN KASTIEL

Group health insurers and benefit consultants are opposing legislation that would deny employers tax deductions for contributions to group health plans if the plans do not cover well-child care.

The proposal, introduced by Sen. John Chaffee, R-R.I., is another example of federal encroachment on the state regulation of the insurance industry, insurers and consultants explain.

They also suggest that the proposal is too vague and would not ensure that children that require well-child care would receive it. And, they add, the legislation, now before the Senate Finance Committee, would cost employers much more than its supporters estimate.

Graphic: Amy Palmer

The proposed Child Health Incentives Reform Plan Act of 1985, S. 376, would penalize employers whose plans did not provide pediatric preventive health care, including physicals, immunizations, vision and hearing tests, and "other medical services as required by. . .the secretary of health and human services and appropriate medical organizations."

"Preventive health care has been proven to be a cost-saver," says Christine Ferguson, legislative aide to Sen. Chaffee. "And there are a lot of children that don't get the proper preventive health care, and they don't get it because. . .health care plans focus on acute care—sickness care.

"Broken arms and broken legs are covered (under a typical health care plan), but preventing illness and making sure children get proper nutritional care and proper checkups is not," she said.

However, insurers and consultants oppose the legislation in principle, in keeping with their longstanding opposition to federal regulation of insured benefits programs.

"We're strongly opposed to mandates for private insurance," said Mary Nell Lehnhard, vp of government relations for the Blue Cross & Blue Shield Assn. in Washington.

"The federal government has never gotten into mandating benefits. When the merits are there, private insurance picks up coverage," she said.

Miriam MacDonald, a Washington-based lobbyist for Metropolitan Life Insurance Co., agreed.

"We don't really think very much of (the bill)," she said. "Federal legislation dictating the content of any insurance policy would set a precedent. It would interfere in the state's right to regulate insurance; it would interfere in the collective bargaining process."

Industry observers also fear that employers might react to federal legislation of insurance programs by

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Citicorp, BankAmerica form political risk brokerage units

By JUDY GREENWALD and STACY SHAPIRO

NEW YORK—The nation's two largest bank holding companies—Citicorp and BankAmerica Corp.—are gearing up to become major political risk insurance brokers.

However, both banks say they have no plans to eventually underwrite political risk insurance on their own, even though federal law allows them to do so.

New York-based Citicorp has hired Peter Clark, a political risk underwriter now with the Overseas Private Investment Corp., to work in the bank's global insurance division. OPIC is a Washington-based federal government entity that writes political risk coverages for U.S. exporters.

A Citicorp spokesman said Mr. Clark will be involved in Citicorp's overseas political risk brokerage activities. He will also be involved in Citicorp's self-insurance program for its own political risks.

Although the spokesman denied reports that Mr. Clark will be involved in underwriting political risk insurance and reinsurance for third parties, Citicorp is empowered to do so under provisions of the 1982 Export Trading Company Act.

In addition, San Francisco-based BankAmerica has established BankAmerica Insurance Services Ltd. in London, a brokerage that will specialize in political risk coverage, says Michael W. Eve, its managing director. While it will initially service only overseas clients, it eventually hopes to expand its operations into the United States, says Mr. Eve.

Observers of the political risk insurance market also say that Merrill Lynch Pierce Fenner & Smith Inc. is actively investigating whether to invest in a new political risk underwriting facility, while American Express Co., parent of Fireman's Fund Insurance Cos., is interested in establishing a political risk insurance brokerage.

A Merrill Lynch spokesman said the company would not comment on any unannounced plans, while an American Express spokeswoman said she was unaware of any such plans.

At Citicorp, the spokesman said he was unsure when Mr. Clark would start work or what his title will be. The spokesman did say, however, that Mr. Clark will fill a "key position." Mr. Clark could not be reached for comment.

The spokesman added that Mr. Clark will be involved in developing Citicorp's political risk brokerage activities via Citibank International, its Miami-based Edge Act subsidiary.

The Edge Act, which was enacted in 1919 and subsequently amended in 1978, allows U.S. banks to establish subsidiaries devoted to international banking activities. Its purpose, says a Federal Reserve Board spokeswoman, is to provide both a source of credit for U.S.

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California self-insurers urged to join settlement

By STEVE TARAVELLA

MONTEREY, Calif.—Many self-insurers are closely watching efforts to settle a complex lawsuit filed against several hundred of California's workers compensation self-insurers, insurers and third-party administrators.

"There's only one undisputed fact in this case, and that is that it's going to cost our industry—both employers and insurance carriers—a great deal in terms of time, energy and, most of all, money," attorney James M. Sevey said March 6 at the California Self-Insurers Assn.'s 55th annual conference in Monterey.

Mr. Sevey is vp and claims manager at California Casualty Group in San Mateo, Calif., one of the original defendants in the case.

Employers at the meeting were encouraged to join a proposed settlement negotiated over the past year by parties to the litigation.

"We're wasting an awful lot of defense dollars in this case, and I'd like to see us put that behind us," Mr. Sevey said. Some 50 attorneys have taken part in various discussions of the suit during the past year, charging from $40 to $150 an hour.

The complaint, *Sak Photocopy Service et al vs. Aetna Casualty & Surety Co. et al*, was brought before the California Workers' Compensation Appeals Board in 1981 by medical and legal service providers against workers compensation self-insurers, insurers and third-party claims administrators. It charged them with not complying with a California regulation requiring timely payment of bills incurred during workers compensation hearings (*BI*, Feb. 4).

Plaintiffs charge they have not been paid for services in accordance with Labor Code 4601.5, which stipulates that bills be paid, or objected to, within 60 days of their receipt.

The bills were submitted by physicians, interpreters, photocopying businesses and others whose services are used in hearings held to determine the degree of an employee's job-related disability.

Plaintiffs are seeking payment, plus penalty and interest provisions, for all bills outstanding, or not paid on time, from July 1976, when the regulation took effect, to the present. They also seek legal costs and are asking the Workers' Compensation Appeals Board to devise new rules to enforce prompt payment of these bills.

Labor Code 4601.5 requires employers to pay a penalty of 10% plus 7% annual interest on any medical or legal service bills that are not resolved in 60 days.

The appeals board, which has jurisdiction over the case, has suspended any action on the complaint while the proposed settlement is being discussed. Although the complaint has not officially been certified as a class action, the board is treating

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CSIA conference attracts 600

MONTEREY, Calif.—A group of more than 600 workers compensation managers, third-party administrators and others gathered in Monterey recently to attend the 55th annual convention of the California Self-Insurers Assn.

This year's CSIA conference set a record for attendance; in contrast, some 570 people attended last year's meeting. CSIA has 299 member employers.

CSIA

Among the topics discussed by the California self-insurers and others at the conference were the best ways to approach settling a class-action lawsuit now pending against California self-insurers, third-party administrators and insurers; proposals to change California's workers compensation law and other workers compensation-related bills that are being considered by the state Legislature; and how to select a competent third-party administrator.

Comp/health cover

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supporters of the concept believe that employee "double dipping"—filing both workers compensation and group health claims for the same malady—is curtailed.

Claims coordination is the biggest element of the CIGNA program, which relies on the interfacing of data analysis and computerized risk management systems, said George Hartz, assistant vp for marketing for Connecticut General Life Insurance Co., a CIGNA subsidiary in Bloomfield, Conn.

"We think claims service is where the heart of 24-hour coverage is. That's where the insured will save money," Mr. Hartz said, explaining that by being able to cross-check workers compensation and employee health care claims, an employer can catch double dippers.

Mr. Hartz explained that state privacy laws prevent different insurers and third-party administrators from sharing claims information. Therefore, if a workers compensation insurer has a claim for a back injury, it would be impossible for it to check with the employer's group health insurer to see if the injured worker has a history of back problems.

However, under a combined program, an insurer is allowed to share internal data for the purposes of adjusting a claim, Mr. Hartz said.

At least one major insurer believes its current separate claims-handling programs already keep double-dippers in check and says there isn't a need for a combined workers compensation/group health product.

"We have looked at it, but decided in our situation that we don't see the real advantage that CIGNA sees," said a spokeswoman for the Hartford Insurance Group in Hartford, Conn. "We feel we have a good enough claims process to prevent (double-dipping)," she said.

Other insurers, like Aetna Life & Casualty Co. and CNA Insurance Cos., also have studied the concept, but decided not to offer a combination plan at this time, spokesmen say.

Another insurer, The Travelers Insurance Cos. in Hartford, says it's been offering something similar to the 24-hour concept for years, though it doesn't call it 24-hour coverage.

Travelers' program coordinates health care and workers compensation claims administration and other risk management services, explains Second Vp George Furbish. This coordination is handled by an account executive in Travelers' corporate accounts department who is cross-trained in workers compensation and group health coverages.

Mr. Furbish adds that a policyholder can receive pricing "leverage" by buying "all lines" of coverage from Travelers.

But under the Travelers' program, the insurer's engineering department handles workers compensation loss-control services, while the group insurance department handles health care benefits.

Since workers compensation claims are managed by one department and group health claims by another, most advocates of combined coverage say the Travelers' product does not meet the criteria to be considered a true combined program.

In fact, the whole subject of the elimination of double-dipping, which is a selling point for most combined programs, is currently under study by Travelers.

In addition to privacy laws, legislative and regulatory restrictions and internal accounting and administrative constraints limit the extent to which workers compensation and group health insurance underwriting and pricing can be combined. This is especially true on the primary level.

"When we say 24-hour coverage, we're not talking about a single combined policy; we're talking about a package of special services," CIGNA's Mr. Hartz says.

For instance, several cost-containment features that are now common in group health insurance plans, like second surgical opinions and mandatory outpatient surgery, cannot be applied to workers compensation programs in most states because of state regulations, Mr. Hartz said.

However, he is hopeful that state legislators and workers compensation administrators can be convinced to amend existing laws so these types of cost-containment measures can be applied to workers compensation claims.

In addition, injured employees filing workers compensation claims cannot—under state laws—be required to pay deductibles or coinsurance as they are under many group health plans, he noted.

"The challenge of combining both coverages, is on the one hand that you want to save money, but you still have to separate out work-related from non-work-related claims," Mr. Hartz said.

There's also different policy filing restrictions for workers compensation insurers and group health insurers, noted Monte Gollub, vp with Marsh & McLennan Group Associates in New York. "And group people don't understand property (the property/casualty coverages)," he added.

Other observers agree with these points.

"You can't do it all in one policy because you have different regulatory agencies involved," said Robert Needle, national marketing director for Alexsis Inc. in Philadelphia, a claims administration subsidiary of Alexander & Alexander Inc.

"Workers compensation is highly regulated," he said, explaining that workers compensation medical benefits levels are set by the state and are virtually unlimited, while employers may set the limits paid under group health plans.

"So, by my way of thinking, what you really have (in 24-hour coverage) is really more of a marketing approach," Mr. Needle said.

Mr. Needle also pointed out that one of the biggest problems in combining workers compensation and group health coverages is that insurers or TPAs who service one of the coverages may not be qualified to deal with the other coverage.

And, he noted, "you have different sellers and different buyers in many companies," referring to the fact that corporate risk managers are usually responsible for purchasing workers compensation coverage, while benefit managers usually handle group health insurance.

"You're dealing with different benefits, and you may have different reinsurance in both areas," he said, pointing out other problems with combining the coverages.

However, Gallagher's combined excess insurance program for self-insurers has apparently overcome these problems.

The Gallagher Integrated Employee Security Plan first was conceived in late 1983 and has been marketed for the past 1½ years. It is a special excess policy underwritten by U.S. Insurance Group in Basking Ridge, N.J., a subsidiary of Crum & Forster Corp., and brokered exclusively by Gallagher, said Siri Gadbois, an account executive with Gallagher.

Because Gallagher's single policy is written on an excess basis, it needed to be approved only by the property/casualty division of state insurance departments, rather than by both property/casualty and group health divisions.

"There seems to be more flexibility on excess policies than on primary," Ms. Gadbois said. About two-thirds of the state insurance

Continued on page 6

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Comp/health cover

Continued from page 4

departments have already approved the new Gallagher excess policy, with only minor changes needed to comply with individual state laws, she noted.

Besides workers compensation and group health, the Gallagher policy also includes employers liability coverage.

Under the excess policy's three-tier self-insured retention provisions, an employer has an annual specific retention of $50,000 per employee in paid benefits, which includes the combination of workers compensation benefits, health care benefits and employers liability claims.

But the plan designers also considered the possibility of a severe workplace occurrence or a multiple-person occurrence piercing the retention and decided to incorporate a second-tier retention, Ms. Gadbois said. This is a specific retention of $150,000 per occurrence for any combination of workers compensation and employers liability claims.

The third tier—the aggregate retention—is determined individually for each account. Ms. Gadbois explained that after reviewing an employer's history, a projection is made of how many claims may be paid during the policy period. The aggregate retention then generally is set 25% higher than the expected paid claims.

"This gives a safety valve to the underwriter," Ms. Gadbois said.

The limits on the employers liability portion of the policy, on an occurrence basis, is $500,000. Workers compensation limits are statutorily set and group health benefit limits may be as broad as the employer likes, Ms. Gadbois said.

If the client cancels the policy before it expires, the Gallagher product includes a built-in provision that will have U.S. Insurance Group pick up all unpaid liabilities, including those that fall within the employer's retention, that stem from occurrences while the policy is in effect, she said.

Of the two self-insurers that have purchased this excess policy, one is based in Illinois and the other, a multistate employer, is based in Michigan, Ms. Gadbois said. One had been a Gallagher client before the new policy was created, and one was wooed on board because of this concept.

Key to Gallagher's new policy is that same integrated approach to risk management used for its other products. For instance, clients receive claims administration services and Risx-Facs, a computerized risk management reporting system (*BI*, June 25, 1984).

Another specialized combination plan also recently introduced was developed by BC/BS of South Carolina in Columbia. The new product—Protector 24—includes health care coverage underwritten by the Blues; life insurance underwritten by Companion Life Insurance Co., a BC/BS of South Carolina subsidiary; and workers compensation coverage underwritten by Companion Property & Casualty Insurance Co., another subsidiary.

"It's brand new. We started writing workers compensation last July and then went public in October with Protector 24," explained Charles M. Potok, vp and chief operating officer of Companion Property & Casualty.

"There's definitely a price advantage to the buyer. We can't discount workers compensation rates, but when an employer buys the package, we discount the accident/life premiums, because we expect to save in administration costs and coordination of benefits," Mr. Potok said, referring to employee double-dipping.

One of the reasons Protector 24 was created was to reduce the administrative effort involved with policies with several different insurers, but also because "a synergism should exist between property/casualty and accident/health," Mr. Potok said.

The BC/BS plan already had generated $1 million in written premiums as of February. Several other Blue Cross/Blue Shield affiliates throughout the country have inquired about the program, he said.

"One thing that's probably different from the big groups is that this plan is marketed for groups of fewer than 50 lives. We're seeing our niche in this area. We're not going to compete with the big guys, with self-insured plans and retro plans," he said.

Each Protector 24 package is tailored to meet the individual needs of the employer, Mr. Potok said.

As each of these plans logs experience data from their first year or two of operations, other plans are likely to spring up, consultants say.

"We are convinced there is going to be more along the lines of 24-hour coverages," said Felix Kloman, a principal and advisory director of the Darien, Conn., office of risk management consultant Tillinghast, Nelson & Warren Inc.

"The laws have to catch up with reality. . . .Employers already are providing 24-hour coverage" by buying both workers compensaion and group health coverage, he noted.

"Insurers and employers are innovative people and will attempt to mold the system in changing times," said David Appel, assistant vp with the National Council on Compensation Insurance, a national workers compensation ratemaking and research organization in New York.

And some believe the push may have to come from brokers.

"Maybe they (brokers) will have to become more aggressive in combining the two," said M&M Group Associates' Mr. Gollub. ■

Florida employers debut combination coverage

By CAROL CAIN

SARASOTA, Fla.—A group of Florida contractors, which has operated a successful workers compensation self-insurance pool for 25 years and more recently offered group health coverage to members, is combining the two coverages into one program.

The new product—dubbed the Total Care Program—has been marketed since Jan. 1 to members of the Florida Gulf Coast Builders Exchange, a 33-year-old, 4,300-member trade association based in Sarasota.

So far, 12 employers have signed up for the new program. Each received an upfront discount on the medical portion of the package of between $2 to $4 per employee per month, compared with the cost of buying group health coverage alone from a trust operated the Builders Exchange.

Gilbert Waters, president of Waters Insurance Management Corp., which administers the new combined package as well as the individual workers compensation and group health programs, notes that immediate and constant monitoring of certain high-cost claims is at the heart of all three programs.

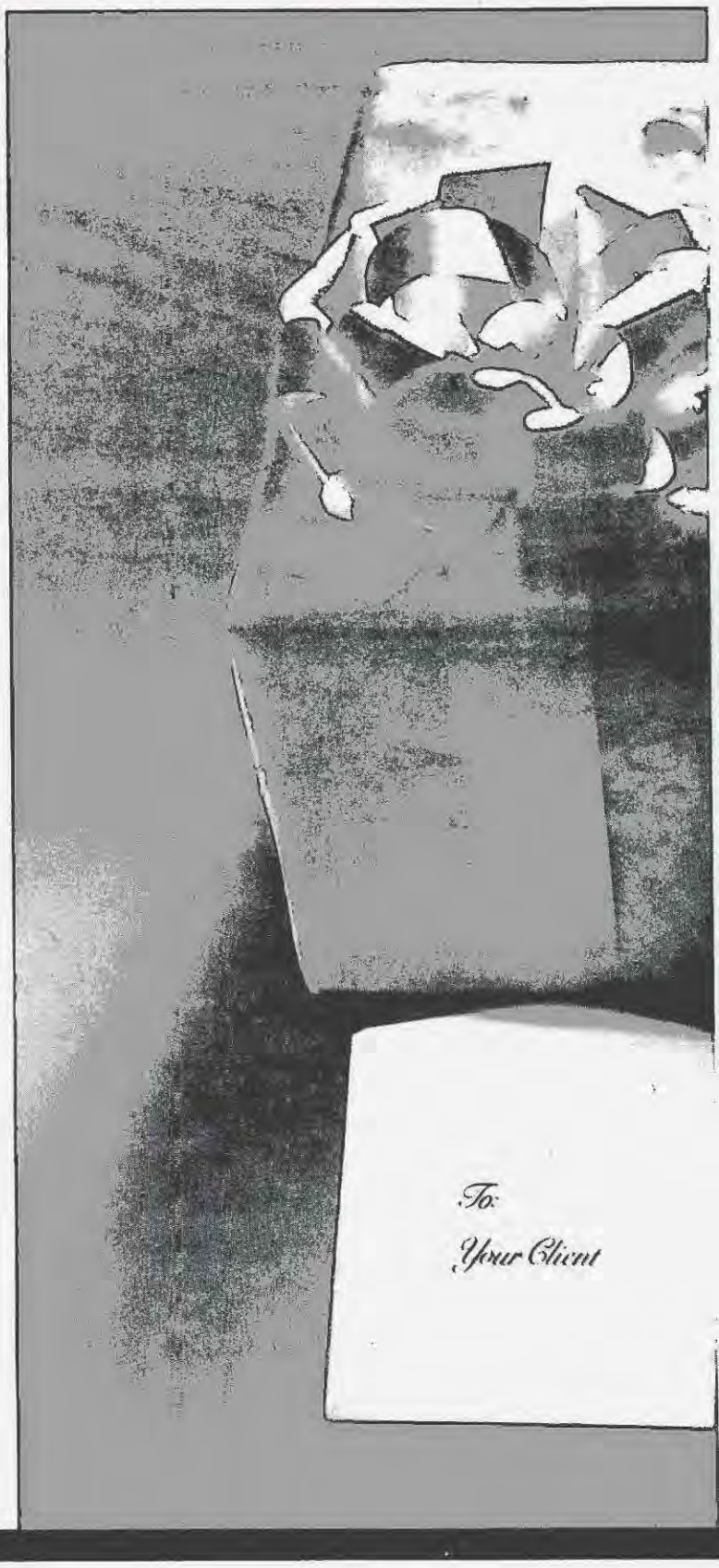
"The big carriers that have been researching seven-day coverage are right.

"It is cost-effective, but its greatest cost savings come with joint field claims managment and counseling," said Mr. Waters.

Mr. Waters' emphasis on claims

Continued on facing page

Containing Costs Effectively Takes More Than Just Expert Packaging.



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Continued from facing page
management and counseling began when the Builders Exchange founded the Florida Construction, Commerce and Industry (FCCI) Self Insurance Fund in 1959 to offer a workers compensation group self-insurance program to its members. Mr. Waters was the first executive secretary of the fund, which now is managed by Waters Insurance Management.

As the program grew—from $39,000 in premiums that first year, to more than $65 million today—Mr. Waters and his staffers discovered that only 6% of the workers compensation claims filed with the fund produced 65% of the employers' claims costs.

"These are the most serious lost-time claims," he said. He noted that after a decade of focusing on this critical minority of "target claims," the FCCI Fund developed a seven-point program for managing work comp costs by concentrating on these claims.

The program's seven-point plan includes:

- Identification of the claims by type and by cause.
- Carefully selecting the risks to be underwritten.
- Accident prevention through loss-control programs.
- Early concentration on the target claims by registered rehabilitation nurses.
- Cost containment during medical coordination by the rehabilitation nurses.
- Cooperative effort by the employer, worker and the fund to encourage case closure through return to work.
- Incentives for loss prevention, cost containment and return to work.

"The proof of the pudding has come during the last decade with an FCCI Fund averaging a 50% loss ratio and tens of millions of dollars in premium savings returned to insureds. In contrast, most of the major carriers in Florida have experienced loss ratios, at least in recent years, half again as bad," Mr. Waters said (*BI*, Jan. 31, 1983).

He cited statistics that show the FCCI Fund reported a 58% loss ratio in 1983, compared with a 108% loss ratio for other Florida workers compensation insurers. According to Mr. Waters, the FCCI Fund tallied a three-year average 57% loss ratio from 1981-83, compared with a three-year average 87% loss ratio for other Florida comp insurers.

With such a good record in workers compensation, the managers of the FCCI Fund were challenged to produce a hospitalization and major medical program for its members, Mr. Waters said.

"I analyzed the elements of the workers compensation management program that produced the 50% loss ratio. I tried to figure out what about our operation produced those results. . .then I tried to project myself into the benefits industry to determine whether the same conditions that create huge costs in benefits were the same in comp, and if what we developed in comp to combat that could also work in benefits," Mr. Waters said.

His research into group health benefits showed a similar pattern in claims and claims cost—63.7% of total health benefits claims go to just 8.6% of the claimants, he said.

Mr. Waters said this research also showed:

- Group health costs were rising more quickly than workers compensation costs.
- Health programs generally do not manage claims; instead, they just pay claims.
- An employer often has no prior warning of a large claim, because they do not require employees to get pre-authorization before undergoing expensive care.
- An employee benefit program by its very definition has to be used in order to be a benefit. Therefore, employees' have an incentive to file claims; there are no apparent employee rewards for reducing claims or containing costs, he said.

"The FCCI Fund management sought to devise a program that followed the FCCI Fund pattern and addressed the perceived deficiencies of health care programs generally in operation. The Keep-Well Trust for Employer-Aided Benefits is the result," Mr. Waters said. "It follows the FCCI concept of intensively managing the worst 6% of the health claims."

For instance, a third-party administrator handles the bulk of the claims submitted to the Keep-Well program, but 6% to 8% of the major-type claims are handled by Waters Insurance Management, he said.

Some 50 employers from the Builders Exchange—1,070 employees and their families—were part of the Keep-Well program at the end of 1984. The program's annualized written premium at the end of 1984 was $752,000. This year, 18 new employers joined the trust.

The program's incurred loss ratio for 1984 was 40.4%, Mr. Waters noted. "We attribute the excellent loss ratio in our first year of operation to medical management, good underwriting practices, emphasis on prevention and rewards for good health," Mr. Waters said.

"With Keep-Well, we're trying to create a mental attitude" toward health care use, he said.

"I think employees should get something if they *don't* have a claim," Mr. Waters said. So as part of Keep-Well, a book of S&H Green Stamps is awarded for each month an employee and his or her family goes without filing a claim.

"We are trying to create a genuine employee benefits program in which the employee benefits without being sick and going to the doctor. The Green Stamps for good health gives the employee a reward for being well," he said. "And we had such a good year, that at the end of 1984, we doubled the Green Stamps for the last quarter."

But there are other facets of Keep-Well that contributed to the low loss ratio. For instance, Keep-Well requires claims in excess of $1,000 to be preapproved, except in emergency situations, he said.

And health counselors—the same rehabilitation nurses used on the workers compensation cases—are assigned to any claim where the diagnosis-related group indicates an expected cost exceeding $3,500.

Cost-containment features include incentives for outpatient testing and surgery, home recuperation and mandatory second opinions on certain specified major surgical procedures.

The pre-authorization helps to prevent unnecessary surgeries and confinements, Mr. Waters said.

Prevention emphasis includes lectures and newsletters in English and Spanish. In addition, an employee may receive a bonus for reviewing and correcting medical or hospital bills, Mr. Waters said.

"The analysis of results for the first year of operation demonstrates the effectiveness of medical management of major claims," Mr. Waters said. "Our rehab nurses, who are called health counselors when they are working for the Keep-Well Trust, have had a remarkable degree of acceptance from the dependents in the Keep-Well program because they are able to provide sympathetic and authoritative assistance in times of complex medical matters."

