IN '85 STRIVE FOR EXCELLENCE

RIMS conference benefit report . . Page 3

APRIL 22, 1985

business insurance®

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update

State judge stays lawsuit filed by Shell against insurers

REDWOOD CITY, Calif.—A state court judge has stayed a lawsuit filed by Shell Oil Co. against more than 200 of its liability insurers over who will pay what could amount to billions of dollars in cleanup costs at two hazardous waste dumping sites.

Judge William Lanam of the Superior Court for the County of San Mateo, Calif., ruled last week that Bermuda-based Oil Insurance Co. Ltd.

Continued on next page

Manville withdrawal won't hurt claims facility, supporters say

By STEPHEN TARNOFF

DENVER—Manville Corp.'s announcement that it will not sign an agreement establishing an industrywide asbestos claims facility by a May 29 deadline will not affect the facility's operations, its supporters say.

Proponents of the so-called Wellington agreement maintain they were aware that Manville could not sign by the May 29 deadline because of the slow progress in the company's bankruptcy proceedings.

They also note they have already extended the deadline for asbestos producers, like Manville, that are currently in reorganization.

However, some observers suggest that Manville's decision is a setback for both the facility and for efforts to negotiate a consensual plan for Manville's reorganization.

Manville, which was the world's largest asbestos producer, filed for reorganization under Chapter 11 of the Federal Bankruptcy Act in August 1982 because of the overwhelming number of asbestos injury claims it faced.

Last October, Manville conditionally signed the Wellington agreement. Manville's decision was hailed at the time by many observers as an important breakthrough in the formation of an asbestos claims facility (*BI*, Oct. 22, 1984).

The Wellington agreement, named for Yale Law School Dean Harry H. Wellington, would establish an out-of-court mechanism to fairly and efficiently settle bodily injury claims related to asbestos litigation.

The agreement would also resolve virtually all coverage disputes between asbestos producers and insurers over who will pay for asbestos-related bodily injury claims.

In late February, proponents of the facility said enough producers and insurers had conditionally joined the facility and set May 29 as a final sign-up date (*BI*, Feb. 25, 1985).

On April 11, however, Manville announced that it is "unlikely"

Continued on page 43

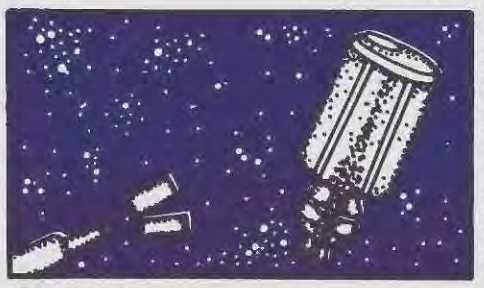
Satellite loss staggers already-reeling market

By STACY SHAPIRO

LONDON—The loss last week of Hughes Aircraft Co.'s $85 million Syncom satellite—the fourth probe lost in the last 14 months—could drastically affect the capacity of the satellite launch insurance market, observers say.

The loss may force additional insurers out of the market, satellite insurers and brokers say.

Some suggest that satellite owners may have to begin self-insuring their launch risks, which could force smaller companies to abandon the satellite business.



Graphic: Amy Palmer

Including the Syncom loss, satellite launch insurers have been hit with $367 million in claims in a little more than a year.

The cost of launch insurance could also increase from the current rate of 15% to 20% of the insured value of the satellite. A little more than a year ago, launch insurance cost only 6% of insured value.

"But if insurance rates went up to say 33%, it wouldn't be insurance anymore," said Brian Stockwell, president of Corroon & Black Inspace Inc.

Market observers agree that some underwriters will still be willing to write satellite risks, despite last week's loss.

"The leaders will probably stay and they will not disappear. . .the question is how many following underwriters will stay in the market," said Gerald Frick, managing director at Marsh & McLennan Inc. in New York, Hughes' broker.

"The biggest problem that I see is capacity. Rates may go up and self-insurance may be more of an element in launch insurance. . . .But if capacity disappears, there may be some (satellite) programs that cannot go forward because their financing depends on the insurance they can buy. It would be serious to the commercialization of space."

"I have no doubt there will be a shock," said Stephen Merrett, chairman of Merrett Syndicates Ltd. at Lloyd's of London and one of the lead underwriters on the Syncom risk.

"It will cause a number of people to believe that it isn't worth trying to keep up. We, too, will have to reassess the situation," he said.

"It is unfortunate that it's happened so early in the new year after the problems of 1984," said James W. Barrett, president of International Technology Underwriters Inc. in Washington, the lead U.S. market on the risk.

"A lot of people will be scratching their heads and saying, 'I'm in trouble. Why should I stay in this (line of insurance)?'"

The Syncom probe was rendered useless last week after its rocket engine failed to fire after deployment from the space shuttle.

Continued on page 40

Injunction limits buyers' ability to switch brokers

By JUDY GREENWALD

BOSTON—A preliminary injunction issued in a court battle between the Massachusetts offices of two major insurance brokerages limits the ability of some commercial insurance buyers to change brokers.

The injunction, which bars Rollins Burdick Hunter of Massachusetts Inc. from handling accounts of some current and former clients of Alexander & Alexander Inc.'s Massachusetts subsidiary, was issued by a Massachusetts Superior Court after A&A sued RBH.

The suit alleges that two current RBH employees had violated non-competitive agreements they signed with A&A by luring former A&A clients to RBH.

The injunction bars RBH from soliciting business from some current and past A&A clients. The injunction applies not only to A&A of Massachusetts' clients whose business was handled by the two employees, but also to A&A clients whose business was handled by other account executives.

Two Boston-area companies that wanted to shift their accounts to RBH originally had been unable to do so because of the injunction, although the court has since given both companies permission to move their business.

The broad scope of the injunction has raised the concern of the Risk & Insurance Management Society.

'We're not chattel. . . .Our concern is simply that we should have ready access to the brokerage house we want,' says Mr. Harkavy of RIMS.

"We're not chattel. We're not the property of any brokerage. Our concern is simply that we should have ready access to the brokerage house we want," says Jon Harkavy, RIMS' director of governmental affairs and general counsel.

"RIMS is concerned about the way the litigation has been going from the perspective of how it affects commercial buyers of insurance," he says. "It limits the buyer's right to go to the broker of his or her choice."

Sparking the battle between the brokerages are non-competitive agreements signed by two current RBH employees: Robert F. Danahy, former senior vp of A&A in Massachusetts, and Kevin M. Daly, a former employee of OBrion, Russell & Co., which has been acquired by A&A. Mr. Danahy is now president of RBH's Massachusetts office; Mr. Daly is an RBH account executive.

A&A is accusing Mr. Danahy, Mr. Daly and RBH of violating the non-competitive agreements and is seeking permanent injunctions that would extend the temporary injunction until 1988, as well as double or triple damages and court costs.

A&A won the first round of the court battle in December, when Massachusetts Supe-

Continued on page 44

Insurer sues to void D&O coverage of company facing shareholder suit
Page 2

Weigh pros and cons when selecting a risk management information system
Page 27

NEWSPAPER

update

Shell lawsuit is stayed

Continued from previous page
(OIL), a petroleum industry mutual insurance company, must be brought into the suit—or arbitration proceedings between Shell and OIL must take place in London—before the litigation can proceed.

In October 1983, Shell brought a declaratory judgment suit against some 270 primary and excess insurers that had written its liability coverage since 1947, contending they should pay part of the bill.

Shell sued all of its insurers with the exception of OIL, which is owned by Shell and a number of other oil companies.

Various insurers then cross-complained against OIL for indemnity and contribution, contending that OIL should be held liable along with Shell's other insurers, said Barry Bunshoft, an attorney for underwriters at Lloyd's of London and other London underwriters named in the litigation.

OIL said in papers filed with the state court that it did not fall under the California court's jurisdiction. OIL also argued that its contract with Shell included an arbitration clause that stipulated that any complaints against it by Shell must be resolved in London-based arbitration proceedings.

Mr. Bunshoft, with the San Francisco firm Hancock, Rothert & Bunshoft, said that no arbitration proceedings between Shell and OIL have taken place. "There is no arbitration. There never has been," he said.

At stake are billions of dollars the government wants paid to clean up sites at Rocky Mountain Arsenal outside of Denver and in McColl, Calif.

Two recent studies estimate the bill to clean up the Rocky Mountain site alone at $500 million and $1 billion, respectively.

The federal government has sued Shell for $1.8 billion for pollution allegedly caused by Shell at the Rocky Mountain site. In addition, the state of Colorado has filed a separate lawsuit against Shell.

From the insurance industry's standpoint, the Shell case is the most important toxic waste cleanup case because "of the dollars involved, the factual situation and the way the coverage is written," said Robert Zeavin, an attorney for insurers in the case with the Los Angeles firm of Buchalter, Nemer, Fields, Chrystie & Younger.

"Shell has received the order and is considering it," said Shell attorney William Boyd, with the San Francisco law firm of Brobeck Phleger & Harrison. He declined further comment.

Merrett syndicates show loss

LONDON—Merrett Syndicates Ltd. said last week that Lloyd's of London's largest marine syndicate and a companion syndicate will report 12 million to 17 million pounds ($15.4 million to $21.8 million) in losses for the 1982 underwriting year. A Merrett-managed non-marine syndicate will also report losses of 4.25 million pounds to 5.6 million pounds ($5.4 million to $7.2 million) for 1982.

Lloyd's syndicates are just now releasing 1982 results under the market's three-year accounting system.

The losses were attributed to runoff reinsurance written for other Lloyd's syndicates and insurers prior to 1976, said Stephen Merrett, chairman of Merrett Syndicates. The reinsurance was unprofitable because of asbestos- and pollution-related losses, he said.

The 3,000 members of marine syndicates 418/417 will be asked to pay from 7,500 to 10,000 pounds ($9,600 to $12,800) for every 50,000 pounds ($64,000) in premium underwritten by the members to cover the losses. The 280 members of non-marine syndicate 421 will pay from 15,000 to 20,000 pounds ($19,200 to $25,600) for every 10,000 pounds in premium underwritten.

Midland reduces underwriting

NEW YORK—Midland Insurance Co. has stopped writing association and excess liability business, Chairman Miles S. Chenault says.

Mr. Chenault said the company decided to drop the business because its surplus fell last year to $23 million from $58 million and could no longer support the additional volume.

The association and excess business accounted for about half of Midland's $75 million in net premiums last year, he said. About $25 million was generated by excess liability lines alone.

Midland, which specializes in federal and state workers compensation, continues to write other new business, says Mr. Chenault.

Mr. Chenault said that Midland's decision to drop its excess liability business has had a severe impact on Capacity Managers International, an affiliated firm that had been Midland's managing general agency on its excess liability business. About half of CMI's business was placed with Midland, said Mr. Chenault.

Former M&M head joins BMF

NEW YORK—Bruce W. Schnitzer, who resigned as president of Marsh & McLennan Inc. in February, has joined Bayly, Martin & Fay International Inc. as chairman of its executive committee.

Mr. Schnitzer said he will explore opportunities in the financial

Continued on page 43

index

Classifieds	42
Datebook	18
Insurance services guide	44
Letters	6
Opinions	6
Perspectives	27
Spotlight report	3
Ticker	45

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Insurer sues to void D&O cover of firm facing shareholder suit

By STEVE TARAVELLA

SAN DIEGO—Federal Insurance Co. is suing to void a directors and officers liability insurance policy it wrote for Oak Industries Inc. that would respond to a shareholder suit pending against Oak.

Federal, a Chubb Corp. affiliate, says it agreed to underwrite the three-year policy, which was issued in July 1982, based largely on information provided by Oak officials. But, the insurer contends, it would not have written the coverage had it known of Oak's ailing financial condition, or it would have charged a "substantially higher premium" for the coverage.

The Warren, N.J.-based insurer filed suit to void the policy earlier this month in U.S. District Court in San Diego. If the court does not void the policy altogether, Federal is asking that the policy be rewritten to exclude coverage against any statements or actions of Oak officials from at least January 1982 through October 1982.

That would effectively remove Federal from liability in a class-action shareholder suit pending against Oak and eight Oak directors or officers charged with fraud, deceit, negligence and various securities violations.

According to an attorney involved in the class-action litigation who asked that his name not be used, parties in the case are discussing a $53 million settlement of the class-action litigation.

The D&O coverage written by Federal for Oak had limits of $50 million, according to sources familiar with the coverage.

Neither Oak nor Federal will discuss policy terms and concitions, which Federal does not spell out in its suit. They also would not comment on the reports of a proposed settlement in the shareholder litigation.

Marsh & McLennan Cos. Inc. placed the coverage. Otto P. Jaehn, an assistant vp with M&M in San Diego who handles Oak's account, declined to comment.

Federal's law firm, Wilson, Elser, Moskowitz, Edelman & Dicker in Los Angeles, also would not comment on the litigation.

Oak, based in Rancho Bernardo, Calif., is a manufacturer of communications equipment used in satellite and cable television systems and also markets over-the-air subscription television services.

Oak asked Federal to respond to the class-action suit shortly after it was filed in March 1983, says Vincent Mercurio, Oak's director of treasury administration. But it was not until this month—on April 5—that Federal notified Oak of its intention to rescind coverage, he said.

Continued on page 45

More price hikes on horizon, British, U.S. insurers predict

By KATHRYN J. McINTYRE

CHICAGO—Insurance prices are going to climb even further next year, two commercial insurance underwriters agree.

And, one underwriter sees the momentum building among liability insurers for the claims-made form.

"The first wave of increases is the down payment," advised Donald E. Harder, vp of the national accounts department of CNA Insurance Cos. in Chicago. "You will see another wave in 1986," he added.

"If you think the market is tight now and expensive now, hang around for six to nine months," warned Robin A.G. Jackson, a director of Merrett Syndicates Ltd. at Lloyd's of London. And, "12 months from now you will consider this a comfortable environment."

Mr. Jackson also predicted reinsurers will force the adoption of the claims-made form.

Mr. Harder and Mr. Jackson spoke at the 1985 Harold H. Hines Jr. Memorial Symposium, sponsored by the Chicago Chapter of the Risk & Insurance Management Society and the Insurance School of Chicago.

Also speaking at the symposium was C. Arthur Williams Jr., professor of insurance and economics at the University of Minnesota.

The symposium was held in memory of Mr. Hines, who had served in the commercial insurance business for 30 years. At the time of his death last year, he was president and chief executive officer of Rollins Burdick Hunter Co., the retail brokerage subsidiary of Combined International Corp.

The increase in insurance prices that occurred at the end of 1984 and continued into 1985 is attributable to the increased price of reinsurance and the decision of primary insurers' to retain more of the risks they underwrite, Mr. Harder said.

In 1984, the insurance industry also began to question the adequacy of its loss reserves. It also suffered its largest underwriting loss since 1906, and investment income did not compensate for the underwriting losses.

As a result, the industry lost $5 billion in surplus.

The price of insurance had dropped far too low, Mr. Harder said, adding that "today's rates are those of 1978."

How much higher prices will go depends on what happens at the next renewal of reinsurance protection, he noted.

CNA's treaty reinsurance renews in July, said Mr. Harder, who added that he can't predict now how much reinsurers will raise prices or whether they will restrict coverage for pollution liability.

Continued on page 37

Firms' officers tried in death of employee

By CAROL CAIN

CHICAGO—Four corporate officials charged with murder in an employee's work-related death will contend during their trial that the fact they had insurance proves they operated a safe worksite.

The four officials and the two Chicago-area corporations for which they worked are on trial for murder and reckless homicide in the February 1983 death of a worker at one of the companies. The trial opened last week in the Cook County Circuit Court in Maywood, Ill.

The case is believed to be the first in U.S. history in which corporations and their officers have been charged with murder in a work-related death.

The now-defunct corporations, both located in the Chicago suburb of Elk Grove Village, Ill., are Film Recovery Systems Inc. and its marketing company, Metallic Marketing.

The case involves FRS employee Stefan Golab, 61, whose death allegedly was caused by cyanide poisoning. FRS extracted silver from used X-ray film chips in an open-vat, cyanide bath process. Mr. Golab had been

Continued on page 43

Four new syndicates join Illinois exchange

By CAROL CAIN

CHICAGO—"Our time has come," says James M. Skelton, executive director of the 3½-year-old Illinois Insurance Exchange in announcing the approval of four new exchange syndicates, all with roots outside Illinois.

The new additions, however, will not increase the number of syndicates on the exchange. Four of the exchange's current seven syndicates are no longer actively underwriting and have notified the board of directors they will withdraw, Mr. Skelton says.

Illinois Insurance Exchange

However, the four syndicates that plan to withdraw wrote only 6.9% of the exchange's 1984 volume.

The exchange's gross premium volume totaled $16 million in 1984, more than double the 1983 volume of $7.02 million, according to preliminary figures released by the exchange. However, the exchange's syndicates posted an aggregate net loss of almost $1.4 million in 1984, compared with 1983 year-end income of $106,884.

Despite the net loss, underwriting losses at the exchange decreased in 1984. The exchange reported a combined ratio of 135.6%, down from 161.2% in 1983.

James J. Ryan, the exchange's comptroller, attributed the improved underwriting results to the withdrawal of several syndicates that had posted 1983 combined ratios exceeding 150%.

The aggregate capitalization of the exchange at year-end 1984 was about $30.7 million, compared with $22.7 million in 1983.

Continued on page 39

RIMS/New Orleans

Control health costs through risk management

By LORRIE GIBSON

NEW ORLEANS—Benefit managers should use risk management techniques to assess their employers' health benefit risks and then design a loss-prevention program to reduce those risks, three experts advise.

However, because many employers are looking for a quick fix for their health benefit cost problems, this proactive approach to health care cost containment—which is still in its infant stage—may not be acceptable at many companies, they admit.

Despite this possibility, about a half dozen companies—including insurers and health care specialty companies—are offering new products to help employers identify high-risk employees and measure their "corporate health risk."

Employee health risk management involves evaluating the employer's risk exposure, identifying high-risk employees instituting a risk-control program and developing a financial plan to carry out the risk-control plan, said Dr. James E. Bernstein, president of General Health Inc. in Washington, a health care management firm.

Dr. Bernstein was one of three panelists who discussed "Employee Health Risk Management: Employee Benefit and Underwriting Tool" at the annual Risk & Insurance Management Society conference last week in New Orleans.

Other panelists speaking with Dr. Bernstein were Kevin P. McCarthy, second vp of group life/medical products for Union Mutual Life Insurance Co. in Portland, Maine, and William J. Thomas, president of Reinsurance Development Co. of America in Princeton, N.J.

The only data an employer has available for evaluating its health care risks are medical claims data and personnel records, Dr. Bernstein said. But, this data, if properly analyzed, will show the employer some of its health risks.

For example, raw claims data, when looked at as a whole, can show the employer what disease is costing the most in claims—or, in other words, what disease is its top health care risk.

This risk represents both the direct cost of illness and what Dr. Bernstein calls the "workforce cost" of illness.

The direct illness cost is money spent on hospitalization and physician care, prescriptions, ambulatory care, laboratory tests, home health care, rehabilitation and disability expenses, he explained.

And, the workforce costs are those that come from absenteeism, diminished production, the cost of training someone to replace an ill or deceased employee and the loss of "corporate memory" when a key employee's experience is lost due to illness.

Together, the illness costs plus the workforce costs equal the corporate health risk.

To move toward controlling this risk, employers need to identify their high-risk employees, Dr. Bernstein explained.

This is done by distributing a questionnaire to all employees that asks them various questions about their lifestyle and medical history. From these questionnaires, a health care profile of each employee is developed. The profile

Continued on page 12

Photo: New Orleans Tourist & Convention Commission

Those attending the Risk & Insurance Management Society conference in New Orleans could visit St. Louis Cathedral, located in the city's historic French Quarter.

Learn to purchase health care 'effectively'

Photo: New Orleans Tourist & Convention Commission

Jackson Square in the French Quarter offered diversion to RIMS participants.

By KATHRYN J. McINTYRE

NEW ORLEANS—Employers that self-fund group health plans need services to manage health care utilization and health care claims—not just claims payment—at the cheapest price.

That's the advice of an insurance company executive, a claims administrator and a corporate internal employee benefits consultant who spoke during a seminar on claims administration at the annual Risk & Insurance Management Society conference last week in New Orleans.

An insurance company, however, is not the only source—or even necessarily the least-expensive provider—of all the needed services, advised a benefit consultant on the panel.

The speakers had been asked to comment on "New Employee Benefits Funding Method—Can Limited Administration Services Only Stop Movement to Third-Party Administrators?"

But, all of the speakers addressed more than just insurers' willingness to unbundle their claims services to clients in direct competition with third-party administrators.

They all agreed that if employers want to control their health costs, simply paying the bills is not enough.

When choosing a claims administrator, employers should select one that will make them "effective and proactive purchasers of health care," advised John D. Moynahan, senior vp of group life and health operations at Metropolitan Life Insurance Co. in New York.

This criterion is a departure from the past, when employee benefit managers tried to control health care costs only by self-funding and squeezing every penny out of administration charges for fast claims service, he emphasized.

Besides this criterion, benefit managers also have recently placed emphasis on plan design and benefit level changes to control health care plan costs, he said.

While "real gains" were made in controlling health plan costs when employee deductibles, coinsurance and premium contributions were increased, more must be accomplished, he urged.

"Your management and your stockholders need more savings and cost control of the benefits dollars area," he advised.

"We must organize ourselves, train ourselves and equip ourselves to put pressure on sellers of health care to squeeze the fat out of the system," Mr. Moynahan said.

But, buying health care effectively is not easy, he added.

In order to "maximize your market power and leverage for the most efficient purchase of health care," an employer must seek a multitude of services, Mr. Moynahan said.

In addition to the ability to settle claims efficiently, Mr. Moynahan suggested that claims administrators include the following services:

- Coding and recording data.
- Reporting, analyzing and using data with the commitment to use the information to intervene on the employers' behalf with hospitals, clinics and physicians to improve their effi-

Continued on page 4

Health care plans

Continued from page 2

ciency.

- Identifying the efficient providers to negotiate economic concessions, including risk-taking by the providers through the adoption of capitation rates or billing using diagnostic-related groups.
- Setting up preferred provider organizations that represent employers, not hospitals or doctors.

And, a service provider that has these capabilities also must have "staying power," he said, because "efficiently purchasing health care is not a one-shot deal."

These value-added services will be priced competitively, he said, but buyers must be able to avoid "buzz-word merchants."

And, among the possible providers of these services are big insurers, Mr. Moynahan said. "There is a clear tendency among some large plan buyers and some consultants to presume that the sources of innovative expertise are not the stodgy insurers but boutiques."

He countered that there are some "boutiques" among large insurers.

But, a representative of a TPA said some insurers are tooling down claims services to be more price-competitive with TPAs, while TPAs are expanding services.

"Do you want to cut costs by eliminating services?" asked Lowell N. Moore, general manager of medical claims for U.S. Administrators in Los Angeles.

Rather than buying reduced claims services, "I suggest that you buy more services," he advised, including hospital bill audits, pre-admission certification and second surgical opinions.

He advised benefit managers to study their claims administration services, list any questions and then make a surprise visit to the claims office with these questions. And, he advised benefit managers to list the basic services they will need.

Mr. Moore suggested TPAs have been able to take business from insurers because "as a rule, insurers are slow to respond to your needs."

TPAs, however, specialize their products to the client's problem, he said. And, it's more likely TPA clients will have more access to the senior management, he added.

General Electric Co. uses a combination of insurers, a TPA and its own staff to manage the claims filed against its health plan, reported John D. Morris, a consultant on payroll practices and insurance benefits at GE in Fairfield, Conn.

GE spent $460 million on its health care plan in 1984 and expects to spend $500 million this year for coverage for its 250,000 U.S. employees. The plan is "very rich," with small deductibles and copayments and a $1,000 annual cap on employee or family medical expenses.

The non-GE providers of claims service and management include: Blue Cross/Blue Shield of Massachusetts, Connecticut General Insurance Co., Metropolitan Insurance Cos. and U.S. Administrators.

Metropolitan was the first insurer of GE's group health plan, which was introduced in 1955.

The original conventional experience-rated plan was replaced with a miminum premium plan in 1967, at which time GE also began to pay some benefit claims directly.

And, in 1975, hospital coverage was switched to Blue Cross.

The following year, the company formed its own Voluntary Employee Beneficiary Assn. to fund almost all benefit plans.

Based on a recent study, GE selected several companies to administer its plan based on seven criteria, Mr. Morris said.

First, a company was judged on how long it had been in business and its past performance.

Second, GE reviewed each company's claims payment system, including a review of the equipment, the efficiency of claims flow and the handling of data.

Third, GE judged data analysis capability and reports.

Fourth, each company was asked to describe its strategy and resources for intervening with providers on behalf of GE.

Fifth, GE talked to customers of the contenders.

Cost was another criteria, and GE found that each service provider differed on what were fixed charges and what were variable.

The seventh criteria was "our perception of the claim payer's commitment to better manage health care costs while paying claims accurately and on a timely basis," Mr. Morris said.

He admitted using several service providers is "complicated and difficult to manage." But, each provider knows its performance will determine if it gets more GE business.

"The selection criteria for claims payers has changed," he said. "It used to be the payer who provided accurate and timely payment of claims at the lowest costs would get the order. Now, the claim payer with the best claim management package providing accurate and timely payment of claims is likely to get the order, even if the administration costs are not the lowest."

"Never has the buyer been in more control or had more options," said Peter B. O'Brien, senior vp and senior employee benefits coordinator at Alexander & Alexander of New York Inc.

All the services that an insurer will provide are also offered by independent companies, he noted.

And, there is a lot of money at stake in buying these services. For example, he cited a $25 million premium account consisting of $4 million in life premiums, $2 million in dental plan premiums and $19 million for the health plan that covers the 16,000 employees of a manufacturing company.

The health and dental coverage is written on a minimum premium basis. The typical insurer retention for such a plan, he said, would be $92,000 for state premium taxes, $100,000 for commissions and fees to brokers or consultants and $1.6 million for all other charges.

Assuming the employer calculated the cost of simply paying these claims, it could be projected at $683,000, arrived at by allocating $3,000 for space needs; $300,000 for 12 adjusters at annual salaries of $25,000 each; $15,000 for a microfilmer; $18,000 for a data entry clerk; $50,000 for a medical/dental professional; and $60,000 for one manager. Funds also were allocated for 15 IBM Personal Computers and a printer, maintenance and software and miscellaneous expenses.

Adding in the $92,000 in state premium taxes and the $100,000 in commissions and fees, the bare-bones claims payment cost comes to $875,000—a $1 million difference from the cost of contracting with the insurer, said Mr. O'Brien.

The $683,000 charge also is not out of line for only claims payment by a TPA, Mr. O'Brien said.

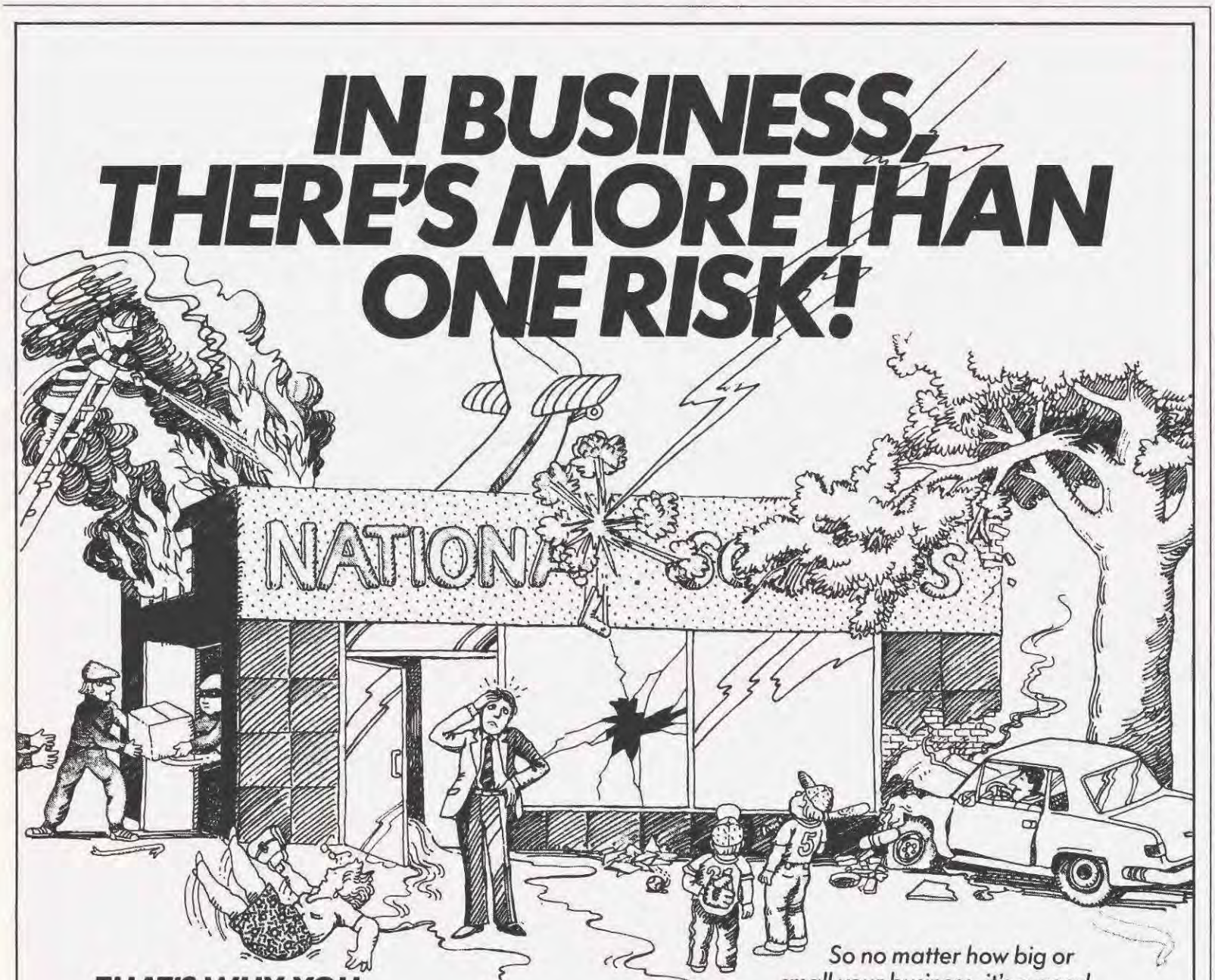
"This is in no way to criticize insurers," he said, because more services must be purchased than straight claims payment. "It's a question of having more than one choice."

That $1 million would be available to purchase from others specialized services, like advice on plan design changes, benefit communications, hospital audits, case management services, data analysis, health promotion, alternative delivery systems and legal advice.

For example, Mr. O'Brien has identified 60 firms offering utilization review services.

"The big buyer can bring home very cost-efficient services to its management," he said, if it selects from among the many providers.

The seminar moderator was Margaret M. Gagliardi, vp of benefits at American Express Co. ■



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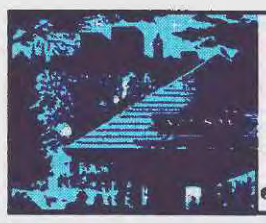

WAUSAU INSURANCE COMPANIES

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opinions

A quick answer is needed

THE QUESTION OF who should pay for the cleanup of many of the nation's hazardous-waste sites is one that cannot be answered quickly. Unfortunately, a quick answer is needed, since the federal Superfund Act must be reauthorized this year.

The current Superfund law established a $1.6 billion fund—financed by tax on oil and certain compounds used to make industrial chemicals—to pay for the cleanup of hazardous-waste sites. The government can then attempt to recover money expended from the fund from companies that contributed to the sites.

We fear that Congress, in passing a Superfund reauthorization act, may not correct flaws in the current law that have prompted courts to rule that companies cited under the Superfund statute are jointly and severally liable for cleaning up toxic-waste sites.

This means that a company may be held 100% responsible for cleaning up a site, even if that company only dumped a small amount of waste there.

Insurers this month testified before a Senate committee that joint and several liability threatens the insurance industry's solvency. But, Reagan administration officials testified that joint and several liability provides an "incentive" for companies to quickly settle when the government seeks compensation for cleaning up hazardous-waste sites under Superfund.

Although we agree the sites should be quickly cleaned up, we disagree with this unfair approach. It allows the government to go after any company with the ability to pay for the cleanup, without regard for the company's liability.

And, we agree with the insurance industry that a joint and several liability standard makes it impossible for the insurers to underwrite pollution risks, since an insurer ultimately would be responsible for the liability of companies that it never insured.

However, although we disagree with the view that joint and several liability should not be specifically eliminated, we cannot support the proposal drafted by property/casualty insurers that would eliminate all liability for toxic-waste dumping before 1981 (*BI*, April 15).

The insurers say they support the proposal because it would speed up cleanup activity, not because it would rid them of billions of dollars of potential liabilities.

Even if that premise could be accepted, there's one fatal flaw in the insurers' proposal: It doesn't specifically address who should pay for cleaning up sites created before December 1980, when the Superfund Act first passed. James L. Kimble, senior counsel for federal affairs with the American Insurance Assn., under whose auspices the proposal was drafted, suggests that a broad-based corporate tax would have to be levied to finance the proposal. In other words, everyone would pay as much for the cleanup of these sites as the parties that caused the problems.

One of the proposals in the insurers' plan does have considerable merit. Under that proposal, joint and several liability would be abolished for waste dumped after 1980. Instead, a mandatory apportionment system would be established, whereby a company's liability would be based on the quantity of waste it contributed to the site.

Of course, the government—and ultimately the taxpayers—would be responsible for the costs that cannot be recovered from companies that have gone out of business or otherwise cannot pay. But that's better than having taxpayers assume the full burden for cleaning up most of the sites, as the insurers propose.

And, the insurance industry would still have to cover their policyholders' share of the cleanup costs. But that's better than joint and several liability, where one company—and its insurers—must pay the entire cost of cleaning up a site polluted by many companies.

If the insurers would amend their proposal to apportion the cleanup cost of *all* hazardous-waste sites, perhaps Congress will listen.

letters

Treasury's 401(k) plan proposal unacceptable

To the editor: Your April 8 editorial suggested that "the proposal to reduce the amount that could be contributed to a 401(k) plan by the amount the employee contributes to a separate Individual Retirement Account is also tolerable."

To me, this proposal is totally unacceptable. Consider the employee who earns $25,000 per year and is limited to 401(k) contributions of 5% on a tax-deferred basis. His maximum 401(k), thus, amounts to $1,250.

If he is also participating in an Individual Retirement Account at $1,250 or higher annually, this proposal effectively eliminates him from participating in the 401(k) plan. The proposal has a negative impact on lower- and middle-income workers. (The same employee earning $50,000 would still be able to contribute an additional $500 to a 401(k).)

A more logical approach would be to require all employers to set a cap on 401(k) contributions (i.e. 5%-10% of annual gross compensation).

If this method is too much for the Treasury to digest, they could also consider installing, at the same time, a dollar cap similar to the IRA, though it would obviously impact the higher income workers.

Dave Heston
Branch Personnel Manager
Kemper Group
Mansfield, Ohio

Drug card plans may not always save money

To the editor: In his letter commenting on controlling drug costs, Donald B. Dahlin, president and chief operating officer of Pharmaceutical Card System Inc. (*BI*, March 11) rightly points out certain savings inherent in a drug card plan. He cites "drug pricing below wholesale cost, mail order, generic incentives. . ." etc.

Nevertheless, there are two inherent flaws when he claims "significant cost savings" over traditional major medical coverage. First, in today's economy, it is common for both husband and wife to work. If one spouse is a drug-card holder, the ready availability of the card encourages the other spouse to use it, thus converting coverage from secondary to primary.

Second, traditional major medical coverage requires the satisfaction of a deductible before any covered expense is payable. Thus, it is quite possible that drug charges are applied to the deductible so nothing is payable.

Therefore, it would be interesting to conduct a study to determine whether the purported advantages of a drug card are apparent or real.

Bernard G. Brody
Corporate Director
Samaritan Health Service
Phoenix, Ariz.

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Recent editorial displayed naivete

To the editor: The author of the editorial on the Wellington agreement (*BI*, April 1) allowed his or her (no male chauvinist am I, Shirley Brown) naivete to show in the ultimate sentence: "We hope attorneys' advice to asbestos disease victims they represent is better than the labor union's."

I am reasonably certain the members of the Assn. of Trial Lawyers of America broke up when they read that sentence.

G.B. Gammie
Senior Insurance Analyst
Baltimore Gas & Electric
Baltimore

Policyholders' needs should take priority

To the editor: An all-too-familiar refrain seemed to go through the Perspective article by Melvin Bradshaw defending the new CGL forms (*BI*, April 8) and unfortunately, most other industry pronouncements in recent times: a preoccupation with the mechanics and problems of their particular problem, with an almost universal dismissal of the one prime factor in this or any other industry—the customer.

If we continue to ignore the legitimate needs of the customer in the preoccupation with our own troubles, there will be no need to worry long, as we will be out of the business completely, supplanted by someone who pays attention to what the customer is saying.

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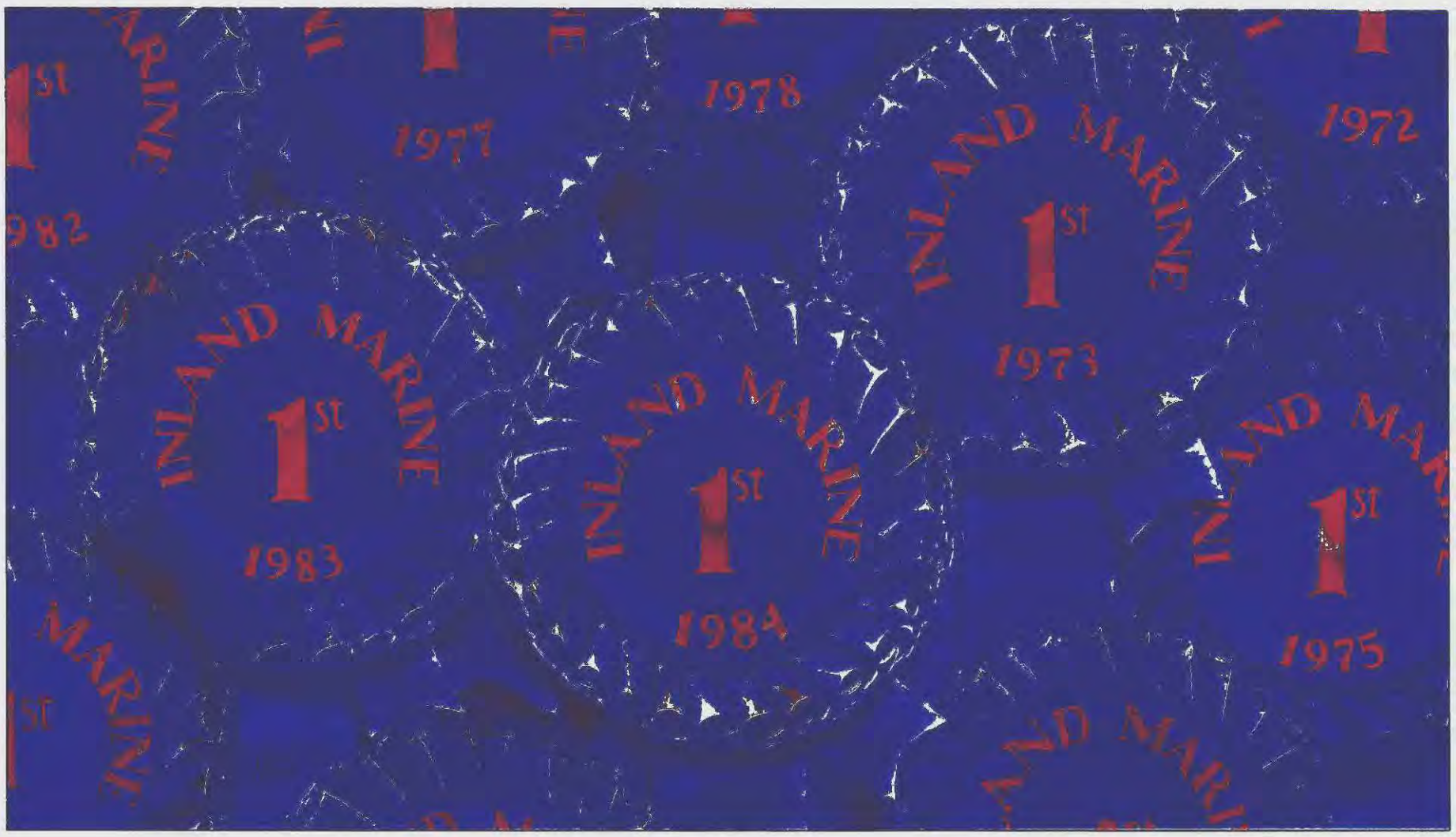

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Don't ease cost-containment efforts: Panel

By DIANE LYNN KASTIEL

NEW ORLEANS—Despite the apparent slowdown in health care inflation, consultants agree employers must continue to expand their cost-containment efforts.

"We should not be lulled into thinking we should stop because the medical inflation rate has slowed," said R. Craig Adams, senior vp at Frank B. Hall Consulting Co. in Hawthorne, N.Y.

"We should not sit back and wait to see what happens in the future."

Mr. Adams was part of a panel discussion on "The Next Step in Cost Management" at the annual Risk & Insurance Management Society conference.

The panelists noted that health costs continue to rise, although more slowly, and the battle between providers and payers rages on.

"The hospitals and doctors have to buckle down, and they won't do it without we, the buyers insisting that they do it," said Richard Citron a Hall executive vp and the panel's moderator. "The doctors and hospitals have been sitting on their hands for years because we've been paying them to sit on their hands. We have to stop being bill payers and start being intelligent purchasers of health care."

Employers should not believe the health care providers' longstanding argument that, "You get what you pay for, and health care is expensive," Mr. Citron said.

"Medicine is not an exact science," he said. "Different doctors require different services to get the same result with the same patient. It's judgment calls—not only by the doctors but by the patients as well.

"The people who are giving you the best services for the least amount of money are the ones you want. Conservative practice of medicine does not necessarily mean less quality," he said.

Judging the efficiency of providers is difficult, but possible, the panelists said.

One thing employers can do is ask employees for feedback on services offered by providers.

In particular, Mr. Citron said, employers should ask employees who left health maintenance organizations or preferred provider organizations why they did so.

Companies also can use medical consultants, usually former medical professionals, as "someone who can talk to the hospitals, can talk to the doctors and steer patients to those hospitals and doctors that are the most efficient," Mr. Citron said.

But, even when the most-efficient providers are identified he pointed out, "There's no guarantee that people will go to efficient providers just because you told them to. People need more prodding—they need financial prodding."

Mr. Adams agreed: "I think employers have a right and a responsibility to change their plans to force employees to use less-costly, more-efficient health care providers.

"And the employees, on the other hand, have a responsibility to use cost-effective services."

Mr. Adams said any type of fee-for-service reimbursement plan encourages waste. And, he said, first-dollar plans are the worst.

"They don't encourage employees to shop around for the best care at the cheapest price," he said.

He urged employers not to hesitate to shift costs to employees to teach them to be wise consumers.

"The surest and quickest way to reduce health care costs from an employer standpoint is to raise deductibles and increase copayments," he said.

"Cost-sharing helps people to think twice about using health care services that aren't absolutely necessary. It does not stop them from getting care when they need it, though. It has absolutely no adverse effects on the long-term health of these people," he said.

Other cost-containment measures he endorsed included:

- Mandatory second surgical opinion programs with strong monetary incentives.
- Programs that bar non-emergency weekend hospital admissions.
- Provisions for home health care, which reduces inpatient hospital bills. "I think every single medical plan should cover home health care. . . .It's a lot less costly, and most people prefer to be at home rather than in a hospital," Mr. Adams said.
- Pre-certification programs, which save money by screening admissions and also by predetermining the length of hospital stay.
- Individual case management programs, which are especially cost-effective in cases of catastrophic or terminal illness. "One large, complicated claim within some employers' health care plan can destroy them," Mr. Adams said.

However, Mr. Adams cautioned that "none of these will ever, ever work if you don't provide the employee with the information necessary to make informed choices."

Providing employees with information is important, but the way that information is communicated is just as important, said Deborah K. Huffman, senior vp at Hall. She said most employers take employees for granted in the health cost battle, expecting them to go along with cost shifting and cost containment because they have no choice.

"What's happened is an understandable backlash," she said.

Ms. Huffman recommended that employers take the following communication steps to stop the employee backlash:

- Build awareness of the health care cost problem well before increasing deductibles or copayments. "Don't tell employees about the problem of health care costs the same week you cost-shift."
- Don't give employees the impression that health care cost inflation is their fault. Instead, suggest it's a problem for which the company needs their cooperation.
- Use terms employees can understand. "Tell the salesman how many widgets he has to sell to pay for his health care," she said.
- Let employees know what other things the company is doing to lower health care costs.

"Employees have had lots of stuff to deal with in this health care crisis," she said. "You have to make people aware of the problems and what you're doing before you can expect them to take on any more."

Also on the panel was Stephen D. Smith, a partner at the accounting firm of Ernst & Whinney in San Francisco. ■

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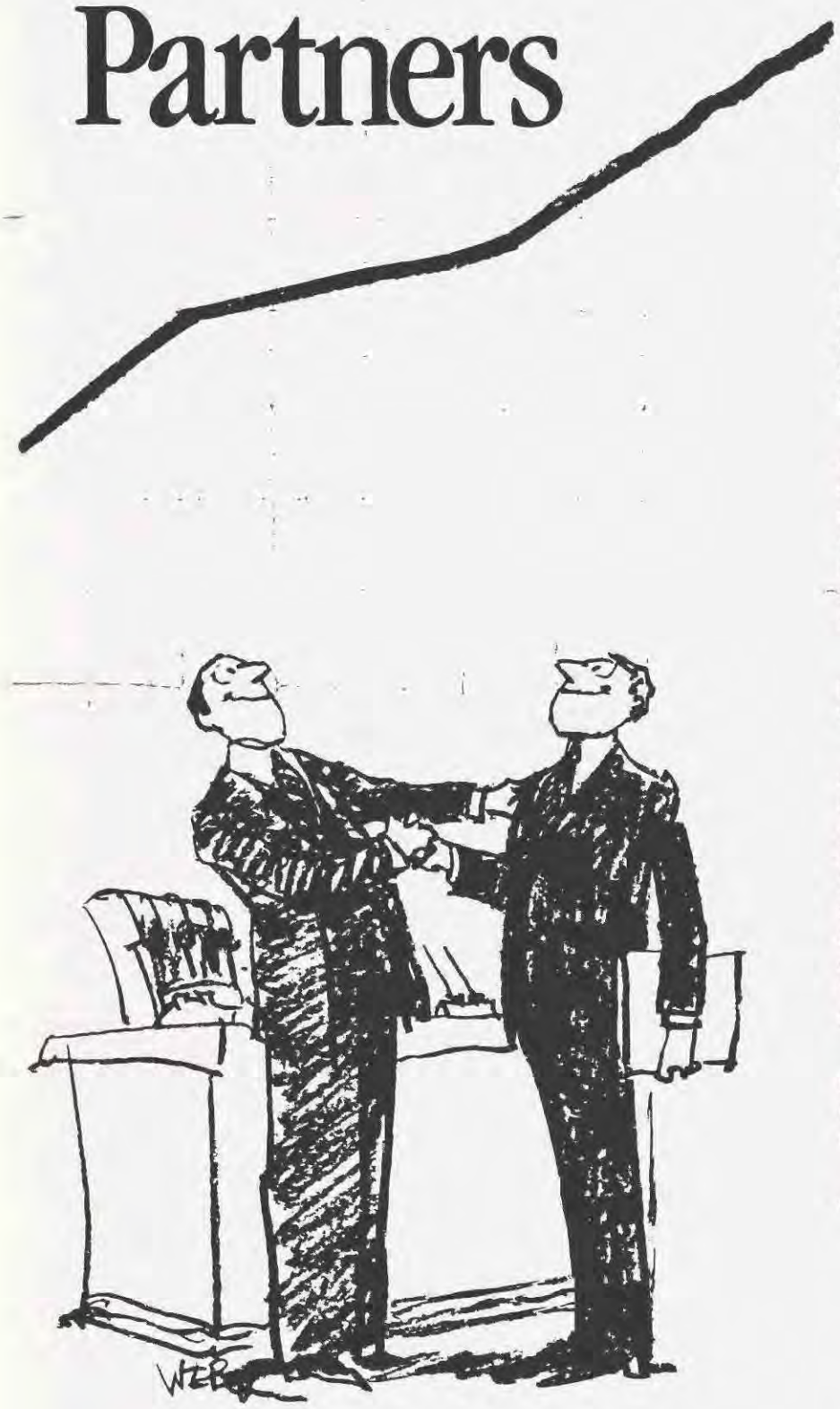

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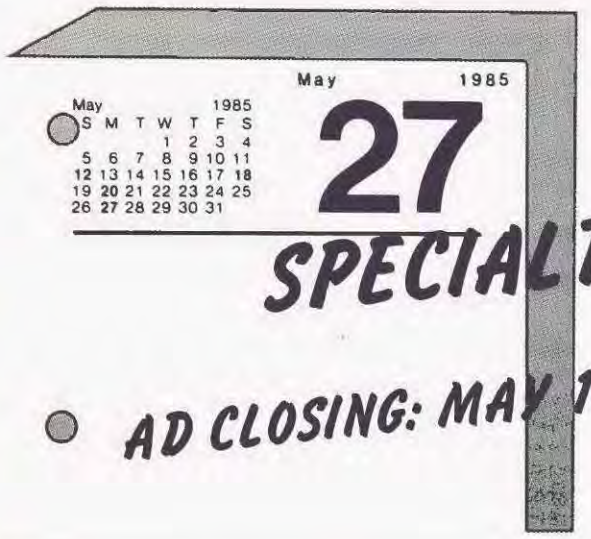

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Tailor health care program to area of country: Experts

By MICHAEL BRADFORD

NEW ORLEANS—Health care cost-containment programs that are successful in one part of the country may not work in another area, experts warn.

A panel of speakers at the Risk & Insurance Management Society conference last week agreed that health care plans should be tailored to the particular needs of each area of the country.

For example, David E. Barton, director of product planning for Resource Information Management Systems Inc. in Oak Brook, Ill., said a health care program for workers in Houston would have to be structured differently than one for Chicago-area employees.

"Houston has a lot of transient workers," Mr. Barton said. "A lot of them don't have family physicians, so (health maintenance organizations) and (preferred provider organizations) work well there."

He explained that many workers in Houston need help just in choosing a general practitioner.

But in Chicago, where the workforce is more stable and many people already have a family doctor, a different kind of program can be set up. For example, there are many specialists in Chicago, and a health plan might involve contracting with those specialists, like in a PPO arrangement, he said.

And, in smaller communities where there is a limited number of providers, health care plans must be designed around the services those providers offer, he said.

Cecil Byers, a partner with Jones, Hill & Mercer Insurance in Savannah, Ga., agreed that, "What works for one area may not work for another." Mr. Byers' company provides a pre-admission certification program called Health Management Services to a coalition of 19 businesses in Savannah.

One of the businesses using the program is Savannah Foods & Industries Inc. Lee Phillips, assistant vp of Savannah Foods and moderator of the panel discussion, explained, "Most of the employers in Savannah are self-insured and union-free. Self-insured firms have to be very conscious of cost management."

The panel suggested that employers' health plans include these cost-containment features:

- Pre-admission certification on elective admissions, which sometimes can determine less costly alternatives to hospitalization.
- Second opinions for non-emergency surgery. Mr. Barton said, "This adds cost to your plan, so savings may be limited. But, you will avoid some surgeries and procedures that might have been unnecessary."
- Monitoring the patient's hospital stay to make sure that no unnecessary tests or procedures are performed and that the patient is discharged at the proper time.
- Keeping in touch with the patient after surgery. This may mean just a follow-up phone call to the patient, or it may mean helping to structure a rehabilitation program.
- Less-costly care alternatives like home health care services, admission to a convalescent center or hospice care.
- Retrospective review programs, which check the medical necessity of procedures that have been performed and review the services of providers. Mr. Byers said that a retrospective review can monitor providers and add long-term savings.

"It doesn't produce a lot of savings but you find out who your most cost-conscious providers are," he said.

Mr. Phillips pointed out that a big challenge facing groups like the Savannah business coalition is to convince providers of the need to bring down health care costs.

"We have to convince the medical community that there has to be cost savings and not cost-shifting."

He said often when hospital costs drop in one area, hospital administrators charge more in other areas to make up the loss. ■

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Curbing illness cuts loss: Panel

Continued from page 3

includes a health risk estimation, which describes that employee's chances of developing a certain illness or dying in the next 10 years.

Looked at in the aggregate, this data shows the employer what percentage of its workforce is likely to develop a particular disease.

This information is compared with national norms so the employer can plot how many of its employees have a high risk of developing a specific disease, Dr. Bernstein said.

Using charts and graphs, he showed ways data could be analyzed and results plotted to identify a company's leading health risks.

In the end, if the data shows that 89% of the employer's workforce has a better-than-average chance of suffering a heart attack, action is necessary to control the losses this

illness is producing, he said.

Just as an employer would take steps to modify a piece of equipment that was repeatedly the cause of workplace accidents—and thus workers compensation claims—the employer must act to cut this major health care risk, he said.

While many benefit managers now take a reactive approach to controlling health care losses, Dr. Bernstein and the other panelists promote a proactive approach, which they say is integral to true health care risk management.

Instead of reacting to increasing medical claims by shifting more of the cost to employees or instituting second surgical opinion programs or utilization reviews, employers should be preventing these losses in the first place, Dr. Bernstein said.

"A proactive approach to controlling health care risks includes health promotion, medical screening and safety programs," he said. For example, an employer might institute a blood pressure screening program to cut the risk of strokes or an exercise program to help prevent cardiovascular problems.

This risk estimation process also lets an employer know what reduction of risk would be attainable if employees participated in a particular wellness program. For example, the health care profiles can show employees how many years they could add to their lives if they quit smoking or lost 20 pounds.

Viewing this type of information in the aggregate will allow an employer to set a goal. And, because the risk estimation process has shown the employer how much in medical costs was being lost because of a particular illness and what improvement in employee health could be expected if certain wellness steps were taken, the employer can project its maximum cost savings if its loss-control goal is met, Dr. Bernstein explained.

So, the cause of the employer's health care losses will be eliminated, instead of the cost merely being shifted to employees or otherwise controlled in a reactive way.

However, Dr. Bernstein and the other panels admit their approach may not gain wide acceptance because businesses may not be patient enough to wait for the results.

Health care risk management requires an initial investment on which no return may be seen for four years or so, Dr. Bernstein said. For example, the cost savings from a corporate exercise program will not be apparent until years down the road, when employees who otherwise may have had heart attacks do not because they have been exercising, he said.

"And at most corporations four years is too long to wait," so employers settle for making sure they have a program that guarantees they will pay the least possible amount when employees do get sick, he said.

Mr. McCarthy of Union Mutual said the insurer began to use personal health profiles in the early 1980s to gauge the risks of its policyholders' employees, but the program did not work out as well as had been hoped.

Like Dr. Bernstein, he said part of the problem was that employers wanted a quick fix.

But another problem is that the health care risk management process is based on personal health profiles of employees. And, if employees do not fill out the questionnaire, an employer's hands are tied.

He said Union Mutual distributed 110,000 health profiles as part of the coverage provided to its group insurance policyholders, but only 15,000 employees returned them. And, for the most part, the employees that did participate were the ones that already were conscious of their health care problems.

Although both the employers and Union Mutual had access only to the aggregate statistics generated from the employee questionnaires and not to the information on individual employees, many employees were afraid to divulge such information, he said.