For instance, in one case, a young woman was scheduled for a cholecystomy (bladder) and a hysterectomy. The health counselor requested additional testing and a second opinion, which resulted in a different diagnosis. The surgery was canceled, Mr. Waters said.

The health counselors were assigned to 74 cases through October 1984, he said, noting a savings of $54,641 on 18 cases as a direct result of the nurses' activities. This is a reduction of 22.9% of 1984 incurred losses of $238,808, he noted. ■

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opinions

Wellington agreement deserves better

THE KNEE-JERK reaction from the AFL-CIO to the proposed asbestos claims facility was predictable, but it's not acceptable.

Workers in the United States who turn to the AFL-CIO for guidance deserve a more thoughtful analysis of this important proposal than was offered last month in testimony by the labor organization's associate general counsel before a Senate subcommittee.

The labor group's attorney, David M. Silberman, said the proposal—known as the Wellington agreement—won't necessarily provide adequate and timely compensation to victims of asbestos-related diseases. He said the labor group's chief concern is that the asbestos producers and their insurers will "use their new-found harmony to wage a unified war of attrition against victims who seek compensation" (*BI*, March 25).

That is a gut reaction exhibiting the paranoia of labor organizations concerning anything business proposes and can be bluntly translated to: Any plan asbestos producers and their insurers have developed to solve the asbestos claims and litigation problems must be to the detriment of the injured workers, or else why would they propose it?

We had hoped that the involvement of Yale Law School Dean Harry Wellington in development of this plan would have signaled to the AFL-CIO that this is a proposal worth studying. Dean Wellington is a man of intellectual integrity and respect for justice who would not lend his name and reputation to an unjust settlement proposal. If the labor group had marshaled its considerable resources to conduct a careful and thoughtful analysis of the Wellington agreement, its staffers would have found that the asbestos claims facility is not a malicious plot to deny workers deserved compensation for asbestos-related injuries.

Upon careful study, the AFL-CIO staff would have concluded that this plan is designed to provide victims of asbestos disease with fair compensation, and to provide it quickly. And, they would have seen that this plan should provide more compensation to more victims because the excess insurance policies that include defense costs within the policy limits won't be so quickly exhausted by defense costs.

The AFL-CIO also is telling workers that the current system of suing a multitude of asbestos producers to obtain compensation is the best method. . . .

But it's obvious the AFL-CIO did not carefully analyze this proposal, its membership and other workers are now being told to be suspicious of this proposal.

The AFL-CIO also is telling workers that the current system of suing a multitude of asbestos producers to obtain compensation is the best method because the threat of big defense costs incurred by these producers forces settlements. And, workers are being advised to secure small settlements from small companies to finance cases against the large asbestos producers.

This is bad advice. If it is taken by the workers injured by asbestos not only will compensation for their injuries be delayed longer than necessary, but also the amount of compensation paid all workers injured by asbestos will be reduced by unnecessary litigation costs. We hope attorneys' advice to asbestos disease victims they represent is better than the labor union's.

letters

Critic should extend an apology to CPCUs

To the editor: Turnabout is fair play! Shirley Brown can join Charles McAlear and extend apologies to those she offended with her letter to the editor (*BI*, March 11). I am a CPCU who did not think her backhanded slap at the designation was appropriate or necessary.

I can agree with the general tenor of her criticism of Mr. McAlear's article "Danger Lurks Behind Lure of Claims-made CGL Form" (*BI*, Feb. 4). While he was not intending to attack women, his analogy regarding a Dallas Cowboy Cheerleader displayed poor judgment and a lack of sensitivity toward women. Furthermore, he probably owes an apology to most members of the insurance industry, because he obviously underestimates the ability and intelligence of average people. Perhaps he doesn't know any of us "average" folk.

However, Ms. Brown exceeded the realm of prudent and responsible editorial comment by stating in her letter: "I know some producers (who by the way carry the designation Chartered Property & Casualty Underwriter) whose knowledge of various items in insurance is rated 2 on a scale of 1 to 10!"

First of all, her anger should have remained with Mr. McAlear. Just because he is a CPCU is no reason to drag the designation into the mudslinging contest. Secondly, she is implying that one can attain the designation without a fundamental understanding of the business. This is absolutely not true.

Anyone holding the designation is proud of it, and rightly so. It cannot be bought, and there are no shortcuts to get it. Each CPCU *earns* his or her designation. When Ms. Brown earns her CPCU designation (I note she did not display it after her name), then perhaps she will have standing to criticize the knowledge of this group. CPCUs have SMARTS, too!

David B. Grant, CPCU
Regional Director
Insurance Institute of America
Columbus, Ohio

An overreaction to cheerleader slur?

To the editor: So Shirley Brown (same name but not the same girl I had a crush on in third grade at Boulevard High School, Shaker Heights in 1939) objects to the impropriety of suggesting a cheerleader can't fly a Concorde (*BI*, March 11).

Touchy-touchy . . . Any intelligent, open-minded person (with or without a CPCU or 3.9 grade point average) understands Chuck McAlear's metaphor and accepts that there is no limitation to what a girl can become, if and when she grows up.

C'mon Shirley, get with the here and now and relegate hope chests and Maypoles to your obscure past.

Your Christmas card was obviously lost in the mail, so I'm pleased that your ex-cheerleader daughters turned out smart. Our newsboy (sorry, newsperson) moved and the dog has fleas.

Stay in touch.

Peter Matthes, CPCU
Growmark Insurance
Bloomington, Ill.

Letter misstates pharmacy system's fee

To the editor: In my recent letter to the editor (*BI*, March 11), there was a small typographical error that could affect our profitability.

Your reprint of my letter indicates that our average administrative fee for processing a prescription drug claim is 20 cents per claim. The actual cost, as stated in my original letter, is 70 cents per claim, which in our opinion is still a pretty low per-claim charge for maintaining a 55,000-member pharmacy network, producing and issuing PCS cards and processing and paying claims.

I will make you a deal, though. . . .If you reduce your subscription fees by 71%, we will consider reducing our fees by the same amount. Who knows, with the number of *Business Insurance* subscriptions we get, we might even come out ahead.

Donald B. Dahlin
President and Chief Executive Officer
Pharmaceutical Card System Inc.
Scottsdale, Ariz.

Little attention paid to letter's real points

To the editor: Why don't Shirley Brown and the editor of *Business Insurance* concentrate on the point Charles A. McAlear was trying to make in "Danger Lurks Behind Lure of Claims-Made CGL Form" (*BI*, Feb. 4) instead of making a federal case out of his unfortunate choice of words (*BI*, March 11)?

Mr. McAlear, you should be more careful about your references relating to this overly sensitive group of people. Next time, you might try "or enlisting a *Texas Cowperson* as pilot for the Concorde."

Lawrence J. Bell, CPCU, ARM
Assistant Vp-Risk Management
Revco D.S. Inc.
Twinsburg, Ohio

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Work comp self-insurers seek settlement

Continued from page 3
it as such while the settlement is being negotiated.

The proposal now on the table calls for two claims funds: a $3 million fund to pay unpaid medical and legal bills and a $750,000 fund to pay fees of attorneys negotiating the settlement.

Mr. Sevey assured those at the self-insurers' conference that the proposal will not provide "an unlimited pot of gold for the physicians to put their hands into."

Potential plaintiffs would be notified of the fund via various trade publications and asked to submit any outstanding or overdue bills by a certain deadline.

To keep the claim values within the $3 million liability cap, the settlement calls for bills submitted to the fund to be automatically reduced to 60% of their original value. If claims exceed $3 million after reduction, they would be discounted further, Mr. Sevey said.

The second fund, which would cover attorneys' fees, would pay out a total of $750,000.

Defendants would be responsible for a portion of the fees based on their share of claims paid. "So, if I paid 1% of the claims in the claims fund, I would pay 1% of the attorneys' fees," Mr. Sevey illustrated.

This aspect of the plan is drawing some criticism.

Concern was expressed at the conference over what would happen if only a handful of bills were submitted to the claims fund. Would those few defendants then be stuck divvying up $750,000 in attorneys fees?

Mr. Sevey said that while this is "a valid concern," he didn't think such a situation would occur. "Every indication we have is that...doctors out there are lining up to participate in this claims fund," he explained.

But, to prevent a few self-insureds from being hit with whopping legal fees, Mr. Sevey suggests that the settlement agreement be voided unless it draws a certain level of participation by the medical community.

Total value of the bills at issue is uncertain, but estimates have ranged from $12 million to $30 million, although one attorney involved says even the $12 million figure is too high.

Mr. Sevey said a company's liability under the proposed settlement will depend on:

- Its size.
- Its geographic location. The likelihood of Northern California employers receiving claims for doctors and other suppliers is "much less" than that of Southern California employers', Mr. Sevey said, because Southern California is a much more litigious area.
- The number of contested workers compensation claims faced by the company over the past 10 years.
- How quickly the company has paid its bills.

All of the state's 1,400 self-insurers, 200 workers compensation insurers and 85 TPAs are expected to be named in the case. When the suit was filed in 1981, only 21 of these parties were named as defendants. However, the suit was amended last September to include some 200 others, including virtually every workers compensation insurer in the state.

"If you haven't already been joined, you're likely to be joined in the near future," Mr. Sevey told self-insured employers and TPAs. "I understand those joinders (notices) are in the mail right now. I wouldn't be surprised if a lot of you have one sitting at your desk back in your office right now."

However, two types of self-insurers in the state may be shielded from the settlement's impact: entities that have only begun to self-insure their workers compensation exposure within the past year and those that can show they completely complied with the payment deadlines in the Labor Code, which took effect July 10, 1976.

'Doctors out there are lining up to participate in this claims fund,' Mr. Sevey says.

"If I had been absolutely correct in my application of Labor Code 4601.5—if I had no outstanding claims, no outstanding medical/legal costs, no outstanding penalties or interest—I would pay nothing under this claims procedure," he says.

But, Mr. Sevey does not expect self-insurers that are facing claims from the plaintiffs to object to the settlement.

"Practically speaking, I don't expect the respondents to contest anything in this settlement agreement if it goes forward. I expect everybody to take their claims and contribute to the fund," he says.

Employers that are named in the litigation do not have to accept the settlement, but Mr. Sevey encourages them to. Self-insurers and others who decide not to take part in the settlement leave themselves open for similar suits naming them individually, he points out.

Since "absolutely nothing" in the settlement will stop this type of suit from surfacing in the future, it is up to self-insurers, their TPAs and insurers to see that it doesn't happen, Mr. Sevey explains. They should follow basic steps of loss prevention: In this case, that means complying with the law, Mr. Sevey adds.

He advises self-insurers and TPAs to pay medical and legal bills, or object to them, within the 60-day limit. When contesting a bill, submit the objection to the provider in writing and make certain the objection has a valid basis. And, lastly, if payment isn't possible within 60 days, automatically add on the 10% penalty and 7% interest payments, he advises.

Mr. Sevey noted the settlement procedure in the litigation "could conceivably have the same scope" as the massive, complex asbestos coverage litigation that began recently in San Francisco, although the amount of money involved is considerably less.

The asbestos coverage case, which may be the largest insurance-related case ever tried, involves so many parties—including five major asbestos producers and about 100 insurers—that a special hall was renovated to accommodate the crowd (*BI*, March 4).

Some self-insurers at the conference asked in which instances should their claims administrator shoulder the responsibility for late payment of bills incurred by the employer.

"I'm not going to touch that one," Mr. Sevey quipped. "That's subject to your own negotiation with your administrator." ■

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California counties develop work comp data base

MONTEREY, Calif.—California counties will soon have access to a comprehensive data base of workers compensation claims filed by county employees.

The County Supervisors Assn. of California, a group of 57 counties that employ a total of about 250,000 people, has been working for the past eight months to develop the data base. Initial data collection results became available this month, according to Allan P. Burdick, the CSAC's legislative representative.

The initial data was compiled from a sampling of 850 workers compensation claims filed by employees in 10 counties between 1980-83.

CSAC will assess the usefulness of this initial sampling before launching into the next phase of data collection, which is expected to include up to 6,000 claims from 40 counties, said Mr. Burdick, who spoke about the undertaking at a recent conference of the California Self-Insurers Assn. in Monterey.

When completed, the data will help risk, safety and workers compensation managers examine injury claims by "a whole variety of issues," according to Mr. Burdick.

It will be broken down by such factors as: the employee's job responsibilities; the region of the state in which the claim was filed; the types of claims most commonly litigated; the amount of money spent litigating claims; the cost and effectiveness of rehabilitation; and the length of time the individual was off the job.

The CSAC's Excess Insurance Authority, a pool that provides excess coverage to CSAC members, probably will manage the data base, according to Mr. Burdick.

Municipal employers often find existing claim information from insurers or other workers compensation organizations of little use because much of it is supplied by private sector companies that often face different exposures, Mr. Burdick said. He cited police, fire and municipal safety officers, who face on-the-job hazards that corporate employees might not.

Giving counties access to the CSAC's data hopefully will help them control their workers compensation and rehabilitation expenses by pinpointing areas of abuse, Mr. Burdick noted.

He added that the data would also help the CSAC evaluate legislative proposals to change California's work comp system.

For example, Californians for Compensation Reform, a statewide employers' lobbying organization that was also represented at the conference, is gaining momentum in its push to implement a wage-loss system of compensating injured employees.

The data first would be available to counties in paper form, printed from CSAC's IBM Personal Computer system in Sacramento, Calif.

But, Mr. Burdick notes the system someday might be put on-line with the counties' information network, Legislative Information Network of Counties.

LINC provides 40 California counties with information on legislative issues that potentially could affect them.

The CSAC is spending $150,000 to develop the work comp data base, Mr. Burdick says. David M. Griffith & Associates Ltd., a Sacramento consulting firm, is collecting CSAC's data. ■

On-the-job disease tests are proposed

MONTEREY, Calif.—Workers that have a high risk of contracting an occupational disease would be able to undergo annual medical examinations at their employer's expense under a bill now before the California Legislature.

The bill, A.B. 990, proposed by Assemblyman Alister McAlister, has been assigned to the Finance and Insurance Committee for study.

Speaking at the recent conference of the California Self-Insurers Assn. in Monterey, Assemblyman McAlister said the legislation is designed to provide the earliest possible diagnosis of occupational disease.

The legislation calls for the California Department of Health Services to identify:

- Those industries and occupations in which workers face "a high risk" of developing occupational diseases.
- Substances that are known to increase the risk of contracting an occupational disease.
- Appropriate medical tests to detect the disease as early as possible.

Based upon those findings, the Department of Industrial Relations would issue regulations requiring those "high risk" employers to offer their workers annual medical tests.

The employee could use any licensed physician or medical facility for the exams.

Employers, both public and private, would be required to notify employees annually of their right to free medical testing.

The bill would prohibit companies from discriminating against an employee because he or she chooses to undergo the medical tests.

Under the legislation, all exam results would have to be made available to the employer, the workers compensation insurer and the California departments of health services and industrial relations.

Testing employees who are at high risk of contracting an occupational disease would present advantages to both employee and employer, according to Assemblyman McAlister.

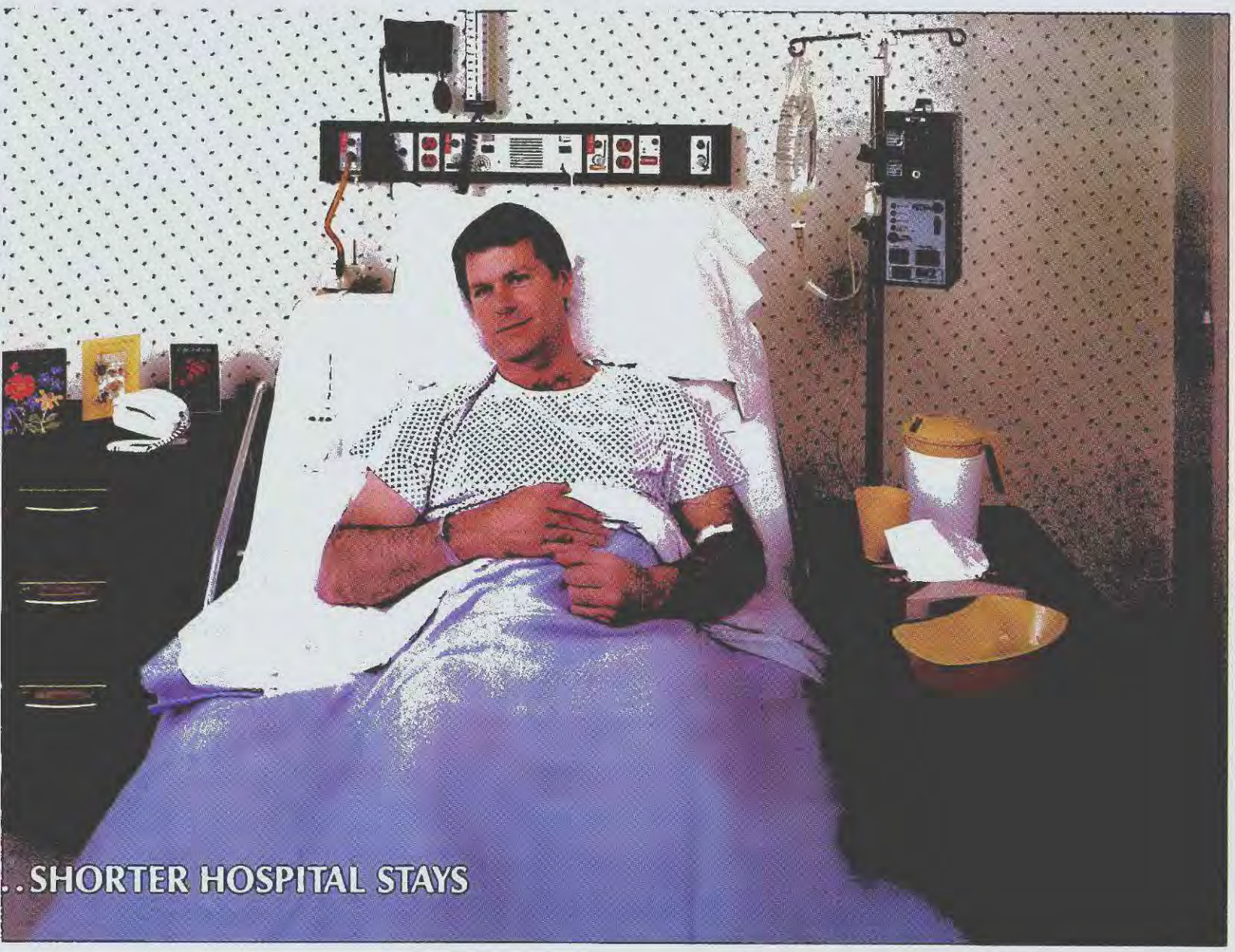
The employee will receive early treatment, when it will be most effective, he added.

And, manifestation of occupational diseases could thereby be avoided, he added.

The program would also provide a data base that could assist physicians in treating work-related illnesses.

The data also could be used to help employers distinguish between job-related medical claims and non-occupational health care claims, and might help prevent further occurrences of job-related illness, he says.

Assemblyman McAlister said that he believes California is the first state to consider such legislation so far. ■



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Bill mandating well-child coverage opposed

Continued from page 3
dropping or altering their benefit programs.

Fredrick L. Schick, principal at A.S. Hansen Inc. in Deerfield, Ill., said, "If there's one thing we don't need more of from Washington, it's additional mandated coverage. Given the mode of American businesses today, (such legislation) would be another reason not to have health care plans at all."

In addition to their philosophical objections, the insurers and consultants have some concrete objections to the proposal.

For example, Ms. MacDonald said the proposal is too vague. "It explains things in very general terms which makes it very hard to underwrite it," she said.

"It doesn't specify the number of visits; it calls for (coverage of) 'approved procedures,' but it doesn't define them."

And, the bill is silent on what effect employee contributions to premiums for the coverage and also doesn't mention deductibles or copayments. All three of these devices could be used to pass most of the cost of well-child care onto the employee, weakening the bill's impact, said Deborah Chollet, senior research associate at the Employee Benefits Research Institute, a Washington-based benefits think tank.

"Many plans already cover well-child care, but they cover it with a deductible—and it can be a substantial deductible," Ms. Chollet said.

"It seems to me the legislation might be meaningless if there is not some definition of 'coverage.' Otherwise, a high deductible might preclude any meaningful coverage."

And, she added, "Congress has always been reluctant to dive into health care coverage and mandate deductibles and copays. There's no indication that they want to do it now. So there's no reason to think they would form a meaningful definition of coverage."

Insurers also say the proposal's estimate of the cost of pediatric preventive care—$2.28 per family per month—is far too low.

"We feel that is incorrect," Metropolitan's Ms. MacDonald said. "We feel it would be much more than that. When we were playing around with the figures, the number we came up with was double that—it was about $4.70."

Currently, Metropolitan offers well-child care as an option under some group plans, a spokesman said. The monthly premium for the coverage ranges from $1.30 to $6 a month per covered employee. The $1.30 plan, which a spokesman described as "the bare minimum," covers seven visits in the first year of a child's life. The plan that costs $6 per month provides full coverage on all preventive care until the child is 20 years old, the spokesman said.

Ms. Chollet could not give an opinion on whether there was a need for this type of coverage to be federally mandated.

"We don't have any way of knowing that," Ms. Chollet said. "The major data sources (Labor Department statistics) aren't as clear in this area as we'd like them to be."

According to insurers and consultants, between 15% and 30% of traditional health care plans include some kind of coverage for pediatric preventive care. In addition, health maintenance organizations regularly offer such care and flexible benefits programs often include it as an option.

Insurers and consultants also argue that most people don't really need insurance for well-child care, because it is a budgetable expense.

"Many employers feel it's a predictable expense," said Ms. Lehnhard of BC/BS. "It's not an emergency; it's something that can be budgeted for."

Ms. Ferguson, Sen. Chaffee's aide, disagrees with this premise.

"If you can't afford to bring your child in for an examination because you're on the lower end of the work scale, how frequently do you think that child will end up in the doctor's office (for wellness care)?" asked Ms. Ferguson. "And the contention is that's the kind of care we should be focusing on."

But, John Hickey, a partner at consultant Kwasha-Lipton in Fort Lee, N.J., said, "(Sen. Chaffee) fails to recognize that most employed people are not going to make decisions on their child's care based on who pays for it."

He continued, "The people who don't use these pediatrics services are those who are unemployed or marginally employed and therefore not covered under an employer health care plan anyway.

"So you wouldn't really change people's behavior—you'd just be making the employer pay for something that their employees used to pay for." ■

Capacity at Lloyd's won't rise

LONDON—The Council of Lloyd's has decided to take no steps to increase capacity at Lloyd's of London for 1985.

"Many were siren voices urging the Council of Lloyd's to do something about capacity for 1985," Lloyd's Chairman Peter Miller said in a recent speech.

"We took several weeks to arrive at our decision to take no action, but I am sure it was the right one, based as it was upon the sound principle that the less one tampers with market mechanisms, the better."

The council had considered basing the formula it uses to convert British pounds to U.S. dollars on a June 1985 conversion rate instead of the year-end 1984 rate. That possibly would have increased Lloyd's capacity to write U.S. risks (*BI*, Jan. 28).

However, the idea was rejected by the council.

Lloyd's gross capacity for 1985 is about 6.7 billion pounds (about $7.86 billion based on the year-end exchange rate). ■

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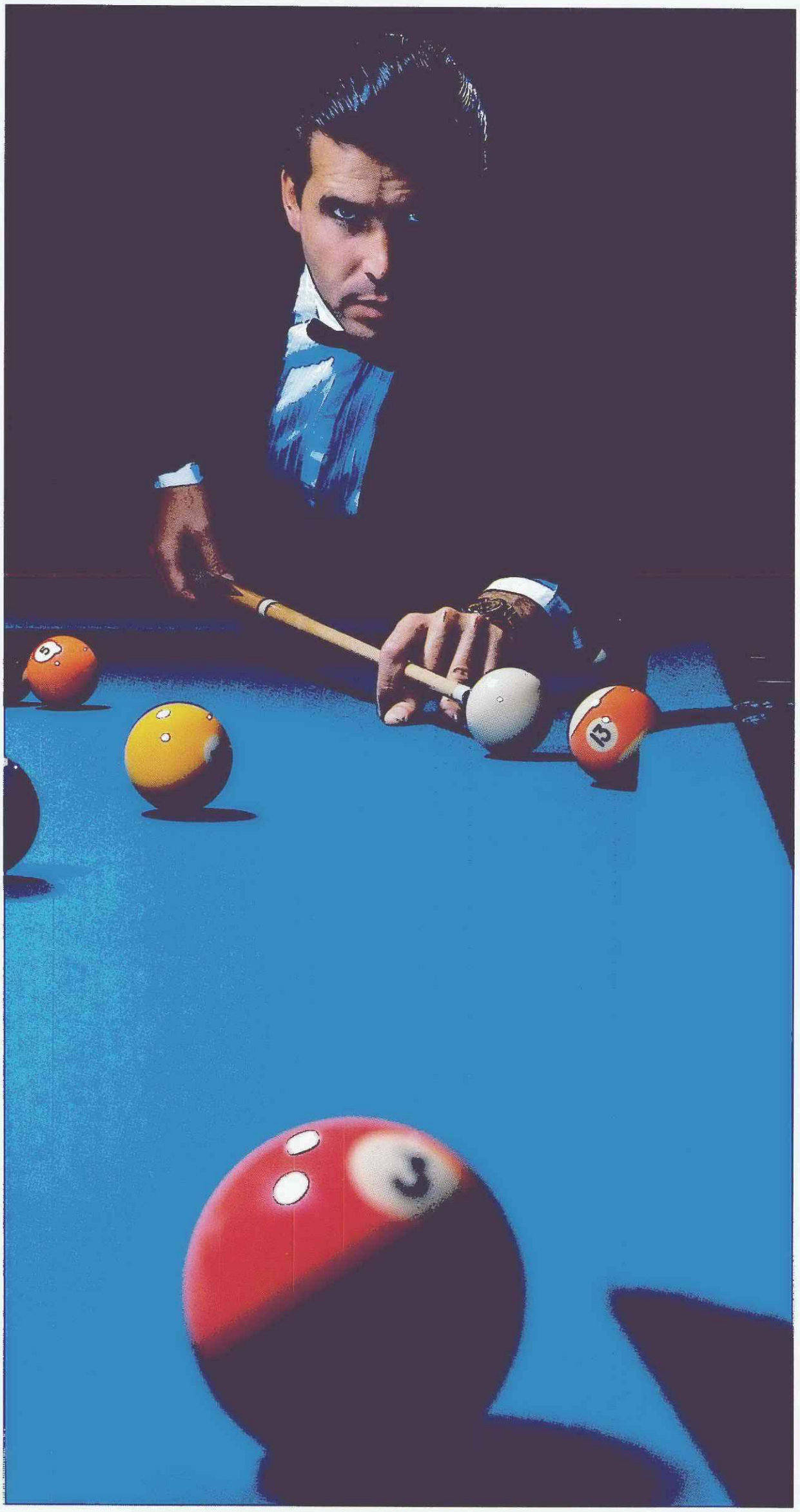

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• A comprehensive guide to **risk management terminology** is now available from the Risk & Insurance Management Society. The "Risk Management Glossary" defines terms applicable to risk identification and control, as well as insurance and reinsurance terms, and statistical, financial and legal concepts. The glossary explains the meaning of the terms within the risk management context. The glossary costs $3.95 a copy; $3.50 a copy for orders of five or more. Order from Risk Management Society Publishing Inc., 205 E. 42nd St., New York, N.Y. 10017.