Despite these initial setbacks, Union Mutual is developing several new health care risk management products that will be introduced this year, he said. ■

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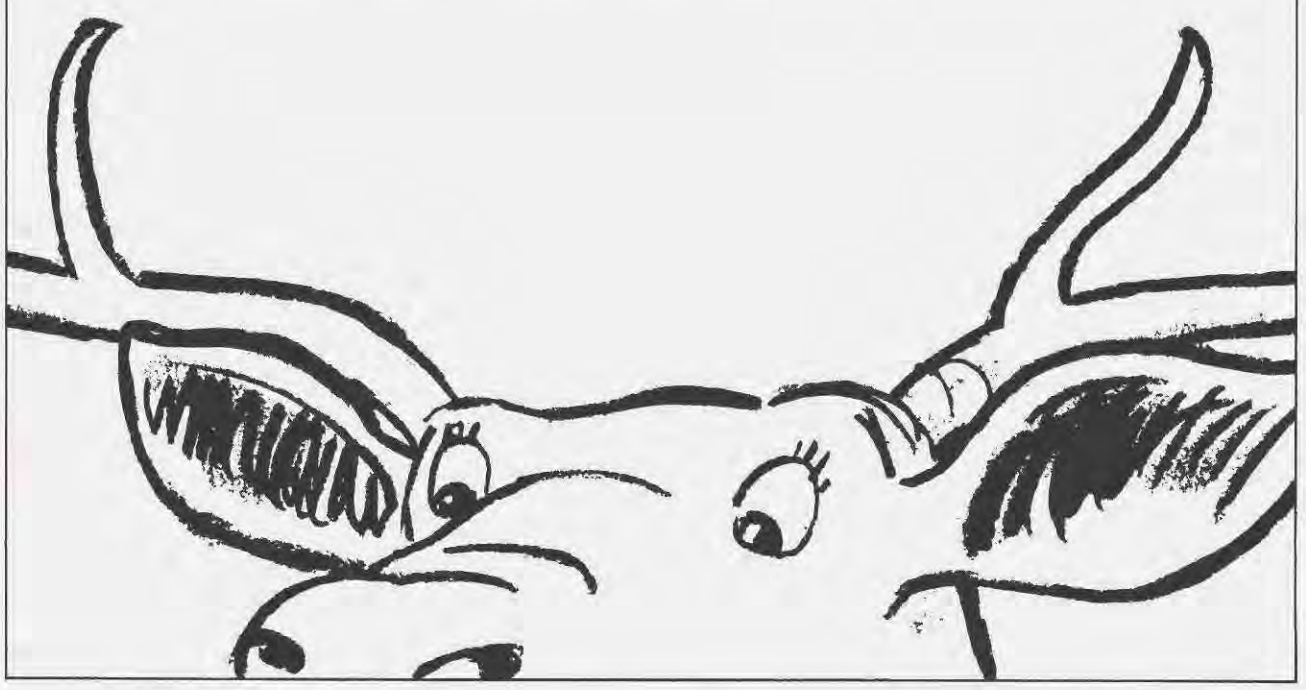

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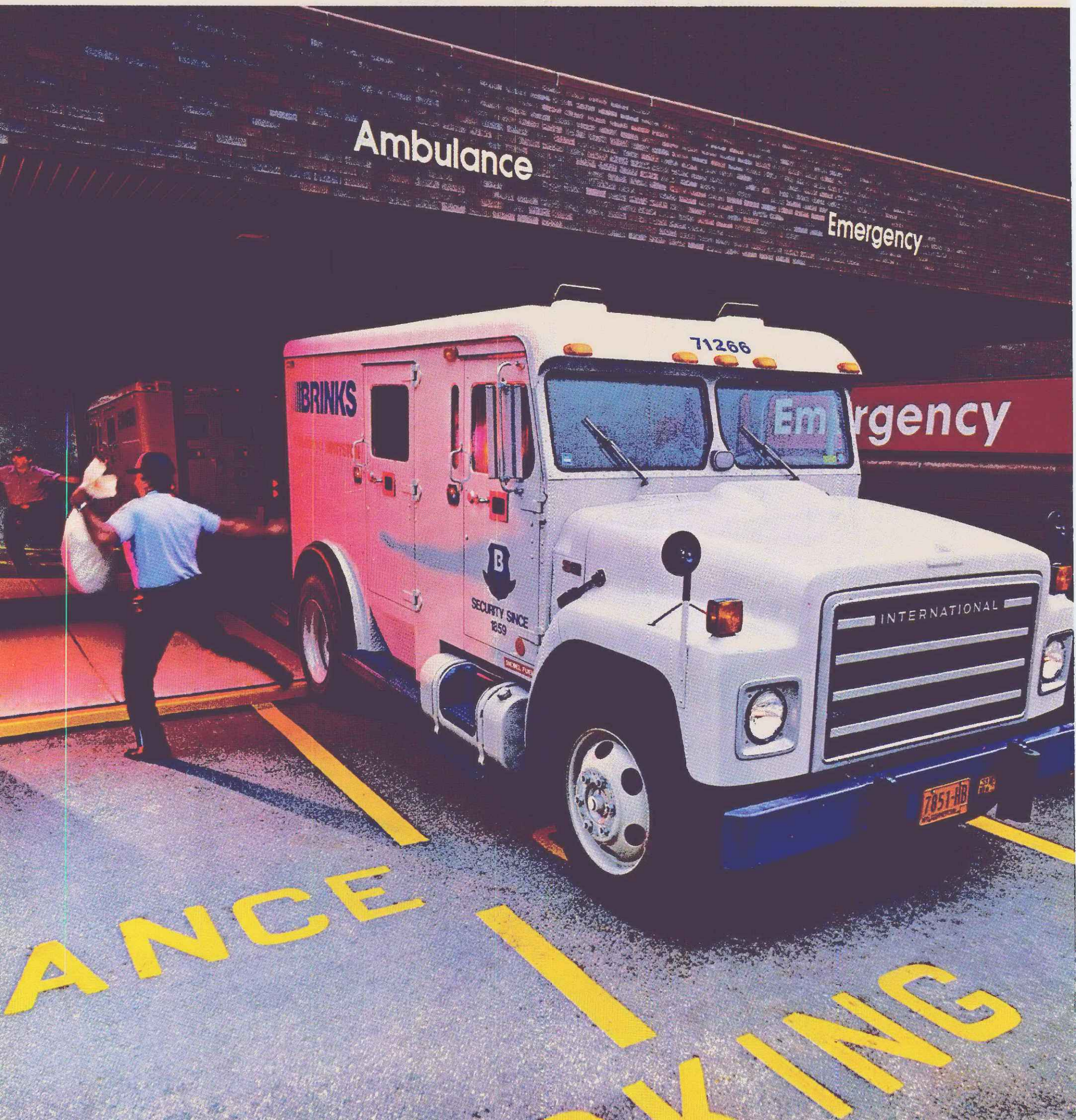

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CIGNA

Insurers can help set up health risk assessments

By LORRIE GIBSON

NEW ORLEANS—For an employer interested in an employee health risk management program, the first place to turn for help might be its group health insurer, advises William J. Thomas, president of Reinsurance Development Co. of America in Princeton, N.J.

Mr. Thomas was among panelists discussing how to control health care costs through risk management techniques at the Risk & Insurance Management Society conference in New Orleans last week.

"Your insurer may be willing to subsidize the cost of a health risk estimation product," he said.

The health risk management program promoted by Mr. Thomas and the other panelists focuses on the development of a health care

profile of all employees based on information about lifestyle and medical history. The profile, compiled from information from a questionnaire filled out by employees, would show at what risk employees are at of either contracting a particular disease or dying (see story, page 3).

Analysis of this information can allow an employer to pinpoint its largest health risks and then develop programs to control or prevent losses. Health risk estimation is new; therefore, there is no set way to approach it or price it.

Only about six companies—including insurers and health care management companies—are selling health care profile products to help employers identify high-risk employees, Mr. Thomas said.

Insurers in some cases are willing to subsidize the cost of such an undertaking, Mr. Williams said.

"I would at least start with your insurer to see what it can offer, because similar products sold by health care management companies currently cost more," Mr. Thomas said.

Indeed, Union Mutual Life Insurance Co. in Portland, Maine—the nation's leading underwriter of long-term disability insurance—began a health risk estimation program for its policyholders about three years ago.

The cost of this program was included in the premium paid for the coverage provided by Union Mutual. Union Mutual is developing new products in this area which are expected to be introduced this year, said Kevin P. McCarthy, second vp of group life/medical products.

He says more insurers in the future will be willing to help an employer make the initial commitment needed to carry out a health care risk management program. Some will, for example, cut the insurance rates of employers that participate in health risk estimation programs. Others will offer the employer a rate discount upfront on a retrospectively rated basis.

If the employer's costs come in above a specified level—despite the health care risk management program it may have initiated—it will be billed retrospectively for additional premium, he said.

Whether an employer turns to a an insurer or a health care management specialty company for assistance in health risk estimation, Mr. Thomas said there are basic questions to ask, including:

- Who will pay the postage when employees are asked to mail health care profiles to the location where results will be tallied? Will this be the employer's responsibility, or will the insurer or health care management firm providing the services foot the bill?
- Will the vendor help the employer analyze the data developed from the employee profiles, or will the employer alone determine what the data shows and what loss prevention measures to take?
- Will the vendor set up a hotline for employees who have questions about the results of the health care profile? If the profile indicates the employee is at high risk of dying or contracting a serious disease, will someone be available to field questions from this employee?
- How often will health care profiles of the employee population have to be conducted to keep statistics current?
- How is a corporate smoking cessation program or exercise program organized? What resources are available in the community?

Employers also must decide whether filling out employee health care profile questionnaires will be mandatory or voluntary.

Despite the fact that health care risk management is still in its developmental stages, Mr. Thomas believes it is necessary, especially for self-insurers of health benefits.

"I would never self-insure without doing a health risk assessment first" to determine potential losses, he said.

Mr. McCarthy pointed out that the results of a group health risk estimation and loss prevention program can also help the employer that buys its group health insurance in the commercial market.

The most immediate benefit an employer can reap is lower health insurance rates, he said.

"You can show that your risks are less to prove to the insurer that you deserve a break," he said. Also, in the future, if insurers move toward basing employers' group health care insurance rates on individual employee risks, instead on community rates, employers will be able to pass costs on to employees based on the individual risks they present, Mr. McCarthy said.

Currently the President's Council of Economic Advisers is discussing a proposal to have insurers charge more for the individuals within a group who present greater health risks, like those who smoke.

If this were to occur, employers would distribute the cost of insurance among employees based on individual risks.

The disadvantages for employers of an individual rating program, according to Mr. McCarthy, would be the high cost to administer it; employees' inability to understand it; and the potential for lawsuits charging the employer with discrimination.

But, rather than only beginning health care risk management programs to affect the pricing of insurance, employers can get involved in them to intervene and make a change in employee health care habits, he said.

This, however, requires efforts to educate employees and an upfront investment on the part of employers when results may not be evident for years down the road, he pointed out. ■

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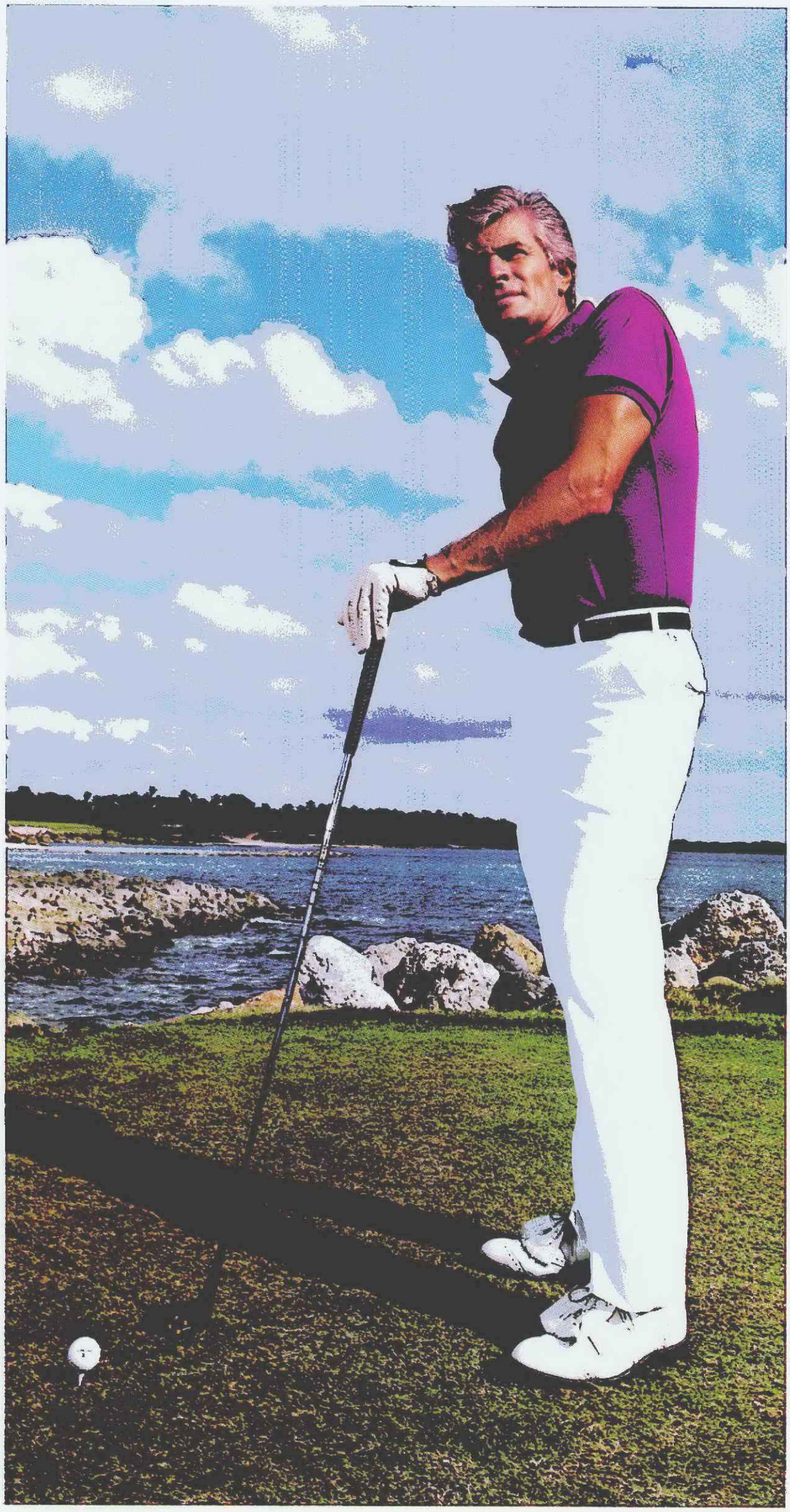

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MAY 10. Termination at Will: Past, Present and Future seminar in New York, sponsored by the American Arbitration Assn.; $85. Registrar, American Arbitration Assn., 140 W. 51st St., New York, N.Y. 10020; 212-484-3232.

MAY 13-14. Health Care Cost Containment workshop in Chicago, sponsored by Health Research Institute; $395. Also **June 17-18** in New York. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596.

MAY 13-14. 15th Annual Employee Benefits Institute seminar in New York, sponsored by the Practising Law Institute; $360. Registrar, PLI, 180 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

MAY 13-15. Product Safety and Liability Prevention: The Role of Human Factors Engineering seminar in Madison, Wis., sponsored by the University of Wisconsin; $495. Professor Richard A. Moll, University of Wisconsin-Extension, 432 N. Lake St., Madison, Wis. 53706; 800-262-6243.

MAY 13-17. Developing and Managing a Basic Safety and Health Program course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $650. Also, **Aug. 19-23** and **Oct. 28-Nov. 1** in Long Grove. Tommy Thomas, National Loss Control Service Corp., Route 22 and Kemper Drive, Long Grove, Ill. 60049; 312-540-2400, 800-323-9585.

MAY 14. Strategies for Medical Cost Containment seminar in Anaheim, Calif., sponsored by the Medical Care Committee of the California Workers' Compensation Institute; $70. Also **May 15** in Los Angeles. Registrar, California Workers' Compensation Institute, 120 Montgomery St., Suite 715, San Francisco, Calif. 94104.

MAY 14-16. Petroleum/Chemical Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Also, **June 11-13, June 24-26, July 16-18, Aug. 20-22, Sept. 10-12 and Oct. 1-3**, all in Marinette. Sara Lambrecht, Ansul Fire Protection, 1 Stanton St., Marinette, Wis. 54143.

MAY 15. Health Improvement/Prevention Workshop in Chicago, sponsored by Health Research Institute; $195. Also **June 19** in New York. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 15. Advanced Cost Containment workshop in Chicago, sponsored by Health Research Institute; $195. Also **June 19** in New York. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 15. Third-Party Administrator workshop in Chicago, sponsored by Health Research Institute; $395; $195 for subsequent registrants from same company. Also **June 19** in New York. Workshop Coordinator, Health Research Coordinator, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 15-16. Marine Issues 1985, seminar in New York, sponsored by the American Institute of Marine Underwriters; $150. Valarie Moffatt, American Institute of Marine Underwriters, 14 Wall St., New York, N.Y. 10038; 212-233-0550.

MAY 16. Medical Directors workshop in Chicago, sponsored by the Health Research Institute; $195. Also **June 20** in New York. Registrar, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 16-17. Labor/Management conference in Chicago, sponsored by Health Research Institute; $195. Also **June 20-21** in New York. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 16-17. Analyzing the Financial Strength of Insurance Companies seminar in New York, sponsored by Executive Enterprises Inc.; $750; $650 for subsequent registrants from the same company. Registrar, Executive Enterprises Inc., 33 West 60th Street, New York, N.Y. 10023; 212-489-2680.

MAY 16-17. Asset/Liability Management: Profitability and Risk in a Time of Change conference in New York, sponsored by Peat Marwick and Darling & Associates; $675. Also **June 3-4** in San Francisco, **July 22-23** in Boston. Registrar, Executive Education Department, 810 Seventh Ave., 28th Floor, New York, N.Y. 10019; 1-800-762-3932.

MAY 16-18. Eighth Annual Physician Insurers Assn. of America meeting in Atlanta; $145 for members; $325 for non-members. Joyce Harbourt, Physician Insurers Assn. of America, Two Princess Road, Lawrenceville, New Jersey 08648; 609-896-2404.

MAY 17. The Tight Market: Opportunity for the Risk Manager conference in Anaheim, Calif., sponsored by the Orange Empire Chapter of the Risk & Insurance Management Society; $55 for members; $60 for non-members. Jeanne Warner, The Bekins Co., 910 Grand Central, Glendale, Calif. 91201; 818-507-1200.

MAY 17. Buying Insurance in a Hard Market meeting in Chicago, sponsored by American Management Assns.; $375 for members; $425 for non-members. Registrar, American Management Assns., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

MAY 19-21. 13th Annual Meeting of Associated Risk Managers International in Cape Cod, Mass., sponsored by ARM Inc.; $200; $250 for non-members. Gene Bodeen, ARM Inc., 305 Perry Brooks Building, 121 E. Eighth St., Austin, Texas 78701; 512-479-6886.

MAY 20-21. Washington Legislative Update program in Washington, sponsored by the International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. Registrar, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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Benefit statements enter new era

By MICHAEL BRADFORD

NEW ORLEANS—Laser printing technology is bringing employee benefit statements out of the Dark Ages and placing them in the hands of workers with new ease, two experts say.

Richard T. Whitman and Peter Hutchings, partners at employee benefit consultant Kwasha Lipton in Fort Lee, N.J., explained the advantages of laser printing at last week's Risk & Insurance Management Society conference in New Orleans.

Companies often issue statements to workers that outline their health coverages and other benefits, along with the cost of these benefits.

Many employers, however, don't provide employees with these statements because they are painstakingly difficult to produce, according to Mr. Whitman.

Printing technology has not kept up with advances in computerization, he said. "Where there has been a whole new burst of technology in computers, print technology is still in the Dark Ages," he noted.

Producing the statements can be a nightmare for some companies that still use traditional ribbon printers, Mr. Whitman said. Using "impact" ribbon-type printers means statements often come out smudged, and printing on both sides is difficult, he explained.

Also, "There is a limited supply of the types of paper you can use," he said. Excessive quantities of the continuous form paper must be fed through traditional printers, and paper often yellows and absorbs water while waiting to be used.

However, "The answer to all this is laser printing. It takes the handcuffs off the printer," Mr. Whitman maintains. Laser printing, he explained, allows an image to be "energized" on virtually any size and type of paper.

"It's a permanent image that won't come off on your hands," he said. Letters drawn by a laser printer are made up of tiny dots, and the quality is very near that produced by traditional, offset-printing methods, he noted.

Other advantages of laser printing include:

- Statements can be sheet-fed instead of rolled through a printer as they normally are, on continuous form paper.
- Printing can be done easily on both sides of the statement. The statement can be printed horizontally or vertically on the form.
- It allows for unlimited design possibilities.
- Computerized data can be combined with other printed materials. For example, individual data explaining benefit plans can be entered into company booklets.

For a firm considering using laser printing to produce benefit statements, Mr. Whitman warns that the technology does not come cheaply.

Purchasing or leasing the equipment requires an investment ranging anywhere from $50,000 to $150,000, he said.

A company might be able to spend less on laser printing by contracting the work to a direct-mail firm that prints high-quality advertising.

However, "If you use it (laser printing equipment) with any regularity, it's better to go ahead and invest in the equipment," he said.

The investment eventually may pay off, Mr. Whitman said. The company can reduce its paper costs by printing on both sides of the statement.

While helping to cut companies' costs, the new technology also provides a valuable employee service.

By providing such personalized information, "Laser statements become a two-way communications tool when people use them to make choices about benefit plans," Mr. Whitman said. The statements can include an enrollment form for the employee to fill out and return, he added.

One company's use of laser printing to personalize benefit forms actually allowed it to reduce its costs for employee health care benefits, according to Mr. Hutchings.

The computer equipment was used to match each employee's ZIP code with the names of health maintenance organizations in his or her area.

The data was added to the benefit statement, and upon doing so, the company watched enrollments in HMOs triple. ■

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Experts review cost-containment options

By JERRY GEISEL

NEW ORLEANS—Pre-admission review programs are one of the most effective health care cost-containment tools, an insurer says.

Such programs can save employers between $5 and $6 in health care costs for every $1 in administrative costs, according to William H. Reed, vp-group accounts in the Philadelphia office of Prudential Insurance Co. of America.

Speaking before a Risk & Insurance Management Society conference session last week on employee benefits financing, Mr. Reed said savings in pre-admission review programs are dramatic because they reduce the number of unnecessary hospital confinements.

Under such programs, an employee's physician will call the in-

surer to discuss an employee's health problem. The two parties will discuss, for example, whether an operation is needed or whether the operation must be performed in a hospital or in a lower-cost health care facility.

"If we can keep the individual out of the hospital, there can be some impressive savings," Mr. Reed said.

Surprisingly, there rarely are disagreements between the employee's physican and the insurer on when and where operations should be performed.

"There is general agreement in 97% of cases," Mr. Reed said.

When there is disagreement, the employee may be reimbursed at a lower rate if he or she decides to go ahead with the procedure that is not approved by the insurer.

Pre-admission reviews are just one way that employers can stem the rising tide of health care costs, Mr. Reed noted.

For example, more and more employers are turning to health maintenance organizations as a cost-containment weapon. In Minnesota, Mr. Reed said, the number of people covered by HMOs has increased by an average of 23% over the last five years.

Mr. Reed said HMOs can be effective in reducing health care costs because HMO participants are much less likely to use hospital services than are employees covered by conventional indemnity plans.

"Since hospitals account for about half of health care costs, you can see how effective HMOs can be in controlling costs," Mr. Reed said.

Employers also can give employees monetary incentives to begin healthier lifestyles.

For example, employers might reduce required premium contributions for employees who walk or ride a bike to work, Mr. Reed said.

"In a contributory plan, a nickle could be cut (from the health insurance premium contrubution) for every mile an employee bicycles to work," he said.

Mr. Reed urged employers to join health care coalitions that are springing up around the country. These groups collect data on hospital and physician practices and can help employers identify the most efficient health care providers, he said.

Mr. Reed noted that there are many reasons why health care costs have increased so much during the last decade.

Employers can blame the federal government for some of their higher health care costs, he said.

The government doesn't reimburse hospitals for all expenses incurred by those covered under the Medicare program, he explained. As a result, hospitals charge an additional amount to employees covered under group insurance plans to recover costs not picked up by Medicare. This "cost shift" may have added up to $8.8 billion to employers' health care bills last year, Mr. Reed said.

In addition, advances in medical technology also are boosting health care costs. Someone has to pick up the costs when hospitals purchase expensive equipment, he said.

Another speaker said that employers with conventionally insured health care programs need to analyze their insurers' costs before deciding if it is time to switch to another funding vehicle.

'The first step is to audit your (insurance) programs,' says Richard Burns.

"The first step is to audit your programs," said Richard Burns, executive vp with Doerr, Burns & Associates, a Chicago-based benefit consultant.

During this audit, an employer should determine what percent of the premium the insurer is retaining for profit, Mr. Burns said. He noted that insurer profit generally equals 1.5% of the premium.

In addition, the employer needs to calculate how much is being paid for commissions and fees to consultants and brokers. Those fees, depending on what kind of services the broker and consultant perform, often range from 2% to 5% of the premium.

The employer also needs to determine what kind of administrative charges the insurer is including in the premium.

For example, the insurer might be charging $50,000 to prepare and distribute benefit brochures to employees. The employer might be able to find a local printer who could prepare the brochures for thousands of dollars less, Mr. Burns said.

Finally, the employer needs to calculate how much in state premium taxes the insurance company is paying. These taxes, which are passed on to the employer in the form of higher premiums, usually are 2% of the premium.

Fully insured employer may be able to cut costs by switching to minimum premium plans, Mr. Burns said.

In a minimum premium plan, an employer agrees to pay the insurer a certain amount, perhaps 10% of the full premium, to cover the insurer's administrative costs and profits.

In addition, the employer will reimburse the insurer for claims costs—up to a certain agreed-upon level—as claims are paid.

These plans allow employers to hang onto cash longer and thus improve a company's cash flow. In

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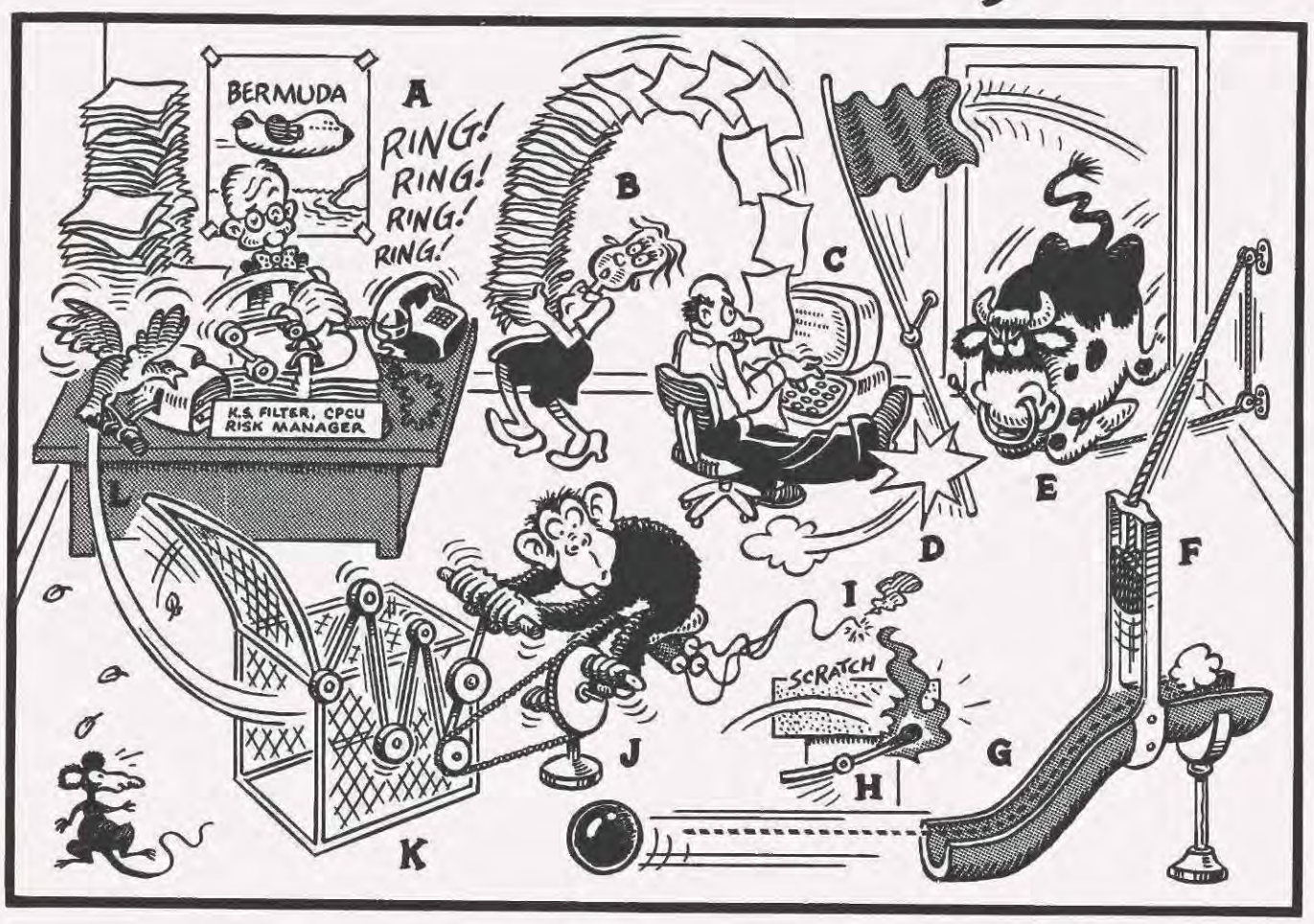

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Continued from previous page
addition, costs can be cut since the premium tax generally is based on the minimum premium, which is much lower than what the fully insured premium would be.