• The Film Library, an extensive collection of safety, training, fire, health, management and motivational films, is offering its **1985 Film Catalog** free of charge. The catalog lists the latest acquisitions of the Film Library, in addition to its current selection of more than 1,600 titles available in 16mm format. To order, write the Film Library, 616 S. Westmoreland Ave., Third Floor, Los Angeles, Calif. 90005.

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• A two-year study of **church property and personal injury losses** is the basis for a guide to the prevention of such losses published by The Atlantic Cos. The booklet suggests precautions church custodians, pastors and trustees can take to reduce the chance of loss due to arson, fire, burglary and storms. For a free copy of "Guarding the House of God," write Howard P. Hoskins, Corporate Communication, The Atlantic Cos., 45 Wall St., New York, N.Y. 10005.

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E.W. Blanch announces closing of Bermuda unit

E.W. Blanch Co., the Minneapolis-based reinsurance intermediary, is closing its E.W. Blanch (Bermuda) Ltd. unit.

Michael Cashman, president of the firm, said the move was "strictly a market decision in Bermuda. With the tightening of the market, we feel it's not practical to maintain an office in that area."

He said Blanch would service Bermuda-based business from its U.S. offices. The company has branches in Atlanta, New York, Chicago, San Francisco and Stamford, Conn.

Blanch is the third-largest reinsurance broker in the United States, according to *Business Insurance's* annual rankings, with 1983 gross revenues of $23.2 million.

Blanch opened its office in Bermuda three years ago to show insurers based in Bermuda a broad spectrum of non-marine U.S. treaty business. Several of the insurers that Blanch offered business too, however, stopped underwriting unrelated risk business in the last year, including Exxon Corp.'s Ancon Insurance Co. and Gulf Corp.'s Insco Ltd. following the acquisiton of Gulf by Standard Oil Co. of California.

Insurer to be sold

National Distillers & Chemical Corp. has agreed to sell Indiana Insurance Co. to Peerless Holdings Inc., a U.S. subsidiary of Nationale-Nederlanden N.V., for $105 million.

In addition, National Distillers will pay $15.5 million to Indiana Insurance to cover tax losses generated by the unit.

Indiana Insurance, a property/casualty insurer based in Indianapolis, produced an underwriting loss of $29.3 million and a net loss of $16.8 million on earned premiums of $146.4 million in 1984, according to an unaudited statement filed with the Indiana Insurance Department.

Proceeds from the sale will be used to reduce National Distillers' debt, a company spokesman said.

Consultant expands

Gage-Babcock & Associates Inc., a risk analysis and consulting firm specializing in fire protection and security systems, has acquired an interest in a Vancouver, British Columbia, engineering firm.

The Canadian company, formerly Compyro Consultants, will be called Gage-Babcock & Associates Ltd. and will continue to offer clients fire protection design and consulting services.

Tim K. Lenahan, president of Gage-Babcock's new operation, said he intends to expand the company's services throughout Canada. The company offers its services to architects, industrial and commercial firms and government entities.

Gage-Babcock is headquartered in Chicago with five other U.S. offices.

NME buys insurer

National Medical Enterprises Inc., a Los Angeles-based health services company, has agreed to acquire Assured Investors Life Co. of San Francisco.

Assured Life is owned by Woodmen of the World, which is a fraternal benefit society located in Denver.

The acquisition is expected to be approved by regulatory authorities this spring.

"Ownership of an insurance company will allow for further integration of our health plans with the company's lines of business throughout the nation," said Richard K. Eamer, NME chairman and chief executive officer. "We will now have the ability to underwrite

Continued on next page

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markets

Continued from preceding page
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In addition, NME offers management and support services to hospitals worldwide, including two facilities in Saudi Arabia. The company owns retail pharmacies throughout the United States.

Assured Investors Life operates in 13 states and is awaiting approval to operate in Florida.

Rogal buys firms

Rogal Co., a division of Richmond, Va.-based Hilb, Rogal & Hamilton Co., has acquired two Pittsburgh insurance agencies.

The Angelo Ratini Agency and the Jules Ehrman Agency were acquired in February by the privately owned agency system for undisclosed amounts.

Hilb, Rogal & Hamilton's 1983 gross revenues of $18.9 million ranked it as 17th in *Business Insurance's* survey of the largest U.S. brokers last year (*BI*, June 25, 1984).

Purchase completed

Manufacturers Life Insurance Co., headquartered in Toronto, has completed a previously announced purchase of Lincoln National Life Insurance Co.'s 89% stake in The Dominion Life Assurance Co. of Waterloo, Ontario.

Manufacturers paid around $106 million for the interest in the Canadian company.

Northbrook offices

Northbrook Property & Casualty Co., a subsidiary of Allstate Insurance Co., has made office changes in three of its marketing territories.

Following a two-year operation to test market potential in Minnesota, the insurer is opening a branch office in that state. It will be located at 7101 Metro Blvd., Edina, Minn. 55435; 612-944-9344.

Northbrook is consolidating its Cleveland and Cinncinnati offices into a new Ohio Valley branch. The new office will be located in Cincinnati and will handle underwriting and policy processing for customers in Ohio and Kentucky.

The company will continue to maintain its Cleveland office for local claim, marketing and loss-control services.

The Ohio Valley branch is located at 7 W. Seventh St., Suite 1950, Cinncinati, Ohio 45202; 513-579-7400.

New offices

Stewart Economics Inc. has moved to Suite 2133, 40 Wall St., New York, N.Y. 10005; 212-742-1740.

Crown Life Insurance Co., a Toronto-based life insurer, has opened U.S. headquarters at 201 N. Union St., Fifth Floor, Alexandria, Va. 22314; 703-684-4100. ■

Officers, directors elected by AIMU

NEW YORK—Thomas O. Clark, vp of Commercial Union Insurance Cos., was re-elected chairman of the board of the American Institute of Marine Underwriters at the group's annual meeting.

Ward L. Mauck was re-elected AIMU president. Others re-elected were Deputy Chairman George S. Zacharkow, chairman of the Marine Office of America Corp.; Vice Chairman Kenneth G.T. Drysdale, president of Wm. H. McGee & Co. Inc.; and Treasurer Harry S. Keefe, president and chief executive officer of Talbot, Bird & Co. Inc.

Elected to the AIMU board of directors were David C. Beebe Jr., vp of Chubb & Son Inc.; Nicholas A. Creatore, vp of the Home Insurance Co.; Terence N. Deeks, president of New York Marine Managers Inc.; William Mack, president of American International Marine Agency; Donald H. Miller, president of Donald H. Miller Inc.; Warren P. Noll, vp of Royal Insurance; Victor P. Simone, senior underwriting officer of the St. Paul Insurance Cos.; Sam V. Tranchina, vp of Great American Insurance Cos.; and James A. Williams, vp of Fireman's Fund Insurance Cos. ■

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The Northwestern Mutual Life Insurance Company

has acquired the residential mortgage insurance business of

MGIC Investment Corporation

We assisted in the negotiations of this transaction and acted as financial advisor to **Management Financing Corporation** and **The Northwestern Mutual Life Insurance Company.**

Donaldson, Lufkin & Jenrette

March 19, 1985

This announcement appears as a matter of record only.

The acquisition of the residential mortgage insurance business of

MGIC Investment Corporation

required the following financing facilities

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Common Stock provided by:

The Northwestern Mutual Life Insurance Company

$230,000,000

Quota Share Reinsurance of the unearned premium reserve and renewals of the residential mortgage insurance business of MGIC Investment Corporation provided by:

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and other reinsurance companies

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Letter of Credit Facility provided by:

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March 19, 1985

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benefit beat

Baton Rouge employees to pay more for coverage

The city-parish of Baton Rouge, La., is asking its 4,000 employees to pay more for medical and dental benefits in an effort to make up the self-insured plans' $1.6 million shortfall.

The plan changes, which took effect last month, require employees to pay higher deductibles and additional contributions to the claims fund and include penalties for failure to use cost-containment programs.

Irvin F. Jones, risk and insurance manager for the city of Baton Rouge and East Baton Rouge Parish, says medical deductibles are now $100 per person for hospital expenses and $100 per person for non-hospital expenses such as visits to doctors' offices and prescription drugs. The per-person deductibles are not limited by the number of people under family coverage.

Employees also pay 20% of all expenses exceeding the deductibles, up to an annual out-of-pocket maximum of $1,000 for individuals and $3,000 for family coverage.

Previously, deductibles were $25 per person for hospital expenses and $50 per person for non-hospital expenses. The next $500 in expenses were fully paid by the city and the parish. Employees then paid 20% of expenses exceeding this $500, up to an annual out-of-pocket maximum of $2,000 per person.

The new benefit plan also requires employees to pay for dental coverage, which was previously paid in full by the city-parish. Employees now contribute $3.40 a month for individual coverage, $7.02 a month for coverage for themselves and one dependent and $12.73 for coverge for themselves and two or more dependents.

In addition to these cost-shifting measures, the city-parish has added cost-containment features to the medical plan.

Pre-admission testing is now required for all non-emergency hospital admissions. If an employee ignores this requirement, he or she must pay a $300 penalty plus the regular deductible, Mr. Jones said. In addition, the city-parish only pays 40% of room and board charges if the employee ignores the pre-admission requirement; however, all other charges would be paid at the normal rate.

A new second opinion program pays 100% of the cost of second opinions, which are required for 13 common surgical procedures, including hysterectomies, knee surgery and foot surgery, Mr. Jones said. If an employee fails to obtain a second opinion for one of the 13 specified procedures, the city-parish only pays 40% of the surgeon's fee; all other charges are paid at the normal rate.

The new program also incorporates some new benefits, designed to steer employees to less-expensive services. Home health care and hospice care now are reimbursed at the same rates as traditional hospital care. The only exception is that an extra $50 deductible is applied to hospice care if the employee has not already paid the $100 hospitalization deductible, making the total deductible $150 in those cases.

Ralston Purina benefits

Union workers at the Ralston Purina Co. plant in Battle Creek, Mich., will contribute more toward their health care coverage under a recently negotiated two-year agreement.

The new contract requires the 320 members of Local 66 of the American Federation of Grain Millers to pay $4 a month to the company's claims fund for indivdual health care coverage or $10 a month for family coverage. Previously, they paid $2 a month for individual coverage and $4 a month for family coverage.

The health care claims fund covers the company's self-insured medical and dental benefits.

In addition, the contract requires employees, when they retire, to pay $10 a month for individual health care coverage and $10 a month for each dependent covered by the health care plan. Currently, retirees do not contribute to the cost

Continued on facing page

Continued from facing page
of their post-retirement health plan.

The contract also increases the lifetime maximum major medical benefit to $175,000 from $150,000.

The monthly retirement benefit for service prior to 1973 increased to $16 per year of service under the new contract, up from $15.

PPO option added

United Auto Workers at Martin Marietta Corp. in Bethesda, Md., have a new three-year contract that adds the option of a preferred provider organization to their health care coverage.

UAW members also can continue to choose either Martin Marietta's indemnity health care plan or a health maintenance organization.

The indemnity plan requires members to pay a deductible of $100 for individual coverage or $200 for family coverage and 10% of expenses exceeding the deductible, up to an annual out-of-pocket maximum of $600 for individuals and $1,200 for family coverage.

The HMO option does not require employee contributions, except for incidentals like deductibles on prescription drugs.

A union spokesman said specifics of the HMO and PPO options will be determined by a joint labor-management committee, but workers will not be required to pay deductibles or copayments on services provided by HMOs or PPOs.

The contract, which was ratified by a 60% margin, also makes improvements in pension, life, and accidental death and dismemberment insurance benefits. And, it establishes an employee stock ownership plan and an employee savings and investment program.

Pension benefits, which had been $16 a month per year of service, were increased to $17 a month in the first year of the contract, $18 a month in the second year and $19 a month in the third year.

The agreement allows workers to retire at age 58 with full benefits if they have 30 years of service. Under the previous early retirement program, workers could not retire until age 60, regardless of the how long they had worked. The normal retirement age is 62.

Workers also will receive additional life insurance through the new contract. Upon ratification, each worker received an additional $1,000 in life insurance, and each worker will get another $1,000 increase in November 1986.

The amount of life insurance workers receive depends on several factors, including the plant where they work and their rank. Before the increases, the amount of life insurance available ranged between $13,000 and $16,00 a year.

The contract increases accidental death and disability coverage by the same amounts it increases life insurance coverage. And, like the life insurance, employees receive varying amounts, depending on the plant where they work and their rank. The range of benefits available before the increases also was $13,000 to $16,000 a year.

Connecticut General Life Insurance Co. insures the health, life and accidental death and disability benefits programs.

Steelworkers contract

Steelworkers for the city of Jackson, Mich., have a new three-year contract that increases dental and life insurance benefits.

The 130 members of Local 14168 of the United Steelworkers of America ratified the contract Feb. 28. The agreement is retroactive to July 1, 1984.

Under the contract, workers are reimbursed on a first-dollar basis for the first $500 of their dental expenses, up from $250 under the previous contract. All expenses above $500 are paid by the workers.

The contract also increases life insurance coverage to $15,000, from $10,000. Workers will receive another life insurance benefit increase, to $20,000, on Jan. 1, 1986.

The city's dental plan is self-insured; its life insurance is underwritten by Union Central Life Insurance Co.

Casket firm shifts costs

Boyertown Casket Co. in Boyertown, Pa., is shifting part of its health care premium cost onto union employees.

The 370 members of the Upholsterers International Union recently ratified a three-year contract under which employees with dependent coverage must pay about $16 of their monthly premium of $173.50.

According to Vp Fred Ihrig, the company had paid the full monthly premium, which was $116, for employees with dependent coverage. But, when the union, which self-insures the health care plan, raised the premium for this coverage to $173.50, the company decided to ask for employee contributions.

The company will continue to pay the full $101 monthly premium for individual coverage, he said.

The new contract also requires union members to pay higher deductibles. Under the new contract, the deductible increased to $150 from $100 for individual coverage and to a family maximum of $450 from $100 per person with no family maximum. In addition, the employee pays a 20% copayment on hospital expenses up to an out-of-pocket limit of $3,000. There also is a 20% copayment for medical expenses, with no out-of-pocket limit.

However, the contract also raises the lifetime maximum medical benefit to $150,000 from $100,000.

It also calls for charges for cost-containment measures—like second surgical opinions, pre-admission testing and outpatient surgery—to be reimbursed at 100%.

•

Made any benefit changes? Write Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

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Oregon court is weighing plan to rescue North-West

PORTLAND, Ore.—An intricate plan to keep intact the bulk of Louisiana policies written by Portland-based North-West Insurance Co. is in the hands of a Multnomah County Circuit Court judge.

The insurer was placed in liquidation by the court on Dec. 4 (*BI*, Dec. 10, 1984).

The plan, which was filed with the circuit court on March 15 by the Committee of Insureds and Agents, a group of Louisiana employers and insurance agents, calls for the creation of a new insurer in Louisiana by spinning off North-West's book of business written by Mid-Continent Underwriters Inc., the insurer's managing general agency in New Orleans (*BI*, Dec. 24, 1984; Nov. 5, 1984; Oct. 29, 1984).

A charter for the new insurer, to be named North-West Insurance Co. of Louisiana, already has the approval of Louisiana Insurance Commissioner Sherman Bernard.

According to the plan, the new insurer will immediately be placed in rehabilitation in Louisiana. The Louisiana Insurance Department will be appointed as receiver.

According to court papers filed this month, it appears that only a "relatively small percentage, perhaps 10%-20%, of the total outstanding loss reserves of North-West arise out of the book of business generated by other producers besides Mid-Continent, while the balance of the losses, totaling more than $60 million in the aggregate, emanate directly out of the surplus lines book of business written through the New Orleans office of Mid-Continent."

Claims from states where the insurer wrote on a surplus lines basis are going unpaid, while guaranty funds have been triggered to pay claims in 13 states where North-West was an admitted insurer.

The plan's opponents have until April 15 to file their objections, according to an Oregon Circuit Court order. However, the Oregon Insurance Department, which is the receiver in the liquidation, is planning to ask for an extension of that deadline.

Some 1,000 "interested persons" must be sent copies of the plan and be given time to respond, noted Kathleen Dahlin, an assistant attorney general in Oregon representing the Insurance Department. The department also needs time to duplicate the 20-page plan and send it out to insureds, agents, creditors, reinsurers, guaranty associations and insurance commissioners, she said.

The Committee of Insureds and Agents developed the plan and has contributed more than $700,000 in cash and several million dollars in financial commitments to rescue the insurer. According to the plan, the insureds have agreed to assume the amount of risk North-West would retain—in addition to their own deductibles or self-insured retentions— to gain access to the insurer's reinsurance. ■

Couple sentenced in embezzlement

LOS ANGELES—A former medical claims analyst at Hughes Aircraft Co. and her husband were each sentenced to 10 years in prison by a federal judge for embezzling more than $12 million from the company's medical benefit plan.

Shirley J. Davis and her husband, Clyde L. (Rocky) Davis, pleaded guilty in October to charges arisng from the embezzlement scheme (*BI*, Oct. 8, 1984).

In addition to the prison term, the court fined Ms. Davis $110,000 and her husband $60,000. The sentences were handed down March 11 by U.S. District Judge Manuel Real.

An FBI investigation of the embezzlement scheme revealed that, while Ms. Davis was working in Hughes' medical claims department, she issued more than 1,600 checks to Dr. C.L. Davis Jr. Dr. Davis is a health care provider for the El Segundo, Calif.-based aerospace company.

But, the investigation revealed that those checks were later deposited by Rocky Davis into the account of Rocshire Records, a recording concern that he and his wife owned. The money was used to finance the now-defunct record company, according to the investigation.

The real Dr. C.L. Davis Jr. had no knowledge of the scheme. ■

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Ralston names Drum risk management director

William E. Drum, 38, has been promoted to division vp and director of risk management at Ralston Purina Co. in St. Louis. Mr. Drum will oversee all risk management functions, including the design and purchase of property/casualty programs for the worldwide organization and its subsidiaries and divisions. Mr. Drum reports to Jack Reimers, treasurer, and replaces **Otto Blumfelder**, who retired. Previously, Mr. Drum was corporate risk manager. The responsibilities of that position are now being split between **Richard B. Hansmann,** manager of casualty risks, and **E. Larry Smith,** manager of property risks. Mr. Drum received a bachelor of science degree in business in 1970, and a master's degree in business administration in 1972, from Southern Illinois University. Mr. Drum also has earned the Associate in Risk Management designation.

Mr. Hansmann and Mr. Smith have both been promoted to newly created positions at Ralston Purina. Mr. Hansmann, 38, is responsible for the purchase and coordination of workers compensation insurance programs and liability insurance for the company. He reports to Mr. Drum. Previously, Mr. Hansmann was the company's casualty claims manager, and he will retain those responsibilities. Mr. Hansmann received a bachelor of science degree in psychology from St. Louis University in 1968 and a master's degree in management from Webster University in St. Louis in 1979.

Mr. Smith, 26, is responsible for the evaluation and insurance of property and marine exposures, including the design and purchase of insurance programs at Ralston Purina. He also reports to Mr. Drum. Previously, Mr. Smith was risk management analyst at Ralston Purina, and he will retain those responsibilities. He earned a bachelor of business administration in risk management in 1980 and a master's degree in business administration, specializing in risk management, in 1981, from the University of Georgia. Mr. Smith also is studying for the Chartered Property & Casualty Underwriter designation.

* * *

G. Buddy Nichols, 38, has been promoted to senior vp of risk management and quality assurance for Methodist Health Systems Inc. in Memphis, Tenn. In this newly created position, Mr. Nichols is responsible for Methodist Health Systems' self-insured programs, including claims administration, and its risk financing and control functions, including loss control and quality assurance. In addition, he will retain the responsibilities of his previous title of director of risk and insurance. He reports to Larry Rambo, chief operating officer. Mr. Nichols received a bachelor of arts degree in political science from The College of the Ozarks in Clarksville, Ark., in 1972.

Mr. Nichols

* * *

James A. Bishop, 33, has been named assistant treasurer of Grolier Inc. in Danbury, Conn. In this new position, Mr. Bishop's responsibilities include the administration of corporate risk management programs and the financing of corporate benefit programs. He also will retain the responsibilities of his previous position, director of corporate risk management. He reports to Richard Webb, vp of finance and treasurer. Mr. Bishop received a bachelor of science degree in business administration from Ohio State University in 1976 and a master's degree in business administration from the University of Connecticut in 1984.

comings & goings: buyers

* * *

Carl J. Kotheimer, 37, has been promoted to risk manager for Diebold Inc. in Canton, Ohio. In this newly created position, Mr. Kotheimer is responsible for managing the company's self-insurance, safety and loss-control programs. He reports to Roy J. Villella Jr., assistant secretary. Previously, Mr. Kotheimer was risk and insurance analyst at the company. He earned a bachelor of arts degree in political science in 1969 and a master's degree in public administration in 1975 both from Ohio State University. He also holds the Associate in Risk Management designation.

* * *

Thomas S. Keel, 37, has joined Bank of America in San Francisco as senior safety specialist. Mr. Keel is responsible for the design and implementation of safety and health programs, including accident prevention programs. In addition, he will monitor the financing of workers compensation programs. He reports to Tom Parrott, manager of safety and health, and replaces **Susan Kelly**, now a safety officer at Wells Fargo & Co. in San Francisco. Previously, Mr. Keel was loss-control manager at Fremont Indemnity Co. in Foster City, Calif. He received an associate of arts degree in sociology from West Valley College in Saratoga, Calif., in 1970 and is on the board of trustees of the National Safety Council.

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We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Just drop a note to Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

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Jerry Silver
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During the two day Pro-Am portion of our tournament, half the contest winners on one day and half on the next will play with 22 of golf's greatest, including Senior pro Arnold Palmer and special guest Gary Player. We're also sponsoring two great days of court skills clinics with tennis legend, Rod Laver. And, during the remainder of the week, you can watch the pros battle each other in another exciting cliff-hanger, as they compete for $160,000 in prize money.

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Let us know if you don't receive an entry.

We'll be sending our full contest details at the end of March. If you haven't received material from Unionmutual by April 7, contact your local field office. We want everyone to have the chance to tee off with the pros at the 2nd Annual Unionmutual Seniors Golf Classic.

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Individual Life Division Contest: Only paid premium received in conjunction with the sale of Unionmutual Stock Life Insurance Co. of America universal life insurance outside of Wisconsin will be considered in awarding prizes in the Individual Life Seniors Contest.

Employee Benefits Division Contest: Unionmutual Stock Life Insurance Co. of America and Union Mutual Life Insurance Company group life insurance products sold in Wisconsin will not be considered in awarding prizes in the Employee Benefits Seniors Contest.

Group Pensions Division Contest: Only pension sales representatives for Unionmutual Pension & Insurance Corporation and Union Mutual Life Insurance Company will be eligible to win prizes in the Group Pensions Seniors Contest.