However, states are becoming concerned about the loss of premium tax dollars that results from minimum premium plans, and some are taking steps to curb the plans' tax advantages, according to Mr. Burns.

For example, in Connecticut, the premium tax is based on claims paid rather than just on the minimum premium and there has been litigation on the issue in Califoirnia, Mr. Burns said.

"The door is being closed (on premium tax savings) more and more every year," Mr. Burns said.

Another funding vehicle that employers should consider is an administrative services only arrangement, Mr. Burns said. Under an ASO, the employer self-insures health care costs but then purchases administrative services from an insurer or third-party administrator.

Self-insured employers usually buy specific stop-loss coverage, which is triggered if any one claim exceeds a certain level, and aggregate stop-loss coverage, which pays if total claims rise above a certain level.

But Michael Sipe, director of risk management at Dresser Industries Inc. in Dallas, warned the audience that stop-loss insurance is becoming very expensive and difficult to obtain.

"The stop-loss market, which is tied to the reinsurance market, is drying up," he said. "You will pay a high premium, with aggregate coverage particularly difficult to obtain."

Mr. Burns noted that some employers that may want to go the ASO route could run into resistance from employee organizations. Labor unions may want the security of an insurer-issued health care policy, he said.

The future of another benefit funding vehicle—Voluntary Employee Beneficiary Assns.—may be in doubt, Mr. Burns said.

Under a VEBA, also known as a 501(c)(9) trust, an employer receives tax deductions for contributions to the trust.

Those employer contributions, which earn tax-free interest when held by the trust, must be used to pay benefits.

Last year, as part of the 1984 Deficit Reduction Act, Congress said employers could not take a tax deduction if VEBA reserves exceed certain levels for non-collectively bargained benefits. Those limits go into effect Jan 1.

The Treasury Department is supposed to issue regulations to help employers comply with the new VEBA reserve limits. Until those regulations are published, VEBAs will be an "awfully gray area," Mr. Burns said.

Until regulations are published, "I'd be very cautious about setting up a new VEBA or making radical changes to an existing trust," Mr. Burns said. ■

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Many elements contribute to self-funded plan

By ROBERT A. FINLAYSON

NEW ORLEANS—Choosing the right claims administrator is only one of several key ingredients needed to set up a successful self-funded employee health benefit plan, a panel of experts says.

"Far be it for an owner of a third-party administration firm to say that claims processing and adjudication are not important," explained Roger M. Slotkin, president of The NBA Group Inc. in Garden City, N.Y. "It most certainly is."

But, other key aspects of self-funding health benefits often are given the short shrift, Mr. Slotkin said.

Speaking before last week's Risk & Insurance Management Society conference in New Orleans, Mr. Slotkin and other members of a panel said benefit managers who consider self-funding health benefit plans also should examine:

- Employer/employee communications.
- Plan design, including co-insurance, deductibles and outpatient coverage.
- Stop-loss coverage for large losses.
- The potential cost of the self-funded plan compared with the cost of an insured plan.

It is extremely important to involve employees in the process of developing a self-funded health benefit plan, Mr. Slotkin said. "You've got to bring the employee back on your side of the table."

Several of the panel members said that many employers do not fully explain to workers management's reasons for switching to a self-funded plan, which can often increase employees' health care costs.

Panel members suggested using newsletters, group meetings and other forms of communication to let the employees know that health care costs are rising dramatically and must be controlled.

"What you're doing is preparing the soil and you're going to till it a little bit down the road," Mr. Slotkin said.

Communicating with employees is as important as the financial considerations of self-funding employee health benefits, according to Linda C. Stetson, personnel director for Commercial Trust Co. of New Jersey.

Commercial Trust, which has about 750 employees and about $750 million in assets, began self-funding its employee health benefits in mid-1983.

"When the plan is introduced, I would urge you to follow up with payroll stuffers, additional articles and newsletters to keep the plan in front of the employees at all times," Ms. Stetson said.

Ms. Stetson also suggested that employers survey their employees before implementing a self-funded plan, to find out which benefits are most important to them and for which they would be most willing

to share the cost.

Ms. Stetson explained that it is important that the TPA for the plan have a toll-free number employees can call with complaints or questions about a claim.

One claims representative handles Commercial Trust's account exclusively, she said. The representative's name and telephone number appear on all claims statements and checks.

"Our employees really like that personal touch," she said

Ms. Stetson recommends that companies that implement self-funded plans hire a consultant to help management explain the new arrangement.

"People are usually very skeptical of any change, and I think it's better taken (by the employees) from an outside consultant," she said.

Ms. Stetson also said that companies setting up self-funded plans should make sure area hospitals know about the new plan and are prepared to accept the company's employees for treatment.

Ms. Stetson added that Commercial Union's management is pleased with its self-funded plan. "Our cost savings far exceeded our expectations.

"We have the flexibility now to design the plan to meet our own needs, and we are in control of what's going on."

Another important aspect of the self-funded plan, according to the panelists, is its design.

Because of month-to-month variations in benefit payout, cash flow is an important issue when considering a self-funded plan, particularly for smaller companies, according to David L. Brenneman, vp for The Becker Co., an actuarial consulting firm.

Mr. Brenneman warned that aggregate claims payment experience can fluctuate by 8% to 12%, depending on how the TPA administers an employer's claims.

Costs also can vary, depending on how eligibility provisions are administered, how medical necessity of treatment is adjudicated and the definition of reasonable and customary charges used by the TPA, he said.

The definition of reasonable and customary charges can account for a 3% to 4% swing in the cost of the self-insured plan, Mr. Brenneman maintained.

Stop-loss coverage for large claims should be examined carefully, particularly in the case of smaller firms, which might not have the cash flow to cover a large loss, the panelists advised.

Mr. Slotkin added that benefit managers should be educated on what is covered under their stop-loss agreements.

"Read your reinsurance agreements carefully," he said. "Some carriers limit certain benefits." For example, some stop-loss carriers limit coverage for organ transplants, he noted.

Employers also must make sure reserves for outstanding claims are adequate and are adjusted each year for inflation, Mr. Slotkin suggested.

A comparison of current and expected costs should be made before deciding to self-fund employee health benefits, panelists said.

"If the cost of your present insured arrangement is understated, maybe you'd better put the self-funded option on the back burner and wait for your insurance company to catch up with your costs," Mr. Brenneman said.

He said employers can expect about a 4% to 8% cost savings under a self-funded plan.

"If you find you have more than an 8% savings, then more than self-funding is involved," he maintains. Other factors, such as plan design changes that involve cost-containment measures, typically account for more substantial savings.

Both Mr. Brenneman and Russell P. Reed, regional director of group sales for Hartford Life Insurance Co., said employers that buy stop-loss coverage can expect a 50% to 60% annual premium increase.

Such an increase is far better, however, than the 200% to 300% increases in stop-loss premium seen by employers in 1983 and 1984, Mr. Reed told *Business Insurance*.

He said the market has stabilized and that increases should remain in the 50% to 60% range. ■

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Experts detail ways to cut disability claims

By DIANE LYNN KASTIEL

NEW ORLEANS—Benefit managers, who have been preoccupied with rising health care costs, are now turning their attention to the expanding cost of disability benefits.

A panel of experts on short- and long-term disability benefits discussed ways to control the rising cost of claims at the Risk & Insurance Management Society conference last week in New Orleans.

Both long- and short-term disability claims are growing in frequency and severity and employers are "taking a long, hard look at disability claims," said Ken MacKenzie, senior consultant at Prudential Life Insurance Co. of America.

The rising cost of health care accounts for much of the inflation in disability benefits, Mr. MacKenzie said, adding that expanding high-technology jobs and the advent of more women in the workplace are among the factors leading to the increasing number of both long- and short-term disability claims.

For example, computer-related claims like strained vision, radiation sickness and stress are increasing, Mr. MacKenzie said.

"As the use of CRTs increases, we're going to see a lot more claims related to them," he said.

And, with more women in the workplace, new types of disability claims are being seen, he said. For instance, women in upper management are more apt to work through their pregnancies, and some of them claim "disability" for ailments like morning sickness and problems related to breast-feeding.

Also, there is still a lot of abuse inherent in the disability claims system, Mr. MacKenzie said.

For example, a condition that was not previously disabling becomes disabling when the plant at which an employee works closes or when the worker is laid off.

"They could work one day with the condition and the next day they couldn't, and the only intervening factor was that they were laid off," Mr. MacKenzie said.

Also, some workers will take a job just to obtain disabilty benefits, he said.

"Some people who are 'insurance-wise' will take a job from an employer just to qualify for beneifts and will use (the disability benefits) as soon as they can." Mr. MacKenzie said. "If they're clever enough to know to do that, they are usually good at substantiating their claim and knowing how to document the 'disability' successfully.

"Sometimes the person's only disabling condition is a psychological one," he said. "We sort of have an in-house joke that often the psychological condition that keeps a lot of these people from coming back to work is their anxiety over coming back to work."

Adding to the problem is a health care system that tends to go along with "fakers," he said.

"Very few doctors will indicate that a person is 100% OK if the person complains," Mr. MacKenzie said. "The best they can do is say their report is based on subjective complaints. But they won't return a person to work because if something is wrong, they can be sued."

Despite these hurdles, employers can control disability claims cost in several ways. One of the most important ways is to practice early intervention on disability claims, rather than letting them "snowball," he said.

"A good way to save long-term disability dollars is to have a good short-term disability program," Mr. MacKenzie said. "If you prolong these claims, if you get these people examined...an awful lot of time can get lost, and many times you wind up on the doorstep of a long-term disability claim."

Proactive early-intervention and cost containment can be achieved by using a disability management company said Karyl Thorn, district manager of Intracorp, a disability management company.

These companies, she noted, specialize in marginal claims which are not only claims where disability is questionable but claims whose benefit duration can be shortened by effective management.

The key to an effective disability management program, whether it's done in-house or by outside consultants, is a strong return-to-work program. Ms. Thorn said

"Saying 'What are we going to do about this terriole claim that's going to cost us so much?' is chasing the horse after the barn door is left open What we have to talk about is a proactive aproach that says, 'How do I keep that barn door closed?

"The first step in controlling disability costs is to see if you have a RTW program that is specific and involves all levels of management," she said.

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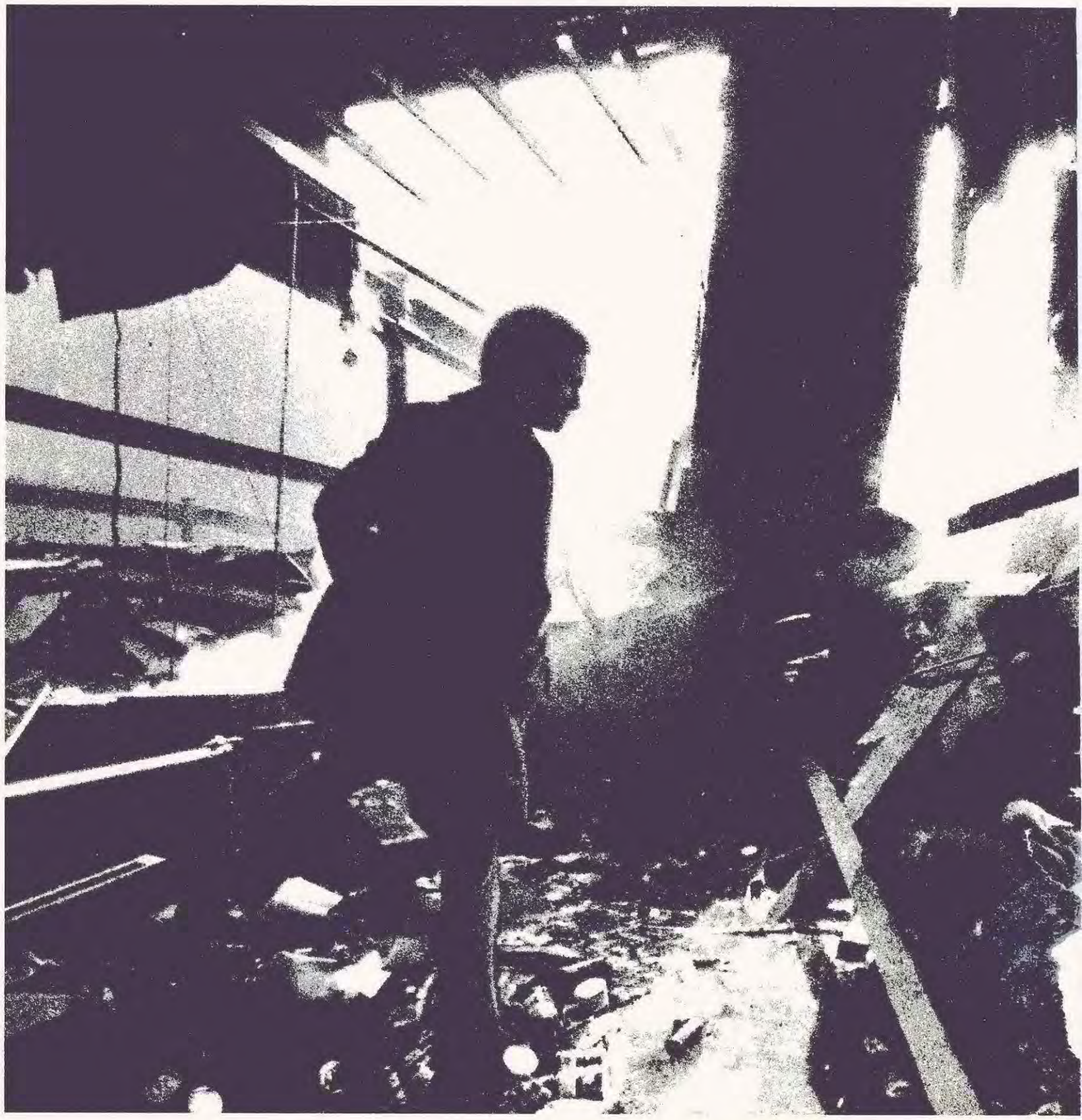
WITH A UAC ADJUSTER THERE'S A LOT GOING FOR



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"And I think that when we start putting an RTW program into place, the question is not necessarily how much money are we going to save, but that any amount of money we put into it will be worthwhile in terms of what you get back in productivity and the money you save in disability payments."

An effective, specific RTW program, she said, would contain most of the following

- Thorough job descriptions for all jobs.
- Exploration of job modifications. An injured person has a better chance of returning to work faster if his or her job can be modified to his or her needs.
- Identification of employee skills. This should be done for all employees so that, if disabled, they can be readily transferred to a different job.
- Identification of alternate job placement opportunities, either in-house or out-of-house, or preferably both.
- Control of immediate costs associated with the disability. This is an excellent way of preventing short-term disability claims from becoming long-term disability claims. This involves pre-certification, utilization review, concurrent review and retrospective review.
- Control of immediate costs should not cease if a short-term claim becomes a long-term claim.
- Provisions for family involvement. Getting a person's family involved speeds up their return to work, according to Ms. Thorn.
- Assurance that the patient is placed in the correct facility for a particular illness or injury and receives care from the appropriate professionals. This may mean hospital care or it may mean a less-expensive alternative, like hospice care or home health care.

- Arrangements for follow-up care at home after the employee is released from the hospital. Although it may seem like an extra expense, it speeds up care and allows the employee to return to work sooner, Ms. Thorn said.
- Coordination of outpatient treatment, therapy and physical rehabilitation. Again, this helps the employer monitor the employee's progress and be better able to determine when the employee is ready to return to work.
- Follow-up with the employee's family to make sure the patient is complying with the health care professionals' recommendations.

Much of this seems like cost containment, and, indeed, it is. Controlling health care costs is the key in controlling disability costs, Ms. Thorn said.

"There are plenty of health care services at all kinds of costs," she said. "You have to have a system set up to identify which health care systems in your area are most applicable and cost-effective."

These steps also bring on a "sentinel effect," whereby people whose care is being monitored tend to return to work sooner than those whose care is not, she said.

Ms. Thorn said there is an average 50% reduction in short-term disability claims for companies that use "sentinels" because people get nervous about "faking" when they know the company is watching.

And, employees who are genuinely sick or injured appreciate the company's concern, said M. Glenn Atkins, human resource supervisor for Engelhard Corp.

"We found it's progressed from the employee saying, 'What's the matter company, don't you trust me?' to 'Gee, company, I'm glad you called because I'm not comfortable with the medical treatment I've been receiving,'" he said.

Another way employers can reduce their long-term disability costs without cutting the benefit paid to the employee is by encouraging the employee to apply for Social Security disability benefits, said Nancy Shor, executive director of the National Organization of Social Security Claimants' Representatives in Pearl River, N.Y., a group of 2,500 lawyers.

"I want to dispel the notion that nobody gets Social Security disability benefits anymore," Ms. Shor commented. "It's hard, but it does happen."

The real problem, Ms. Shor explained, is that employees don't apply for Social Security disability benefits, and employers don't urge them to because they feel their insurers should pay.

"After all, that's what they pay their premiums for, right?" she said. "What they don't realize is that (payment of disability claims) ultimately affects their premiums by affecting their experience."

But, Ms. Shor agrees it is hard to get Social Security benefits. "Social Security prides itself on having the No. 1 toughest definition of disability in the world," she said.

Basically, to be considered "disabled" under the Social Security definition, an employee must not only not be able to perform his or her job but must not be able to perform any job, considering the employee's age, education level and job experience.

"If you have a physician who has been in a car accident and is brain damaged, but can wash test tubes, he's going to be found not disabled by Social Security." ■

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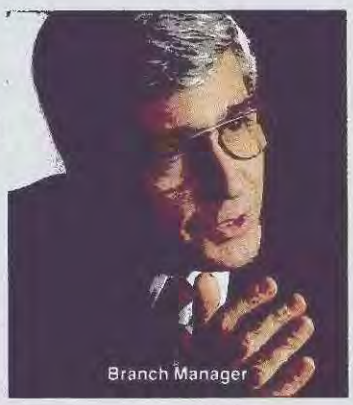

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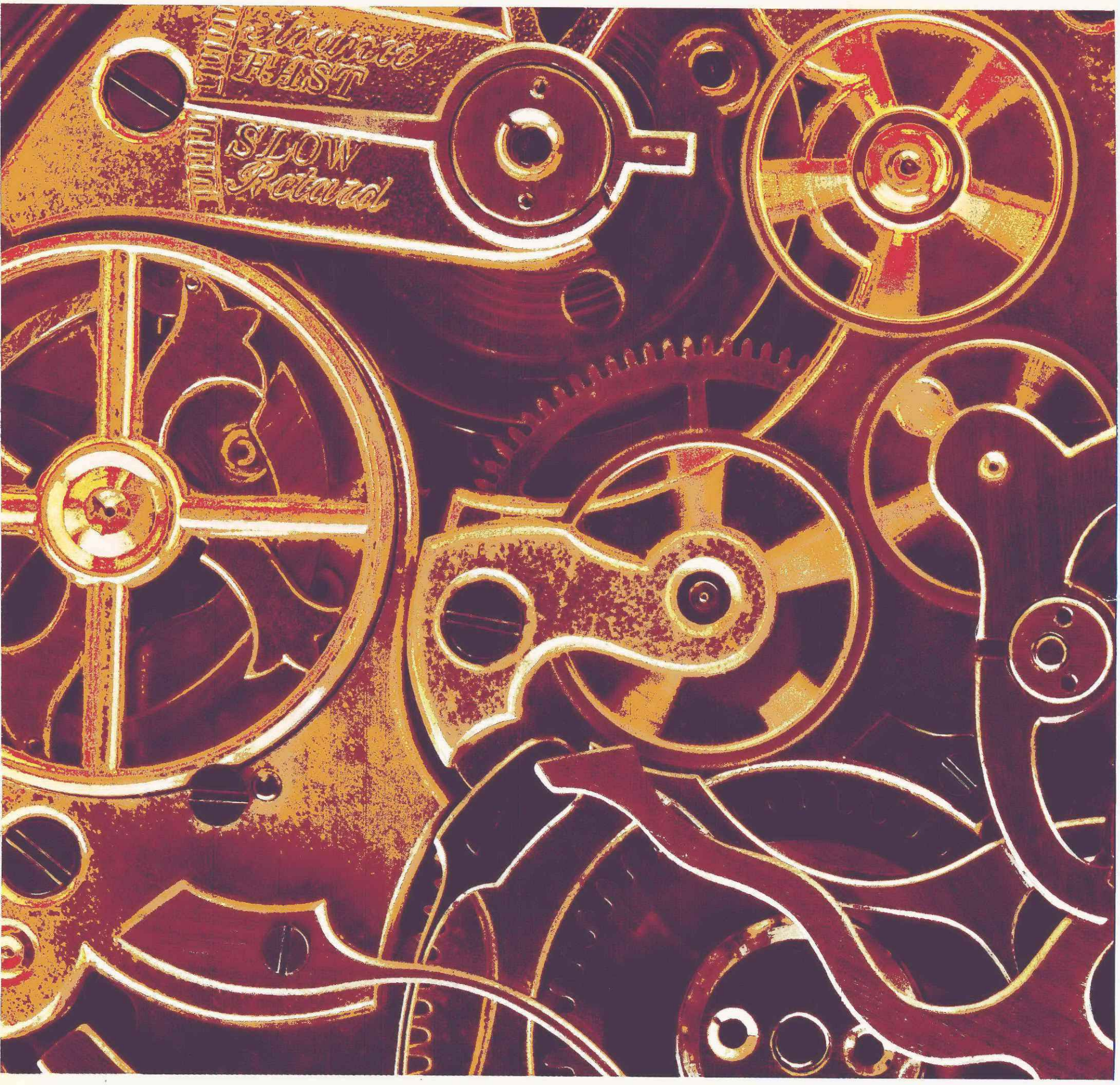

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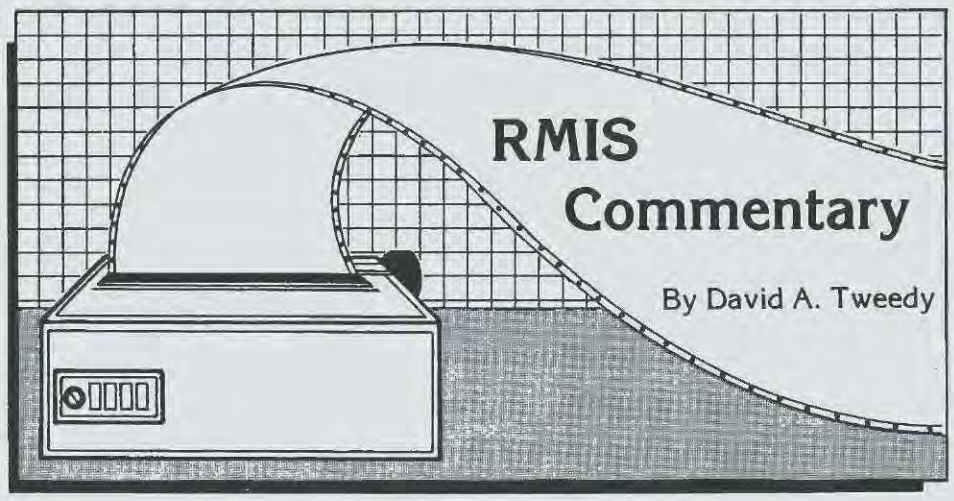
COMPARE SYSTEM OPTIONS

Stand-alone, vendor-supported systems both have strong and weak points



WHILE THE EMERGENCE of the microcomputer into the risk management information systems industry offers great potential and solutions to many applications, don't be misled. The mainframe-based system has by no means been replaced.

New research and development continually produce more flexible, analytical, interactive decision support systems, and a mainframe/micro joint RMIS can be a very effective system.

But, the essence of this debate is not just mainframe vs. micro. A more pertinent question facing risk managers is the degree of autonomy they desire and/or need in their RMIS.

This article will examine the relative pros and cons of each extreme on this system spectrum. Hopefully, this will give the risk manager a framework for charting out his or her own system needs and support service requirements.

For the purposes of this article, a stand-alone system is defined as an RMIS (usually a microcomputer, although there are stand-alone mainframe and minicomputer systems) with little or no outside third-party support. Most data and hardware maintenance, system upgradings, report generation, etc., are controlled internally by the user. Although ongoing relationships with the provider of the RMIS are available, it's usually on an "as needed" basis.

Vendor-supported systems are those managed externally by a third party. These are usually mainframe systems but can also be micro- or minicomputer-based, or a combination. Data conversion, system upgrading, data maintenance, etc., are usually handled by the vendor. The relationship is continual, rather than "as needed".

Each system is evaluated below:

Stand-alone system

The **advantages** of a stand-alone system include:

• Convenience. Obviously, a great asset of a stand-alone system is its accessibility to the risk manager. Usually, the stand-alone system is a microcomputer in the risk manager's office. There is no wait for reports or "ad-hoc" (what if) analyses.

• Price. Another benefit of the stand-alone system is its reasonable price when compared with expensive time-sharing systems. Usually, a well-equipped personal computer/microcomputer hardware system, including computer, printer, hard disk drive, monitor, etc., can be purchased for around $10,000.

Software costs vary considerably, depending on the degree of customization. For example, Cantor & Co., a California-based vendor of stand-alone systems, offers software products costing anywhere from $600 to $40,000.

• Autonomy. For the risk manager desiring total control over all aspects of his position, the stand-alone RMIS offers the greatest flexibility. If the risk manager has sufficient support from the company's electronic data processing department or the technical capabilities of software design to implement desired features, the stand-alone system offers great potential. The risk manager is not bound by any vendor service contract or by time and cost constraints imposed by time-sharing systems. The system can be changed and modified as desired.

The **disadvantages** of a stand-alone system include:

• Ongoing maintenance. Risk managers relying solely on their own stand-alone systems must accept full responsibility for data control and integrity. Quality control over data gathering and entry into the RMIS is one of the most important aspects of an RMIS. Unless the information being processed is sound, the resulting output will be meaningless and even misleading.

Therefore, if the risk manager directly controls his micro RMIS, he must ensure that proper quality control measures (validation, editing, reconciliation) are instituted and judiciously maintained. The additional costs, in time and money, to ensure data integrity may double the cost of operating the stand-alone system.

• Time constraints. The increased demands placed on the risk manager by running his or her own system may place a strain on other responsibilities. After all, the RMIS is designed to free the risk manager from the mundane, time-consuming chores of data gathering and calculations. If the data maintenance/data integrity operations needed to maintain an effective RMIS place a burden on the risk manager, it may not be a wise investment.

Vendor-supported system

The **advantages** of a vendor-supported system include:

• Experience and expertise. Probably the greatest strength a vendor brings to a risk manager is accumulated experience in managing the often-complex operational issues that surround data management and data integrity preservation. After all, vendors are full-time professionals and should be familiar with most types of problems that can arise. They also offer continued technical assistance in upgrading software specifications as the risk manager's needs change.

Other valuable services include coordination of data and information from various providers, internal systems security features and data conversion. Obviously, if a risk manager is receiving tapes from a variety of insurance sources—brokers, insurance companies, claims administrators, etc.—all with different characteristics, there must be a "centralized data conversion capability" to translate the data into a format compatible with the RMIS. This is one advantage of a vendor relationship.

• Technical. Although this point of difference is narrowing, the mainframe computer provided through a vendor still has significant capacity and speed advantages over a desktop microcomputer.

And, at this point, security features are more easily included within a mainframe or minicomputer system than in a micro environment.

• Risk transfer. Another advantage of a vendor-supported system is that the data of the company is stored at the vendor location. Because the vendor is controlling and managing the information for its client, the vendor bears full responsibility over the preservation of this data.

Under an autonomous stand-alone situation, the risk manager would retain this responsibility and therefore should take adequate measures to store tapes off site and to back up the system regularly to ensure continuity if a loss occurs.

The **disadvantages** of a vendor-supported system include:

• Cost. The paramount difficulty with vendor-controlled, mainframe systems is the time sharing/telecommunications costs resulting from the link-up between vendor and customer as well as various alternate locations. Large companies using this extensive RMIS easily generate more than $100,000 a year in time sharing/telecommunications costs alone.

Although many of the major vendors have taken steps to make this a more cost-efficient process, a recommendation to reduce the amount of computer time used by the client is not prudent. The RMIS will be as effective only so far as it is used. Reducing the amount of computer use, therefore, probably will reduce the benefit of having the computer in the first place. Therefore, cost still is a barrier to risk managers desiring a mainframe-based system.

• Technical problems. Because the vendor and the client often are separated by significant distance, much reliance must be placed on the telecommunications linkup between the two entities. Realizing that a large vendor has hundreds of clients, all seeking varied services, there may be an occasion for certain computer downtime. This is not usually a significant problem, but it is an inconvenience to the risk manager needing quick information.

Finally, because vendors do have many customers, there may be occasion where reports are delayed, which will cause certain inconveniences. That is why it is preferable to have a dedicated terminal (with a printer) at the client location to provide instantaneous information.

• Standardized approach. Although many vendors are making significant efforts to provide customized systems for different clients, the mainframe-based RMIS is quite standardized.

After all, a basic mainframe RMIS probably satisfies about 70% of most risk managers' needs. However, that remaining 30% requires custom tuning to truly fit the system to the individual application. Unfortunately, this process is expensive, depending on how much customization is needed.

The debate on whether mainframe computers are being replaced by microcomputers should not be the key concern to risk managers desiring an efficient RMIS.

Richard W. Kieffer, vp of the Information Services Division of Arthur J. Gallagher & Co. asserts that, while microcomputers show great opportunity for decision support capabilities in information management, they should not replace vendor-supported mainframe computers. An effective blending of both mainframe and microcomputer can offer flexibility and opportunity.

I agree. However, I would add that, beyond the mainframe/micro issue, a risk manager should focus on his or her specific needs and resources to determine the level of sophistication, degree of autonomy or continued service and the like that best fits the individual situation.

It is not a quick decision. Risk management information systems can range in price, including both hardware and software, from $15,000 to in excess of six figures, including support service fees and time-sharing costs.

It seems to me that a well-constructed union of both extremes—vendor support and stand-alone—offers great potential. Combining the data management and ongoing technical support capabilities of a vendor with the stand-alone system's flexibility, accessibility and autonomy will yield a truly responsive RMIS.

The arrival of the stand-alone RMIS into the risk management community offers great opportunity to the risk manager. However, he or she should not view the micro as a panacea to information management needs.

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

ASK A RISK MANAGER

Retro premium charges require special handling

Q **Retrospective insurance premium charges create budgeting and forecasting problems for my profit center controllers—and a big headache for me. How do you handle these retro charges?**

A That's a good question—and the cause of my migraine for the past 10 years.

In addition to the retrospective charge, we have several other adjustments we make to the workers compensation, general and automobile liability self-insured expense. These adjustments are made annually and generally together with the retrospective adjustment.

They involve an actuary adjustment for the combined plan, which we are doing with our Corporate Systems FORESTAR Program, a payroll audit adjustment for the immediate past year and an equity credit to profit centers, based on their participation in our captive.

In the past, all these adjustments have been made three months after our July budget forecast and late enough in our corporate calendar year to cause a forecasting/budget problem for profit center controllers.

Our new proposal is to combine our forecasted premium (for these three coverages), the actual retrospective adjustments for prior policy periods, the audit and actuary adjustments and equity credit at the same time we do our budget.

This combined number will represent our "guaranteed" cost program expense for profit centers that will not have any adjustments made to it until the next budget period.

Without our information system, data bank and computer programming, this exercise would be impossible.

Risk management saves more than premiums

Q **With the upward turn in the insurance marketplace and almost complete elimination of any premium expense savings, what do you do to show the "savings" value of your risk management efforts?**

A This is not an easy question to answer when much of the effort in the past has been directed toward premium savings. To be honest, our past efforts in documenting and communicating "other than insurance premium savings" to management has been minimal. This is unfortunate, and we hope to change it.

There are several areas where risk management efforts can be shown to be very cost-effective. Many of these efforts cannot be translated into immediate cost benefits and must be measured over time.

Several years ago we, together with our property insurance engineering company and broker, convinced one of our resort properties to put sprinklers in their clubhouse and connecting buildings. The premium savings to put sprinklers in the facility was minimal, but the loss potential substantial. During this past winter, the clubhouse caught fire. The sprinklers responded and contained the fire to the lobby, and the major property loss resulted from water damage.

There was no interruption of business or other club activities. The loss was approximately $125,000. The replacement value of the clubhouse was $5 million. Our adjusters report stated the "sprinkler system has effectively contained the fire, quite possibly saving a total loss to the building." This item shows a positive contribution and should be a part of the annual report to management.

Appraisals can make money, too. Two years ago, one of our local, progressive risk managers was foresighted enough to persevere in getting an up-to-date appraisal of one of their large canneries. Four months after the appraisal was completed, a major fire destroyed the cannery for a total loss of more than $13 million. Without the proof of the true replacement value of this property, the loss recovery would have been less than $10 million, leaving the company $3 million short.

Claims administration supervision is another area of control that becomes more important every year. The in-house supervision of your claims administration and its effect on severe claims cost though active participation in the negotiating process can be substantial. These efforts should be recorded. Measure the effect of cost savings using structured settlements where cash outlay and future expense in claim handling can be substantially reduced.

We believe all the "savings" should be documented in your annual report and communicated to management on a regular basis.

Allocate premium costs like an insurer would

Q **How do you allocate insurance premiums on your major lines of insurance and on your departmental expense as well?**

A We attempt to allocate our workers compensation, general and automobile liability, self-insured and insured expense to our profit centers as close as we can to the way an insurance company would develop a premium for them. The same premium bases are used, which include payroll, revenues and number of units. We emphasize, however, profit center loss experience over the past 3½ years, making this expense allocation very loss sensitive.

The reason for this is obvious. We promote from our financial (premium allocation) strength, risk control and safety management programs. We also want to reward, as quickly as possible, those who are successful in practicing risk control.

The past 3½ years of incurred loss experience represents between 60% and 80% of the profit centers' premium for these coverages, and the balance reflects a charge for exposure. The size of exposure is measured by payroll, revenues or number of units.

The premiums for each profit center are individually developed, using a computer program. If the prospective premium is not correctly determined, then a retrospective premium is charged. This retrospective charge always causes problems, even though quarterly retrospective reports to the profit centers for all open underwriting years show experience trends and anticipated expense. Reminding managements to review these quarterly reports lessens the surprise of a retrospective charge.

Property insurance premium expense is allocated without regard to loss experience and based entirely on the replacement and business interruption values insured.

An elaborate manual premium estimate is made by our broker for each of some 600 locations. The so-called manual premium takes into consideration all those physical exposures affecting a risk—construction, protection, location and occupancy—first for the conventional named perils, the major "all risk" perils and, of course, flood and earthquake. The manual premiums for all locations are then totaled, and each location's proportionate share is determined.

The total premium we are able to negotiate with insurers for all our property is then allocated on the percentage basis developed by applying the locations' manual premium to the total manual premium. Our charge shows a sizable savings compared with the manual premium.

Department expense includes our payroll and benefits, rent, travel and entertainment, supplies and outside purchased services. Until this year, this expense was allocated through a corporate overhead formula. We now are allocating this expense to the profit centers, based on their proportionate share of the entire risk management and insurance budget.

Data, communication vital as market changes

Q **With the rapid change in the insurance marketplace, what steps are you taking to offset its adverse effect on your risk management program?**

A I may have answered part of that question in the Feb. 11 issue of *Business Insurance*, but it is obvious from rapidly changing market conditions that have taken place since February that those earlier comments are not enough.

First, we are preparing more complete specifications for our property and casualty programs, with a clear and concise picture of our operations and the risk exposure.

Current loss and underwriting information is a must.

We have spent more time on alternate approaches to our desired program—and more time with our senior management discussing these alternatives. There are certain coverages and extensions of coverage we feel are more important to us than others.

From all we hear, capacity has been cut drastically and we will be forced to accept higher retentions and deductibles. We have discussed these larger risk assumptions—along with our current estimate of increased costs—with senior management.

Are there any viable trade-offs acceptable to management? Concurrent with the greater risk assumption, we re-emphasize to our management the greater need for risk control, safety management or loss prevention—whatever label fits and is best understood.

Our steps emphasize those points outlined above. What is of greater interest to me is how the risk management community will fill the void of lower limits, higher retentions/deductibles and greater cost. Will captives continue to be part of our financial scene?

Would you like advice from an experienced colleague on a risk management or benefit management problem? Two features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues.

Mr. Perry

This month's column, on risk management issues, is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Next month, Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York, answers benefit management questions.

Mr. Duva's and Mr. Perry's columns appear alternately, usually on the second Monday of each month. Mr. Perry's next column will appear in May.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer, however. Business Insurance will consider unsigned letters.

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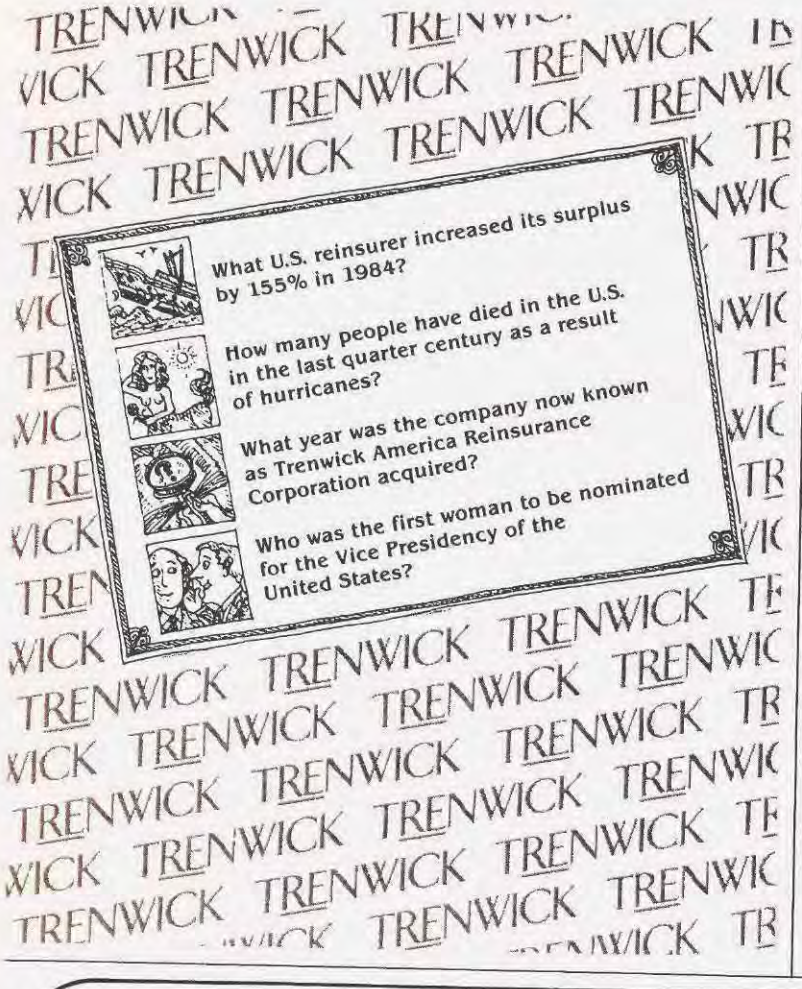

Health claims audits called a valuable cost-control tool

By MEG FLETCHER

NEW ORLEANS—A claims management audit is a benefit manager's most effective tool in controlling the cost of health care benefits for employees, experts say.

But, designing an appropriate structure for an audit is the "meatiest" and most neglected part of most audits, said M.A. "Pete" Cornell, senior employee benefits consultant with Warren, McVeigh & Griffin Inc. of Newport Beach, Calif.

Mr. Cornell was speaking at a seminar at the annual Risk & Insurance Management Society conference held last week in New Orleans.

He said an audit should focus on claims of between $500 and $5,000, which account for more than 90% of the errors.

The audit also should emphasize charges for hospital care and medical services, he added.

A crucial area that should be covered in any audit is coordination of benefits, according to Mr. Cornell.

"Coordination of benefits is an

area that is poorly handled and not well understood," he said.

Auditors should be on the look out especially for claims made by a husband under his wife's policy, claims by 19- to 23-year-old dependents and photocopied bills, which can alert an auditor to potential coordination-of-benefits problems, he explained.

While fraudulent claims are a "very serious" problem, inadequately or improperly handled claims are responsible for much of the $4 billion to $8 billion lost annually through claims-handling problems, Mr. Cornell said.

He estimated that an average of 7% to 8% of all claims are handled incorrectly. But, Mr. Cornell added, the range of incorrectly handled claims can be between 0.25% and 26%.

Mr. Cornell recommended that a comprehensive audit be based on a structured random sample of claims between $500 and $5,000 from each month of the year.

And, he suggested following this "credibility audit" a few months later with a compliance audit to ensure that any suggested changes have been implemented.

"We find that this is very effective," he said.

The quality of an audit depends on the experience of the claims auditor, Mr. Cornell pointed out. He recommends that an auditor have at least 10 years of varied experience.

"It is important to choose the right type and caliber of person," agreed Mary Burroughs, president of Essential Benefit Plan Services in San Rafael, Calif., which is an outside auditor for Warren, McVeigh.

Too often an audit is done by an accountant who takes a narrow financial view rather than a broad one, she said.

Even when a claims specialist is used, it is important for employers to check the specialist's experience. With the increased use of data processing, too often the claims specialist is a top-notch keypunch person and not a seasoned veteran who worked up through the ranks, she said.

There is 30% to 50% annual turnover among employees in the claims handling field, Mr. Cornell said. Consequently, the outcome of audits can change from year to year, she said.

Another potential problem in an audit concerns an employer's access to an employee's medical file when the claims are paid by a third party.

Mr. Cornell urged employers to persevere in trying to get the files. He said employers are more likely to face more challenges in trying to obtain files from insurers that administer claims rather than from third-party claims specialists.

Although state laws limit access to a patient's confidential medical file, an employer should be able to get access to an employee's file as part of an audit to ensure that benefit money is being well-spent, said Ralph N. Jackson, chairman of Southwest Administrators Inc. of New Orleans. He based his conclusion on a three-month study of state laws.

And, he recommended that employers obtain a copy of applicable state law for their own review.

Mr. Cornell pointed out that an audit can be worthwhile not only to identify past mistakes, but especially to prevent future problems.

Mr. Cornell said an audit can cost between $100 and $160 per hour and the total cost may range from $1,900 to $25,000, he said, depending on the size of the audit sample the number of claims and the type of information the employer is seeking.

Moderating the panel's discussion was Dick Smith, director of risk management for Cedars-Sinai Medical Center in Los Angeles. ■

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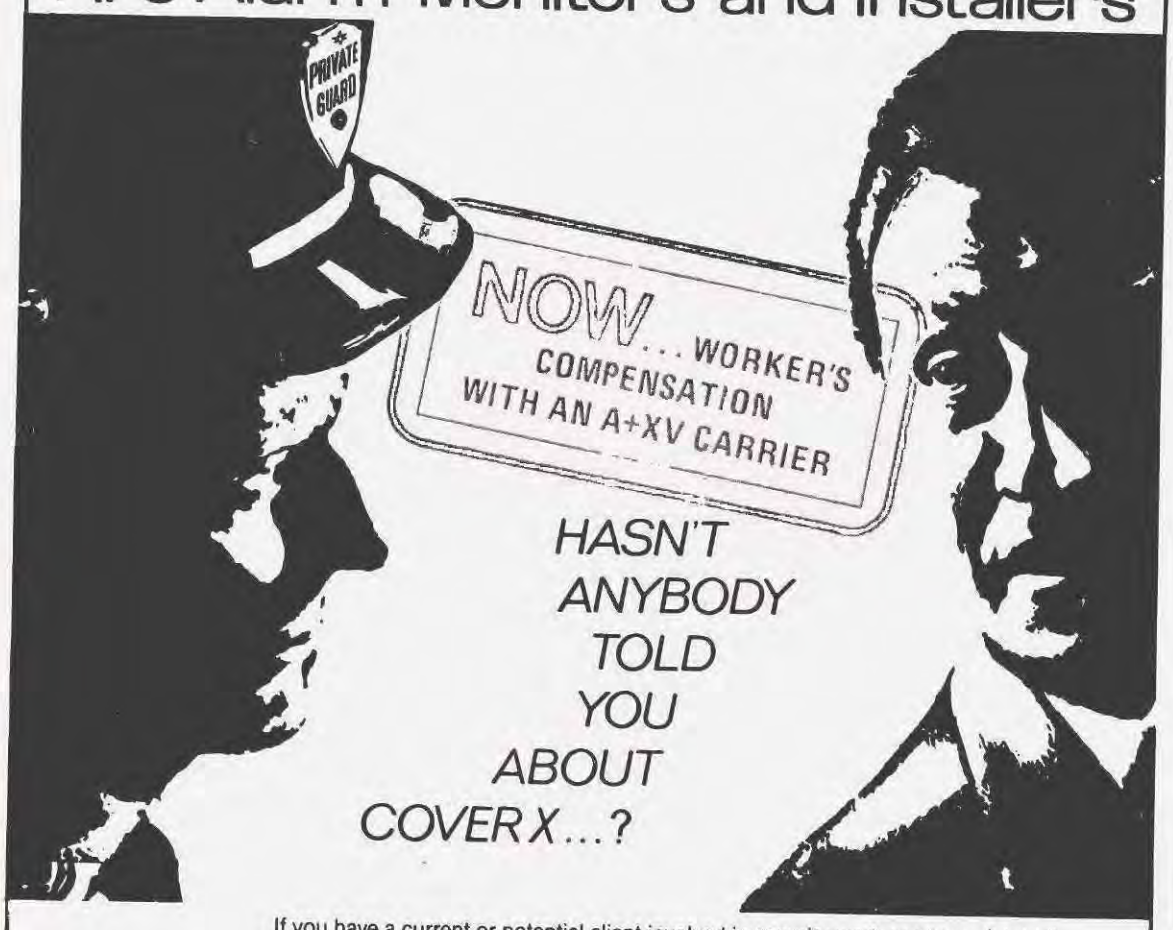

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BI 4/85

401(k)s will survive, with restrictions: Expert

By DOUGLAS McLEOD

NEW ORLEANS—Attempts by Congress to eliminate 401(k) salary reduction plans probably will fail, although the plans may face further restrictions in the future, an attorney predicts.

Both the Treasury Department's package of revenue-raising propcsals and an alternative bill sponsored by Rep. Charles Rangel, D-N.Y., call for a repeal of Section 401(k) of the Internal Revenue Code, noted Frank H. Smith Jr., an attorney with Musick, Peeler & Garrett in Los Angeles.

But, the Treasury Department has given some "fairly strong signals" that it will not pursue repeal of the section and will press for limits on the uses of 401(k) plans

instead, Mr. Smith told an audience at the Risk & Insurance Management Society's annual conference last week in New Orleans.

A 401(k) plan allows employees to defer a percentage of their pretax salaries into a savings plan.

"Any attempt to repeal 401(k) is going to find a rather large lobbying effort," Mr. Smith said. He explained the plans have become so popular that a survey of Fortune 500 companies showed that about 70% now have 401(k)s.

"I really do not think that 401(k) is going to be eliminated. That's the good news," Mr. Smith said.

The bad news, he added, is that several limitations are likely to be placed on how 401(k)s can be used.

These likely limitations include:

- Limits on the dollar amounts of employee contributions to the plans. Federal regulations now permit employees to contribute up to $30,000 per year.

"I would expect them to be cut back fairly dramatically, perhaps to as little as $5,000 per year," Mr. Smith said, adding that smaller cuts are also possible.

- An offset provision to account for employee contributions to other retirement savings vehicles. For example, employees may now contribute up to $30,000 to a 401(k) plan and contribute separately to an Individual Retirement Account. This may be changed so that an employee's allowed 401(k) contribution would be reduced by the amount of his or her IRA contribution, Mr. Smith explained.
- Tougher discrimination tests that limit contributions of higher-paid employees relative to those of lower-paid employees.
- Stricter restrictions on distributions from 401(k) plans to employees who are still working, to ensure that 401(k) contributions are used for their intended purpose of providing retirement income.

Some of those favoring repeal of Section 401(k) argue that the plans are unfair because they are available only to employees whose companies have set up the plans, and not to other employees, self-employed people or the unemployed.

One possible substitute for 401(k)s, opponents say, is to raise the limit on contributions to IRAs, which are available to everyone.

But, Mr. Smith said IRAs aren't a good substitute for 401(k)s, because the matching employer contribution included in most 401(k) programs encourages employees to save more for retirement.

Mr. Smith added that attempts to repeal Section 401(k) are based solely on the government's need to find new sources of tax revenue to reduce the federal budget deficit.

The government's arguments against 401(k)s "have nothing to do with the plans themselves," he said. "As far as Congress is concerned, there is gold in 'them thar employee benefits hills.'"

While new limitations may be imposed on 401(k) plans, the Internal Revenue Service still has not issued final regulations governing the plans, Mr. Smith added.

The IRS issued proposed rules in November 1981, upon which employers and employees have relied in the absence of final rules.

"The whole thing has pretty much proceeded at a snail's pace," Mr. Smith said. "One could only wish the Treasury would collect taxes at the same rate as they issue regulations."

In spite of the regulatory uncertainties surrounding 401(k)s, the plans offer a number of advantages and have proven very popular, said Mr. Smith and William T. Johnson, vp with Bayly, Martin & Fay Inc. in Los Angeles.

Among the tax benefits of the plans, Mr. Johnson noted, are:

- Reduction of employees' taxable income.
- Deferral of taxes on investment accumulations until an employee collects from the plan on retirement.
- Ten-year forward averaging on lump-sum distributions of 401(k) benefits upon retirement.
- Deductibility of matching contributions by employers.

Mr. Johnson said that some companies have supplemented or replaced their defined benefit pension plans with 401(k) plans, partly because of worry about the Financial Accounting Standards Board proposal that unfunded pension liabilities be included on corporate balance sheets.

"A lot of companies want to retain their defined benefit plan but have decided they are not going to add to it," he said, explaining that they may add a 401(k) instead.

For companies interested in starting a 401(k) plan, Mr. Smith and Mr. Johnson offered some words of caution and advice.

For example, a 401(k) plan must meet IRS non-discrimination tests, which are designed to ensure that the plans don't discriminate in favor of highly paid employees.

Plans must pass either of two mathematical tests, Mr. Smith noted:

- The average percentage of salary deferred by the higher-paid one-third of employees cannot exceed 1.5 times the average deferred by the lower-paid two-thirds.
- The average percentage of salary deferred by the higher-paid one-third cannot exceed 2.5 times the average deferred by the lower-paid two-thirds, and the difference between the higher-paid and lower-paid employees' averaged deferrals cannot exceed 3%.

The "2.5 test" works best when the average deferral of the lower-paid employees is 6% or less; the "1.5 test" is best when the average deferral of lower-paid employees is more than 6%, Mr. Smith noted.

For example, if the lower-paid employees defer an average of 2% of salary, the higher-paid employees would by limited to an average 3% deferral under the "1.5 test," but could defer an average of 5% under the "2.5 test."

But, if the average deferral of the lower-paid employees is 10%, the "2.5 test" limits contributions from higher-paid employees to an average 13%, because of the 3% difference limitation; the "1.5 test" allows contributions of up to 15% from the higher-paid employees.

The lack of final IRS regulations also has led to uncertainty about when withdrawals from 401(k) plans will be allowed, he added.

Proposed regulations provide for withdrawals by employees at age 59½, upon death or termination or in case of hardship.

Hardship is defined in the proposed regulations as the "immediate and heavy financial needs" of an employee who has no other "reasonably available" resources.

The IRS had indicated informally that hardship withdrawals will be allowed for the purchase of primary residences and for medical and educational expenses, Mr. Smith said. But the lack of precise definitions is causing administrative problems for some companies.

For example, he asked, if an employee had a certificate of deposit with a substantial penalty for early liquidation, would that be considered a "reasonably available" asset?

Loan provisions, which are also popular with employees who may want early access to money in 401(k) accounts, can also cause administrative problems, Mr. Smith added.

Employers who include a loan provision in their 401(k) plan must decide on the rate of interest to be charged, the repayment schedules to be used and the limits on the amount and frequency of loans to individual employees.

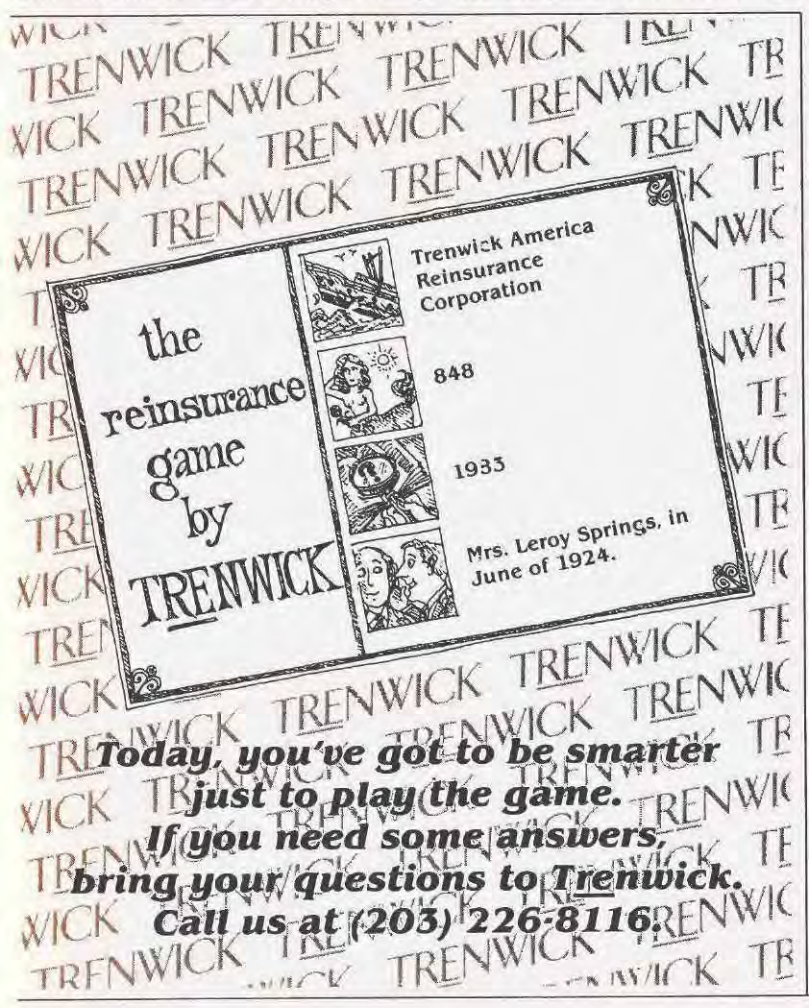
Mr. Smith advised against setting a minimum loan amount too high, warning that such a move could be deemed discriminatory against lower-paid employees.

Most 401(k) plans with loan provisions require loan minimums of $1,000 or $2,000, Mr. Smith said.

He also advised that loan repayments be handled on a payroll deduction basis. Otherwise, a default on a 401(k) loan could be considered by the IRS as an illegal distribution from the plan and could threaten the plan's qualified status.

Mr. Johnson added employers can reduce administrative costs of 401(k) plans by allowing new entries into and withdrawals on a quarterly or semi-annual basis only.

Employers should also keep track of the forfeited non-vested 401(k) benefits of terminated employees. These forfeitures can be used to cover some of the plans' administrative costs, he said. ■



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RIMS exhibitors make pitch to self-insurers

By JERRY GEISEL

NEW ORLEANS—Self-insured employers that want to self-administer their health benefits are being wooed by a growing number of specialized service providers.

Many of the first-time exhibitors at last week's Risk & Insurance Management Society conference were companies offering a wide range of claims administration services for employers seeking new ways to control health care costs.

For example, Dallas-based ARC Health Services Inc. has developed a software package that allows employers to completely self-administer employees' health care claims.

"We give employers the tools to administer claims," said Chuck Laughlin, vp-marketing.

The program, which is targeted at companies with more than 1,000 employees, includes a Hewlett-Packard System 3000 minicomputer, software and a printer.