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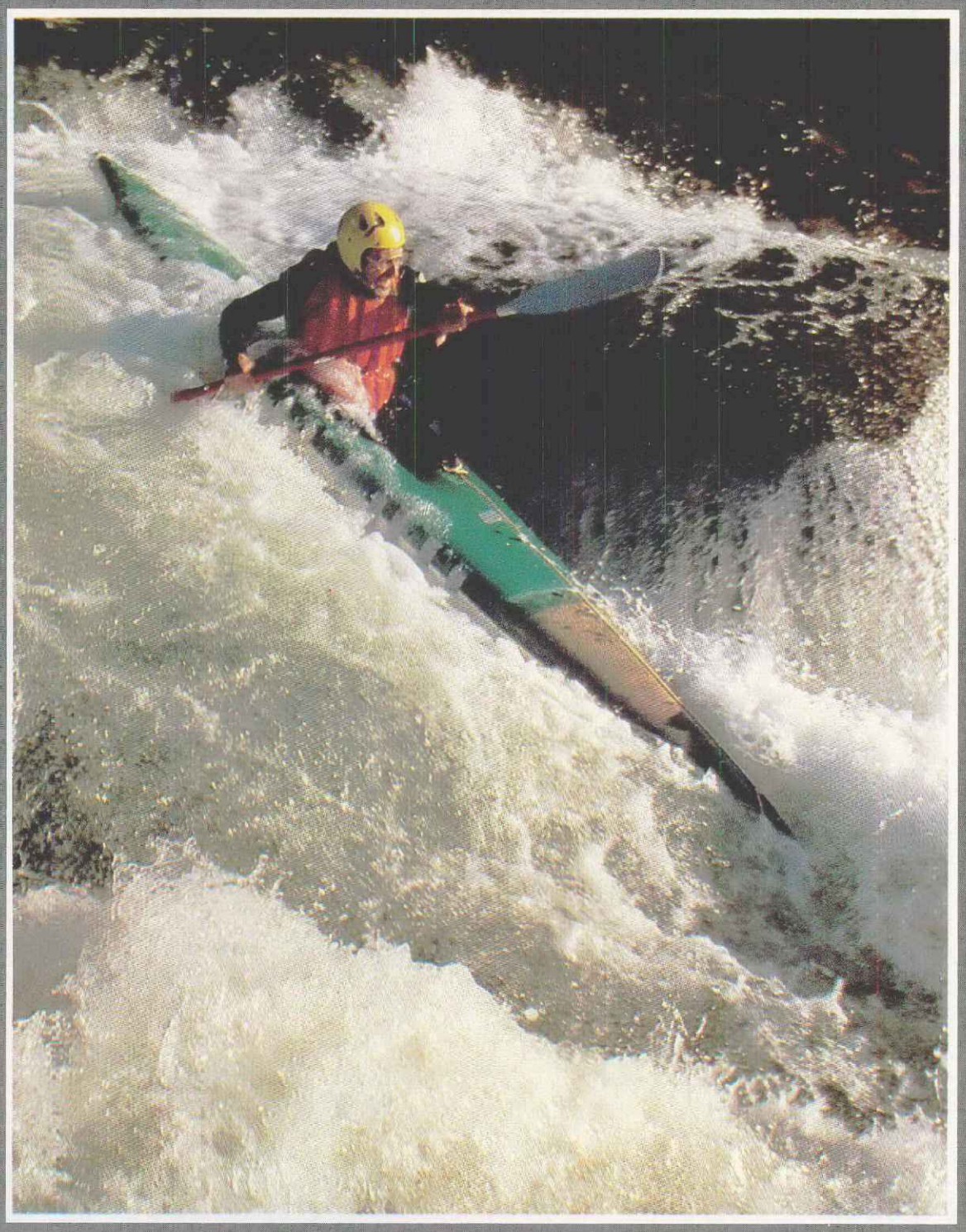

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Illustration: Roger Schillerstrom

SAVING THE FSA

'Flex' can—and should—survive tax changes

By Carson E. Beadle

WHY WOULD ANY employer want to get involved with a flexible spending account after all the flap in 1984 about whether its benefits are taxable, non-taxable or nondescript?

In fact, with the truly serious threats to the current tax status of all benefits, why should we spend time on benefit changes at all when we should be focusing every piece of artillery we have on the legislators in Washington, demanding that they fully understand the consequences before they act?

First, we need to define a "flexible spending account." I found recently in a meeting with Department of Health and Human Services staffers that there was an important difference of opinion on what constitutes a flexible spending account for purposes of their study, mandated under the Deficit Reduction Act of 1984.

Some employers believe it is a plan that allows an employee to reduce his or her salary by the amount needed to cover an eligible expense "after it has been incurred." I call that a zero-balance employee benefits reimbursements account. Until they were rejected by the Internal Revenue Service, ZEBRAs might have been one component of a flexible spending account.

My definition of an FSA is more general. It is an account into which an employee and/or employer can put dollars from a variety of pretax sources and hold them tax-free until used for any number of approved purposes that may or may not produce income taxable to the employee.

The sources of the money could be savings from cuts in existing benefits, like reduced medical or life insurance; money contributed specifically to the account by the employer; or salary reduction elected by the employee.

The plan would qualify under Section 125 of the Internal Revenue Code.

To return to my opening question, why would any employer want to get involved in such a plan, after the trials and tribulations these plans have encountered during the last year?

There are four basic reasons:

- First, FSAs, regardless of their tax status, work to the advantage of employers and employees alike, because they permit choice in the use of benefit dollars so that benefits can more closely meet the needs of each employee.
- Second, the most recent IRS transition rules and proposed regulations contain considerable opportunities for flexibility, especially options to support health cost management programs, while still retaining the tax advantage of traditional benefits.
- Third, your analysis of the worth of flexible benefits and a flexible spending account for your company will prove to be extremely valuable in determining if your benefits are cost-effective and appropriate in this era of changes in the makeup of the workforce.
- Fourth, but far from least, an FSA will help you and your employees develop an understanding of how employee option benefit plans function. This will be especially important if tax preferences are indeed reduced or discontinued over the next few years, which is a distinct possibility.

I believe that if a compensation dollar and a benefits dollar are treated equally for tax purposes, we will see two developments. Employees will want more control over how their dollars are being spent, and employers will want to corral some dollars from the compensation package into a category they classify as benefits. Through communications and incentives, they will then encourage employees to use these dollars for those benefits the employee needs, regardless of whether they are taxable.

Before expanding upon these four points, we need to know more about the current tax situation as it applies to benefits.

The urgent need to cut the deficit has spawned a re-examination of fundamental philosophies about the role of taxation in this country.

In employee benefits, the use of tax incentives to encourage the private sector to take care of its own income security and social needs has been waived aside as inappropriate. The tax reformers take the position that:

- Highly paid employees are the ones really benefiting from the tax-free status of employee benefits.
- Tax incentives for employees of companies are unfair to the self-employed.
- Tax practices should be for the sole purpose of raising revenues and not for inducing the private sector to meet the nation's social goals. In a later section, the tax reform proposal reverses its philosophical position by saying that "retirement income security" is a worthy social policy and its tax-favored status should be continued.

The major benefits that are currently tax-free and that would become taxable income, or would no longer be tax-deductible to the employee if tax reform proposals suggested by the Treasury Department were to be implemented, include employer contributions to health insurance premiums above a cap of $70 a month for individual coverage and $175 a month for family coverage; group term life insurance up to the current $50,000 tax-free limit; dependent term life insurance up to the current $2,000 tax-free limit; accidental death and dismemberment insurance; dependent care; educational assistance for employees; and group legal services.

And, the Treasury proposal would eliminate Sections 401(k) and 125 of the tax code, effectively eliminating the tax advantages of 401(k) salary reduction plans and most cafeteria plans.

These benefits are quite likely to lose their current tax status for two reasons. First, employers are generally displaying little interest in this subject in the halls of Congress. William M. Mercer-Meidinger Inc., along with some other consultants, insurance companies, and a handful of employers are speaking out. But, on balance, private and public sector employers have greeted the benefit taxation proposals with a yawn.

Second, even if the tax reform bill dies in its tracks, it will have served as an outstanding trial balloon on what employers and unions will accept as the Treasury searches in every nook and cranny for revenue to reduce the deficit.

The serious question for the country's policymakers and for employers to consider is whether the loss of these tax incentives will truly have any effect on the ongoing maintenance and growth of private sector benefit plans to meet the needs of its workforce. As employers, you are at least as able to divine the answer to that question as any consultant. But, if you believe, as I do, that incentives really do work and that when incentives are discontinued there is a gradual deterioration in any program that incentives helped to build, then you must be prepared for change if the proposed tax reforms become law.

When I testified before Congress last fall, I heard both employers and unions alike state that removing tax preferences "will constitute a tax increase that will

Continued on next page

Flexible benefits still a great idea, despite tax changes

Continued from preceding page
fall most heavily on middle- and lower-income classes." If that is true, and I believe it is, we can expect that:

- Employees will demand pay increases to cover the new tax on benefit plan contributions.
- Pressure will build to cut benefits so employees can afford the remaining benefits out of reduced take-home pay.
- Some benefits will be dropped altogether as employers seek to use the available dollars to keep remaining benefits at an adequate level.
- Unions will pursue reopening of collective bargaining agreements in an attempt to "keep whole" the benefits presently committed.
- Many employees will spend dollars they would otherwise save in 401(k) plans or would have been used for medical, disability and life insurance plans, to buy consumer goods they have wanted.

That is, if there is no differentiation between spendable income and income assigned to benefits, many employees will opt to spend for today.

It is these possibilities that suggest to us some compelling reasons why flexible benefit plans and the FSA have an important future.

Let's look at what is currently permissible. First, "salary reduction" is permitted under the regulations proposed by the Internal Revenue Service, as a method of funding cafeteria plans.

Second, DEFRA (not to be confused with the Treasury's tax reform proposals) defines cafeteria plan choices as between cash and statutory non-taxable benefits. This definition became effective Jan. 1, 1985, and includes several separate sections of the Internal Revenue Code, such as group life insurance, Section 79; medical plans—Sections 105 and 106; legal services—Section 120; dependent care—Section 129; deferred compensation—Section 401(k); dependent life insurance—Section 79.

Contributions for group term life insurance over $50,000 and dependent life insurance over $2,000 also can be included in the available choices under a cafeteria plan, even though they will be produce taxable income to the employee.

Cafeteria plans can include up to five days of vacation, which can be bought or sold and which if sold, will be treated the same as the tax status of the benefit for which it is exchanged.

If key employees select more than 25% of the total non-taxable benefits selected by all employees under the cafeteria plan, they will be taxed on a basis related to the taxable benefits they could have selected. Employers must file a return showing total number of employees, numbers that participate in the plan and its total cost.

In spelling out these provisions in DEFRA, Congress has laid out its intent. In addition, the IRS's proposed regulations of May 4, 1984 tell us what the IRS is ready to accept. Their rules require that:

- Advance elections must be made by employees before the plan year begins. The elections must be irrevocable except for changes in family status.
- Elections must be made separately for each benefit available.
- Once the election is made, the amount directed to each benefit must be used for that benefit only and for expenses actually incurred during the coverage period. There can be no cash-outs, rollovers or carryovers. Or, in the current vernacular, "You use it or you lose it."

You now have two specific pieces of documentation that confirm the acceptability of cafeteria plans and of salary reduction, and that spell out the rules employers are expected to meet. That is not quite as good as formal regulations, but we have all learned that we must either live without regulations or make very few changes in our plans.

What I have described to you so far now leads us back to a fork in the road.

Down one branch we can proceed with a wide range of flexible benefit planning, pretty secure that properly designed plans will not be disqualified and future changes imposed by Washington will be no more significant than those we have already come to expect.

Over the other branch hangs the ominous possibility of further significant tax changes dropping upon us in respect to a number of the benefits that as recently as Jan. 1, 1985, we had been reassured are tax-free under a "flex" plan. Examples are group life insurance of less than $50,000, health premiums over the prescribed cap, dependent care costs, and 401(k) plans.

So, while you can gun the accelerator full speed ahead, using "flex" to accomplsh truly useful objectives in your benefits plans, the faint of heart will want to have their foot just as firmly on the brake.

But, I believe there is an answer. Let's examine Mercer-Meidinger's definition of what a flexible plan and an FSA in particular can do:

"It is a plan which allows employees to use those dollars assigned to benefits, in the manner that best meets their personal needs. It involves employees directly in the decisions on how much to spend on each benefit. It makes them aware of which benefits have increasing costs and which have steady or declining costs. It provides a means for employees to know the real cost/worth of their benefits."

We already know this approach has been helpful in explaining health benefit premium increases and introducing higher contributions or larger copayments or some combination of both.

And, what is the difference between a premium increase and a tax increase? Both result in less take-home pay for the employee.

Through the medium of flexible benefit plans and salary reduction plans, employees are developing an understanding and feel for the true net cost of benefits. Communication of changes in their cost is easier, in part because employees understand their benefits better and, in part, because they have the freedom to meet their own needs.

We might picture the compensation package of the future, for example, as a large box labeled "cash consumption" and a smaller box labeled "income security benefits," much like today.

The difference would be that the "income security benefits" box would contain taxable as well as non-taxable dollars, which the employee could spend on any of the benefits I described as permissible under a cafeteria plan. If the employee did not spend them on the basic benefits sponsored by the employer, then those dollars would be lost, much like unused vacations are frequently lost.

In this example, the employee could increase the dollars in his or her benefits box by electing some salary reduction, but could not convert to cash those dollars the employer had assigned to basic benefits, whether or not they were taxable.

A flexible spending account could turn out to be the ideal vehicle through which to provide benefits, whether or not they are taxable. In fact, given the urgent need to involve employees in the cost of benefits and to give them the choices they need. . .I don't think you can move too quickly.

My point is that a flexible spending account could turn out to be the ideal vehicle through which to provide benefits, whether or not they are taxable. In fact, given the urgent need to involve employees in the cost of benefits and to give them the choices they need to meet a range of needs—from those of the single parent, to the two wage-earner family, to the principal wage-earner nearing retirement—I don't think you can move too quickly to install a flexible plan and spending account.

Consider for a moment that under current rules, your benefit plan could provide the following flexible features:

First, a pot of money consisting of dollars from:

- Your employer contributions toward the cost of your current medical/hospital coverage. You might first have a stripped-down base plan with, say, a $500 deductible and credit to the spending account the value of the rest of the coverage. Or, you might credit a bonus to the account for those who agree to utilization review provisions under your plan, a device that can be critical for those with unions where copayments cannot be increased.
- Your contribution to group life insurance in excess of one times annual salary, where this is less than $50,000.
- Current aftertax employee contributions toward medical/hospital and group life insurance plans.
- Salary reduction in amounts chosen by the employee, which could include the otherwise taxable contributions for medical/hospital and group life insurance.

Together, that could produce a significant amount to be spent on discretionary benefits such as:

- Medical/hospital coverage in the deductible area—i.e., between, for example, $100 and $500.
- Additional group life insurance—tax-free up to $50,000, taxable thereafter, but at group rates and with payroll deduction.
- Dependent care costs, where the employee knows he or she will have certain minimum predictable costs unless family status changes, in which case the election can be changed.
- Legal costs where the employee knows he or she will have certain costs in the forthcoming year so that forfeiture of any unused election is not an issue.
- Contributions to a 401(k) plan, although not technically a part of a Section 125 plan. These 401(k) contributions could also be made from the account to bolster the employee's retirement income, a valuable option even if the current flexibility some employers are offering for loans and early withdrawals, should become disqualified.

The gains to be made from having a flexible spending account are significant:

First, the involvement of employees in the cost of their benefits is already important, and if benefits become taxable, it will become even more important.

Second, the flexible accounts give employees the chance to choose the benefits that best meet their personal needs, and such a choice has never been more timely.

And, the value to management of examining benefits in their totality, and of giving thoughtful, comprehensive consideration to the overlapping issues of rising health costs, changing workforce demographics and uncertain tax developments, has never been greater.

You might still be wondering how all this will work if Section 125 is repealed. The bottom line would be that we return to the era where, if the options permitted include taxable and non-taxable benefits including cash, then any such options taken would produce imputed taxable income. That still leaves non-taxable options available to employee choice and funding of a flexible spending account by the employer either with new money or with money saved from reducing benefits.

In short, if there ever was a need to go slow on flexible spending accounts, that time has gone. The place to exercise caution is not in having a flexible account, but in how it is designed and implemented.

Three years ago, when the flames of flexible benefits plans were being fanned into an inferno by some folks in the business, I coined a phrase to the effect that "flexible benefits plans were a solution in search of a problem."

I still believe that description applies. The value in "flex" is not as a product or as a generic plan, but is in its ability and timeliness to solve problems of cost, communication and taxation peculiar to your company and in improving the cost/returns ratio of your benefits expenditures.

If these are not priorities for your company, you do not need a "flex" plan right now. In fact, there are some companies that have decided that 1985 is the year in which to catch up with all the paper work produced by DEFRA and the Tax Equity and Fiscal Responsibility Act of 1982.

But, when you consider the importance of knowing how tax changes will affect your bottom line, of being able to react quickly to questions on the implications of your company policy and of having established the needed changes in your employees' outlook, as well as how long it can take to implement changes in your benefit plans, the time to study "flex" and how it can best be used is now. ■

Carson E. Beadle is managing director of William M. Mercer-Meidinger Inc. in New York.

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perspective

Benefit plans for TCNs pose problems

By S. Robert Beane

international issues

ONE OF THE major business concerns of a multinational corporation is the staffing of key positions overseas.

Historically, executive positions have been filled by foreign assignees who may be U.S. expatriates or third-country nationals. Companies tend to hire foreigners rather than local professionals when local executive talent is lacking, when they need special technical expertise or better corporate control, when regional management is responsible for several countries and, in some cases, when they want to provide international exposure to executives on a fast career track.

Whatever their reasons for hiring foreign assignees, multinational companies must provide a compensation program that enables foreign employees to perform their duties without being preoccupied with the possible adverse financial consequences of working in a foreign environment.

Benefits in particular can be of concern. For U.S. expatriates, the solution is straightforward: They generally continue to be covered by a U.S. benefit program while on foreign assignment.

But, establishing a benefit program for third-country nationals can be complex. Several factors must be taken into account, not the least of which is the company's desire to see that the TCN's benefits are kept whole, despite one or more moves.

First, companies must consider their philosophy on overseas executive staffing, in order to design a program that responds to the executives' needs. Are assignments for short or long periods? Usually, TCNs are assigned to a foreign location for a relatively short time—three years or so—and returned to their home country or assigned to another foreign site.

If the assignment is short-term, certain benefits, like pensions, may be lost or accruals may be discontinued, leaving the TCN disadvantaged. Thus, if short-term assignments are the rule, an effective TCN program should protect against this. Also, a TCN on a short assignment may have property in his home country. Protecting this property should be addressed.

In some cases, TCNs are expected to remain permanently in a foreign location. If this is common, the employer should develop a TCN program that provides appropriate expatriate benefits.

Whatever their reasons for hiring foreign assignees, multinational companies must provide a compensation program that enables foreign employees to perform their duties without being preoccupied with the possible adverse financial consequences of working in a foreign environment.

How benefits are provided also is important. Should the TCNs continue to be covered by their home country plans, by host country plans or by U.S. plans? Or, should a plan be designed especially for them? If the group is small, companies may want to provide benefits on a case-by-case basis.

Administration can be a central concern, especially if the TCN group is large and transfers are frequent. Variety in the number and types of benefits to be provided will add to the administrative complexity. Some companies have extended U.S. benefits to TCNs. While this could reduce administrative problems, issues such as regulations of the Employee Retirement Income Security Act, over- or under-insurance or currency exchange still might prove troublesome.

Companies would do well to look at the practices of other multinationals in their industry. Competitive comparisons provide benchmarks for designing a TCN benefit plan. Because information regarding company practices may be scanty, it may be helpful to refer to the broad data bases established by some private benefit consultants. To be helpful, a data base should include information about TCN program design, financing practices and other administrative and technical details of the program.

A 1984 Johnson & Higgins survey of TCN benefit programs among U.S. multinational companies indicates that the most common TCN benefits are life insurance, accidental death and dismemberment coverage, travel accident insurance, retirement benefits and health care coverages. A majority of companies provide long-term disability insurance, and a number have implemented dental coverages. Profit-sharing, thrift and stock option plans, which are growing in popularity here in the United States, are not common in TCN programs.

While TCNs generally receive most traditional benefits, the manner in which these benefits are provided varies considerably.

Pension plans, which are subject to intricate design requirements taking into account Social Security integration, years of service, currency translations and other issues, tend to be provided as separate TCN plans. In most cases, the TCN plan acts as an umbrella plan: A reasonable retirement benefit target is defined, and all benefits received by the TCN from Social Security and other compulsory or private plans in the host or home country are deducted. Health care plans also tend to follow an umbrella approach, either through a separate plan or through the U.S. plan.

Practices regarding risk benefits like life insurance and accidental death and disability benefits vary, although these are sometimes provided through either the U.S. plan or a separate TCN plan. Travel accident coverage, a popular benefit, is invariably provided through the U.S. plan.

Just as the type of plan varies, the amounts and levels of benefits differ from company to company. Thus, life insurance coverages may be based either on salary or on a flat amount, pensions may be computed according to different accrual rates, and medical lifetime maximum benefits can range from $25,000 to $1 million.

In setting specific benefit amounts, companies should examine their competitors' practices carefully, determine where their own locations are and what is provided in each location, and assess the cost of certain benefit alternatives.

The cost of the plan and how it is to be financed are the most important considerations in putting together a TCN program. An actuarial valuation is valuable in analyzing the cost of an umbrella pension plan. For judging the cost of risk benefits, it is possible to get quotes from U.S. and European insurers that underwrite TCN risk programs. If companies already have some pooling arrangements in effect, they may find it cost effective to pool TCN benefits. Who should pay for the cost of the plan is yet another question. Should the plan be contributory or not? Should U.S. headquarters assume the cost, or should the subsidiary be charged for the cost? Perhaps TCNs should assume the cost of dependent coverages, if such coverages are available. All cost-sharing alternatives should be explored so that the cost of the plan is reasonable and does not impede successful implementation.

Financing arrangements are significant to the overall cost of the plan. Sometimes, for tax or tariff considerations, it may be advisable to insure benefits in offshore arrangements. Alternately, self-insuring benefits may be best—especially if the benefits are patterned after U.S. benefits that are self-insured.

Pension financing decisions are especially complex because they involve long-term corporate obligations. Cash flow, tax consequences, the company's internal rate of return and the investment outlook all have an effect. Thus, some companies opt to fund pension plans through deferred annuity or deposit administration policies; others pay benefits as they arise, setting book reserves to reflect ongoing pension liabilities.

Once design and financing have been determined, it is important to adopt an effective communication program to let TCNs know exactly what their benefits are, as well as such administrative details as where they should send claims and whom to contact with questions. Good communications also help benefit recipients fully appreciate their benefits.

Companies about to embark on a communications program may find that they do not have a complete list of eligible TCNs.

This is a common problem, and companies are well-advised to make an audit of their foreign assignees before embarking on a program, to make sure that the right people are covered.

The design and implementation of a TCN benefit program is not a simple task. Aside from defining and identifying TCNs, employers must address other issues, such as defining the rules of an "umbrella" pension plan, allocating benefit costs among subsidiaries, finding the optimum method of financing pensions, dealing with currency conversion rules and keeping track of salary and benefit histories.

When designed properly, however, a TCN benefit plan becomes a powerful management tool in attracting, remunerating and retaining key personnel.

As such, TCN programs deserve the full attention of corporate management, even if the number of professionals affected is relatively small. ■

S. Robert Beane is vp and manager of the New York International department of Johnson & Higgins. His column on international issues appears the first Monday of every month.

Mental injury called compensable

legal briefs

A Massachusetts appellate court has ruled that an employee sustained a compensable personal injury arising out of and in the course of her employment when she suffered an emotional breakdown after being informed by her employer that she had been laid off from her current department and would be transferred to another.

Helen Kelly was employed by her employer for 22 years prior to August 1977. She ran the employer's training center. On Aug. 19, 1977, Ms. Kelly was informed that the company was cutting back in her department and she would be laid off.

Upon being told she would be laid off, Ms. Kelly became upset and went home, unable to compose herself.

She returned to work on Aug. 22, 1977, and was told she could work as a foreperson in the cable department. She was not pleased with the assignment in the cable department and became depressed, developed chest pain and had to be hospitalized.

Ms. Kelly remained out of work for six weeks, taking medications. She returned to work in October, and about nine days later she again developed chest pain and was hospitalized. Thereafter, she underwent regular psychiatric treatment.

Her claim for compensation was denied on the ground that she had suffered no industrial accident. However, the trial court reversed the decision and awarded benefits.

The appellate court pointed out that Massachusetts' workers compensation law did not require that an injury occur "by accident." Nor was compensation dependent on employer fault or upon the foreseeability of harm, according to the court.

The court said that mental injury arising from either a specific stressful work-related incident or a series of such incidents was compensable.

The court also said that compensation should not be denied just because mental injuries are more difficult to substantiate and, therefore, more prone to fabrication.

Kelly's Case, Appeals Court of Massachusetts, April 11, 1984 (*BI*/02/A.-$5) ■

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for $5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

Majority of risk managers admit rate hikes are needed

Continued from page 1

"I seriously question the need for such traumatic rate increases and restrictions in coverage," wrote the director of the office of risk management for a county government, that as of March 1, had not been able to replace liability coverage that expired Jan. 1.

"I place primary responsibility for the problem on the reinsurance underwriters for their cyclical behavior.

"I was a property insurance underwriter during the 1970s. While underwriting positions were conservative, they were somewhat rational," he continued. "It is not the case now. There is no logic or reason behind the existing and probably coming insanity."

"The carriers are greedy," was the conclusion of the risk manager for a transportation and trucking company.

"It's all so unnecessary—insurers continue to overreact to conditions, creating cycles," said another respondent.

'Risk managers and brokers have lost their bargaining positions,' one risk manager says.

"I certainly agree that companies need higher premiums, but they shouldn't try to get it all back in one year," lamented the risk manager for a household products manufacturer who was hit with an 87% premium increase. (He did not indicate what type of insurance he was renewing.)