The ARC system can be an important health care cost-containment tool, Mr. Laughlin said.

First, the employer no longer will have to pay fees to a third-party administrator, since it will be self-administering claims.

Also, the software package will pinpoint exactly how and where health care dollars are spent.

For example, the system can provide reports on fees charged by different hospitals and doctors so employers can determine the most cost-efficient health care providers in a geographic area.

"We can give the company the information it needs on providers and utilization so it can provide a super-efficient health care program. In short, we allow companies to control their own destiny," Mr. Laughlin said.

The cost of the ARC system depends on the size of a company's workforce. A company with 5,000 employees would pay about $250,000 for the system, including installation charges and training.

Mr. Laughlin said the system usually pays for itself in 18 months to two years, and employers often can cut their health care expenditures by at least 5% a year.

CG Data Corp. of St. Petersburg, Fla., a new exhibitor at the conference, offers a software package allowing employers to completely automate health claims administration.

CG Data's software package, called Fully Automated Claim Terminal System or FACTS, can operate on many corporate computer systems, said James Seymour, director of education for the 5-year-old company. "Our potential users are not tied to any one (computer) system."

FACTS can analyze health care claims so a company, for example, can know the average length of stay for different medical procedures, Mr. Seymour said. With that information, a company can encourage employees to use the most cost-efficient providers.

The FACTS software package costs between $40,000 and $70,000, which includes four weeks of training and software installation.

The system has been purchased by companies ranging in size from 500 employees to more than 50,000. TPAs and small insurers also have bought the package.

Health Systems International Inc., a New Haven, Conn.-based company that developed the advance payment system used by the federal Medicare program, now is marketing its expertise to employers.

With HSI's software package, a health care claim is assigned to one of 468 different diagnostic-related groups, or DRGs.

Based on information compiled from a variety of sources, such as the American Hospital Assn. and Medicare, HSI can determine a reasonable payment for a claim.

As a result, employers can negotiate with hospitals before claims are paid, said Dave Sparrow, director of product development.

In some cases, the HSI software package has kicked out 20% of bills sent by a hospital because of problems like unreasonable charges, he said.

The cost of the software package, known as Medical Claims Monitoring System, depends on the number of health care claims. An employer with fewer than 100,000 claims a year could buy the software for $20,000 or rent the package for $8,000 annually.

One new exhibitor is concentrating on companies that want to cut the cost of prescription drug plans.

Health Care Sevices of Bala-Cynwyd, Pa., fills prescription orders by mail. Because the company buys in huge quantities, it can cut the cost of filling prescriptions by between 20% and 30% a year, said Mary Casale, senior account executive.

Costs also can be cut because HCS aggressively tries whenever possible to substitute generic drugs for more-costly brand name products. HCS said its generic dispensing ratio is more than 20%, compared with a national dispensing ratio of between 5% and 8%.

Los Angeles-based Maxicare, the nation's largest publicly traded health maintenance organization chain, set up a booth at the RIMS conference to try to attract more national employers as HMO subscribers, said Jeanette Trefzer, manager of national accounts.

Maxicare has grown from one HMO in California in 1973 to operating 11 HMOs in 10 states with 550,000 members who work for more than 2,500 employers. More than 330 national employers—companies with operations in more than one state—have employees enrolled in Maxicare HMOs.

A multistate HMO chain like Maxicare offers many advantages to major employers, she said.

A big company with employees in different states faces fewer administrative problems if it can deal with one company in different locations than if it had to work with independently owned HMOs.

"It is much easier to talk to one HMO company than a dozen different HMOs," Ms. Trefzer said. "Employers don't want the hassle.

"People know this (multistate HMO networks) is the way the HMO movement is going. Employers much prefer dealing with one company," she said.

And, dealing with an HMO multistate network assures that a company's employees receive uniform HMO benefits, she said.

Maxicare predicts it will have 1 million members by 1990 and annual revenues of about $1 billion.

Last year, Maxicare reported revenues of $316.7 million, up from $196.7 million in 1983. Net income climbed to $10.7 million from $5.4 million.

Maxicare now operates HMOs in California, Illinois, Indiana, Wisconsin, Utah, Missouri, Texas, Louisiana, Ohio and Kentucky. It will open an HMO in June in Fort Smith, Ark. ■

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Flexible program takes careful planning

By JERRY GEISEL

NEW ORLEANS—Employers should establish a strategy before they take the plunge into flexible benefit plans, a consultant says.

"You should go through a multi-step acid test," said Frank DiBernadino, a vp in the Philadelphia office of broker and benefit consultant Johnson & Higgins.

For example, an employer considering a flexible benefit plan must decide how plan design can meet corporate objectives, Mr. DiBernadino said last week at a Risk & Insurance Management Society conference session on developing alternative benefit strategies.

Answers also must be found to practical questions, like how the plan will be communicated.

Some companies may boast that

they implemented a flexible benefit plan in a few months, but start-up can take much longer.

For example, 19 months passed between the time Thomas Jefferson University in Philadelphia considered a move to a flexible benefit plan and the time it began operating, said Jim Geier, manager of reserve compensation at Jefferson.

Jefferson's experience was examined at the seminar as an example of how to set up a flexible plan.

During those 19 months of planning, Jefferson's employee benefit department evaluated different consultants, launched a feasibility study and obtained senior management approval for the program.

From the outset, Jefferson identified its objectives in setting up a flexible benefit plan, including giving employees more benefit options, controlling health care costs and maximizing tax advantages to employees, Mr. Geier said.

Before Jefferson's October 1984 implementation of a flexible benefit plan, the 5,000-employee university had what Mr. Geier called a traditional benefits package.

The health care plan, offered through Blue Cross/Blue Shield of Pennsylvania, provided 100% hospital expense reimbursement after a $5-per-day co-payment fee. It also paid 80% of doctors' bills after a $100 deductible.

Other benefits included a short-term disability plan that paid two-thirds of salary—up to a maximum of $165 a week—for up to 26 weeks, and a long-term disability plan that paid 60% of salary up to a monthly maximum cap of $6,000.

Term life insurance coverages varied from one to two times the employee's salary, depending on the employee's position.

When Jefferson surveyed employees, it found they generally were satisfied with the type of benefits they had, but they were interested in "trading" benefits

For example, many of the employees were covered under a spouse's health plan and didn't need the same coverage as an employee with a non-working spouse and children.

As a result, employees were given the opportunity to choose among benefit options.

For example, employees could continue their existing health care plan or select a plan with a $250 deductible for physician and hospital expenses and 20% co-insurance above the deductibles.

Under another option, only available to employees with health care coverage under a spouse's policy, the plan would pay 25% of health care expenses after a $100 deductible. The employee would be responsible for the remaining 75% of expenses, most of which would be paid by the spouse's plan.

Short-term disability options included elimination of coverage, sticking with the basic two-thirds of salary up to a maximum benefit of $165 a week, and opting for two-thirds or 80% of salary without caps on maximum benefits.

For long-term disability, three options were offered: a basic benefit of 50% of monthly salary; the old benefit of 60% of monthly pay; or a new, more generous benefit of 70% of monthly pay.

Employees also were given several life insurance options, including reducing existing coverages or increasing coverage in amounts up to four times of annual salary.

Other benefits, like dental and vision care and retirement benefits, were not changed.

The key to the Jefferson plan is a "benefit credits" feature. The employees get a certain amount of credits at the start of the plan, and they can use the credits to "buy" the type of benefits they want.

For example, an employee who opts for the least-expensive LTD benefit, which would "cost" fewer credits, would have more credits to buy additional life insurance.

Credits also can be transferred to a flexible spending account, which can be used to pay uncovered medical expenses, dependent care and legal expenses. And, employees can reduce their pretax salaries by up to $6,000 a year and transfer the funds to the FSA.

Mr. Geier said that communicating the new flexible benefit plan to employees was a challenge.

"Employees were used to receiving certain benefits. Some people probably were scared," he said.

To allay fears, Jefferson mapped out a broad-based benefit communications strategy.

First, Jefferson selected an emblem—a representation of Thomas Jefferson—for use on all flexible benefit brochures.

And, employees received a letter from the president of the university announcing that benefit changes were being planned.

Groups of 150 employees were briefed on the plan. Employee supervisors were designated as "key communicators" to answer questions.

Enrollment forms were mailed to employees' homes. "We made a conscious decision to mail forms home so employees could discuss options with their families," Mr. Geier said.

With the program now 6 months old, "Employees think the greatest thing going is that they can trade benefits," Mr. Geier said.

While there has been considerable trading of benefits, few employees—less than 10%—have elected to contribute funds to the flexible spending account.

Mr. Geier said the low participation rate has been caused by proposed Internal Revenue Service rules that require employees to forfeit unused funds that remain in an FSA at the end of the year (*BI*, May 7, 1984; May 14, 1984). ■

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Personal computers can administer benefits

By ROBERT A. FINLAYSON

NEW ORLEANS—Benefit managers desiring an in-house computerized benefit administration system should consider a personal computer instead of tapping existing corporate data processing capacity or using outside computer services, two consultants advise.

The difficulty in gaining access to a centralized corporate data processing facility and the cost of adapting that system to handle benefit administration can fustrate efforts to computerize the benefit department, they say.

"The human resources manager has had to rely on the (data processing) department, trying to get access to the mainframe computer for information," W. Brian Harrigan, a vp with Johnson & Higgins in New York, said at last week's Risk & Insurance Management Society conference.

"And often we find that many human resources managers are not the first in line when it comes to having access to the mainframe computer."

Corporations commonly use their mainframe computers for accounting, payroll and research-and-development functions. According to Mr. Harrigan, these functions usually take priority over benefit managers' data processing needs.

Furthermore, Mr. Harrigan said, the initial cost of programing a mainframe computer to process employee benefit information can range from $250,000 to $750,000, adding that it can take months and sometimes years to get the benefit programing in place.

An alternative to using existing data processing capabilities is to tap an outside computer utility or timesharing company for benefit data processing. But this alternative can also be very costly and, because the data is stored outside the company, confidentiality of the data becomes an issue, the panelists explained.

Because of these problems, many benefit managers say they would like their own systems to process benefits claims, agreed Mr. Harrigan and Carl S. Swope, vp for research and development at Johnson & Higgins in New York.

The two panelists maintained that a personal computer can provide the kind of data processing capabilities that benefit managers want, while—at the same time—give them total control over the flow of benefit information to other corporate departments and outside administrators and insurers.

With a capital investment that can be less than $50,000, a benefit manager can have data processing capability—based on a personal computer—that can administer a benefit program with as many as 10,000 lives, they said.

A typical data processing configuration for benefit administration would include a sophisticated personal computer, which costs between $3,500 and $6,000; a hard disk drive for storing benefit data files, which costs between $5,000 and $15,000; a tape drive used to provide information to the payroll and accounting departments, which costs about $7,500; and a printer to produce management reports and other docments, which costs between $1,500 and $3,000.

The required software can cost between $30,000 and $50,000, depending on its level of sophistication and its data handling capabilities, the panelists said.

One of the first questions that comes up when a large company considers a personal computer for benefits administration is whether a PC can handle information for several thousand employees.

"The first thing we have to explain is that the personal computer has tremendous expansion capabilities," Mr. Harrigan said. By adding an external hard disk drive, a PC's storage capacity can be expanded "to the point where we can administer 10,000 or more employees," he added.

Another concern that is often raised, the speakers said, is whether the personal computer can communicate with other computer equipment, including mainframe computers.

By using a tape drive, Mr. Harrigan explained, the personal computer can communicate with "virtually any other system."

"For example, organizations now will take a (computer) tape from the payroll department, bring it into the human resources department, load it in on the tape drive and read that information into the PC," Mr. Harrigan said.

As a result, the tape drive allows the benefit department to gain access to any information on the company's mainframe computer via the department's personal computer, the speakers said.

Using the existing payroll computer tapes in this way means that most of the employee information needed to establish a benefit administration system does not have to be keyed into the computer. Rather, the information can simply be fed into the personal computer from the payroll computer tape.

One of the major advantages of using a personal computer, according to the panelists, is that it provides what is called "on-line inquiry," meaning that data can be accessed immediately and at virtually no cost.

The personal computer can be programed to automatically perform all calculations required for each benefit program just by entering the employees salary and benefit elections. Other capabilities, according to the speakers, include:

- Maintaining all employee and dependent eligibility information, including when the employee will become eligible for various plans and which dependents are eligible.
- Maintain all benefit information required by third parties.
- Maintain flexible spending account information, handle disbursements and maintain balances from prior years.
- Produce reports on benefit selections, number of dependents, etc.
- Produce annual benefit statements for employees or on-demand benefit statements when an employee has a change in pay or a change in status.

"So what we have with a benefit administration system on a personal computer is centralization in the human resources department and control of information and the ability to control the flow of that data and the use of information," Mr. Harrigan pointed out.

One of the drawbacks of using a personal computer is that currently very few companies provide benefit administration software for PCs. But, according to Mr. Swope, a number of companies are considering entering this market.

Johnson & Higgins is one of about four or five companies that offer benefit software for personal computer applications, the speakers said. ■

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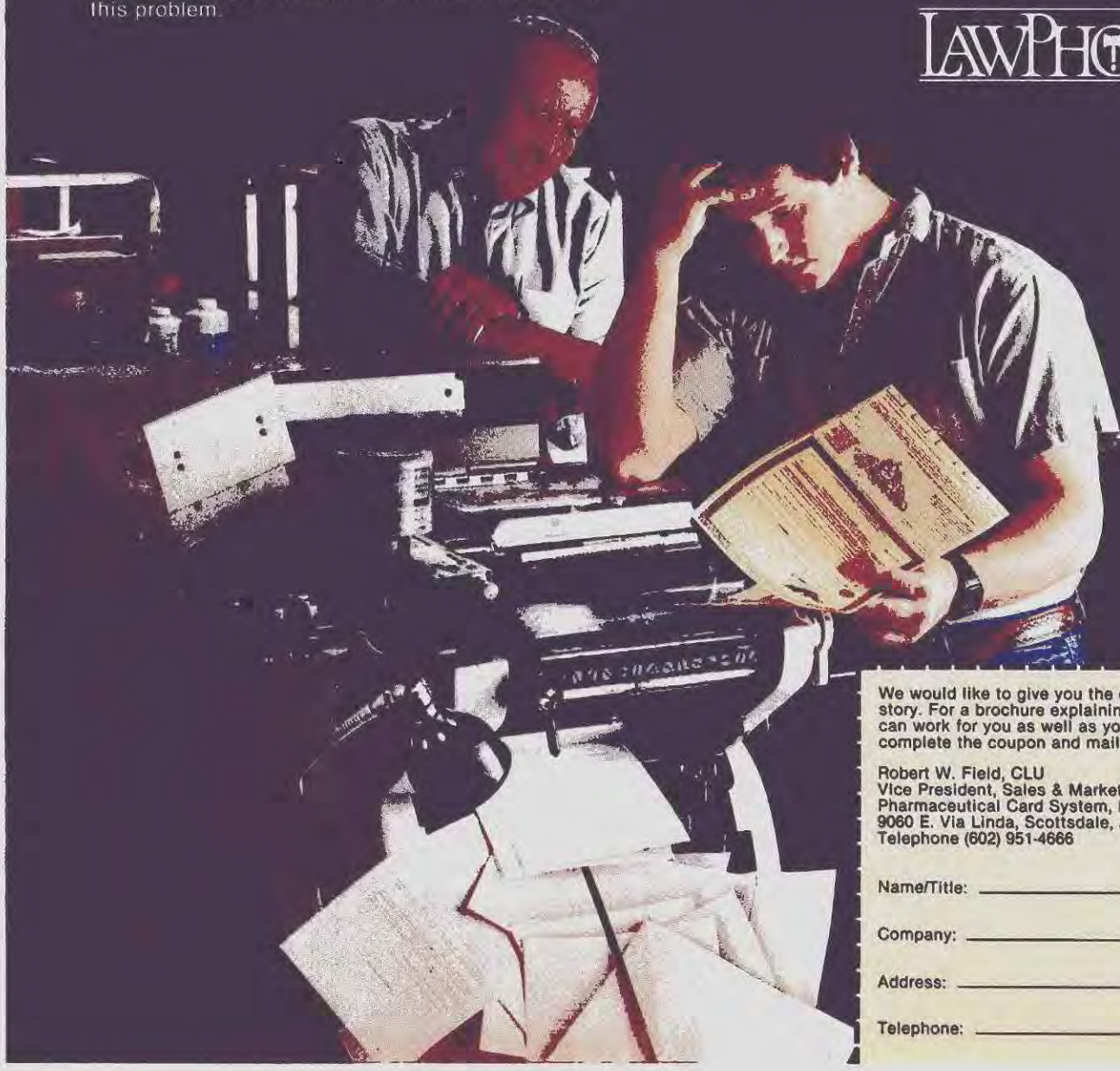

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Health care data can improve cost control

By MEG FLETCHER

NEW ORLEANS—Gleaning vital information from cost-containment reports requires benefit managers to carefully analyze health care data from a variety of sources, experts say.

A panel at last week's Risk & Insurance Management Society conference told benefit managers how to categorize data and evaluate software packages to assess cost-containment measures.

Cost-containment reports should draw comparisons between employees' health care histories and data available from sources like the National Center for Health Statistics, said Joseph Marlowe, director of health care management services for Hartford Insurance Group in Windsor, Conn.

He said that to put information in perspective, a benefit manager should break down hospitalization utilization data by specific categories like sex, length of stay and especially geography.

There is "tremendous" variation in hospitalization rates by geographic regions in the United States, he said. For example, the annual hospital admission rate per 1,000 persons under age 65 is 115 in the West; 129 in the Northeast; and 153 in the North Central states.

The number of days of hospitalization per 1,000 persons was 581 in the West; 844 in the Northeast; and 968 in the North Central states, Mr. Marlowe said.

Critical data elements that a benefit manager should track for cost-containment reports include name, age, sex, residence, hospital, admission date, discharge date, admitting and operating physicians, primary and secondary diagnoses and procedure codes, Mr. Marlowe suggested.

This data could be used to profile hospitals to determine which are most cost-effective, he said.

Mr. Marlowe added that hospital costs can best be compared by using a software program that uses an average length-of-stay figure that is adjusted for the case mix, which takes into account the severity of the cases handled by each hospital.

A software program to adjust for a case mix weighs factors like the primary and secondary diagnoses, procedures performed, age, sex and discharge status, Mr. Marlowe said. Without adjusting for the case mix, a hospital could claim the patients treated there had more serious ailments, he explained.

Usable or "good" data on health care claims also is needed to analyze and evaluate the existing design of a health care plan, he said. Such analysis is the benefit manager's best way to see where health care dollars are going—an increasingly important issue to employers, Mr. Marlowe said.

American business and industry spent more than $100 billion last year for employee health care. Employee health care claims have doubled every five years since 1955 and have an annual growth rate of about 15%, he said.

Looking at properly "refined" or categorized data—in its proper perspective—has another purpose.

The data can be used to identify employee health problems that may lead to preventive programs. For example, discovering a high rate of stomach and liver problems could suggest the need for an alcoholism treatment program, Mr. Marlowe said.

Having good data also will aid benefit managers in making decisions to offer such programs as pre-admission certification, contingent stay review, second surgical opinions and others.

While good data is one of the best tools benefit managers have to make such decisions, it also must be noted that data can be inaccurate.

Historical data can fall prey to inadequate diagnosis codes, inability to profile specific providers, excessive raw data that is poorly formulated, little interpretation and no normative standards or statistics for comparison, according to Mr. Marlowe.

Benefit managers can avoid repeating past mistakes in data collection by buying hardware and software that suits their specific needs, said Walter Wieners, director of cost containment for Health Systems International Inc. in New Haven, Conn.

Buyers should consider automated reporting packages for prospective rates, provider selection and benefit plan modeling, he said.

The type and degree of data coding needed also should be considered. Both Current Procedural Terminology (CPT) and ICD-9-CM codes are available, he noted.

CPT coding, used primarily to describe procedures, is more anatomically precise and is used more by physicians. ICD-9-CM coding is used more for diagnosis and is used by hospitals, the panelists said.

Benefit managers must weigh the advantages and disadvantages of using a system that is based on a microcomputer vs. a mainframe, Mr. Wieners said.

One advantage of a microcomputer is that it offers direct control, he noted. Disadvantages are that downloading information can be technically difficult, and data storage is often constrained.

Advantages of a mainframe are that it allows for large-scale retrospective analysis and has the potential of merging its function with the processing of workers compensation claims.

To get the most from cost-containment reports, a benefit manager must consider the advantages and disadvantages of regularly scheduled standard reports vs. one-time ad hoc reports done on either a microcomputer or a mainframe computer, Mr. Wieners said.

Standard reports have the advantage of being predefined and can be used to establish a data base. They also allow for consistency and trend analysis. However, it is costly to change them and there is often a time lag involved, he said.

Ad hoc reports can address specific questions, he noted. However, it is difficult to use such reports to make comparisons, he noted.

One example of the value of cost-containment reports was provided by panel moderator David S. Oltman, manager of benefits administration for Ciba-Geigy Corp. in Ardsley, N.Y., a pharmaceutical and chemical company. Ciba-Geigy employs more than 15,000 people who have 25,000 dependents covered by the company's medical and dental plans.

The company was approached by several vendors that offered to provide second surgical opinions for $155 each. Although management thought that was a fair cost, Mr. Oltman ran a report on the company's cost in 1984 for second surgical opinions and found that it had paid only an average of $50 per second opinion.

"If it were not for that report, we would have signed the contract and spent more money than we already were spending," Mr. Oltman said.

Ciba-Geigy also produced a report that showed which hospitals had short length-of-stay records for certain procedures. "By guiding employees to these hospitals, not only does the company save money on hospital days, but our employees get to go home faster," said Mr. Oltman.

The issue of selecting and evaluating a preferred provider organization also was addressed by Angelo Masciantonio, director of cost containment in the Philadelphia office of Advanced System Applications Inc.

Criteria for selecting and evaluating a PPO should include cost effectiveness, utilization, the degree of dependency between the employees and the physicians in terms of options, quality, geographic access, kinds of services provided and the financial viability of providers, he said. ■

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More rate hikes

Continued from page 2

Pollution coverage for chemical and drug companies is almost totally excluded now, Mr. Harder said. "I wouldn't be surprised to see pollution totally excluded in our treaties," he commented.

Mr. Harder suggested that risk managers and insurance brokers begin negotiations as many as 60 days before their insurance is set to renew. He agreed that insurers had not been willing to commit their limits 60 days before renewal at the end of 1984, because they were waiting to find out how much facultative reinsurance they could buy.

And, he advised asking primary insurers to increase their limits and requesting that the primary insurer provide the first layer of excess insurance.

Mr. Harder also recommended that risk managers carefully analyze the financial stability of their insurers. An insurer's Best's rating, its surplus position and its bond rating are all important, he said.

"There are 318 carriers on the NAIC watch list," he said, referring to the list of insurers that are under scutiny by the National Assn. of Insurance Commissioners.

"The next two years will be trying times for all of us," Mr. Harder added.

Mr. Jackson told the audience that he could not say, "Don't worry, we're in great shape," to respond to insurance capacity needs.

Lloyd's is a viable market, Mr. Jackson assured the audience. However, he predicted that Lloyd's results for 1982, the next year to close under Lloyds' accounting system, will not be good.

"We all lost sight of the basic principle: We are here to make an underwriting profit," he said.

Mr. Jackson argued that underwriters are entitled to the investment income they earn as a "dividend" for the risks they take as a cushion against the years that are exceptionally unprofitable.

Investment income should be used to pay investors dividends and underwriting profits used to increase the amount of business insurers can underwrite, he suggested.

While increasing prices should provide underwriting profits in 1986 and 1987, Mr. Jackson said that may not signal an end to price increases if underwriters have to compensate for inadequate pricing in prior years.

In addition, Mr. Jackson reported that in the last three months he has seen a "significant growing momentum" for the claims-made form for underwriting liability insurance.

He predicted that the pressure to switch to claims-made policies will come from reinsurers, who will refuse to write casualty reinsurance on an occurrence basis. "I am going to say that," he said. "I do not believe we can continue to use occurrence wording."

Insurers and their policyholders have to stop fighting over which coverage applies to losses, he suggested. "And underwriters need certainty," he declared.

Underwriters want to use the claims-made form to shorten the tail and to avoid the stacking of many years of insurance policies for one type of liability, such as asbestos, Mr. Jackson said.

With claims-made coverage, losses will be paid by insurers up through the limits purchased in a given year instead of by insurers on an account over many years, he said.

"The only way we can provide the limits that are needed" is under a claims-made form," Mr. Jackson declared.

By July and year-end, he predicted, coverage of $200 million to $500 million will not be available under an occurrence form.

"What's better, $250 million of claims-made coverage or $50 million of occurrence?" Mr. Jackson asked.

Mr. Jackson acknowledged that the general reaction to claims-made forms is that "they are terrible."

But, he countered that the claims-made form does not take anything away from the policyholder.

To assure policyholders that they will not lose all coverage for a particular type of loss as soon as the first loss is reported, Mr. Jackson said that underwriters will have to include a discovery period in the claims-made form. That discovery period, which could be purchased if the underwriter decides to exclude a particular type of loss in the future, could be forever, five years or 10 years, Mr. Jackson said. The length of the discovery period will be subject to negotiation, he said.

"As long as you buy enough coverage (in one policy year), you will be covered," Mr. Jackson said.

"I am not trying to walk away from losses," Mr. Jackson declared. "I want to know what year we will pay them."

Mr. Jackson advised the audience not to expect prices to break when they buy a claims-made form compared with an occurrence form.

If occurrence form prices were correct now and if the claims-made coverage included a retroactive date to exclude coverage for prior occurrences, there would be a reduction in premium for the first five years. Then, after five years, the claims-made price would be about the same as the occurrence price.

But, because prices are too low now, "Those who go claims-made will ask for two times the occurrence rate," Mr. Jackson said. But, underwriters will charge four times the rate for an occurrence form, he predicted.

Continued on next page

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Claims-made form

Continued from previous page

Claims-made forms should, however, create more price stability in the future, Mr. Jackson said. With the claims-made form, the problem of properly reserving for incurred-but-not-reported losses will be eliminated, he noted.

And, claims-made forms will provide reinsurers with certainty so that they will provide the needed reinsurance to primary companies, Mr. Jackson said.

"Let's work on this together," Mr. Jackson suggested. "Give thought to claims-made. It is not an inferior product."

Mr. Harder commented that three months ago he believed that national accounts would stay on an occurrence form. But, now he believes that if there is support for the claims-made form from excess insurers, "we will write claims made."

But, he added that he "personally questions whether the insurance industry will support the claims-made form."

Mr. Jackson and Mr. Harder agreed that the insurance industry must develop a market for environmental impairment liability insurance, which covers losses associated with gradual pollution damages.

"You will see some creative things, or else the federal government will have to provide it," Mr. Harder said. He suggested that a pooling arrangement among major insurance companies, with support from London, could provide the coverage.

Mr. Jackson agreed that such a pool of insurers could be established, as has been for nuclear insurance. But, he stressed that the coverage would have to be written on a claims-made form.

Professor Williams explained why the insurance marketplace is subject to the cyclical swing in pricing and availability that has occured in the last year.

The reasons for the insurance price cycle, he said, are:

- Even actuaries make mistakes.
- Factors affecting the costs and profits of insurance are subject to their own cyclical changes.
- There are swings in the supply and demand for insurance.

Actuaries cannot precisely price insurance, Professor Williams explained. They are asked to project expected losses and the loss expense allowance and to add a certain factor for profits.

But, there are too many uncertainties regarding expected losses, Professor Williams said. Losses, especially for smaller lines of insurance, may be too few to form a statistically credible loss history. And, future losses will not necessarily be the same as those in the past.

"The world changes," Professor Williams said. "It's a long step from the past to the future."

And, higher deductibles, broader coverages and new types of insurance "make the experience of the past even less reliable," he said.

Pricing for a particular profit also is difficult, Professor Williams said. For an actuary to price insurance for a certain rate of return, the actuary must know what the company's premiums-to-net worth will be and the amount of investment income to be earned must be predicted.

The prices that actuaries do suggest, Professor Williams noted, are within ranges and are imprecise.

Even if actuaries priced insurance to the penny, factors such as loss frequency, loss severity and interest rates affect the ultimate results of an insurer.

Explaining the forces of supply and demand at work in the insurance marketplace, Professor Williams started at the point of the cycle when insurers are earning profits.