However, 12% of the respondents said the cyclical nature of the insurance market is uncontrollable because the law of supply and demand dictates insurance prices. Nine percent said the swing in cycles is inevitable because of the uncertain ultimate cost of insurers' assumed liabilities.

A majority of the respondents to the *BI* survey also conceded that risk managers and their brokers played a role in driving down the price of insurance over the last eight years.

Almost three-quarters of the respondents said risk managers must share the blame for pushing insurance prices into the bargain basement. Sixteen percent said they played a tremendous role in forcing nsurance prices down because they purchased insurance based primarily on its cost.

An additional 56% said they had "some" influence on the cost of insurance because they did consider price as well as other factors in choosing insurers.

And, 84% said their brokers helped create and sustain the last competitive cycle. Nineteen percent said brokers had a tremendous part in forcing prices down because they played insurers off one another to drive down premium quotes.

An additional 65% said the brokers influenced insurance prices "some" because they generally sought the lowest price possible so they would not be underbid by a competitor.

On the other hand, 28% of the respondents absolved risk managers of any blame for the underpricing of insurance, agreeing that insurance companies willingly drove prices down in their quest for a larger market share. Similarly, 19% said brokers had nothing to do with forcing insurance prices down because insurers—not brokers—issue the quotes.

Regardless of who is to blame, it is a fact that insurance prices have shot up over the last year; available limits have been reduced; and insurers have placed more restrictions on policies. Two-thirds of the risk managers surveyed said current market conditions are the worst they have ever seen.

The respondents, however, are somewhat split on exactly how tight the market is.

Half said risk managers can get whatever coverage they want if they are willing to pay for it, but about a third disagreed with that assessment.

Several risk managers pointed out that availability often depends on what type of coverage is being sought.

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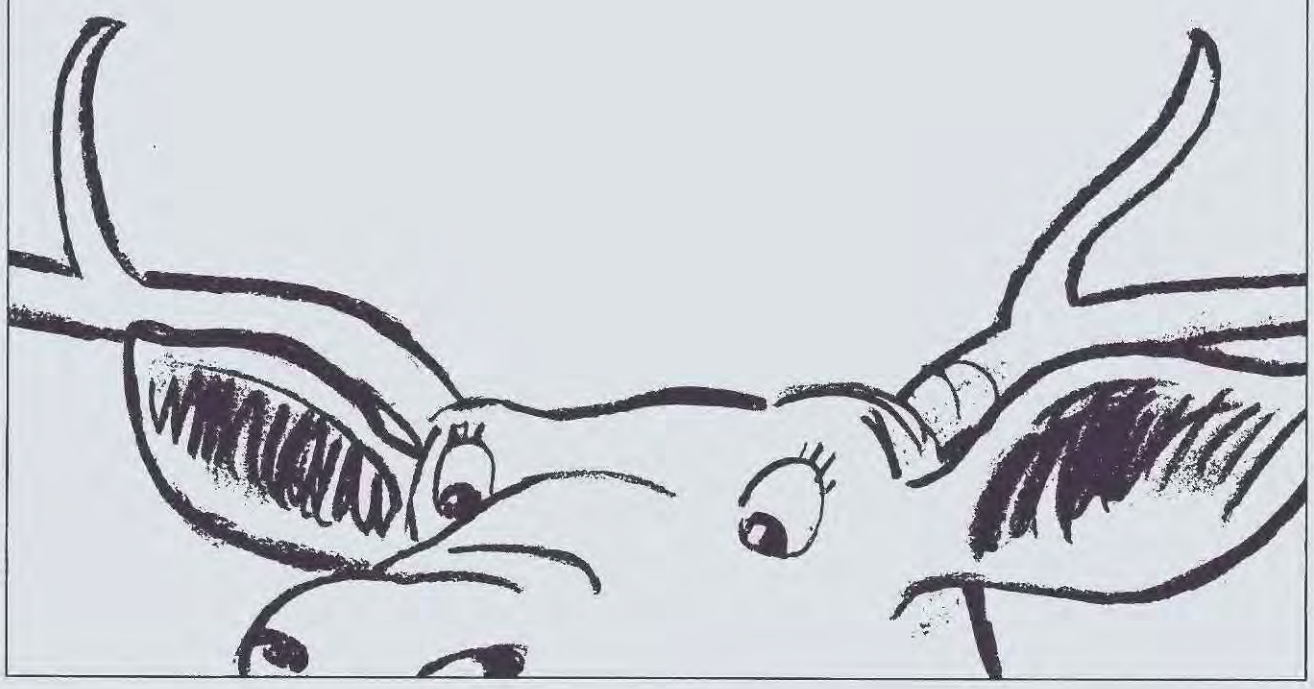


Risk managers report rate increases

Continued from preceding page

Fifty-three percent said environmental impairment liability coverage is the most difficult to obtain; 44% said finding high limits of liability coverage is the risk manager's biggest headache.

Twenty-six percent said professional liability coverage—including medical malpractice coverage and errors and omissions insurance for insurance agents, architects and engineers and publishing companies—was the most difficult to obtain. Another 21% said they had the most trouble finding directors and officers liability insurance. (Many respondents marked more than one type of coverage as the most difficult to obtain).

While the majority agreed that the market appears to be tighter for liability coverages, three respondents cited difficulties in obtaining property coverage, both primary layers and high-layer difference-in-conditions coverage.

'I seriously question the need for such traumatic rate increases and restrictions in coverage. I place primary responsibility for the problem on the reinsurance underwriters for their cyclical behavior,' says one risk manager.

To counter these tight market conditions, risk managers have developed strategies for successful coverage renewals.

Forty-four percent said the most important thing a risk manager can do before renewal negotiations is to prepare detailed underwriting information to show the insurers exactly what the policyholder's exposures are and what the loss experience has been.

About a fifth of the respondents said a risk manager should meet with top management before renewals and decide what risk retention levels will be acceptable if they must be increased to hold down premium costs. Others stressed the need to let management know ahead of time that insurance costs will probably increase significantly.

Twenty-three percent advised risk managers renewing coverage in this market to start early.

But, when the actual negotiations begin, risk managers' strongest bargaining chip for getting coverage they want at the most reasonable price in this market will be good loss experience, a longstanding relationship with insurers and the existence of sound loss-control programs, survey respondents said.

Good loss experience is the best thing a company can have going for it when renewing coverage in a tight market, according to the survey. It was cited as one of the most effective bargaining tools by 47% of the respondents.

Another 37% said the existence of a sound loss-control program will help convince insurers that a good risk will continue to be a good risk.

And, 30% said risk managers' past loyalty to their insurers will pay off.

In another section of the survey, 26% said risk managers who built long-term relationships with insurers will be able to secure lower prices than those who shopped around. Forty-two percent said those who remained faithful will find limits closer to what they are seeking than those who switched often.

However, many others surveyed doubted loyalty would pay off in this market. A third said risk managers who built long-term relationships would get no better treatment.

"Insurers preached longevity and then they ignored it," complained one risk manager.

"Loyalty means nothing in this market," agreed another. "Loyalty does not exist anymore."

Forty-seven percent said that if a risk manager could achieve a premium savings of 25%, he or she should forego a longstanding relationship and switch insurers to save money. Another 30% said the savings would have to be 50% of their previous premium before they would switch insurers.

Only 5% thought a 10% savings would warrant changing underwriters. Another 7% recommended hanging onto the existing insurer unless the savings achieved by switching would be 75% to 100% of the current premium.

However, the assistant vp for a chain of retail drug stores cautioned against choosing an insurer whose price is too low. "Accepting too low a price lessens security. Sooner or later we will be paying our own losses," he warns.

Twenty-three percent said a company's ability to accept higher deductibles or self-insured retentions also increases its bargaining position.

In fact, most of the respondents are considering abandoning the commercial insurance market completely and self-insuring their risks.

Seventy percent said the tightening of the market has prompted them to explore alternative risk-funding mechanisms such as captive insurers, group captives or other forms of self-insurance.

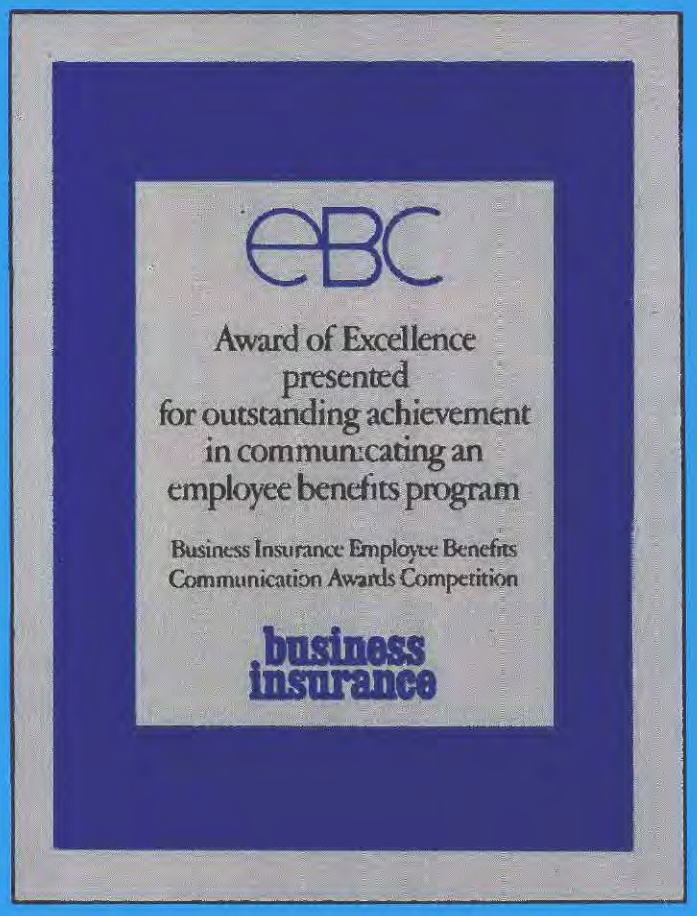
But, others will "grin and bear it" until the cycle turns again in their favor.

"Risk managers and brokers have lost their bargaining positions," admits the manager of corporate insurance for a building materials manufacturer. His company's premium for architects and engineers professional liability insurance increased 111% to $230,000 from $109,000 for only $10 million in coverage with a $250,000 self-insured retention, down from $15 million limits with a $75,000 retention.

"For the time being, the insurers have it all their way—but it won't last because insurers won't hang together on rate increases," he said. "Eventually, desire for new business will become important."

The assistant vp of risk and insurance management for a commercial bank shares this optimism:

"I can't wait for 1987 for the price-cutting to begin again!" ■



The 13th Annual EMPLOYEE BENEFITS COMMUNICATION AWARDS will be presented on August 5th during the Business Insurance *"Communicating Benefits"* Conference in New York City.

A panel of benefit managers, directors of communication and advertising specialists will select winners from five different categories of programs.

The Competition is open to all companies in the U.S. and Canada and has no restrictions as to the size of the company.

Entries will be accepted beginning April 15th. No entry will be accepted after May 20th.

To obtain rules and entry forms call Ann Vazquez, Communication Services Department, Business Insurance, 212/210-0137.

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agent/broker topics

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Total account selling

Expanding services key to keeping clients as rates begin to rise

By LINDA J. COLLINS

Agents and brokers, who have the unenviable job of telling commercial lines clients that their rates may rise through the roof, must make sure they're able to keep an account after they convey the bad news.

One way to retain this business, experts say, is to offer their existing clients a broad range of insurance products addressing all their coverage needs.

In other words, total account selling is becoming the name of the game.

Keeping business is especially important now since rates are rebounding, which translates into higher commissions for agents and brokers.

Robert S. Seltzer, president of Cohen-Seltzer Inc., a brokerage in Center City, Pa., explains that an account that generated $500,000 of premium volume in last year's soft market may now represent $700,000 or $800,000 in premium volume "if that business can be retained."

"In the past few years. . .agents were aggressively looking for new business to stabilize their income as rates were slashed," Mr. Seltzer notes. "Now that rates are increasing, I expect that a lot of agents who were aggressively seeking new business in the last few years will now slow down this activity and concentrate on account retention."

Retaining the business, he adds, may be difficult, because "the availability of markets is restricting and cost is rising."

Mr. Seltzer points to the dramatic increases some commercial policyholders are facing at renewals. "A quick poll of agents would probably show—as we are experiencing—renewal increases on the low range of 15% to 20% to, on the upper end, 400% to 500% for some umbrella coverages."

Retaining accounts whose rates are rapidly escalating is forcing agents to restructure their operations so that they can meet all a client's needs.

"Now the agent needs a large service unit behind him to handle servicing of business, loss-control and risk management needs of existing clients," Mr. Seltzer said.

"Total account selling is the only answer to profitability for independent agents today," said George Nordhaus, president of Insurance Marketing Services Inc. in Santa Monica, Calif., a marketing consulting firm. "This is a process, not a progress.

"Agents can't simply say: 'Next week we go after this business, this business and this business.'. . .It must be an ongoing effort," Mr. Nordhaus added.

Another consultant, Gary B. Holgate, president of Holgate & Associates Inc., a Fort Myers, Fla.-based agency management consulting firm, said "a critical point" for agents to consider is that an agency's "retention rate is doubled when it insures a client's whole account."

To practice what the consultants preach, agents and brokers are actively marketing personal lines life coverage and employee benefit coverages to their commercial lines clients. In addition, some provide risk management and loss-control services to their commercial clients.

"It is more important than ever before to develop an effective life and employee benefits department within the (property/casualty) agency," points out David Hales, president of Hales & Associates Inc., an agency management consulting firm in Oak Brook, Ill.

In addition to helping round out a client's existing coverages, Mr. Hales noted that life and health insurers "are anxious to get new business, unlike property/casualty companies."

Mr. Nordhaus agreed, saying, "Life, health and employee benefits should all be written on commercial clients, or you leave yourselves open to everything. When these coverages are secured, you can keep the client locked in on the average of nine to 10 years."

One agency, Young & Perry Insurance in Bridgewater, N.J., created an employee benefit and life insurance department last fall as an account selling device, according to its president, Willard R. Young.

"Although the department was initially designed primarily to solidify existing commercial accounts, we have found that it stands on its own as a profit center," he said.

Mr. Young said that, as another means of solidifying commercial lines accounts, Young & Perry has developed an "upscale personal lines strategy aimed at key people from our commercial lines accounts. The strategy involves counseling and extra services.

"We are trying to provide so many services to those accounts that we will be assured of retaining their business through our service, and they won't be as likely to consider just price," Mr. Young explained.

Fred W. Berger, president of Insurance Planning Inc. in Hays, Kan., notes that one of his producers is licensed to sell securities and offer financial planning services.

In addition, his agency has designed a 16-page personalized risk management booklet to distribute to its commercial clients describing the firm's risk management philosophy and the steps clients can take in implementing a "sound risk management program." The booklet describes loss-control methods and risk retention as well as different types of insurance.

Mr. Berger said his agency stresses the need for clients to establish safety programs and will help the clients establish such programs.

One of the partners in Mr. Berger's agency is an engineer, who can inspect the property at prospective commercial lines clients to obtain complete underwriting information and photographs of the premises to submit to insurers.

E. Donald Lewis, executive vp of the Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass., says his agency has a separate department to handle life, health and employee benefits business for commercial clients. Unlike other agencies that have established such departments only recently, Hastings-Tapley has had its life/employee benefits department since the 1960s.

Mr. Lewis said that although this department is a separate part of the agency, "Our property/casualty producers are

Continued on following page

Emphasize service to keep clients: Experts

By LINDA J. COLLINS

Complete, high-quality service is the name of the game if an agent wants to sell additional lines of coverage to existing clients, management and marketing consultants say.

Since account service mechanisms are already in place, the cost of maintaining an existing client's business is less than the cost of producing new business, they point out. Thus, an individual account becomes more profitable with each additional line of business it includes.

But, consultants note, rising commercial lines rates also make account retention more difficult for agents and brokers, because many clients will be tempted to shop around for lower rates.

An agent's or broker's emphasis must be on quality service and on meeting a client's complete coverage needs in order to make the client less likely to take his or her business elsewhere, they point out.

Gary B. Holgate, president of Holgate & Associates Inc., a Fort Myers, Fla., agency management consulting firm, noted that an agency's "retention rate is doubled when it insures a client's whole account."

But, he said, all too often an agent does not sell a client all of his or her insurance needs.

Mr. Holgate says he has run spot checks in nearly 100 agencies that reveal that in commercial lines accounts generating less than $10,000 in annual premium volume, 24% of the accounts are monoline, or one-policy, accounts. And, an additional 25% are one-policy package accounts that could be developed further.

In personal lines, the percentage of one-line accounts is even higher, Mr. Holgate said. On the average, 66% of an agency's personal lines clients are only insured for one line of business.

"Rather than concentrate on insuring new clients, agents need to concentrate on developing the accounts they already have," he warned.

George Nordhaus, president of Insurance Marketing Services Inc., a Santa Monica, Calif., marketing consulting firm, suggested that each time an agent or customer service representative talks to a one-policy or two-policy client, the agent should request the expiration dates on any policies the client has that are not written by the agency. Then the agency can follow up on this information closer to the time the policies are due to expire.

Mr. Holgate says to wait for the client to call instead of contacting the client 'because, no matter what that person is doing, he or she will enjoy doing that more than talking to you.'

"It's a constant evolution," he said.

David Hales, president of Hales & Associates Inc., an Oak Brook, Ill.-based management consulting firm, stressed the value of setting up a life insurance and employee benefits department, both as a way of holding clients and because these insurers are actively seeking new business opportunities.

But, he cautioned that agencies should "hire people who are specialists in these areas rather than trying to train property/casualty producers to sell (life and employee benefit) products."

He said that two problems must be overcome in finding the right life and employee benefits producer to work within the property/casualty agency.

First, life and employee benefit agents are accustomed to using higher-pressure sales techniques, since the lines of coverage they sell are often not viewed by consumers as "demand items."

Property/casualty producers, on the other hand, sell a more tangible product, such as auto, homeowners, business owners or renters insurance, he explains.

So, property/casualty agencies may be concerned that the life and employee benefit producer will offend their existing clients. This "personality difference" often makes it more difficult for the two to establish a working relationship, Mr. Hales stressed.

A second problem is that successful life and employee benefits producers probably already have profitable businesses of their own, and they may not be interested in splitting their commissions with a property/casualty agency.

Mr. Hales said, however, that if both parties consider the advantages, they will realize that "retention increases when more coverages are added, and both parties can find such a relationship to be very beneficial."

In account selling for personal lines clients, Mr. Holgate suggests the agency wait until the client makes the contact.

"Never contact an existing (personal lines) client about insurance unless you absolutely have to," he warned, "because, no matter what that person is doing, he or she will enjoy doing that more than talking to you about insurance. So, on personal lines, wait until the customer calls. Then it is the client who is bringing up insurance—not you."

But, he said, when the client does call, "for any reason, use that incoming call as a sales tool. Get expiration dates during these calls.

"If an account executive gets two expiration dates a day in this way, that would give the agency 500 for the year," he said.

Mr Holgate said that the agency should use color-coding to mark its personal lines files according to coverage, so the account representative can immediately see which coverages the client has.

Mr. Hales suggested that agencies should get commercial lines producers out of the personal lines business and establish a department run by customer service representatives who are "licensed, sharp and motivated with extra money to account sell."

He does not think that the customer service representatives should be paid commission. "Rather, if the CSRs sell extra policies on existing accounts, pay them a flat fee for each additional policy sold. Have them trained so that every time they open a file they go after the entire account," he said.

An alternative to this arrangement is for the agency to have a licensed person in the personal lines department who goes after additional lines of business on a commission basis—"high first year commission, low renewal or no renewal."

"Renewal commission is not necessary because the service mechanism is already set up," Mr. Hales said.

Agents urged to use total account selling

Continued from preceding page

reasonably familiar enough with these products to ask the right questions, so that they can go back to the department and tell them the information they need to know.

"We look for creative ways to insure risks and try to be sensitive to exposures, even if they don't require an insurance product," Mr. Lewis added. "We want our producers to look like problem-solvers and advisers as well as agents."

'We look for creative ways to insure risks and try to be sensitive to exposures, even if they don't require an insurance product. We want our producers to look like problem-solvers and advisers as well as agents,' Mr. Lewis says.

Mr. Seltzer of Cohen-Seltzer Inc. says his agency has its own loss-control unit and is risk management-oriented. The firm even offers seminars, primarily for accountants and lawyers, to educate clients on risk management.

The seminars also benefit the agency, Mr. Seltzer stressed, because Cohen-Seltzer can later tap these professionals for referral business. The accountants are particularly helpful in developing business from the property/casualty side he added.

The average commercial lines client served by Mr. Seltzer's firm generates annual premium of from $50,000 to $100,000 and more, and these clients require a highly sophisticated employee benefits program. So, he explains, Cohen-Seltzer does not promote its employee benefits products to its larger clients. However, the company is licensed to sell life and health coverages and they do provide these services in some cases.

Willis J. Hargrave Jr., president of Harco Insurance Service in Houston, said his company's life, health and employee benefit department is introduced as part of Harco's "overall marketing scheme."

He explained that an agency must be able to offer such services, because consumers expect it. "They assume that if you sell insurance, you sell everything. They think of all insurance as one thing," he said.

Some agencies do not have their own employee benefits and life departments, but they contract with other agents to provide these coverages to clients.

For instance, Levitt/Kristan Co. in Los Angeles markets life, disability and other employee benefits coverages via outside producers, with the two companies splitting the commissions.

"When we first talk about these lines, we tell clients we handle the coverages, and when they request a specific coverage we say we have a specialist who handles that," says Executive Vp Dennis S. Kristan. "Most of the time the client will deal with the agent directly from then on, and we are not involved further," Mr. Kristan said.

He said the agency's employee benefits specialist works only through independent agencies and does not write business on his own. The life agent has his own agency and simply works with Mr. Kristan's agency on any life business it refers to him.

According to Mr. Kristan, most major property/casualty insurers that also offer life insurance have been pushing these coverages recently. He said that some of the property/casualty insurers plan to write up to 50% of their volume in life business within the next 10 years.

Dennis F. Murphy, president of D. Francis Murphy Insurance Agency Inc. in Hudson, Mass., said his agency sells personal and group life insurance as well as property/casualty coverages, but it does not try to sell health coverages, "because, in this (rural) area, the Blues would murder us."

Mr. Murphy's agency uses direct mail marketing to sell life coverages to existing and potential property/casualty clients. He said the marketing takes a "soft-sell" approach, basically designed to let people know these coverages are available through his agency.

Jack L. Mandeville, vp and secretary for Rich & Cartmill Inc. in Tulsa, Okla., said his agency has an "excellent life man who knows the markets, group business, employee benefits, etc. We try to pick up group and employee benefits coverages, and turn the business over to him to handle."

Mr. Mandeville said it can be difficult to find the right person to handle life insurance in a property/casualty agency, noting that the agency looked for some time before finding someone compatible with its marketing approach and philosophy.

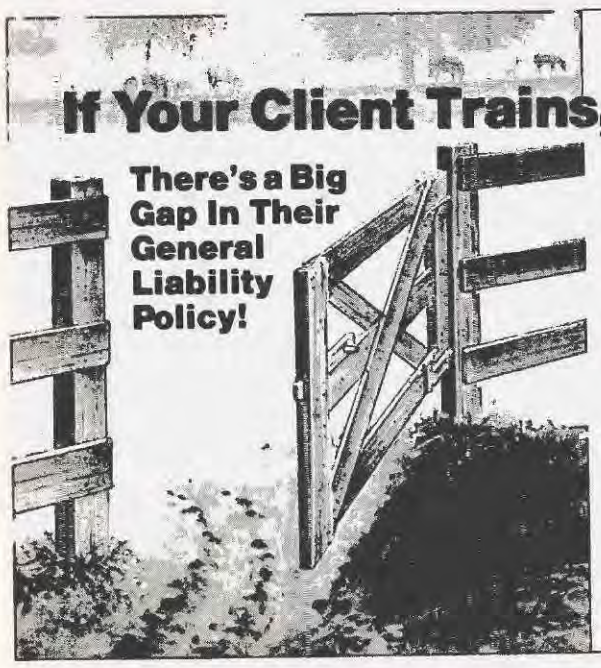
Now, he added, property/casualty producers often take the life agent with them on the initial call to a new client.

William E. Brady, vp of Crump/Kindler & Lucci Insurance Brokers in Long Beach, Calif., said his firm, a subsidiary of The Crump Cos. Inc., notes that although the agency has an employee benefits department, "we only write on an account basis.

"When two or three different producers are involved with an account, there is too much exposure to errors and omissions claims.

"Businesses are getting more complex and people are more litigious minded. When more than one producer is involved with a client, gaps can be left in the coverage," he said.

Agents say that smaller commercial accounts pose a unique problem, because they can be expensive to handle. Smaller commercial accounts are frequently viewed by larger agencies and brokerage firms as being "more trouble than they are worth," since the servicing time involved is often greater than the potential commission income. ■



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Insurance distribution seminar

Workplace sales seen as a growing market

By LINDA J. COLLINS

PHILADELPHIA—The way for agents to reach the middle-income market is to hit 'em where they work, a consultant says.

James W. Gouthro, a senior vp of Huggins Financial Services Inc., suggests agents can expand their sales by negotiating with employers to offer a variety of insurance products through the workplace.

While such products include group employee benefit coverages that are fully or partly employer-funded, the agent can also market personal lines coverages that employees can opt to purchase on their own without employer contributions.

Such an arrangement would especially benefit both the agent and the employer, he said, because making insurance easily obtainable in the workplace addresses the needs of middle-income workers, who make up the bulk of employees.