When insurers are earning profits, their net worth increases as a result of profits and new investors who want to share in those profits. As insurers' net worth increases, their capacity to underwrite insurance increases.

Eventually, the insurance business reaches the point of overcapacity to write insurance, when the supply of insurance exceeds the demand for it. That creates vigorous price competition.

In the competitive marketplace, prices are driven well below the acceptable range of prices suggested by the actuaries. Eventually, insurers' profits drop below an acceptable level due to these low prices.

When profits fall below an acceptable level, prices are increased. But, because prices increase faster than insurers' net worth, the supply of insurance relative to the demand for it declines.

Eventually, profits do increase and the cycle starts all over, Professor Williams said. ■

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Hertz faces challenge in Louisiana

BATON ROUGE, La.—New York-based Hertz Corp. has until the end of the month to become a licensed insurer in Louisiana, or it must stop selling collision damage waivers in the state, the state insurance commissioner has ruled.

Commissioner Sherman Bernard found Hertz guilty last month on three counts of acting as an insurance company without a license.

He initially cited Hertz, which is one of the nation's largest car rental companies, last May. In that initial charge, Mr. Bernard said Hertz was acting as an insurer through the sale of collision damage waivers and the inclusion of customer liability and property damage insurance in its rental agreements (*BI*, Aug. 6, 1984).

If the collision damage waivers are insurance, then the rates would be regulated by state insurance departments. If not, then the rental agencies can set any rate, as they do now. Louisiana is one of several states that have tried to regulate the sale of the waivers (*BI*, Oct. 18, 1982). No state has yet had the waivers classified as insurance.

Currently in Louisiana, Hertz charges $6.95 a day for a collision damage waiver, which releases the automobile renter who has an accident from a $1,500 deductible that is not covered by the company's rental agreement, said John T. Browne, Louisiana's deputy insurance commissioner.

Hertz plans to appeal the decision, said John Britton, manager of news and information for Hertz.

If the court holds that the waivers are insurance, the state could gain as much as $1.5 million in premium taxes, Mr. Browne said.

The Insurance Department also is challenging a provision in the rental agreement that provides liability coverage amounts of $100,000 per person and $300,000 per accident, and property damage coverage limits of $25,000, Mr. Browne said. That coverage is included in the regular rental agreement.

The Insurance Department is seeking regulation of the coverage, because, "even though (the insurance) is not broken out as a special charge, it must be included in the daily rate," he said. Because Hertz is self-insured, it is able to furnish the coverage, Mr. Browne added.

However, Hertz's Mr. Britton said, "Based upon the initial review of the hearing officer, it is clearly contrary to precedence in all jurisdictions, including a 1981 decision of the Louisiana Department of Insurance, and we are confident that upon court review, the decision will be reversed." ■

Illinois exchange

Continued from page 2

Each of the new syndicates will have initial capital of at least $2 million.

"We have sat here waiting for the market to change...With the hardening of the market and the disappearance of other markets, brokers are looking for an alternative," Mr. Skelton said, stressing that the exchange is such an alternative.

"We're growing; there's no doubt about it," said Mr. Skelton, who predicts an additional six syndicates by the end of this year.

The new syndicates still are raising capital, finishing paper work and putting final touches on their organizational charts. They are:

- The Classic Syndicate Inc., to be co-owned by J.W. Beresford-Wood & Co., a 5-year-old reinsurance intermediary in Concord, Calif.; Classic Insurance Co., a 2½-year-old Bermuda-based insurer that until March was known as Excalibur Insurance Co. Ltd.; and Concord General Inc., the parent holding company of both the intermediary and offshore insurer.
- Britamco Underwriters Inc., which is being organized by Weicholz Management Corp., a 15-year-old managing general agent based in Coral Springs, Fla.
- Inspro Insurance Syndicate Inc., which is being organized by Inspro Insurance Services Inc., a company specializing in underwriting management, based in Walnut Creek, Calif.
- Transco Syndicate #1 Ltd., which will be owned by Transco Insurance Services, a 10-year-old underwriting manager based in Solvang, Calif.

The four syndicates received approval earlier this month from the exchange's board of directors, and all expect to be writing business by this summer.

"The exchange is supposed to be a market to provide capacity where the admitted market doesn't...(provide) capacity for tougher risks," Mr. Skelton said.

In the past, the exchange has written relatively few direct risks. Instead, most of the exchange business is reinsurance, and a good deal of that is treaty reinsurance, Mr. Skelton said.

But, the new syndicates plan to change that.

Inspro Insurance Syndicate is planning to write architects and engineers professional liability and related coverages on a direct basis and as reinsurance, said Grant H. Weaver Jr., president of Inspro Insurance Services.

Mr. Weaver is expected to be either president or chairman of the new syndicate.

Inspro is planning on initial capitalization of at least $2.5 million, but it would like to put up more. "That's what we're trying to determine now," Mr. Weaver said.

The Classic Syndicate also is planning to write on a direct basis, according to Jeffery Beresford-Wood, president of all three co-owners of the new syndicate. He also is expecting to be president of the syndicate.

"We'll write only excess/surplus (coverage), but it will be direct as opposed to treaty or facultative," Mr. Beresford-Wood said.

He hopes the syndicate will be writing business by July 1, at the latest. The organization is hoping to capitalize the syndicate at $2.2 million and still is negotiating with banks for funding, Mr. Beresford-Wood said.

Weicholz Management Corp. will bring an existing book of business to its new syndicate, Britamco, according to Stephen Weicholz, who is president of the MGA and also is expected to be president of the new syndicate.

Britamco expects to write umbrella liability coverage and special multiperil policies, mostly on a direct basis, Mr. Weicholz said. He hopes the syndicate will be writing as early as June 1.

The new syndicate is planning on initial capitalization of $2.5 million.

Transco will also write on a direct, rather than a reinsurance basis. Its main emphasis will be excess/surplus lines, said Peter O'Shaughnessy, president and chairman of the board of the underwriting management firm. He also is expected to be president and chairman of the new syndicate.

Transco expects to be up and running by next month, Mr. O'Shaughnessy said. The syndicate will start with a capitalization of $2.4 million, he said.

As these four new syndicates gear up, four others in the exchange are winding down, Mr. Skelton said.

The four syndicates that have ceased underwriting are: Midwest General Syndicate Inc., owned by Reliance Insurance Group; Sentry Syndicate Illinois Inc., owned by Sentry Insurance Group; RCA Syndicate #1 Ltd., owned by Reinsurance Co. of America; and Northbrook Underwriters Syndicate Inc., owned by Allstate Insurance Group.

The four syndicates combined wrote gross premiums of $1.1 million in 1984, or 6.9% of the exchange's total premium volume, and had capital and surplus of $8.6 million.

The exchange lost one other member last year—Lincoln Union Syndicate Inc.—owned by The 1972 Co., Mr. Skelton said.

However, the four new syndicates indicate a "healthy sign" for the exchange, according to Mr. Skelton.

"In addition, we also have two new broker members," he said.

The two are Thomas E. Sears of Boston and Pridemark of Northern Illinois, which join 50 other brokers at the exchange, Mr. Skelton added. ■

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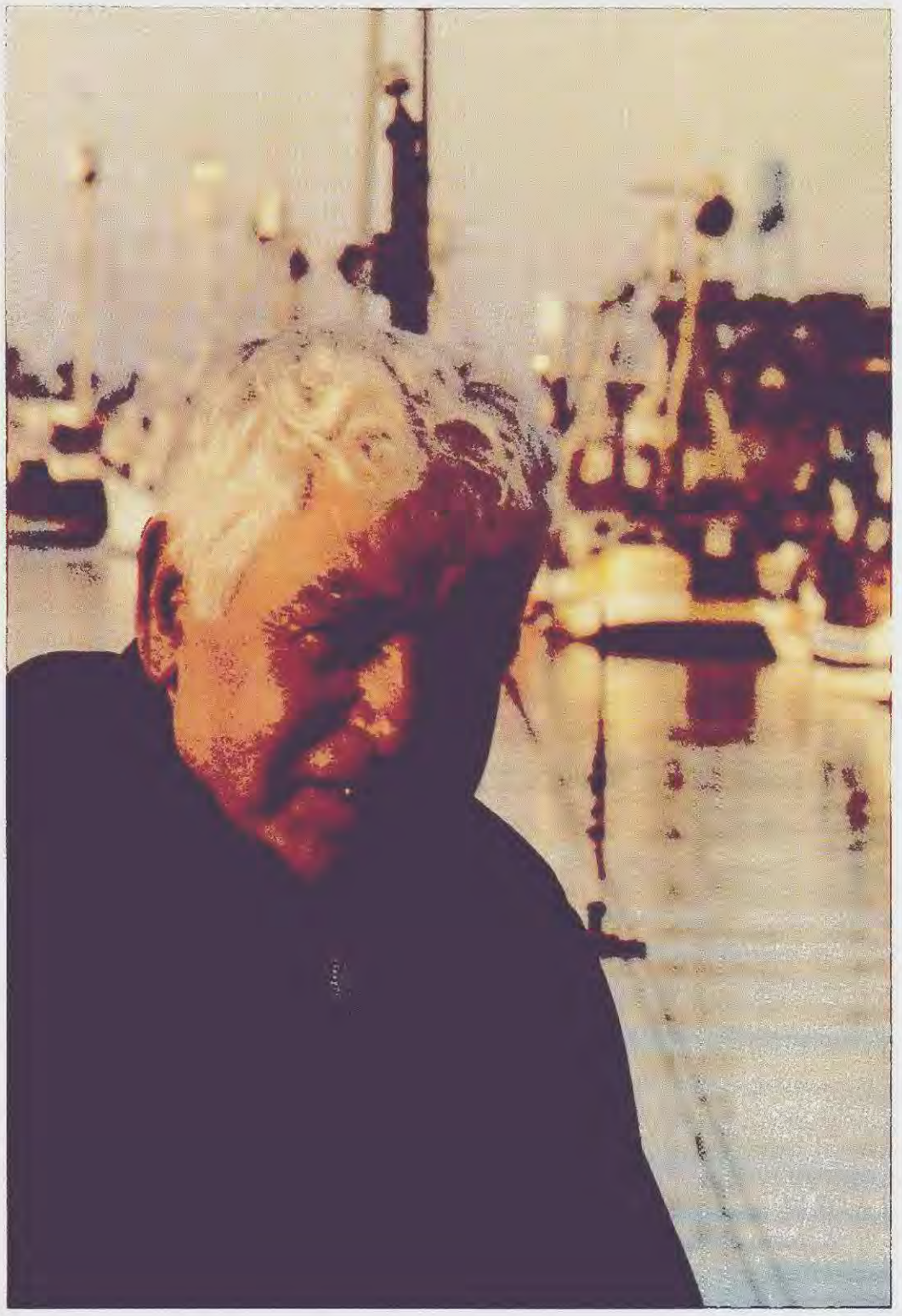

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Satellite market

Continued from page 1

The National Aeronautics and Space Administration originally believed the engine failure was caused by a failure to flip an automatic timing sequence switch when the probe was deployed from the shuttle's cargo bay.

Last Wednesday, astronauts tried to flip the switch using a makeshift "flyswatter" attached to the arm of the shuttle. But, the procedure failed to activate the satellite's electrical system, and the probe remained in a useless orbit.

A NASA spokesman said it was unlikely that future shuttle flights will salvage the probe because of the volatile nature of the fuel it has on board, confirming the loss.

The satellite is the third in a four-satellite series to be leased to the U.S. Navy. All of the satellites were insured by Hughes nearly two years ago for a rate of less than 6% of their insured values, sources say.

The Syncom III was insured for just less than $85 million. The coverage was brokered by Marsh & McLennan and Bowring Space Projects in London.

Intec, the lead U.S. underwriter, will pay in excess of $25 million of the loss, according to sources in the satellite insurance market. Underwriters in London, led jointly by Merrett Syndicates and Lloyd's Ariel Syndicate insured about $35 million dollars of the loss, the sources say.

The remaining $25 million is placed with other insurers in the United States, France and other nations.

The loss is the fourth to hit the satellite insurance market in the last 14 months, costing insurers more than $367 million dollars in that time. There have been more than $585 million in the last three years in satellite claims.

The recent series of losses began in February 1984 when two satellites launched by the space shuttle Discovery failed to reach proper orbit, costing insurers $180 million in claims. The satellites were subsequently retrieved on another shuttle flight, but so far underwriters have not recovered any money by selling the probes (*BI*, Feb. 13, 1984; Nov. 19, 1984).

In June 1984, another satellite valued at $102 million also failed to reach orbit (*BI*, June 18, 1984).

As a result, launch insurance rates jumped to 15% to 20% of the insured value from 6% to 8% of the insured value.

Therefore, satellite owners and brokers are using new approaches to handle capacity shortages and reduce costs of insurance. Some are considering assuming some of the risk themselves to reduce costs (*BI*, Feb. 4).

For example, when Brazil's state telephone company EMBRATEL went shopping for launch coverage for its satellite Brazilsat, it didn't want to pay more than 17% of the insured value of the probe. At that premium rate, it could place only $44 million of the value of the satellite. So, it insured $44 million in the commercial market and assumed the rest of the risk—tens of millions of dollars—itself. The coverage for the probe was brokered by Marsh & McLennan.

Brokers and underwriters had hoped that a combination of higher rates and creative underwriting would revive the satellite market after last year's losses.

"We have the rates right now," said Mr. Barrett. "We are a lot closer than we were a year and a half ago. The market has the potential to continue."

Market sources believed the tightened market could handle one loss a year, despite last year's losses.

"Underwriters would expect one loss a year with these kinds of rates being charged," said one London broker. "It's like the aviation market. One must expect these kind of losses to happen."

But, sources also believe that the loss of the Syncom, coming so close on the heels of the disastrous 1984, has not given underwriters enough time to build any profit back on their satellite coverages, despite the higher rates.

"We were hoping we could build back confidence in the market," said Mr. Barrett. "If this is the only loss in 1985, it will be difficult but not impossible to underwrite. But, if there is another catastrophe, there will be a serious situation."

And, the loss of Syncom also is a blow to plans to establish a novel insurance package for those launching satellites aboard rockets owned by France's Arianespace S.A.

Up until last week, negotiations had been under way between underwriters and Arianespace to put together a package that would insure Arianespace's clients for the cost of relaunch and the value of the satellites from the time the Arianespace rocket lifts off from French Guiana to the time the satellites are deployed.

The proposal calls for underwriters to charge a fixed rate for the launch coverage to clients whose satellites are included on the next 10 to 15 Arianespace launches. Then, after a three-year period, underwriters could charge a retrospective penalty to Arianespace if there were more than an agreed-upon number of losses during that time, says Roland Deschamps, general secretary for Arianespace in Paris.

"Arianespace is willing to participate in the risk," he said.

A key part of the proposal is the separating of launch risks from risks associated with the design of the satellite. Currently, launch insurance covers a satellite from the time the rocket or shuttle lifts off until the satellite is functional—or is declared lost. If the satellite becomes functional, satellite life insurance coverage takes over.

If the satellite fails to begin functioning because of some problem that is not related to the launch itself, the launch insurance still must pay.

But, for example, under the Arianespace proposal, the Syncom would not have been covered by launch insurance, since there was no problem with the launch. Instead, some new type of coverage would have to be designed.

Mr. Deschamps hoped that negotiations would be complete in time to offer this package this summer. But, last week's loss of the Syncom has made underwriters more wary of such long-term commitments, he admitted.

"Our negotiations will need more time," he said. "Some of the underwriters are not excited by our proposal. With a new claim, most of the underwriters will wait and see and not commit themselves to the new scheme."

Indeed, many leading satellite underwriters say they see potential problems. The biggest drawback, they say, is that it could be difficult to determine whether a problem that occurred during a launch was the fault of the launch vehicle or of the design of the satellite.

Mr. Merrett, one of the leaders in satellite launch underwriting, said he wouldn't want to get involved in such a plan.

In addition, NASA says it is not interested in participating in a launch insurance package, said a NASA spokesman at Johnson Space Center in Houston.

"The impression we get from underwriters is that they want us to stay out of their business," the spokesman said.

However, sources agree, if the Syncom loss forces more insurers out of the market, solutions to the capacity crunch will have to be found somewhere.

"I see it as a fact that the space insurance market is in a chaotic situation," said Frederic d'Allest, chairman of Arianespace. ■

DuPont offer gets big response

WILMINGTON, Del.—Twice as many Du Pont Co. employees as expected are accepting a one-time early retirement program.

The unexpected response will result in an estimated $125 million aftertax charge against first quarter earnings, or a pretax cost of $245 million.

But, officials say during the last three quarters of 1985, the program is expected to yield aftertax savings of more than $230 million, or pretax savings of $450 million.

The bulk of Du Pont's 122,500 U.S. employees had until April 8 to accept the offer, which is part of the company's effort to become a "leaner, stronger organization." This is the first companywide early retirement offer, a spokesman said.

Some 11,500 employees—both management and hourly workers—took advantage of the plan. The plan increases retirement income by adding up to five years to an employee's age and service total used in calculating pensions.

When the program was announced in January, the company expected between 4,500 and 6,500 U.S. employees to sign up. ■

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Risk/employee benefits:
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Sub-total 22,627
Associations 1,081
Government, unions and educational systems 944

Commercial Consumers Sub-total 24,652
Insurance agents and brokers 9,524
Insurance companies 5,867
Financial institutions 556
Actuaries, attorneys, adjusters, appraisers and consultants 3,265
Others allied to the field, ... 1,143

TOTAL 45,007

* Source: Business/Occupational breakdown of qualified circulation, Nov. 5, 1984 issue, as submitted to BPA for Dec. 1984, BPA Publisher's Statement.

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The Dunlap Agency

Claims facility

Continued from page 1

the company will commit to the facility by the May 29 deadline, although it left the door open to join in the future.

Manville blamed its decision on the delay in working out a reorganization plan in bankruptcy court and the "uncertainties" in the Wellington agreement.

"Because of the pendency of its Chapter 11 proceeding, the delay in negotiations toward a plan of reorganization and uncertainties surrounding the operation of the asbestos claims facility, Manville believes it will be unable to make a final commitment to Wellington by the deadline," Manville Senior Vp G. Earl Parker said in a prepared statement.

Manville Vp and General Counsel Richard B. Von Wald said last week Manville could not unconditionally sign the agreement without bankruptcy court approval, and added that approval will not be granted by May 29.

Mr. Von Wald also noted that the claims facility has no operating history and there was no way to tell how the Wellington agreement would compare with a potential claims settlement facility established through Manville's bankruptcy proceedings.

"We just don't know enough yet how our plan of reorganization or how the Wellington facility will operate," said Kathleen Page, another Manville attorney.

Last week, proponents of the Wellington agreement played down the impact of Manville's announcement, saying it would not hurt the facility and that the facility did not necessarily need Manville as a participant.

"It is not a setback," said James J. Restivo Jr., a principal negotiator of the agreement and an attorney for Pittsburgh-Corning Corp., an asbestos defendant.

"It will have little impact on the Wellington group. It was not unexpected and is not a significant event," he said.

"I'm surprised at (the announcement) being seen as a story," said Dean Wellington, who chaired the negotiations to establish the facility. "No one in our group anticipated Manville would be in a position to sign on the 29th because of the very slow progress in the bankruptcy court."

Mr. Restivo said participants recognized weeks ago it would be difficult for conditional subscribers in reorganization to get the necessary approvals to finally sign by the May 29 deadline.

Accordingly, he said the Wellington agreement had been amended. A new section allows a reorganized company to join the facility after May 29, provided the company satisfies several conditions and receives court approval within a certain time period, said Mr. Restivo, with the Pittsburgh law firm of Reed Smith Shaw & McClay.

Those conditions include:

- The company in reorganization conditionally subscribed to the agreement prior to May 29.
- The company agrees to all the provisions in the agreement and appendices, including allocations of asbestos liabilities and costs.
- A court of competent jurisdiction confirms a plan of reorganization that authorizes and directs the company to become a signatory to the agreement.

Companies in reorganization must have their reorganization plans approved by a court on or before Dec. 31, 1986. If they do not, they will be treated like any company that did not subscribe by May 29, Mr. Restivo said.

Companies that are not in reorganization and that have not signed the agreement by May 29 can only become part of the asbestos claims facility after approval of the facility's board of directors and the existing members of the facility, Mr. Restivo added.

Another company besides Manville that is affected is Amatex Corp., which filed for reorganization in November 1982 and has also conditionally signed the Wellington agreement.

Victor Drexel, Amatex's corporate counsel, said last week that the company also would not be able to sign the agreement by the deadline.

"Any company in Chapter 11 is not in a position to say it will or won't sign until it gets its act together and a reorganization plan in place or confirmed."

However, other observers disagree that Manville's decision not to sign the agreement next month is a "non-event" that will not impact the creation or operation of the facility.

"It clearly has an impact," said one source who asked not to be idenitified.

"Manville is a big player, with the biggest exposure. They had to have been banking on Manville's ultimate participation."

The source characterized the comments by proponents of the Wellington agreement as "damage control."

In addition, another attorney who last October called Manville's conditional approval of the agreement "an enormous PR exercise," says that Manville's latest decision has borne that assessment out.

"When the time came for Manville to do something concrete, they withdrew their PR gambit," said Barry Ostrager, an attorney who has represented insurers in the asbestos litigation, and is with the New York firm of Simpson, Thatcher & Bartlett.

Manville was never in a position to make a binding legal commitment to a facility without the approval of the bankruptcy court, Mr. Ostrager said in explaining why he considered the announcement to be a public relations exercise.

However, Mr. Von Wald disputed this, noting Manville conditionally joined the asbestos claims facility in order to find out as much as possible about it.

Mr. Ostrager also contends that because Manville has such a large share of the liability for asbestos injuries, "it remains to be seen what it (Wellington) does with the gap."

Without Manville, Mr. Ostrager speculated, plaintiffs with lesser claims might proceed against asbestos defendants through the facility and later press their claims against Manville in a separate proceeding.

However, plaintiffs with more substantial claims will likely bypass the facility altogether and proceed against Manville and other defendants in the courts, he added.

The facility "is essentially unworkable without Manville," Mr. Ostrager said.

Some also suggest that Manville's decision not to sign the agreement next month could have an impact on the company's bankruptcy proceedings.

According to one attorney involved in the bankruptcy, if Manville doesn't join the Wellington agreement, it could force consideration of a second claims facility for Manville alone, ultimately making resolution of claims more expensive and cumbersome.

A second facility would mean plaintiffs would have to bring claims to the Wellington facility to collect from some asbestos defendants, to a facility set up by the bankruptcy court to collect from Manville claims and possibly to state or federal courts to press claims against companies that did not sign the Wellington agreement.

In addition, some also suggest there may be a link between Manville's announcement it would not join Wellington next month and its opposition to a reorganization plan that is being considered by various creditor groups.

Details of the plan, proposed by attorney Leon Silverman, who represents future claimants in the reorganization, could not be confirmed last week. Mr. Silverman and others connected with the reorganization would not comment on the plan.

Manville has not yet seen the entire plan, but Mr. Von Wald said elements of the plan are hostile to Manville's interests.

One plaintiffs' attorney suggested that Manville came out with its announcement to blunt the Silverman plan.

"They are trying to put themselves in a better position with respect to the Silverman plan," the attorney speculated.

"They are more concerned with their settlement posture than about the Wellington proposal, which can't do anything but benefit them."

Robert Rosenberg, an attorney for a committee representing asbestos litigants in the Manville bankruptcy, said the committee was disappointed by Manville's lack of cooperation and that the company's joining Wellington could have been a step toward resolving the litigation.

However, Mr. Von Wald denied there was any link between Manville's decision not to sign the Wellington agreement and the bankruptcy proceedings.

Despite Manville's announcement it would not sign the agreement by May 29, Mr. Restivo said nine additional producers have conditionally signed, bringing to 42 the number of producers that have joined the facility.

The new companies to join include H.K. Porter Co. and eight others that Mr. Restivo would not identify.

Twenty-two insurers have also signed the agreement.

Beginning April 24, the insurers and producers that have conditionally joined Wellington will meet in Pittsburgh to agree on terms and conditions of thousands of insurance policies in question in the asbestos litigation.

Manville attorney Ms. Page said Manville would not be participating at the April 24 meeting. ■

Officials on trial for worker's death

Continued from page 2

working near a vat of cyanide when he collapsed and later died.

The Cook County state's attorney's office said in opening arguments in the trial last week that it will present evidence that the process used at FRS was "a constant source of danger" to employees, who were "never instructed in the safe use and handling of cyanide."

Gary Leviton, an assistant state's attorney, said testimony from other FRS workers is expected to "establish that safety equipment was rarely and sporadically provided, but in those instances where it was provided, it was grossly inadequate and ill-suited to the process."

But, defense attorneys said their clients were unaware of any alleged danger, and, in fact, had been told by inspectors from public and private agencies the plant and its operations were safe.

"(The court is) going to learn that in order to get insurance to operate any business, you have to be qualified, and Film Recovery Systems was in fact insured from the day it opened its doors until the day it was closed. . . ." defense attorney Ronald D. Menaker told the court.

"Between 1979 and 1983, there were loss-control experts from insurance companies. . .industrial hygienists, safety consultants, all of whom were employed for the express purpose of going in there and looking at what was going on. . . .They saw absolutely nothing unacceptable about the process," Mr. Menaker said.

Another defense attorney, Thomas J. Royce, said that in 1982 the corporations' president "sought safety consultants pursuant to his insurance executives' (and) insurance brokers' recommendations. . .to conduct inspections" at the plant.

When presented as evidence, these reports will show that there were "safe working conditions and practices," he said.

The Home Insurance Co., a subsidiary of City Investing Co. in New York, wrote FRS' property/casualty insurance coverage," said William Boockford, president of Boockford & Co. in Oak Brook, Ill., FRS' broker. He said he could not provide details of the coverage.

A spokesman from Home Insurance Co. would not provide any information about the policy.

Charged in the criminal indictments were Steven O'Neil, president of FRS and Metallic Marketing; Gerald Pett, vp and manager of FRS; Charles Kirschbaum, FRS plant manager; and Daniel Rodriguez, plant foreman.

Also indicted on the charges was B.R. MacKay & Sons of Salt Lake City, which processed the recovered silver, and Michael T. MacKay, a director of FRS and president of MacKay. But, Mr. MacKay so far has successfully fought extradition from Utah.

In addition, 30 former employees of FRS and their families have filed civil suits against FRS, its managers and business associates, seeking $115 million for exposure to an "illegal and dangerous process." Those cases are pending. ■

update

Former M&M head joins BMF

Continued from page 2

services industry for BMF. The post is not intended to be a "full-time effort" and has no managerial responsibilities, he said.

Mr. Schnitzer, who will be based in New York, said he has become a part-owner of BMF, but refused to elaborate. He said he also will spend part of his time investigating the financial services industry on his own behalf and that of the Bass family of Fort Worth, Texas, which is also a BMF investor.

Meanwhile, Timothy J. Mahoney, former senior executive vp for North American operations at Fred S. James & Co. Inc., has joined M&M Inc. as a managing director. He will be responsible for M&M's New York operations, which include offices in New York City; Philadelphia; Morristown, N.J.; and Hartford and Stamford, Conn.

Value of A&A merger lowered

NEW YORK—Alexander & Alexander Inc. says it will pay less for Reed Stenhouse Cos. Ltd. because A&A's earnings are expected to rise at a faster rate than those of the Canadian-based broker.

Instead of of exchanging 0.667 A&A shares for each Reed Stenhouse share, 0.576 shares will now be exchanged, says Peter Densen, A&A's chief financial officer.

Based on last Wednesday's $30.50-per-share closing price for A&A stock and the approximately 16.7 million Reed Stenhouse shares outstanding, the merger will be valued at $293.4 million, compared with $339.7 million under the original terms of the merger agreement—or $46.3 million less than originally projected.

A&A said that as the two companies compared one another's books, it was determined that A&A's earnings would rise at a faster rate because of changes in the U.S. insurance market. Also influencing the decision to change the terms of the merger, according to A&A, was favorable reaction to its decision to discontinue its insurance underwriting operations (*BI*, March 11).

In a separate development, most employees at Reed Stenhouse of Minneapolis have joined Fort Worth-based Bayly, Martin & Fay International Inc. because they did not want to become part of A&A's Minneapolis operation.

Five of the six producers in Reed Stenhouse's offices, plus three support staffers, decided they did not want to join the A&A office, primarily because of the growth in staff size to 200 from 10 employees, says Norman Hagan, a vp at BMF's Minneapolis office.