"The middle-income market is too large a market to abandon," he said. Although agents and brokers —especially life insurance agents— have spent a lot of money trying to reach the upper-income market, not enough has been done to reach the middle-income person, he said.

Mr. Gouthro outlined ways to reach consumers through workplace marketing during a session at the "Profiting From New Insurance Distribution Opportunities" seminar, recently presented in Philadelphia by Huggins Financial Services.

'The middle-income market is too large a market (for agents) to abandon,' says James W. Gouthro.

In the past, workplace sales of insurance tended to be a "fringe or niche activity," Mr. Gouthro said. "Now there are global attacks on the workplace."

And, he said, employers are often willing to work with agents to market insurance products to their employees.

Mr. Gouthro pointed out that the massive influx of people born after World War II into the workforce has slowed as those "baby boomers" have matured.

Fewer people are entering the workforce, he said, and this trend is likely to continue. Thus, he says, there soon will be a change in the workplace from a "buyer's market," where the employer did not have to offer "extras" to entice new employees, to a "seller's market," where the employer will be forced to offer incentives to attract new workers.

Mr. Gouthro predicts that this means that employers will be interested in offering new benefit options to their workers. And, they will be interested in making additional insurance products available at reduced rates for their employees.

These employees, in turn, will demand flexibility in benefits, in response to changing economic pressures.

Insurance agents can also then step in to help fill this need.

For example, Mr. Gouthro said, many young employees are now interested in setting up retirement funding devices because they are unsure of the financial stability of the federal Social Security system.

Such a perceived need increases the potential for life insurance sales in the workplace, Mr. Gouthro pointed out.

And, such workplace marketing is needed to replace traditional ways of finding clients, which are no longer economically feasible, he said.

For example, he referred to Hay Group figures that show an agent makes an annual average of 1,008 "cold calls"—calls made to people the agent has never met. These cold calls initiate only 144 closing presentations, and of the 144 closings, only 48 result in a sale, Mr. Gouthro says. ■

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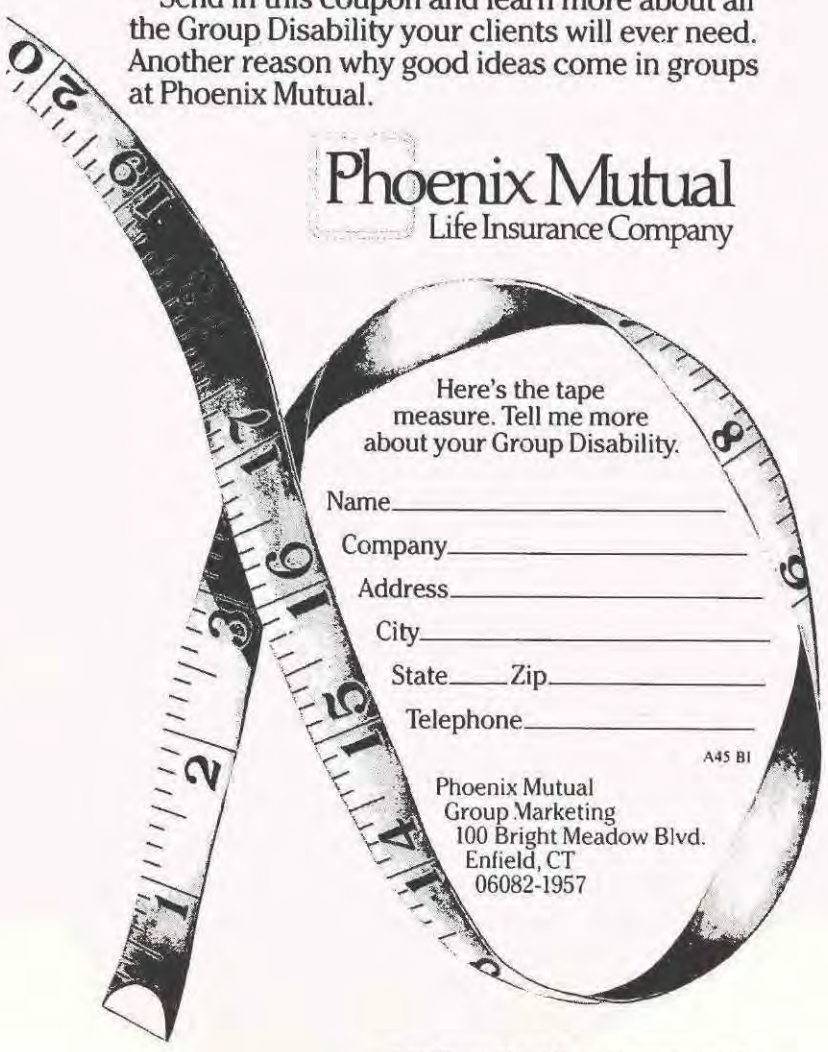

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Small, one-line agents least likely to survive market change: Expert

By LINDA J. COLLINS

PHILADELPHIA—What role will the traditional agent and broker system play in the varied financial services market of the future?

According to Martin L. Zeffert, a vp in the life/health actuarial unit of Huggins Financial Services Inc., the multiline producer of property/casualty as well as life business "is likely to be better fitted to survive than most of his peers, although the smaller agent is in trouble because of underwriting problems."

This multiline agent will be better able to survive than a life-only agent because "his product line includes some (products that) may be termed demand items, unlike the more discretionary purchases of life insurance and investments," said Mr. Zeffert. He made his remarks during Huggins' "Profiting From New Insurance Distribution Opportunities" seminar in Philadelphia.

'I believe we should anticipate an increasing role for the multiline agent,' Mr. Zeffert says.

"To the property/casualty company, the independent was and is, in many cases, the preferred distribution system for casualty insurance. In many ways, this individual. . .has been the first to feel the swells of the tides rolling up on our beaches," he said, referring to market changes.

Mr. Zeffert said that "competition and underwriting losses coupled with outright rate regulation in many personal property/casualty lines have exposed (the independent agent) to commission rate reduction long before the life lines ever talked about this. In the past years, bank sales as well as the longtime direct writers have furthered his problems."

Through the sale of these property/casualty "demand" items, however, the multiline independent agent can make "a considerable dent in the under-$50,000 income market," he said.

"I believe we should anticipate an increasing role for the multiline agent, especially outside of the major metropolitan areas," he predicted.

Mr. Zeffert said he also believes that clients in higher-income brackets will continue to need and use the services of larger agencies and brokerage firms for either life or property/casualty insurance, rather than turning to the insurance vendors springing up as part of larger financial services operations.

"Whether this (client-income level) is over $50,000 or over $75,000 I won't dispute, but the better-income client with greater diversity of needs and sophistication cannot be handled by a desk or booth in Sears or some bank lobby," he said.

However, he said, small commercial clients will remain the cornerstone of the traditional agent's market.

"The rest of the market—down to the point where they buy nothing at all but depend on the government—will be served by a mixture of exclusive agents, brokers, bank clerks and other part-timers, if they can survive the onslaught of direct marketing," Mr. Zeffert explained.

He added that two things can materially improve the current agent and broker system.

First, better agency and home office management is needed, especially more careful selection and training of employees, he commented.

And, agents need to replace the current hit-or-miss methods of finding clients, which Mr. Zeffert called "ruinous and inefficient," with a more efficient system of prospecting. ■

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Agents urged to adapt to changing market

By LINDA J. COLLINS

PHILADELPHIA—Agents and brokers soon may need a road map to find their way around a rapidly changing market, according to one consultant.

The current insurance climate is marked by the consolidation of financial services, inter-industry competition and new players in the field, said Phillip A. Turberg, general partner of The Hay Group and president of Huggins Financial Services Inc.

He also cited the emergence of a more enlightened consumer, especially in the middle- and higher-income brackets.

In particular, this new type of consumer takes a different approach to life insurance, he said. Now, middle- and upper-income consumers are interested in assuring their financial security through their purchase of life insurance products, rather than simply in death benefits, he said.

Mr. Turberg presented an overview of key issues in the financial services marketplace to kick off a two-day seminar, "Profiting From New Insurance Distribution Opportunities," presented by Huggins.

He emphasized that new entrants into the insurance field will cause lower profit margins because of the increased competition.

The key to a lasting competitive advantage for underwriters, Mr. Turberg said, is finding the most cost-effective distribution system.

Three main alternative distribution systems are being developed, according to Mr. Turberg:

- More emphasis is being placed on arrangements to offer individual life and property/casualty products through an employer. Some might be benefits that are fully or partly employer-funded, but others might be additional coverages offered at group rates to individual employees through the workplace (see related story).

"This offers the most efficient opportunity to distribute insurance products," he said. But, he added, "For sales through a workplace to be successful, there must be multiple product distribution. This is not just desirable, but economically necessary."

For example, it would be best to offer a variety of products, such as auto insurance, life insurance and individual retirement accounts.

- Direct marketing continues to grow. Mr. Turberg said that telemarketing helps to identify the profitable markets, and home computers now permit companies to deal directly with some consumers. He also pointed out that expenses and results are easily measured in direct-response marketing.
- Insurers are actively seeking partners through joint ventures with banks, thrifts, retail outlets or credit unions.

He said that when using alternative distribution channels, "the distribution source must be profitable on its own. Everyone involved must make money on the transaction if (the distribution channel) is to survive and prosper."

And, Mr. Turberg said, agents contemplating an alternative delivery system should anticipate problems and learn from their mistakes. And, they should have clearly defined profit objectives.

The new delivery systems are just some of the many new opportunities for agents, Mr. Turberg said. But, he added that agents must change in order to survive.

"The independent agent who doesn't automate his back office is probably going to have to pack it in—he won't survive," he said.

Automation demands constant updating of the system—with ongoing costs—Mr. Turberg said. Automation investments are "not short-term, not discrete. You must recognize that very few technological investments can be made where you don't have to make improvements" down the road.

He also stressed that agents must realize that, although product and price will attract consumers, quality and service are what will retain the business. And, he said, agents' ability to give personal, quality service can give them an edge against newer insurance distributors, like banks and retail outlets.

"Customers are not as cost conscious as we will be led to believe," Mr. Turberg said.

But, he said, many agents may be banking too much on the most affluent, "upscale market."

"There is a fundamental weakness in the existing agency system regarding the 'upscale' market," he said. There are probably only about 2 million to 3 million households that are truly upscale.

"Is there a problem that this market is too small to support the number of players?" he asked.

Instead, he suggested that agents target middle-income consumers, through the alternative delivery systems, for example.

And, he cautioned that, given the current changing climate, some agents may not survive.

Insurers, he said, are now trying to determine who their profitable agents are, and deciding "what to do about the unprofitable ones."

He added, "There is a move toward controlled sales forces," meaning agents would be required to produce a certain amount of business for a particular insurer. ■

Future of bank legislation uncertain: Expert

PHILADELPHIA—Congress remains a House—and Senate—divided over the issue of the sale of insurance by banks, says Robert B. Schneider, a vp and counsel for Huggins Financial Services Inc.

"In spite of promises that financial services reform legislation would be a first priority for the 99th Congress, most sources now say there probably will be no resolution of this issue this year, as the budget and taxes will be the major issues," he said at a recent Huggins seminar.

He said action on bank deregulation is hindered because members of the financial services industry—and their champions in Congress—can't agree on the basics in the debate on financial services reform.

For example, the two major congressional players in the bank dispute—Rep. Fernand St Germain, D-R.I., and Sen. Jake Garn, R-Utah—disagree on the issue of allowing banks to sell insurance.

Rep. St Germain, D-R.I., chairman of the House Banking Committee, opposes deregulation and wants to "end the turf-crossing of the last few years" and force banks, insurers and other financial service firms "back to their respective corners," Mr. Schneider said.

But, Sen. Garn, chairman of the Senate Banking Committee, agrees with the Reagan administration that U.S.-chartered banks should have broad new powers.

"Sen. Garn's proposals would permit banks to expand into underwriting all forms of securities and limited forms of brokerage activities, together with new powers to enter real estate brokerage and insurance underwriting," he said.

Another major continuing effort in both the House and the Senate, he said, is aimed at closing the loophole in South Dakota law that permits South Dakota state-chartered banks to conduct insurance activities outside and, to a limited extent, inside the state (*BI*, Jan. 28).

Mr. Schneider anticipates that banks will push for enactment of laws similar to South Dakota's.

For instance, New York Gov. Mario Cuomo openly favors allowing banks to sell insurance. Mr. Schneider says other states where bank deregulation legislation is likely include California, Colorado, Florida, Georgia, Illinois, Massachusetts, Michigan and Texas. ■

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Direct marketing system requires careful planning

By LINDA J. COLLINS

PHILADELPHIA—Careful planning is needed to avoid costly mistakes in a direct marketing program, according to a JCPenney insurance sales executive.

"You need to know who you want and how to go after them," said Fred A. Williams, executive vp of sales for JCPenney Insurance in Dallas. Mr. Williams has been involved in Penney's direct-response and retail marketing of financial services for more than 20 years.

"The marketing challenge is to know which customer wants to buy which products and when," he said. "It is also necessary to know what the customer is willing to pay for the product and to be able to match that with a selling price that will produce a profit."

At a Huggins Financial Services Inc. seminar recently held in Philadelphia, Mr. Williams discussed Penney's direct marketing methods, some of which can be adapted by any agent interested in developing an effective program.

Mr. Williams said that agents should take advantage of the growth in direct, or mail-order, sales. Currently, 14% of all retail merchandise transactions are direct sales, and it is estimated that that figure will rise to 20% by 1990, he said.

Conversely, only 1.2% of U.S. adults had purchased insurance by mail in 1983.

The increase in direct sales, Mr. Williams said, is due to several factors, including:

- The growth of two-income families, which makes time a "precious commodity."
- The perception of some people that direct marketing is a more convenient way to do business.
- The use of toll-free WATS line phone numbers.
- The buying public's belief that direct-mail purchases save money.
- Increasingly efficient technological tools.
- Better delivery systems to get the product to the customer.

The personal lines insurance products now being sold through direct mail, Mr. Williams said, are:

- Replacement-type coverages like auto, homeowners, tenants and condominium insurance.
- Supplemental insurance, such as accident only, accident and health, Medicare supplement and group life.
- Basic life insurance coverages like whole life, term life and universal life.
- Single-need products, like mortgage insurance.

Mr. Williams suggested that an agent developing a direct marketing system first make sure it is aimed at the most likely targets.

He said the people most likely to buy insurance by mail are women, people between the ages of 45-64 (younger for life coverages), people who have an average annual income of between $25,000 and $30,000 a year and those who live in the Pacific Northwest and the Northeast.

Mr. Williams cautioned that there are few software packages on the market specifically designed to help develop a direct marketing program. He said Penney developed its own software program because it could not find a satisfactory package through an outside vendor.

Once a system has been set up and a target group established, Mr. Williams suggested:

- Compiling a "Do Not Solicit" file of people who have said they do not wish to be contacted further.
- Analyzing and ranking groups according to their response rate.
- Promoting homeowners insurance to auto policyholders as a cross-selling measure. Mr. Williams said auto coverages are more profitable, so they should be the primary sales goal.

But, he added that once an auto policy has been written for a customer, it is easier to write a client's homeowner coverage. Penney averages about three homeowners sales to every 10 auto sales, he said.

Mr. Williams also noted that Penney sells more life coverage by mail than property/casualty products. Property/casualty products, Mr. Williams said, sell better through the company's agent forces in Penney stores. ■

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Agent's deal with banks prompts criticism, threats

MEMPHIS, Tenn.—The idea of financial institutions bypassing the agency system to sell insurance on their own angers many agents. However, an agent who has a sales agreement with a chain of Memphis banks is now the object of public criticism from agents' groups and anonymous threats.

Bill Craddock Jr., principal of the Craddock Insurance Agency in Memphis, is being sued by the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents over his arrangement to market Aetna Life & Casualty Co. products through Memphis branches of Tennessee First National Bank. The suit disputes the legality of the arrangement.

Mr. Craddock's marketing operations also have been criticized in numerous association publications.

And, he says he has recently received hate mail enclosed in marketing envelopes he has placed in the bank's branches. He also has received several bomb threats directly related to the banking arrangement.

Mr. Craddock prefers not to elaborate on the threats, since he is concerned for his safety. But, despite the threats, the marketing operations are continuing.

More bank marketing

SAN FRANCISCO—ISU Corp., a San Francisco-based independent insurance agency franchise organization with more than 500 franchisees nationwide, has established a program to market insurance through its franchisees to the customer bases of financial institutions.

Through the franchiser's ISU/Financial Institutions Insurance Services program, franchisees can form partnerships with financial institutions and market insurance products through direct mail to the banks' customer bases.

So far, 23 financial organizations have signed up for the program, and 242 others have submitted information to form partnerships with franchisees.

American International Group Inc. is the principal market for the program, although Transamerica Insurance Corp. of America, The Travelers Corp., Progressive Casualty Insurance Co. and Credit Life Insurance Co. are marketing some specialty products through the program.

Other major insurers are now negotiating with ISU/FIIS to offer a broad portfolio of coverages to serve as backup markets, according to an ISU spokesman.

AIG is offering more than 20 life, health and property/casualty coverages to franchisees. The insurer has designed some of the direct response products specifically for bank customers. For example, some of the coverages can be paid for with automatic monthly withdrawal of premiums through the clients' savings or checking accounts or can be added to clients' monthly mortgage payments.

AIG has established dedicated facilities with telecommunications equipment and personnel in Fort Collins, Colo. and Wilmington, Del. to service policies written through ISU/FIIS franchisees.

Arrangements are subject to federal and state regulations, as well as any regulations pertaining to specific types of financial institutions.

IIABC to move

SAN FRANCISCO—The board of directors of the Independent Insurance Agents & Brokers of California has announced its plans to move the association's headquarters from San Francisco to Sacramento by Sept. 1, 1986.

Since Sacramento is California's state capital, the relocation will give IIABC ready access to legislative activities, said an association spokesman. In addition, many statewide associations are headquartered in Sacramento, which will help the IIABC in forming coalitions with business groups outside the insurance industry. ■

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Risk managers cite reasons for higher coverage costs

The restrictive reinsurance market is the main force driving up the cost of property/casualty insurance, according to the *Business Insurance* Risk Management Board.

According to the board, the next most important force is the decrease in insurers' investment income due to lower interest—followed closely by increased underwriting losses.

In a distant fourth place is shrinking capacity in London, attributed to the strength of the dollar against the pound.

The most recent survey asked board members to rate from 1 to 4 the role each of the above occurrences played in forcing insurance prices up. Each first-place vote was worth five points, each second place worth four, each third place worth three, and each fourth place worth two.

Based on this formula, the restrictions in the availability of reinsurance was voted as the most important force with 156 points.

Decreased investment income and increased underwriting losses were voted the second and third most important forces with only two points separating them. Decreased investment income received 149 points while increased underwriting losses garnered 147 points.

The restrictive reinsurance market received 15 first-place votes for 75 points, while the decrease in investment income received 14 first-place votes for 70 points. However, the restrictive reinsurance market also received 13 second-place votes for 52 points while the decrease in investment income received only eight second-place votes for 32 points.

Increased underwriting losses received three fewer first-place votes than the decreased investment income, but earned four second-place votes to keep its point total only two short of second place

Sixty-three percent of the board members believed that the shrinking capacity in the London market due to the strenghth of the dollar against the pound had the least to do with forcing insurance prices up. It received 27 fourth-place votes, one first-place vote, two second-place votes and five third-place votes. ■

Insurers' return could be hiked, risk managers say

Although the majority of the *Business Insurance* Risk Management Board members believe the current property/casualty insurance crisis is due to insurance companies' poor management, most also maintain that insurers deserve a better return on equity.

Sixty percent of the respondents to a recent survey said a return on equity of 10% to 14% would be appropriate for the property/casualty insurance industry. Another 19% said they would allow the industry a 15% to 19% return on equity.

Two board members said it would be appropriate for insurers' return on equity to be as high as 20% to 24%. Others said return on equity should be 35%.

The equity levels deemed appropriate by the majority of survey respondents are much higher than what insurers' actually saw in 1983 and 1984. According to Conning & Co., the property/casualty insurance industry as a whole posted only a 0.7% return on equity in 1984.

While the industry saw a higher return on equity in 1983—5.5%—it still fell far below what survey respondents indicated was fair.

The insurers' return on equity in 1981 and 1982 came much closer to the 10% to 14% considered appropriate by the majority of the risk management board. In 1982, property/casualty insurers posted a 10.2% return on equity, according to Conning. In 1981, it climbed to 13.3%.

If history repeats itself, insurers' current return on equity is expected to climb again along with the increase in insurance premiums. Return on equity shot up to 18.7% and 19.8% in 1977 and 1978, respectively, when the insurance market constricted after a period of lower insurance prices, according to Conning.

In 1974 and 1975 when prices were low, return on equity was only 8.6% and 6.4% respectively. ■

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Umbrella liability renewal a tough task

By LORRIE GIBSON

Renewing umbrella liability coverage can be one of a risk manager's toughest tasks in this tight market, according to a *Business Insurance* survey.

Seventy-seven percent of the risk managers responding to the most recent survey of the *BI* Risk Management Board renewed some type of coverage within the last eight months. Of these respondents, 40% said renewal of umbrella coverage was the toughest in terms of the price charged, the limits available and the restrictions attached to the policy.

The task may have been the roughest for the director of risk management for a manufacturing and retailing company that was hit in January with a 500% increase in premium for $250 million in coverage, down from the original $500 million. The risk manager obtained this quote after going into the market and essentially replacing the current insurers.

"Coming from the base they were at, 100% (increase) for two to three years could be understood; 500% in one blow is poor management," he said.

"Generally," he adds, "insurers want to return to their pet preprinted forms and shy away from manuscripts."

Umbrella liability insurance costs rose 160% for a government entity that also renewed its coverage in January. However, its risk manager says market conditions were worse when the market tightened in the mid-1970s than they are now.

The bulk of the risk managers who renewed umbrella coverage in the last eight months reported increases in the range of 70% to 85%. The lowest increase was 25%, reported by the risk manager for an auto club services and personal lines insurance company who renewed coverage in January.

Two other respondents reported relatively small premium increases of 40% and 35%, but said the umbrella insurers insisted on an "absolute pollution exclusion."

The risk manager who reported the 35% increase also was able to raise the policy limits to $25 million from $10 million. However, he had sought limits of $50 million for his company, a manufacturer of industrial and consumer goods.

The 40% increase was reported by the risk manager for a chemicals and precious metals company, who had sought limits of $150 million but had to settle for his current limits of $101 million.

The director of risk management for a manufacturing company whose premium was increased 79% —and who had to agree to a $150,000 deductible when the policy originally required no deductible—said his lead umbrella insurer required an increase in the limits of the primary comprehensive general liability policy.

However, renewing umbrella liability insurance is not the only tough task for risk managers.

The director of risk management for a chemicals manufacturer who renewed environmental impairment liability coverage in January is paying 334% more, after the premium was increased to $160,000 from $46,500. He also had to accept a 900% increase in his deductible, which rose to $500,000 from $50,000. He did not indicate the limits of the policy.

The premium for directors and officers liability insurance for a department store increased 240% to $170,000 from $50,000. Limits of $45 million were retained, but the self-insured retention was increased to 5% of all losses. Formerly, the 5% retention applied only to the first $1 million in losses.

And, a small manufacturing firm renewing its product liability coverage reported a premium increase of 232%, to $83,000 from $25,000.

A building materials company that had its premiums for architects and engineers professional liability coverage increased 111% also had its limits cut to $10 million from $15 million, and its deductible increased 233% to $250,000 from $75,000.

And, on top of everything else, the insurer slapped on an exclusion for liability arising from product testing.

A hospital that renewed its medical malpractice is now paying more than twice as much for its coverage, but coverage for doctors that are doing their residency at the hospital was reduced drastically.

A California education and research company squeaked by with a 20% premium increase for earthquake coverage in September, only to have one-third of its insurers cancel its coverage in January. As of last month, the coverage still had not been replaced.

Others, however, apparently have still been able to find bargains. A manufacturing and services company renewed its casualty coverage in January with an increase of less than 10% in premium for its loss-sensitive program.

Although the fidelity bond market for financial institutions has tightened dramatically (*BI*, March 18), a state university that renewed its blanket fidelity and crime bond in January had its premium increased only 9% for three times as much coverage. However, its deductible was increased to $25,000 from $10,000.

And, a hospital succeeded in renewing its excess workers compensation coverage in October with primarily the same insurers on its expiring policy for about 30% less, while doubling its limits and reducing its deductible.

Although it had received a quote of $40,000, it finally negotiated a premium of $15,300, down from the $22,000 it paid for the expiring policy. The limits of the new policy are $2 million, up from $1 million. The hospital's deductible was reduced by 33.3%. ■

'Issues in Insurance' revisions made

MALVERN, Pa.—CPCU 10—"Issues in Insurance"—has been revised by the addition of four new monographs, according to Norman A. Baglini, senior vp and dean of the American Institute for Property & Liability Underwriters.

The new monographs added to the two-volume text are: "Environmental Impairment Liability—An Insurance Perspective," by David Sterling of The Hartford Insurance Group; the National Assn. of Insurance Commissioners report on "Regulating Workers Compensation Groups"; "Report of the Investment Income Task Force to the National Assn. of Insurance Commissioners"; and "Expansion of Banks into Insurance," by the Financial Services Consulting Group of Coopers & Lybrand.

For more information, contact Everett Randall at the American Institute, 720 Providence Road, Malvern, Pa. 19355. ■

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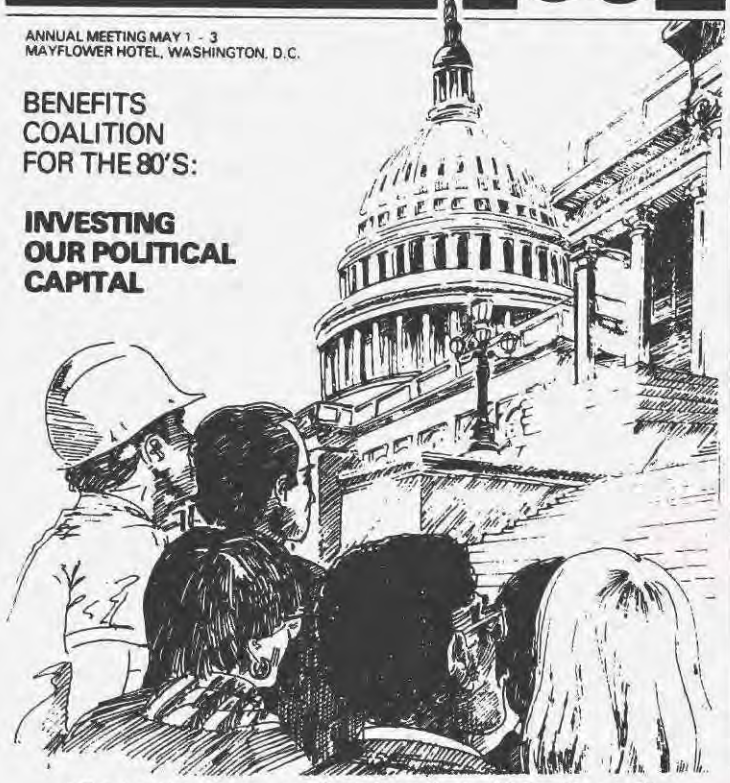

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Amendments threaten product liability measure

Continued from page 2

The injured person could still sue the manufacturer in court. Or, under the alternative compensation system, the victim could file a claim against the manufacturer to recover out-of-pocket economic losses, such as medical bills not covered by health insurance or lost wages that exceed workers compensation benefits.

Such claims would be allowed, even if the victim could not identify the specific manufacturer. In such a case, a consumer could file a claim against any manufacturer that made the product at the time of injury.

Once a manufacturer received a claim, it would have 75 days to decide whether to pay it.

If the manufacturer did agree that some compensation was called for but was to dispute the amount of the economic loss, either party could request binding federal arbitration.

However, if the manufacturer rejected the claim outright, the victim could sue the company in court for full damages.

Sen. Dodd says that Sen. Kasten's bill won't do anything to help people injured by products.

Or, the victim could go to court to continue to seek compensation for economic losses.

In this case, the victim would not have to meet traditional legal tests —such as identifying the specific manufacturer—to recover damages.

If a court said the manufacturer should not have denied the claim, the company would have to pay damages for economic losses, interest charges and the plaintiff's attorneys' fees.

Sen. Dodd says the trouble with Sen. Kasten's bill is that it won't do anything to help people injured by products.

A uniform federal product liability law still would fail to compensate a significant number of people who deserve compensation, Sen. Dodd said.

However, Mr. O'Day said he worries that the alternative compensation system would, in time, be expanded by courts to also cover non-economic losses, such as pain and suffering.

"That is bound to lead to much higher insurance costs," he explained."

Interest in Sen. Kasten's bill—which, among other things, would bar many suits against manufacturers in cases involving products more than 25 years old and make it more difficult to sue in cases where an accident was caused by the faulty design of a product—could decline as other senators unveil their own proposals, a lobbyist worries.

"As more people get involved, there is less certainty about the direction that a bill will take," according to Victor Schwartz, counsel for The Product Liability Alliance, Washington-based business lobbying group that favors the product liability bill.

However, he added that interest in the measure is high, and there is still time to work out a compromise.

Although the recent Senate action creates questions over whether a tort reform bill can be passed by Congress, Rep. Dingell's backing increases the chances that the House finally will consider federal product liability legislation.

Until now, only the Senate Commerce Committee, which last year passed a tort reform bill introduced by Sen. Kasten, has taken any action on product liability legislation.

The Kasten bill died on the Senate floor last year after a threatened filibuster, but Sen. Kasten introduced a new bill this year.

The interest of a key member of the House is critical, because concurrent House and Senate action is needed to advance a bill, said Mr. O'Day.

"The Senate isn't going to engage in a (legislative) blood bath unless it has expectations that the House also is going to move forward," Mr. O'Day added. ■

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Rhode Island considers comp bills

Continued from page 2

D-Westerly, and Rep. Charles C. Baldelli, D-Woonsocket, is backed by labor interests, although Mr. Holbrook said that certain provisions in H.B. 7162 would be backed by the employers' federation as long as they echo those in the governor's bill.

Both bills are similar in their intent to establish a Cabinet-level department for workers compensation that would combine administrative, adjudicative and rehabilitative functions now handled by the Department of Labor or the Workers Compensation Commission, an independent state agency.

The two bills also give the new department general responsibility for:

- Administering a medical and rehabilitative unit including the state's existing John E. Donley Rehabilitation Center.
- Establishing an informal unit of "employee assistants" who would help injured workers with administrative procedures so that the workers receive benefits as promptly as possible. The assistance is aimed at settling problems as early as possible while preserving an injured employee's right to legal redress.
- Keeping workers compensation statistics and records.

However, the bills' similarity ends there.

The representatives' bill, backed by labor, proposes making the new department responsible for setting workers compensation insurance rates, whereas the governor's bill keeps the responsibility for rate-setting under the state's Banking and Insurance Division of the Department of Business.

Administration of workers compensation matters for state employees would be transferred to the new department from the Department of Labor under the representatives' bill.

The governor's bill, on the other hand, calls for these duties to be undertaken by the Department of Administration's Division of Personnel.

The representatives' bill also proposes provisions that would speed benefit payments to injured employees, whereas the governor's bill does not.

A package of four other workers compensation bills are also being co-sponsored by Reps. Boeniger and Baldelli. These pieces of legislation are designed to streamline operations and tighten regulation of insurers. They include:

- H.B. 6173, which would require every insurer, including all of its subsidiaries, to file individual rates if it writes more than 1% of the previous year's gross premium in the state.

Under current law, only insurers that write more than 2% of the previous year's gross premium in the state are required to file their rates independently and have them approved separately.

- H.B. 6142, which would establish new procedures for setting workers compensation insurance rates.
- H.B. 6144, which would increase to $250 from $50 the penalty for a workers compensation insurer that fails to fully complete forms relating to its rates.

Rep. Boeniger says the need for this proposal arises from the fact that insurance companies often do not fill out forms completely, thereby making it difficult for the state to gather the data needed to properly regulate them.

- H.B. 6110, which would prohibit insurers from using incurred penalties and interest charges as the basis for requesting a rate increase and thereby passing those costs onto employers.

In the face of proposed rate hikes, both employers and labor representatives hope passage of some type of legislation will serve to improve the business climate and the workers compensation delivery system.

"We are convinced that this type of (legislative) re-structuring will improve the efficiency of the programs and, consequently, serve to benefit both employee and employer," said Rep. Boeniger. "Additionally, it will ultimately work to improve the business climate of Rhode Island."

Hearings ended last month on a 30% rate increase for workers compensation which was filed last year by the National Council on Compensation Insurance.

Although the NCCI requested a 30% hike, its analysis shows an average increase of 87.8% would be in order (*BI*, March 26, 1984; April 30, 1984).

State Insurance Commissioner Clifton A. Moore is expected to approve or reject the rate increase request in the next 30 to 60 days.

Another approach to workers compensation reform being considered by a legislative commission is the establishment of an exclusive state fund.

The state Legislature extended to Feb. 1, 1986, the commission's deadline to complete its report on the feasibility of such a fund. The commission originally had expected to finish the report by March 1.

The commission, which was appointed in December 1984, requested more time because it is proposing that bids be sought for an actuarial study by an outside consultant, said Rep. Boeniger, who is chairman of the commission and the state Legislature's House Labor Committee (*BI*, April 30, 1984; May 21, 1984).

The actuarial analysis is needed in light of insurance companies' criticisms that the start-up costs of such a fund are too high, Rep. Boeniger added.

Currently, 19 states have state funds and all but one of those were established more than 50 years ago. Thirteen states have competitive state funds and six have exclusive state funds that exclude commercial insurers from underwriting workers compensation risks. (*BI*, Jan. 14). ■

Illinois legislators look at VDT bill

SPRINGFIELD, Ill.—Illinois legislators again are considering a bill to regulate the use of video display terminals in the workplace.

H.B. 620, also called the User Safety Act, was introduced March 12 by Rep. Michael D. Curran, D-Springfield. The bill is in the House Labor and Commerce Committee.

Rep. Curran said the measure would require employers to provide adjustable chairs and tables for users; pay for eye exams to be taken on company time; provide the option of alternative work for pregnant operators; allow a 15-minute break of alternative work every two hours; and install noise-reducing covers on the word processors and printers.

The state's Department of Labor would be responsible for enforcing the act, and violators would face a $1000 fine, he added.

H.B. 620 is "substantially different" from H.B. 2397, a VDT bill introduced last session, according to Rep. Curran.

That bill, introduced by Rep. John Matijevich, D-North Chicago, was stranded in a House Labor and Commerce subcommittee when the Legislature adjourned (*BI*, Jan. 14).

Provisions in the User Safety Act would apply only to employees who work at least 50% of their time on a VDT, while provisions in last year's bill affected anyone working with the terminals for any length of time, Rep. Curran said. ■

New York department studies insurer

Continued from page 2

haven't written off MLMIC."

The spokesman refused to discuss details of the department's hearings, which began last December and ended in February.

MLMIC, a physician-owned mutual company, was formed in 1975 and writes non-assessible medical malpractice insurance policies in New York only.

The company has not yet filed its 1984 annual statement. In 1983, MLMIC recorded underwriting losses and expenses of $282.6 million on earned premiums of $166 million, making for a net underwriting loss of $116.7 million.

After investment gains of $116 million, MLMIC reported a net operating loss of $325,515.

Policyholders surplus stood at $51.6 million at the end of 1983 and the company's total assets amounted to $1.15 billion.

In a footnote to its 1983 annual report, MLMIC, which discounts its loss reserves to reflect future investment income, reported a projected undiscounted liability of $2.3 billion on business written through Dec. 31, 1983.

The $1 billion loss reserve and the company's surplus were projected to earn investment income of $700 million at an assumed annual rate of 11%. This income, added to the loss reserve itself, would leave the insurer $600 million short of meeting its projected liabilities.

Other actuarial studies of the company have reached similar conclusions. Tillinghast, Nelson & Warren produced a study of MLMIC and Medical Malpractice Insurance Assn., another New York insurer, for medical malpractice rate hearings concluded earlier this year.

The Tillinghast study found that on business written through the end of 1983, losses and expenses for the two insurers would exceed premiums and investment income—earned at an assumed rate of 12%—by $989 million.

The study didn't separate financial data for the two insurers, but MLMIC accounted for about 90% of the business written by the two companies.

The Tillinghast study did not include an allowance for reinsurance recoverable, however.

According to its 1983 financial statements, MLMIC maintained aggregate excess reinsurance contracts with more than 26 reinsurers, including Kemper Reinsurance Co. and New England Reinsurance Co.

Amounts recoverable from reinsurers on unpaid losses, net of discounts for expected investment return, were $9.5 million in 1983, $18.9 million in 1982 and $19.6 million in 1981, according to MLMIC's annual report.

The terms of the reinsurance contracts varied from year to year, but the 1983 contract stopped MLMIC's liability for individual claims at $500,000 for losses involving one policyholder and $1 million on losses involving two or more policyholders.

The reinsurance coverage, on which MLMIC itself was a 10% participant, was limited to $2 million per occurrence after the aggregate of all losses exceeded $13 million, according to the MLMIC annual report.

However, there was no aggregate limit on the amount of reinsurance recoverable.

Contracts prior to 1979 contained a $10 million aggregate limit.

MLMIC's management concedes that the company may face a reserve problem.

"The actuaries have raised significant questions about our reserves," said Donald J. Fager, president of Donald J. Fager & Associates Inc., which manages MLMIC.

Mr. Fager said that the Insurance Department is at least partially to blame if a problem exists, since the department denied requested rate increases between 1981 and 1983.

MLMIC had requested increases of 71% in both 1981 and 1982, and a 52% increase in 1983. It received a 52% increase in 1981, and an increase of 15% in both 1982 and 1983.

Before 1981, the department had granted the company's full requests for rate increases.

"We've had inadequate rates for the past several years, and those inadequate rates can produce inadequate reserves," Mr. Fager said.

The Insurance Department, which granted MMIA a 52% rate increase earlier this year, is expected to allow MLMIC its requested 55% increase retroactive to July 1, 1984.

However, the Tillinghast study indicated that this increase would only produce break-even results for MLMIC on losses attributable to the current policy year, and would

Continued on next page

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As Questions Occur in Developing and Preparing a Claim, insureds should not hesitate to bring them to the attention of the adjusters. Any number of variables might be affected, including cost estimates, reporting requirements, restoration plans, record keeping, partial payments, expense handling, and the like. One of the adjusters' concerns is to avoid surprises months later. Insureds, insurers, and adjusters are seldom comforted by the unexpected discovery of unobserved damage, underestimated charges, or uninsured items long after the loss occurred. Good communications is not just a "buzz word", it is an essential ingredient for a smooth and timely conclusion of a claim.

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MLMIC reserves

Continued from preceding page

not generate any surplus premium or investment income that could be used to reduce the prior years' reserve deficiency.

Nevertheless, MLMIC maintains that rate increases and better-than-projected loss development will offset any reserve shortfall. Losses, for example, may take longer than expected to develop, allowing increased income on invested premiums in the interim. Rates of return on investment may also be greater than assumed.

"We have many years to make up any deficiency at adequate rates," said Michael Ellenberg, an attorney with LeBoeuf, Lamb, Leiby & MacRae in New York, which represents MLMIC.

MLMIC also could build larger reserves by using more conservative assumptions in its reserve discounting, assuming a rate of return of 7% or 8% instead of 11%, Mr. Ellenberg said.

The company would also benefit from a contingency fund similar to the one established for MMIA by the New York Legislature. MMIA is allowed by statute to charge policyholders an additional 20% over approved rates to maintain a contingency fund for claims payments, Mr. Ellenberg said.

The Insurance Department has blocked the establishment of such a mechanism for MLMIC, he said.

Some observers doubt that rate increases, better-than-expected loss experience or a contingency fund will eliminate the anticipated reserve deficiency, though.

MLMIC is "playing catch-up," and in such a situation "you're always going to fall behind," said Richard Zatorski, vp in the actuarial services division of Frank B. Hall & Co. Inc.

"The more people concentrate on rate increases, the more likely that shortfall will occur," he added, explaining that what medical malpractice insurers and policyholders really need is legislation limiting physicians' liabilities.

Another possible solution to MLMIC's problems is a capital infusion.

Edward J. Amsler, vp with Fager & Associates, said that the company is discussing various methods of raising additional capital with the New York Insurance Department.

Mr. Amsler wouldn't comment on what sources of new capital were being discussed.

Several observers, however, doubt that the company will be able to arrange a capital infusion.

Since MLMIC's policies are nonassessible, the company would not be able to tap the physician policyholders who originally capitalized the insurer.

Policyholders could only be expected to make voluntary contributions, sources say.

"I don't think the doctors are going to put in any more capital," said Harold Tract, a lawyer with the firm of Rein, Mound & Cotton in New York. "It's a hopeless situation to raise capital." ■

update

Court rules on premium taxes

Continued from page 2

by Metropolitan Life Insurance Co. and 39 other insurers, that levies a 3% tax on life insurance premiums paid to out-of-state companies, but charges domestic companies only a 1% tax.

In addition, the Alabama law imposes a 4% tax on out-of-state property/casualty underwriters, while Alabama-based insurers pay only one 1%.

The tax rate on an out-of-state company can be reduced by 1 percentage point as long as it invests at least 10% of its assets in Alabama.

In addition, the decision throws into doubt laws in more than half of the states that also have preference taxes that favor local insurers.

The justices remanded the case back to an Alabama court to decide whether there are other reasons to justify discrimination against out-of-state insurers.

Hospitals drop antitrust suits

PEORIA, Ill.—Two Peoria hospitals have agreed to drop lawsuits against each other that were spurred by competition between the hospitals' preferred provider organizations.

In September, Methodist Medical Center of Illinois filed an antitrust suit against St. Francis Medical Center and Proctor Community Hospital, after St. Francis subcontracted with Proctor to provide some services and extra beds for groups enrolled in St. Francis' PPO.

The suit charged that St. Francis and Proctor had "agreed not to compete with each other. . .(and) have contracted, combined and conspired to restrain competition. . ." (*BI*, Oct. 8, 1984).

On Jan. 2, St. Francis countersued, charging that Methodist was also engaged in antitrust actions and was spreading false and malicious rumors about St. Francis.

Both suits were dismissed March 21 after both parties agreed to drop their complaints.

"After having examined relevant information, we believe that no acts of conspiracy, price fixing or illegal competition have been committed by Proctor and St. Francis," Robert Stevenson, chairman of Methodist's board of trustees, said in a statement.

Sister Frances Marie, executive vp of the Third Order of St. Francis, issued a similar statement: "We also have examined relevant information. . .and now believe Methodist Medical Center has not engaged in overt acts to monopolize (business) or disseminate false and malicious information."

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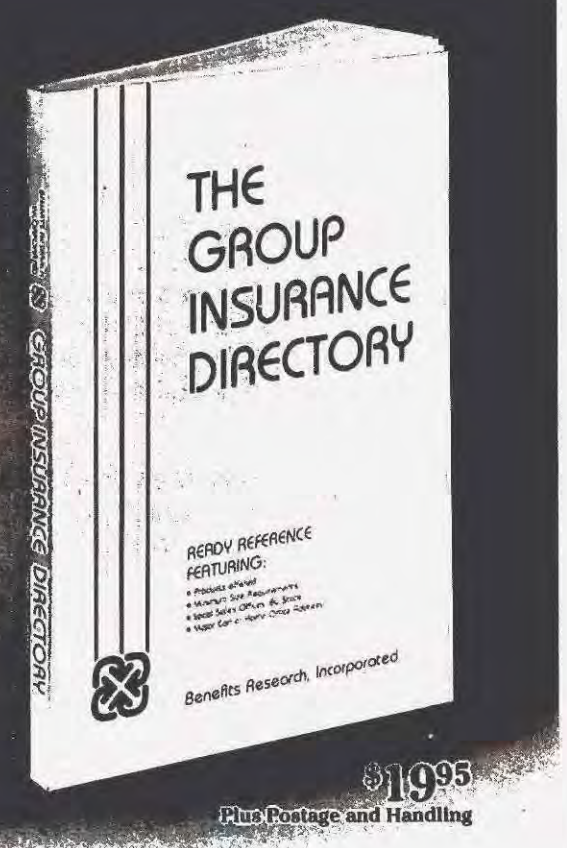

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Andersen will contest judgment

Continued from page 3

Despite the complexity of the case, which included more than 60 witnesses, the jury deliberated only about five hours before reaching its decision.

"The decision shows that a jury in New York in federal court is prepared to resolve an accounting case entirely on the merits and is prepared to award substantial sums to an aggrieved plaintiff even if that aggrieved plaintiff is the fourth largest bank in the United States," said Barry Ostrager, who represents Manufacturers Hanover. He is with the New York law firm of Simpson Thatcher & Bartlett.

"We're very disappointed in the decision," an Andersen spokesman said. "The jury took only several hours to reach its decision following a seven-week trial involving numerous complex issues."

"Clearly, the jury did not understand the differing roles and responsibilities of professionals such as accountants and direct participants in complex financing transactions.

"We don't believe the jury findings are supported by the weight of evidence. We are considering the alternatives available to us, including appeals," the spokesman said.

"It was a crazy decision by a totally unqualified jury," said Mr. Jackson, Andersen's lead underwriter.

Robert L. King, an attorney for Andersen with the New York firm of Debevoise & Plimpton, said the company is preparing a motion that will ask the court for a new trial, a judgment in favor of Andersen despite the verdict, or a reduction in the size of the award.

"We think the verdict is such as to shock the conscience of the court," Mr. King said.

It was clear the jury did not grope with the complex issues involving auditing and banking standards and repurchase agreements, Mr. King said.

Mr. King said that some jurors contacted after the trial believed both Andersen and Manufacturers Hanover had some fault in the loss, but that Andersen had greater responsibility.

Mr. King said the jurors' verdict also may have been influenced by the recent collapse of E.S.M. Government Securities Inc. Its collapse triggered the failure of an Ohio thrift institution and the temporary closing of about 70 others.

Recently, the Securities and Exchange Commission charged a managing partner with accountant Alexander Grant & Co. with knowingly filing false and misleading audit reports and receiving $125,000 in secret payments from E.S.M. officers.

Mr. King added that the verdict will continue to encourage suits against accountants and requests for jury trials.

If the verdict stands, other accounting firms facing lawsuits might reconsider settling out of court, he added.

He noted that Andersen has been criticized in recent months for being too anxious to settle lawsuits against it. However, it went to trial in the Manufacturers Hanover case because it believed it had a meritorious case, he added.

Besides settling in October with Chase Manhattan in the Drysdale case, Andersen agreed in November to pay $21.9 million to Marsh & McLennan Cos. Inc. to settle out of a derivative action lawsuit filed by an M&M shareholder following the massive government bond trading losses reported by M&M last year (*BI*, Nov. 12, 1984).

In March 1983, Andersen settled for $45 million a suit brought by Fund of Funds Inc., a 77,000-member mutual fund that charged Andersen with violating federal securities laws, fraud and breach of contract.

A federal court jury had previously ordered Andersen to pay $80.7 million in that case, but that award was reduced twice by the trial judge before it was settled (*BI*, Nov. 12, 1984).

In addition to Andersen revealing to the SEC that it has paid $137 million since 1980 in judgments and settlements, other accountants' losses reported included Peat Marwick Mitchell & Co., $19.4 million; Ernst & Whinney, $6 million; Deloitte Haskins & Sells, $5 million; Coopers & Lybrand, $4.4 million; Price Waterhouse, $3.5 million; Touche Ross & Co., $2.3 million; and Arthur Young, $1.5 million.

The figures do not include defense costs or some settlements and verdicts reached late last year or so far this year, explained Ed Coulson, deputy chief accountant for the commission. ■

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RTD wins suit

Continued from page 1

Co., RTD's former liability insurer which continued to administer RTD's claims after it began self-insuring its liability risk in 1973.

GAB was to provide "complete administration, investigation and adjustment" of all third-party, bodily injury and property liability claims arising from transit-related incidents, the court papers say.

GAB's services to the RTD were provided for a fixed yearly fee, that would have totaled $2.66 million at the end of the three-year contract in July 1, 1981. RTD paid the fee at a monthly rate of $73,939 until it canceled the contract.

Since 1974, the volume of claims against the RTD has averaged 8,500 per year, according to court papers.

In his decision, Judge Kelleher found that GAB breached its contract with the RTD by failing to perform its specific obligations to the level required by the terms of the contract.

These obligations included "a staff sufficient in size and competence to handle the matters presented in a workmanlike fashion, prompt action with respect to claims, reasonable investigation, periodic review by supervisors, various reporting requirements, maintenance of adequate documentation, appropriate efforts to settle claims and adequate resistance to suspicious or potentially fraudulent claims," the judge ruled.

As a result, the judge ruled, RTD not only was entitled to terminate the three-year contract after 21 months but also was entitled to $350,000 to cover GAB's excessive payment of claims from Aug. 1, 1978 to April 15, 1980 and $1.853 million for the extra costs it incurred because the GAB contract was terminated.

The $1.853 million included $1.353 million in extra costs incurred by the RTD for adjusting pending claims filed between Aug. 1, 1978, and April 15, 1980, when GAB was still administering claims, and $500,000 in additional costs for adjusting new claims filed between April 15, 1980, when GAB's contract with RTD was terminated, and July 31, 1981, when the GAB contract should have expired.

On Feb. 15, 1980, the RTD gave GAB a 60-day cancellation notice. When the contract subsequently expired on April 15, 1980, Leonard J. Russo Inc., a Los Angeles-based TPA, took over the administration of the RTD claims.

"It was a simple failure of GAB to ever devote the time and resources to the branch to do a job consistent with GAB's own internal standards," said William Miller III, RTD's lead trial counsel. He worked on the case with attorney R. Joseph De Briyn. Both are with the law firm of Musick, Peeler & Garrett of Los Angeles.

A main source of problems, according to court papers, was GAB's failure to keep an adequate diary of claims.

"The lack of any working diary system to control all the claims. . .meant that inexperienced, trainee adjusters were handling claims, including litigation claims without supervision," said RTD attorneys in post-trial briefs.

That resulted in claims being settled wihout proper investigation and negotiations, they said.

About two-thirds of the 4,000-plus RTD files were not regularly reviewed by supervisors in January, 1980, according to the brief.

This resulted in poor reserving practices by GAB which caused sudden requests for substantial funds from RTD to cover claims, according to RTD.

"GAB's egregious failure to control claims through any sort of effective diary was the root cause of the reserving problem," said RTD attorneys.

GAB promised in the August 1978 contract to regularly review reserves at least every 90 days. However, five months later in December 1978, a request to RTD for a multimillion dollar reserve increase prompted a letter to GAB from RTD warning of the possibility of contract termination unless there was an improvement in reserving practices.

Seven months later in July 1979, GAB was preparing to request a $5 million reserve increase, the court papers say.

In December 1979, GAB still had no working mechanism for bringing the majority of open claims to the regular attention of supervisors for reserve review, RTD attorneys said.

At this time, RTD sent GAB another letter warning it that the contract would be canceled if problems were not resolved.

While GAB did begin a diary system in 1979, it diaried only new claims leaving "the vast bulk of the inventory, uncontrolled, unsupervised, and in some cases, untouched," according to court papers.

Judge Kelleher noted that GAB's performance substantially improved after the December 1979 termination warning. However, he added, it was still beneath the standard required by the specific terms of the contract and both parties were aware of this.

But, he ruled that GAB hadn't violated "general industry standards," noting that the industry standard varies greatly with the kinds of claims involved.

The judge also found that GAB hadn't breached its fiduciary duty so he denied RTD's request for an unspecified amount in punitive damages from GAB.

However, the judge also rejected GAB's cross-complaint seeking between $170,000 and $227,000 in lost profits for its "wrongful" termination by RTD.

And although he did not find RTD comparatively negligent for its losses, as requested by GAB, he did note that RTD didn't expect and didn't contract for the highest level of services from GAB.

He said RTD knew of some problems with the administration of its claims and seemingly acquiesced to them.

"I think we are very distressed and dismayed," said GAB Chairman Mr. Williamson about the judge's ruling. "We thought we had done a good job for RTD."

However, he acknowledged there had been some problems with the administration of RTD claims and lapses in service. To remedy the situation, GAB had added $300,000 in additional personnel to handle RTD account, he added.

A factor that contributed to GAB's problems was the unusual claims environment provided by the public mass transit district, said GAB's attorney Mr. Prager.

He also said RTD expected services from GAB that were not spelled out in the contract. For example, GAB was expected to represent RTD in small claims court, which was time consuming, Mr. Prager added.

Mr. Williamson said RTD had contracted for a "bargain-basement" rate and then wanted a "Cadillac" claims administration program with extensive investigation and quick disposition.

Mr. Powers, RTD's general counsel, said: "I was not aware they had various levels of competence which they offered their customers."

"I think they should be a little reluctant to admit they did bargain-basement work," he said.

Mr. Williamson contends that different clients request different styles of claims handling and what resources they want made available to their accounts.

GAB was not asked to quote on a "Cadillac" level of service, Mr Williamson said, but said GAB could have provided that level of service. "We would have been reluctant to do it at the price" RTD had negotiated, he noted.

In the end, Mr. Williamson contends that the service RTD receives and the results achieved will speak for themselves. "I think the results were good as far as RTD was concerned," he said.

The average payment per claim from 1974 through 1979 increased only slightly to $2,100 from $1,900, according to Mr. Prager, GAB's attorney in the case. Considering the effects of inflation, the amount actually decreased, he said.

When asked of the effect of the judgment on GAB's business, Mr. Williamson said, "Clearly it is not going to help." However, "the effect should not be that serious over time," he added.

His hope is that self-insured employers choosing a TPA will be "sufficiently informed" to judge what happened and look at GAB's capacity to serve them, he said. ■

Insurer disputes GAB coverage

Evanston Insurance Co. says the claims-made errors and omissions liability policy it wrote for GAB Business Services Inc. should not have to respond to a $2.2 million judgment against the third-party claims administrator.

On March 20, a U.S. District Court judge in California ruled that GAB must pay $2.2 million in compensatory damages to the Southern California Rapid Transit District for breach of contract in administering claims for RTD (see story, page 1).

In a suit filed in New York state court against GAB and its former errors and omissions insurer, American Home Assurance Co., Evanston Insurance contends that GAB was aware of the RTD claim while the American Home claims-made professional liability policy was in force.

GAB's current errors and omissions coverage includes a $50,000 self-insured retention. Evanston, which has paid GAB's defense costs in the RTD lawsuit, provides $5 million in primary coverage above GAB's self-insured retention. With excess insurance, GAB has approximately $15 million in coverage, according to one source.

American Home would not comment on the coverage provided under the primary errors and omissions policy it wrote for GAB. ■

Political risks

Continued from page 3

importers and exporters and services to facilitate U.S. trade.

Under the act, she said, banks can act as insurance brokers for companies provided the risks brokered are non-U.S. risks.

Citicorp, she said, received permission from the Fed in early February to open an insurance brokerage specializing in overseas risks. She said it is the only bank to receive this permission so far.

The Citicorp spokesman said the brokerage has not yet been established, "but it is planned to provide insurance brokerage services that we are allowed to provide under the Edge Act.

"We are clearly becoming more involved in corporate insurance brokerage," he said.

Citicorp has been involved in insurance brokerage activities through its overseas operations for several years, the spokesman said, but these operations were not domestically based until now.

This is Citicorp's second recent venture into insurance brokerage. Last June, it acquired Lloyd's of London broker Grindlay Brandts Insurance Brokers Ltd. (*BI*, June 11, 1984).

The Citicorp spokesman noted that the global insurance division was involved in its efforts to obtain a $900 million policy from CIGNA Corp. to insure some of the bank's foreign loan exposures. The plan collapsed because of disagreements between CIGNA and its political risk treaty reinsurers over how the treaty could be used, according to market sources (*BI*, Feb. 11).

The spokesman said, however, that the collapse of the CIGNA policy is unrelated to Citicorp's decision to hire Mr. Clark from OPIC. "I don't think you can tie it to that. That's a separate thing altogether."

The spokesman would not reveal details of Citicorp's own coverage.

The Citicorp spokesman denied that the bank is planning to underwrite third-party political risks. However, observers point out that it can readily do so.

While the Bank Holding Act forbids Citicorp from establishing a domestic underwriting operation, it is permitted to set up an insurance underwriting operation for overseas risks under provisions of the 1982 Export Trading Company Act, explains Gary Welch, an attorney with the Washington-based firm of Prather, Seeger, Doolittle & Farmer. Mr. Welch is also general counsel to the Bankers Assn. for Foreign Trade, an industry group.

Mr. Welch said that according to the act, if a bank controls more than 5% of an export trading company, that company can engage in insurance activities, "but only in respect to underwriting risks outside the United States."

The spokeswoman for the Fed, which also supervises the Export Trading Company Act, said Citicorp received approval in May 1983 to establish City International Trading Co., a wholly owned subsidiary. No additional permission would be needed for Citicorp to begin insurance underwriting activities. The only constraint on the company's activities is that more than 50% of its business comes from U.S. exports, she added.

Thomas A. Cook, managing director of New York-based Cook & Miller International Ltd., a brokerage specializing in international business, says if Citicorp were to become involved in political risk underwriting, it would be a "natural alliance" in view of the volume of the foreign loans it writes.

Observers say Citicorp's effectiveness as an insurer providing political risk coverage that insures companies against losses caused by foreign government actions may be aided by the fact that it loans money to foreign governments.

Observers say capacity in the political risk insurance market is now tight. Five or six leading underwriters at Lloyd's of London that wrote political risk coverage have been forced out of the market by large losses, and other London markets have also withdrawn (*BI*, Oct. 15, 1984).

Simultaneously, demand for political risk coverage from U.S. markets has risen dramatically recently, primarily because of increased awareness of the coverage among U.S. multinationals, brokers and underwriters say.

BankAmerica is also gearing up a political risk brokerage operation.

When BankAmerica first began examining entering the insurance industry some years ago, it decided the first area it would enter would be brokerage and the best place to start an operation would be London, explained BankAmerica Insurance Services' Mr. Eve.

"It was decided that we would specialize in political risk and associated coverages to begin with," said Mr. Eve.'

Mr. Eve, formerly chief executive of worldwide retail brokerage operations at Jardine Insurance Brokers Ltd. in London, was hired by the bank to establish its London insurance office last November.

Among those who have joined the office are Jack Barnes, former director of Sedgwick Ltd.'s political risk division, and David Martin, former manager of political risk underwriting for CIGNA in London.

"Basically, we are out to generate political risk business to underwriters working through the BankAmerica account offices structure," said Mr. Eve. "The whole area of financial risks we identify as a major growth area, and there is tremendous growth potential. It is a matter of finding more underwriters.

"But, we are not going to become political risk underwriters."

What BankAmerica's brokerage arm will try to do, he says, is develop new packages and strategies that will marry the bank's current activities to protect clients against political risks with what the underwriters have to offer.

He would not specify the packages BankAmerica will offer. Like Citicorp, BankAmerica also received approval to start an export trading company, BankAmerica World Trade Corp., through which it can write overseas risks. ■

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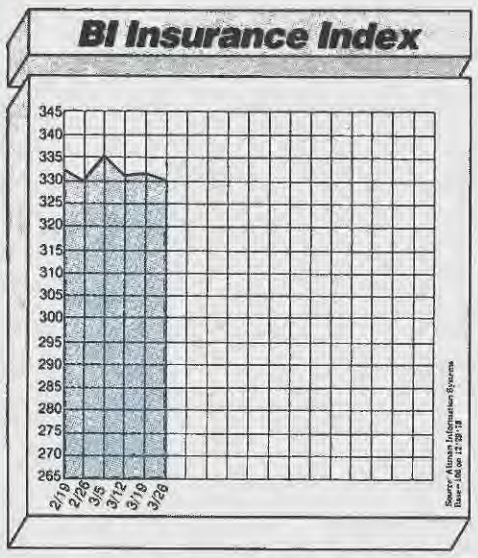

The *Business Insurance* index of insurance industry stocks declined slightly for the trading period ending March 26, after a slight increase the previous week. The *BI* index closed at 330.108 on March 26, down 1.8 points from 331.9 on March 19. Altogether, 20 stocks posted increases, 26 suffered declines and four remained unchanged. The biggest gains for that week were posted by Crown Life Insurance Co., up 8.3%; Fremont General Corp., up 5.3%; CNA Financial Corp., up 2.7%; Alexander & Alexander Services Inc., up 2.5%; and American International Group Inc., up 2.5%. The biggest losses for the week were posted by Frank B. Hall & Co. Inc., down 12.9%; Statesman Group Inc., down 7.7%; Reed Stenhouse Cos. Ltd., down 7.0%; Washington National Corp., down 6.8%; and Zenith National Insurance Corp., down 5.9%. The *BI* index dropped 0.5% during the period. By comparison, the New York Stock Exchange composite fell 0.6% and the Dow Jones 30 Industrials lost 0.9% during the period.

British Issues

26 March Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	199	N/M	16.9	8.5	210—	198
Genl Accident	595	100.8	28.6	4.8	600—	588
Gdn Royal Exch	685	19.0	36.4	5.3	697—	685
Royal	585	N/M	33.9	5.8	618—	585
Sun Alliance	460	51.1	21.4	4.7	460—	448
Brokers						
CE Heath	643	11.0	30.0	4.7	658—	643
Hogg Robinson	284	16.2	11.6	4.0	290—	281
JH Minet	304	21.0	8.0	2.6	306—	302
Sedg Grp	384	16.8	14.3	3.7	397—	384
Stew Wrightson	635	18.1	24.0	3.8	645—	635
Willis Faber	678	23.2	18.6	2.7	708—	678

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Insurers' 1984 profits inflated by variety of outside factors

By MYRON M. PICOULT

Special to Business Insurance

IT IS SAID that during good times, the property/casualty industry reports operating profits, and that in lean years it posts accounting profits. The 12 months ending Dec. 31, 1984, certainly underscores the statement.

In those few situations where operating results were better than anticipated, it was invariably due to a tax factor—specifically, the effect of last year's tax on life insurance subsidiary earnings (where applicable) or the restoration of the 46% tax credit.

Mr. Picoult

Almost without exception, fourth-quarter operating results and underwriting experience was worse than expected and, in all too many instances, adjustments to reserve coffers was, at best, minimal. Ultimately, this deficiency will have to be addressed.

There is no question that rates in the bread and butter commercial arena have soared. The first round of rate increases posted in the second half of 1984 will be followed by even heftier levies this year.

The critical question is what will happen in 1986. By the end of the second or third quarters of this year, many companies will have secured rate relief to such an extent that they will be approaching or be very close to rate sufficiency on present writings—at least this is what managements are implying. Logic says that capacity constraints and the need to significantly reduce underwriting losses will dictate a prudent pricing approach.

We are beginning to see underwriters come to market for capital. A bull would argue that this is the correct time to raise capital to take advantage of market opportunities and buttress balance sheets.

The bears would argue that an offering implies that, at the margin, property/casualty underwriters can now make or will shortly be in a position to make some money. Hence, price competition is just around the corner.

There is nothing wrong with companies seeking to expand their capital base as long as the funds are used intelligently. The recent past underscores the inability of the industry to act prudently. Hopefully, prudence will outweigh greed this time around. However, it is going to be interesting to see how the companies that rank low on the marketing scale compensate for their deficiency.

Our data base includes 17 of the major publicly held property/casualty insurers and accounts for about 42% of the total premium volume of the stock segment of the industry. The data is complete except for results for The Home Insurance Co. For the 1984 fourth quarter, our survey of these underwriters revealed the following:

- Net written premiums, on average, rose 11.2%. However, excluding Kemper Group, because of a pooling change effective in July 1984, the average gain jumped to 13.4%. These increments were materially better than the figures posted for the first three quarters of 1984.

Nine companies were above the average and seven were below. All of those above the average recorded gains in excess of 14%. Only Kemper and Crum & Forster had declines in premium volume. The sharpest gain—28.4%—was posted by Chubb Corp.

- Pretax net investment income expanded 10.2%. Although better than the second- and third-quarter increments, it was still below the first-quarter gain of 10.4%. Nine companies were above the average and seven were below. On an aftertax basis, the increment was flattish, reflecting movement into taxables. Cash-flow trends were mixed, with some better and some worse. On a pretax basis, only Fireman's Fund Insurance Cos. and Travelers Corp. recorded declines for the period.

- The aggregate combined ratio, after policyholder dividends, equaled 123.3%, compared to 117.2% in the 1983 fourth quarter. All of the deterioration was in the loss ratio, despite more favorable weather-related experience. The improvement in the expense ratio reflected the growth in written volume and, to some extent, previous cost-cutting measures.

Seven underwriters were above average and nine were below. Only GEICO Corp. came in below 100%. The award for the highest ratio went to American General Corp., but it was a fairly close race.

As an interesting sidelight, for the year, only one company was able to record an improvement in its combined ratio. Continental Corp. was 0.9% better.

- Loss reserves, on average, expanded 11.8%. This was the best quarterly showing of the year. For the full year, reserve growth outpaced written premium growth. Some companies began to address their reserve inadequacies in the fourth quarter. However, the gap remains astoundingly wide for all too many players.

- Premium-to-surplus and reserve-to-surplus ratios deteriorated for most carriers. The relationships would have been far worse had it not been for some "fancy footwork" in shifting funds around.

- Finally, property/casualty operating earnings were down 26.5% in the quarter, while consolidated results slipped a more modest 8%. We were unable to ascertain the quality of the casualty earnings. The scales do not go low enough!

HealthAmerica to join NYSE

HealthAmerica Corp. of Nashville, Tenn., has formally filed an application for listing of its common shares on the New York Stock Exchange. The corporation anticipates approval of its application and that trading of its shares on the exchange probably would begin in mid-April.

A&A debt rating

Moody's Investors Services Inc. has lowered its commercial paper rating for Alexander & Alexander Services Inc. to Not Prime from Prime-3.

According to Moody's, uncertainty over the proper valuation of tangible and intangible assets as a result of A&A's 1981 acquisition of Alexander Howden Group P.L.C. has adversely affected A&A's earnings and "weakened the company's financial structure to the extent that Moody's no longer considers it investment grade," according to Moody's Bond Survey. About $9 million of outstanding commercial paper is affected by the change.

Torchmark stock offered

Torchmark Corp. is making a public offering of 1 million common shares at $42.75 per share. Morgan Stanley & Co. Inc. and First Boston Corp. are the underwriters.

These securities represent a portion of the shares Torchmark acquired from American General Corp. on Nov. 1, 1984, which have been held by the company as treasury stock since that time. The net proceeds from the sale will be used to retire part of the indebtedness incurred in connection with the transaction with American General.

Sedgwick results up

Sedgwick Group P.L.C., Britain's largest Lloyd's of London broker, reported that its operating income rose 7.1% to 85.8 million pounds ($100.4 million) in 1984, from 80.1 million pounds ($93.7 million) in 1983.

An exceptional charge of 7.2 million pounds ($8.4 million) from unspecified underwriting activities did affect results, noted Sedgwick Chairman Carel Mosselmans. "But, the change does not detract from the underlying growth in the group's operating profit," he said.

Crump Cos. dividend

The Crump Cos. Inc. of Memphis, Tenn., has declared a quarterly dividend of 11 cents per share, payable April 12 to stockholders of record March 29.

Combined dividend

Chicago-based Combined International Corp. has declared an increase in the quarterly cash dividend to 54 from 52 cents per common share, payable May 20 to stockholders of record April 30.

Lincoln National dividend

Lincoln National Corp. of Fort Wayne, Ind., has declared a quarterly cash dividend of 46 cents per share on the corporation's common stock and a 75 cents per share quarterly cash dividend on preferred shares.

The dividend on Lincoln National Corp.'s common shares will be payable May 1 to shareholders of record on April 10. The dividend on its $3 cumulative covertible preferred shares, series A, will be payable June 5 to shareholders of record May 15. ■

BI Industry Stock Report

March 26, 1985 3/20/85 thru 3/26/85

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	30.63	2.5	340.3	1.00	3.3	30.63	29.63	525.1
Baldwin & Lyons Inc	OTC	53.00	-1.9	11.3	0.80	1.5	54.00	53.00	8.7
Corroon & Black Corp	NYSE	42.25	0.6	33.3	1.00	2.4	43.00	42.13	193.2
Crump E H Cos Inc	OTC	25.88	-0.5	21.7	0.44	1.7	26.25	25.88	47.3
Emett & Chandler Cos Inc	OTC	15.00	1.7	0.0	0.00	0.0	15.00	14.75	0.1
Gallagher Arthur J & Co	OTC	37.00	-2.0	23.3	0.28	0.8	37.50	37.00	7.3
Hall Frank B & Co Inc	NYSE	22.75	-12.9	0.0	1.00	4.4	25.25	22.75	350.0
Marsh & Mclennan Cos Inc	NYSE	61.75	-1.8	38.1	2.40	3.9	62.50	61.75	258.5
Poe & Assoc Inc	OTC	8.25	0.0	0.0	0.00	0.0	8.25	8.25	3.0
Reed Stenhouse Cos Ltd	OTC	23.00	-7.1	32.9	0.60	2.6	24.63	23.00	297.7
AGENTS/BROKERS	AVERAGE			37.3		2.4			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	42.13	0.3	15.1	1.28	3.0	43.13	41.25	3,430.9
Anderson Clayton(Ranger/PanAm)	NYSE	41.00	5.1	21.1	1.32	3.2	41.75*	39.50	184.1
Armco Inc	NYSE	9.25	-2.6	0.0	0.00	0.0	9.75	9.25	267.8
Berkley W R Corp	OTC	15.13	-0.8	0.0	0.32	2.1	15.13	14.88*	100.4
CIGNA Corp	NYSE	48.13	-1.0	437.5	2.60	5.4	48.13	47.75	586.7
City Investing Co. (Home Ins.)	NYSE	37.00	-3.6	8.9	0.00	0.0	38.25	37.00	2,081.8
CNA Finl Corp (CNA)	NYSE	37.75	2.7	15.7	0.00	0.0	37.75	36.88	96.9
General Re Corp	NYSE	74.00	1.7	46.2	1.56	2.1	74.25	73.50	527.2
ITT (Hartford Grcup)	NYSE	34.13	7.1	11.5	1.00	2.9	35.38	33.50	7,684.5
Optimum Hldg Corp	OTC	0.50	0.0	0.0	0.00	0.0	0.50	0.50	1.0
Sears Roebuck & Co. (Allstate)	NYSE	34.75	-0.4	8.7	1.76	5.1	34.88	34.50	1,800.8
Teledyne Inc (Argonaut)	NYSE	252.50	-1.3	13.8	0.00	0.0	253.13	251.00	207.0
Transamerica Corp (Occidental & Fred S. James)	NYSE	28.75	-0.9	12.4	1.64	5.7	28.88	28.50	382.8
CONGLOMERATES/HOLDING COS.	AVERAGE			20.5		1.8			
Insurers									
Aetna Life & Cas Co	NYSE	40.50	1.2	25.5	2.64	6.5	40.50	39.88	653.7
American General Corp	NYSE	28.38	1.3	9.5	1.00	3.5	28.38	27.75	914.1
Amern Heritage Life Invt Co	NYSE	31.13	-1.2	9.3	1.08	3.5	31.50	31.13	1.7
American Indty Finl Corp	OTC	17.50	-1.4	0.0	1.12	6.4	17.75	17.50	3.9
American Intl Group Inc	NYSE	71.50	2.5	16.7	0.44	0.6	72.00	69.88	669.6
Aneco Reins Ltd	OTC	1.50	0.0	0.0	0.00	0.0	1.50	1.50	0.0
Avemco Corp	NYSE	24.50	-3.0	11.9	0.60	2.4	25.25	24.38	8.9
Bitco Corp	OTC	13.50	0.0	0.0	0.40	3.0	0.00	0.00	0.0
Business Mens Assurn Co Amer	OTC	55.50	2.3	7.0	2.08	3.7	56.00*	54.50	25.8
Chubb Corp	NYSE	56.75	-2.2	16.1	2.20	3.9	59.00	56.75	68.1
Combined Intl Corp	NYSE	42.50	-0.3	8.6	2.16	5.1	43.63	42.38	166.5
Continental Corp	NYSE	39.50	-4.0	20.5	2.60	6.6	41.25	39.50	783.7
Crown Life Ins Co	OTC	130.00	8.3	13.5	5.00	3.8	130.00	120.00	0.6
Durham Corp	OTC	39.75	-0.6	7.7	1.28	3.2	40.00	39.75	12.8
Farmers Group Inc	OTC	55.38	-1.3	10.1	1.76	3.2	56.25	55.25	257.4
Fremont Gen Corp	OTC	27.00	5.4	0.0	0.48	1.8	27.00*	25.63	505.1
Great West Life Assurn Co	OTC	350.00	0.0	9.4	14.00	4.0	350.00	350.00	0.0
Hanover Ins Co	OTC	35.50	-0.7	32.9	0.56	1.6	35.88	35.50	7.2
Hartford Steam Boiler Insptn	OTC	77.50	0.6	69.2	3.00	3.9	79.00*	76.50	26.0
Kans City Life Ins	OTC	83.00	0.0	9.5	2.88	3.5	83.00	83.00	3.7
Kemper Corp	OTC	50.25	-0.5	29.2	1.80	3.6	50.50	50.25	56.9
Liberty Corp S C	NYSE	32.00	2.4	15.4	0.72	2.3	32.25*	31.75	67.2
Lincoln Natl Corp Ind	NYSE	40.75	-3.0	10.7	1.84	4.5	42.25	40.75	404.1
Mission Ins Group Inc	NYSE	7.38	-4.8	0.0	0.50	6.8	7.38	7.25	174.7
Monumental Corp	OTC	30.38	1.2	12.7	1.30	4.3	30.38	30.00	42.5
Northwestern Natl Life Ins	OTC	35.63	-0.3	8.3	0.80	2.2	36.25*	35.50	454.8
Ohio Cas Corp	OTC	51.25	0.0	19.3	2.80	5.5	51.25	51.13	211.4
Old Rep Intl Corp	OTC	34.75	-0.7	6.7	0.88	2.5	35.00	34.75	46.2
Orion Cap Corp	NYSE	24.38	1.6	0.0	0.76	3.1	24.75	23.88	78.0
Protective Corp	OTC	21.75	1.2	7.4	0.62	2.9	21.75	21.13	186.9
Provident Life & Acc Ins Co	OTC	97.00	0.0	7.0	3.38	3.5	98.00	97.00	15.1
St Paul Cos Inc	OTC	57.00	0.9	0.0	3.00	5.3	57.00	56.13	162.9
SAFECO Corp	OTC	35.63	2.5	11.7	1.50	4.2	35.63	34.38	169.1
Sri Corp	OTC	17.38	-0.7	29.4	0.68	3.9	17.75	17.38	192.1
Seibels Bruce Group Inc	OTC	23.25	-4.1	0.0	0.80	3.4	23.50	23.00	70.6
Statesman Group Inc	OTC	6.00	-7.7	9.0	0.15	2.5	6.25	6.00	30.4
Tokio Marine & Fire Ins Co	OTC	170.50	-2.8	29.5	1.05	0.6	174.50	170.50	10.4
Torchmark Corp	NYSE	42.13	0.9	10.0	1.00	2.4	42.13	41.75	168.0
Travelers Corp	NYSE	42.13	2.1	10.2	2.04	4.8	42.50	41.25	855.6
United Fire & Cas Co	OTC	24.00	0.0	0.0	0.80	3.3	25.00	24.00	1.4
United States Fid & Gty Co	NYSE	30.38	-3.6	17.7	2.20	7.2	31.63	30.38	968.7
Uslife Corp	NYSE	40.13	0.0	9.2	1.04	2.6	40.25	39.63	275.2
Washington Natl Corp	NYSE	25.75	-6.8	8.0	1.08	4.2	27.50	25.75	70.3
Zenith Natl Ins Corp	OTC	12.00	-5.9	21.8	0.68	5.7	12.75	12.00	25.6
INSURANCE COMPANIES	AVERAGE			16.0		3.5			

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