As a result, the producers, who control about 40% of the business in the office themselves, bought the remaining 60% share of the business from Reed Stenhouse in a complicated transaction that involved the exchange of cash as well as an agreement to leave some of the office's business with Reed Stenhouse. The producers sold this share to BMF, which until now hasn't had a Minneapolis office.

High court rules on benefit issue

WASHINGTON—In a decision favorable to employers, the Supreme Court ruled last week that unionized employees involved in disputes with employers over benefits must use the grievance procedures established by their collective bargaining agreements, and cannot sue in state courts.

Stephen Bokat, general counsel for the U.S. Chamber of Commerce, said an increasing number of employees have been bringing disputes over benefits to state courts, which can award actual as well as punitive damages. Punitive damages cannot be awarded under union grievance procedures, he said. And, while federal labor law stipulates that an employee can appeal a decision made in a grievance proceeding to a federal court, punitive damages normally will not be awarded, according to Mr. Bokat. The high court's ruling "will help stem" part of the wave of employee suits, he added.

Schrempf joins Teledyne

LOS ANGELES—David W. Schrempf, who recently resigned as president of CIGNA Worldwide Inc., began work last week as president of Teledyne Insurance Group's property/casualty operations in Los Angeles.

Mr. Schrempf, in this newly-created position, will be responsible for Teledyne's 12 property and casualty companies, including its four largest: Argonaut Insurance Co. in Menlo Park, Calif.; Trinity Universal Insurance Co. in Dallas; Financial Indemnity Co. in Los Angeles; and Great Central Insurance Co. in Peoria, Ill.Mr. Schrempf reports directly to George Roberts, president of Teledyne Inc. in Los Angeles.

Brokers' dispute

Continued from page 1

rior Court Justice Paul K. Connolly granted its request for a preliminary injunction forbidding RBH from soliciting business from current or prospective A&A clients during the two years prior to June 1983, when Mr. Dahany left A&A.

RBH was also prohibited from accepting business from existing or potential OBrion, Russell clients for the six months preceding December 1983, when Mr. Daly left the firm.

RBH appealed the decision to the state Appeals Court, which modified the preliminary injunction to apply only to actual—not prospective—A&A clients.

In addition, in response to an order from the appellate court, Justice Connolly ordered A&A to post a $500,000 bond against any damages that might be caused to RBH by the preliminary injunction if it were decided after a full trial that it should not have been issued in the first place.

RBH also has filed a $9 million suit against A&A, accusing the brokerage of violating the state's antitrust law and of "maliciously and intentionally" interfering with its contractual relationships.

The case is set for trial May 15, although a source involved in the litigation says the trial could be postponed.

According to papers filed with the court by A&A, Mr. Dahany was the president and principal shareholder of John T. Keyes Insurance Agency Inc., which was acquired by A&A in 1979.

As part of the takeover agreement, Mr. Danahy signed a non-competitive agreement that said that for five years after leaving A&A, he would not solicit business from any John T. Keyes customer or from any client that was actively solicited by Keyes.

He also agreed that the terms of the non-competitive agreement would apply to any A&A office in which he subsequently worked for a period of one year.

Mr. Dahany then joined A&A as senior vp in its Massachusetts office.

In March 1983, Mr. Danahy received 480 shares of A&A stock and, at the same time, signed another non-competitive agreement, stating that for two years after leaving A&A he would not "solicit, sell, service, divert, accept or receive" insurance business from any account that he "personally, alone or in combination with others" dealt with during the two-year period immediately before his resignation from A&A.

Mr. Danahy left A&A to join RBH in June 1983 and became its president in July 1984.

According to A&A, Mr. Danahy began to solicit business from A&A clients in 1983 "in flagrant violation" of his non-competitive agreements. A&A "customers and prospective customers" that have left A&A to do business with RBH, according to the court papers, include ADRA Inc., Apollo Computer Inc., Cabot Corp., Computer Corp. of America, H.K. Porter Inc., Leesona Corp., Nixdorf Computer Corp. and Pantry Pride Enterprises Inc.

According to court documents filed by A&A, RBH "was at all relevant times aware of the non-competition covenants" between Mr. Dahany and A&A.

The A&A court papers also say Mr. Daly signed an agreement in February 1980, while working for OBrion, Russell, stating that for three years after leaving the company he would not solicit business from any OBrion, Russell customer or from any firm that had been negotiating with the brokerage for services during the six months before he left.

In December 1983, the same month A&A took over OBrion, Russell, Mr. Daly left the firm to join RBH. According to the court papers, Mr. Daly, either personally or through other RBH employees, solicited business from Corporate Risk Advisors, Rockland Golf Course, Store Services Group and W.J. Trudelle Co., all of which were either OBrion, Russell customers or prospective customers.

As a result of these cases of "unfair competition," says A&A, the brokerage "suffers the threat of immediate and irreparable harm."

RBH responded in its answer and counterclaim that A&A's non-competitive agreements "have been interpreted and enforced by A&A against employers of former employees of A&A for the primary purpose of restraining competition by the new employer for the insurance business of A&A's customers or active prospects."

RBH says enforcement of these agreements "is part of a concerted plan and scheme by A&A to restrain trade and increase its share of the commercial insurance market in Massachusetts and is presently being enforced by means of threatened or actual litigation against former employees and their new employers."

RBH says in the papers that A&A, with 1983 estimated revenues of $12 million in Massachusetts, is the state's largest broker, while RBH, with $3.5 million in revenues, is the ninth-largest.

A&A has also pursued enforcing these agreements, says RBH, "by instructing its potential customers that any new employer of a former employee under either covenant cannot accept or receive that prospect's insurance business, and further by intimating that acceptance or receipt of the prospect's business by the new employer would involve the prospect of litigation between A&A and the new employer."

In a deposition obtained by RBH in connection with the case, J. Deane Somerville, chairman and chief executive officer of A&A's Massachusetts operation, said all 25 account executives in A&A's Boston office are under non-competitive agreements, as well as some of its department managers.

Mr. Somerville, a former OBrion, Russell employee, said he understood that under A&A's non-competitive agreements, former employees and their current employers are restricted from accepting or receiving new business from prospective A&A clients as well as actual clients.

In response to questions from RBH's attorney, Mr. Somerville said this restriction would apply regardless of how much business the employee produced; whether the employee was connected with the new account; or whether A&A was quoting prices 50% higher than its competitor and was the sole other bidder.

Benjamin P. Gill Jr., vp and general counsel for Alexander & Alexander Inc. in Baltimore, said A&A asks all its employees who will be involved with customer accounts to sign non-competitive agreements, although the specific wording of the agreements varies according to the laws of individual states.

But, he said that A&A only rarely has brought litigation over violation of these agreements. He described Mr. Danahy's case as a "rather unique situation," both because Mr. Danahy had sold his business to A&A and because of Mr. Danahy's current position with RBH.

But, Raymond I. Skilling, general counsel for Rollins Burdick Hunter Co. in Astoria, N.Y., said: "In this litigation, the real battle between RBH and A&A relates to the freedom of institutional buyers of insurance, which had nothing to do with the Keyes Agency bought by A&A all those years ago, to place their brokerage at any time for any line with any house of their choosing."

Mr. Gill disagreed, saying, "Neither A&A's non-compete agreements with its employees nor its practices in enforcing such agreements is intended to unreasonably restrict insurance buyers from a fully competitive marketplace.

"Based on A&A's past experiences, I do not believe that our non-compete agreements have had an anti-competitive effect."

RIMS' Mr. Harkavy points out there's a possibility that other brokers may adopt A&A's policy in self-defense, which could lead to a "horror system" where a risk manager could trigger litigation between brokers every time he or she wanted to move business.

However, Mr. Gill responded, "I don't see that as any kind of reasonable possibility" because of the uniqueness of the Danahy case.

Mr. Harkavy says he has no objection to applying non-competitive agreements to individuals, who would be prohibited from taking their accounts with them to another brokerage, but he objected to expanding the concept to include entire brokerages as well. There are "too many potentials for misuse if you apply it to the employer rather than the individual," he says.

A brokerage "could almost lock up the entire market" if it had enough former employees, said Mr. Harkavy, noting that brokerage employees tend to switch jobs frequently.

In addition, he said it is likely that A&A is either doing business with, or actively soliciting business from, a vast majority of RIMS members.

"RIMS believes very, very strongly that our business or patronage should be decided by price or quality of service, rather than court order."

Mr. Harkavy said he is now working with both parties in an effort to persuade them to alter their positions so that risk managers' access to the market is not prejudiced. He said he would also be available to testify on behalf of either side on the potential impact of the injunction on the market.

The case, he said, has "all the aspects of a divorce case," where a spouse spends $50,000 in legal costs for a $5,000 property. "There's a lot of emotion rather than logic involved in this litigation."

One risk manager already affected by the A&A-RBH case is Ann McDowell of Boston-based Bay Financial Corp. According to a statement Ms. McDowell gave to the court, Bay had at one time used A&A as a broker, although it had had no direct contact with Mr. Danahy.

In July 1984, Bay moved its account from A&A to Reed Stenhouse Cos. Ltd. and another broker after Bay was informed by A&A that it was unable to place a major portion of Bay's coverage.

Bay recently decided to consolidate its account to Rollins Burdick Hunter so the account could be serviced by a former Reed Stenhouse employee, Pamela J. Haughawout, who had joined RBH. But, although Ms. Haughawout had never signed a non-competitive agreement with either Reed Stenhouse or any other broker, the temporary injunction blocked Bay's attempt to move its business to RBH, Ms. McDowell said.

"If I had known when I had given Bay's insurance brokerage business to A&A that I would ever be restricted in the future from moving any of Bay's brokerage business to any other brokerage house, I would have seriously considered not placing business with A&A," Ms. McDowell said in her statement to the court.

Ms. McDowell later told *Business Insurance* that she subsequently received special permission from the court to move Bay's business to RBH. However, she finally decided to move the business to Johnson & Higgins, because J&H does not require its employees to sign non-competitive agreements.

Ms. McDowell said she was afraid if she moved her business to RBH and A&A subsequently won the suit, A&A would seek damages from Bay and that Bay would be "dragged into" litigation.

"I should be able to do business with whomever I want to do business," says Ms. McDowell, who had complained about the issue to RIMS.

"Never in my life did I dream I would be in a position of having my business decisions questioned or thwarted."

Also presenting an affidavit in the case was Richard C. Somerville, risk manager of Waltham, Mass.-based Thermo Electron Corp., which had also once used A&A as its broker and also wanted to follow Ms. Haughawout from Reed Stenhouse to RBH.

Mr. Somerville said in his affidavit that: "A move to anyone other than Ms. Haughawout would be unfair and prejudicial to TEC, because such a move would necessitate the education of a new account executive in the areas (especially medical products) already familiar to Ms. Haughawout."

Thermo Electron also received the court's special permission to move its business to RBH. Mr. Sommerville could not be reached for comment. ■

Carbide should provide funds: Judge

NEW YORK—A federal judge last week said that Union Carbide Corp. should provide interim emergency relief of between $5 million and $10 million in connection with the Bhopal disaster (*BI*, April 15).

This is a matter of "fundamental human decency" and wouldn't be considered an admission of liability by the company, said U.S. District Court Judge John F. Keenan at a preliminary hearing on litigation filed in the case.

Bud Holman, an attorney with Union Carbide's law firm, New York-based Kelley, Drye & Warren, said while an interim settlement is possible, Union Carbide prefers to reach an early final settlement.

Judge Keenan also called for the creation of a three-attorney executive committee to coordinate litigation in the case.

One of the attorneys would be from Robins, Zelle, Larson & Kaplan, the Minneapolis law firm that represents the Indian government. The other two would be selected from among the dozens of other attorneys who have filed lawsuits in the case. ■

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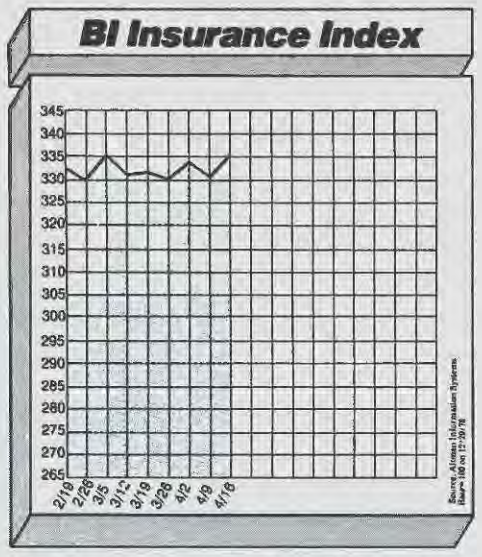

The *Business Insurance* index of insurance industry stocks posted an increase and set a new record high for the trading period that ended April 16. The *Business Insurance* stock index closed at 335.5 on April 16, an increase of 4.4 points from 331.1 on April 9. The previous record of 334.5 was set April 2. For the period ending April 16, a total of 26 stocks were up, 17 stocks were down, and 15 stocks were unchanged. The biggest gains were posted by American International Group Inc., up 8.1%; Statesman Group Inc., up 7.7%; St. Paul Cos. Inc., up 7.4%; Emett & Chandler Cos. Inc., up 6.7%; and American General Corp., up 6.6%. The largest losses were posted by Tokio Marine & Fire Insurance Co., down 4%; Baldwin & Lyons Inc., down 3.6%; Poe & Associates Inc., down 3%; Old Republic International Corp., down 1.9%; and Protective Corp., down 1.5%. The *Business Insurance* index rose 1.3% during the trading period. By comparison, the Standard & Poor's 500 index rose 1.7% and the Dow Jones 30 Industrials rose 1.3% for the same trading period.

British Issues

16 APR Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	226	N/M	16.9	7.5	226—213	
Genl Accident	590	100.0	28.6	4.8	592—581	
Gdn Royal Exch	668	19.4	37.1	5.6	668—651	
Royal	588	N/M	33.9	5.8	588—573	
Sun Alliance	460	22.1	21.1	4.8	460—440	
Brokers						
CE Heath	598	10.2	30.0	5.0	615—598	
Hogg Robinson	275	15.7	11.6	4.2	280—273	
JH Minet	274	18.9	8.0	2.9	295—274	
Sedg Grp	362	15.9	14.3	3.9	391—362	
Stew Wrightson	568	14.9	25.7	4.5	595—563	
Willis Faber	627	21.5	18.6	3.0	658—627	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Price-to-book relationships of insurers are overstated

By MYRON M. PICOULT

Special to Business Insurance

ARE THE price-to-book value multiples reported for the major commercial insurers inflated?

We believe they are as seen by the fact that the price-to-book relationships are running somewhat above historic norms.

A representative grouping of 10 primary property/casualty insurers currently sells at an average of a shade more than 1.7 times the book value reported at year-end 1984. The same average relationship for multiline companies is a tad more than 1.0 times the reported book value. Putting the two groups together produces an unweighted average price-to-book relationship of 1.53.

Mr. Picoult

These relationships are running somewhat above historic norms. Over the past five years, the price-to-book relationship for the property/casualty companies has averaged between a low of 1.0 and a high of 1.5. The comparable average weighed in at 1.3 times book value to 1.5 times book value.

Going back to 1975—at the low point of the previous cycle—the price-to-book multiples ranged between 0.9 and 1.4 for the property/casualty companies and 0.6 to 0.9 for the multilines. At the peak of the cycle in 1978, the comparable ranges were 0.8 to 1.1 and 0.6 to 0.9, respectively.

We stress that the current relationships are based on reported book values. If across-the-board adjustments were made marking the bond portfolios to market, for reserve deficiences and the questionable values of deferred acquisition expenses carried on the balance sheets, the adjusted book value would work out to be about 55% of the reported figures and the resulting price-to-book relationships would obviously be materially higher.

One explanation as to why the current relationships are above historic levels is that book values have been under pressure because of 1984's less-than-spectacular earnings performances. In addition, the ratios have also been distorted by the relatively strong performances of the stocks.

Hence, some argue that there is no cause for concern and, in fact, it is a positive development because it is forcing insurers to continue to push for high rates. There is some validity to this statement, although recent offerings shade the statement a bit.

Furthermore, some investors say the inflated values are not worrisome because of the sizable and still growing tax-loss carryforwards that most insurers have been accumumlating and the prospective benefits to be derived when the carryforwards are used to offset taxes.

The benefits of these carryforwards will be utilized, thereby enhancing then-existing book values. This assumes no change in tax laws affecting the insurance industry.

We developed data on 12 primary property/casualty and multiline companies and found the following:

On average, for the primary property/casualty sector—which includes General Re Corp.—carryforwards at year-end 1984 were equal to about 30% of reported year-end 1984 book value. For the multiline companies, the average was about 15.5%.

Within these averages, however, there were some very material spreads.

The figures for the companies were as follows: Chubb Group, 32%; General Re, 36%; Ohio Casualty Insurance Co., 19%; SAFECO Corp., 7%; The St. Paul Cos., 51%; USF&G Corp., 54%; Aetna Life & Casualty Co., 25%; American General Corp., 6%; CIGNA Corp., 20%; and Travelers Corp., 11%.

Some of the tantalizing questions raised by the magnitude of these figures is whether or not this will attract predators to the foray again; whether or not long-term return on equity will fall shy of present expectations; and whether or not enhancement of book values—and the concommitant feeling of being healthier and wealthier—will produce an underwriting cycle similar to the current situation.

It may seem silly to think in this context, but it seems to be a real possibility that the stock market may totally discount the current cycle from bottom to top before any tangible evidence is produced of a meaningful turn in underwriting experience and operating earnings. ■

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. His column appears the fourth Monday of every month.

Insurer sues to void D&O coverage

Continued from page 2

Federal has since returned premiums Oak paid for the coverage, plus interest, said Mr. Mercurio, who added that Oak intends to send that check back to Federal. He would not disclose the premium paid by Oak.

Mr. Mercurio also noted that Federal has been involved in the settlement negotiations.

"To my knowledge, this is the first time an insurer has tried to rescind (D&O) coverage when there's already a claim involved," Mr. Mercurio notes.

Federal says in its suit that it became aware of certain "misrepresentations and omissions" by Oak officials only after Oak called upon it to defend the company against the shareholder's lawsuit.

The insurer says in its complaint that although Oak was suffering "serious financial, manufacturing, personnel and marketing problems," company officials made no mention of such conditions in discussions with Federal prior to purchasing the coverage.

Before Federal accepted the risk, Oak's D&O coverage was written by Lloyd's of London underwriters.

Before writing the coverage, Federal examined Oak's annual reports and financial statements for 1980, 1981 and the first quarter of 1982, but it also relied on public statements made by Oak officers and directors, the Federal suit says.

The suit alleges that certain Oak officials made "a series of false and misleading statements, concerning the condition of Oak's businesses, management, products, finances, profits and its future business products" from at least January 1982 through October 1982, when Oak began acknowledging its financial setbacks.

That 10-month period represents time both before and after Federal's coverage took effect.

Federal says that on Aug. 12 and 13, 1982, just after the D&O insurance was issued, Oak issued reports indicating the company "was continuing to achieve substantial profits, that Oak was not suffering a decline in earnings or a loss and that Oak would earn nearly as much as it had earned in 1981."

In fact, Oak's 1982 earnings declined more than $10 million from 1981 and were much less "than the $30 million Oak had led Federal, the investment community and the public to expect," the suit says. Oak reported a pretax operating loss of $13 million for 1982.

The suit claims Oak's pretax income for the first half of 1982 was overstated by at least $23 million, partly because of Oak's improper capitalization of its satellite television development costs.

Federal also claims Oak's estimates of the number of subscribers to its satellite TV systems were inflated because they included at least 25,000 people who were delinquent up to 90 days on their accounts.

Oak has been under investigation for almost two years by the Securities and Exchange Commission, which is reportedly examining certain stock transactions and the awarding of company contracts to an interior design firm run by Brenda Mason, the wife of Everitt A. Carter, former chairman of Oak.

SEC officials will not discuss the investigation, but an Oak spokeswoman confirms that the probe is ongoing.

In addition, a Chicago television station announced last week that it would stop broadcasting Oak's ON-TV subscription television service later this year.

Federal's suit names eight Oak directors or officers whom it claims misled Federal and others about Oak's status, both before and after Federal wrote the coverage. These are the same eight individuals named in the shareholder class action.

All but one of the directors named in the suit have left the company over the past two years, including Oak's president and chief operating officer, Raymond W. Pierce, whose resignation becomes effective May 1. ■

BI Industry Stock Report

April 16, 1985 **4/10/85 thru 4/16/85**

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	30.50	5.6	0.0	1.00	3.3	30.50	29.63	893.9
Baldwin & Lyons Inc	OTC	53.00	-3.6	11.3	0.80	1.5	53.00	53.00	0.0
Corroon & Black Corp	NYSE	44.38	4.7	0.0	1.00	2.3	44.38	42.13	122.6
Crump E H Cos Inc	OTC	26.00	0.0	21.8	0.44	1.7	26.13	25.88	33.3
Emett & Chandler Cos Inc	OTC	16.00	6.7	266.7	0.00	0.0	16.00*	15.00	43.5
Gallagher Arthur J & Co	OTC	37.25	2.1	23.4	0.28	0.8	37.25	36.50	35.5
Hall Frank B & Co Inc	NYSE	24.50	1.0	0.0	1.00	4.1	24.88	24.13	131.5
Marsh & Mclennan Cos Inc	NYSE	63.75	-1.2	39.4	2.40	3.8	65.50	63.75	429.7
Poe & Assoc Inc	OTC	8.00	-3.0	0.0	0.00	0.0	8.25	8.00	1.3
Reed Stenhouse Cos Ltd	OTC	21.75	2.4	28.2	0.60	2.8	21.75	21.00	385.9
AGENTS/BROKERS	AVERAGE			63.4		2.3			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	41.50	1.2	14.9	1.28	3.1	42.25	41.50	2,066.5
Anderson Clayton(Ranger/PanAm)	NYSE	37.75	-6.5	19.5	1.32	3.5	40.13	37.75	58.4
Armco Inc	NYSE	7.25	-7.9	0.0	0.00	0.0	7.75	7.25	770.1
Berkley W R Corp	OTC	14.75	0.0	0.0	0.32	2.2	14.75	14.25*	58.5
CIGNA Corp	NYSE	48.63	1.3	442.0	2.60	5.3	49.13	48.63	557.9
City Investing Co. (Home Ins.)	NYSE	38.63	-0.6	3.7	0.00	0.0	38.75	38.63	384.3
CNA Finl Corp (CNA)	NYSE	36.25	-0.3	15.0	0.00	0.0	36.38	36.25	46.0
General Re Corp	NYSE	76.75	4.1	48.0	1.56	2.0	77.13*	74.88	438.7
ITT (Hartford Group)	NYSE	34.63	1.5	11.7	1.00	2.9	34.88	33.38	2,834.7
Optimum Hldg Corp	OTC	0.50	0.0	0.0	0.00	0.0	0.50	0.50	0.5
Sears Roebuck & Co. (Allstate)	NYSE	33.00	-1.5	8.2	1.76	5.3	33.50	32.88	2,461.1
Teledyne Inc (Argonaut)	NYSE	243.88	3.3	5.2	0.00	0.0	243.88	236.50	277.6
Transamerica Corp (Occidental & Fred S. James)	NYSE	29.63	-0.8	12.8	1.64	5.5	29.88	29.63	940.8
CONGLOMERATES/HOLDING COS.	AVERAGE			9.7		1.8			
Insurers									
Aetna Life & Cas Co	NYSE	40.25	2.5	25.3	2.64	6.6	40.50	39.88	1,666.4
American General Corp	NYSE	30.38	6.6	10.1	1.00	3.3	30.75	29.75	3,542.2
Amern Heritage Life Invt Co	NYSE	30.75	-0.4	9.2	1.08	3.5	30.88	30.75*	0.9
American Indty Finl Corp	OTC	17.75	-1.4	0.0	1.12	6.3	18.00	17.75	1.6
American Intl Group Inc	NYSE	75.38	8.1	17.7	0.44	0.6	75.38	70.38	696.4
Aneco Reins Ltd	OTC	1.50	0.0	0.0	0.00	0.0	1.50	1.50	3.4
Avemco Corp	NYSE	25.25	2.0	12.3	0.60	2.4	25.25	25.00	7.3
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	58.00	2.2	7.3	2.08	3.6	58.13*	56.75	62.4
Chubb Corp	NYSE	58.75	2.4	16.7	2.20	3.7	59.38	58.50	350.6
Combined Intl Corp	NYSE	44.38	-0.3	8.9	2.16	4.9	45.00	44.25	83.5
Continental Corp	NYSE	40.13	3.9	20.8	2.60	6.5	40.13	39.25	447.5
Crown Life Ins Co	OTC	133.00	0.0	13.8	5.00	3.8	133.00	133.00	0.5
Durham Corp	OTC	39.00	-0.6	7.5	1.28	3.3	39.25	39.00	8.0
Farmers Group Inc	OTC	57.25	3.4	10.4	1.76	3.1	57.25	55.38	499.1
Fremont Gen Corp	OTC	27.88	4.7	0.0	0.48	1.7	27.88	27.00	341.3
Great West Life Assurn Co	OTC	365.50	0.0	9.8	14.00	3.8	365.50	365.50	0.0
Hanover Ins Co	OTC	38.00	3.8	35.2	0.56	1.5	38.00*	37.00	58.2
Hartford Steam Boiler Insptn	OTC	80.50	0.6	71.9	3.00	3.7	80.50	79.50	20.3
Kans City Life Ins	OTC	87.50	1.7	10.0	2.88	3.3	87.50*	86.00	3.5
Keaper Corp	OTC	52.00	1.0	30.2	1.80	3.5	52.88	51.75	104.8
Liberty Corp S C	NYSE	31.13	0.8	15.0	0.72	2.3	31.38	31.00	16.4
Lincoln Natl Corp Ind	NYSE	38.00	0.0	10.0	1.84	4.8	39.00	38.00	559.5
Mission Ins Group Inc	NYSE	7.75	0.0	0.0	0.00	0.0	7.88	7.38	66.9
Monumental Corp	OTC	30.50	-0.8	22.4	1.30	4.3	31.13	30.50	25.5
Northwestern Natl Life Ins	OTC	34.50	-1.4	8.0	0.80	2.3	34.63	33.25	115.2
Ohio Cas Corp	OTC	51.50	1.0	19.4	2.80	5.4	51.63	51.13	124.9
Old Rep Intl Corp	OTC	38.63	-1.9	7.5	0.88	2.3	39.25	38.50	490.1
Orion Cap Corp	NYSE	25.00	-0.5	0.0	0.76	3.0	25.25	25.00	101.2
Protective Corp	OTC	24.00	-1.5	8.1	0.62	2.6	24.50*	24.00	124.6
Provident Life & Acc Ins Co	OTC	94.00	0.0	6.7	3.38	3.6	94.00	92.50	125.6
St Paul Cos Inc	OTC	63.88	7.4	0.0	3.00	4.7	63.88*	59.75	628.1
SAFECO Corp	OTC	36.25	-1.4	11.9	1.50	4.1	36.50	36.25	426.8
Sri Corp	OTC	18.13	5.8	30.7	0.68	3.8	18.13	17.25	55.5
Seibels Bruce Group Inc	OTC	21.75	-1.1	0.0	0.80	3.7	22.25	21.75	104.8
Statesman Group Inc	OTC	5.25	7.7	7.8	0.15	2.9	5.38	5.13	261.6
Tokio Marine & Fire Ins Co	OTC	161.00	-4.0	27.9	0.00	0.0	168.00	161.00	12.4
Torchmark Corp	NYSE	47.13	5.9	10.4	1.00	2.1	47.13*	44.13	498.9
Travelers Corp	NYSE	41.00	0.0	10.0	2.04	5.0	42.25	41.00	1,184.3
United Fire & Cas Co	OTC	20.00	0.0	0.0	0.80	4.0	20.00	20.00	0.6
United States Fid & Gty Co	NYSE	32.50	6.1	18.9	2.20	6.8	32.50*	30.75	1,013.4
Uslife Corp	NYSE	39.13	-0.3	9.0	1.04	2.7	40.50	39.13	340.6
Washington Natl Corp	NYSE	27.13	-1.4	8.4	1.08	4.0	27.25	27.13	51.1
Zenith Natl Ins Corp	OTC	12.50	0.0	0.0	0.68	5.4	12.50	12.38	18.5
INSURANCE COMPANIES	AVERAGE			16.6		3.4			

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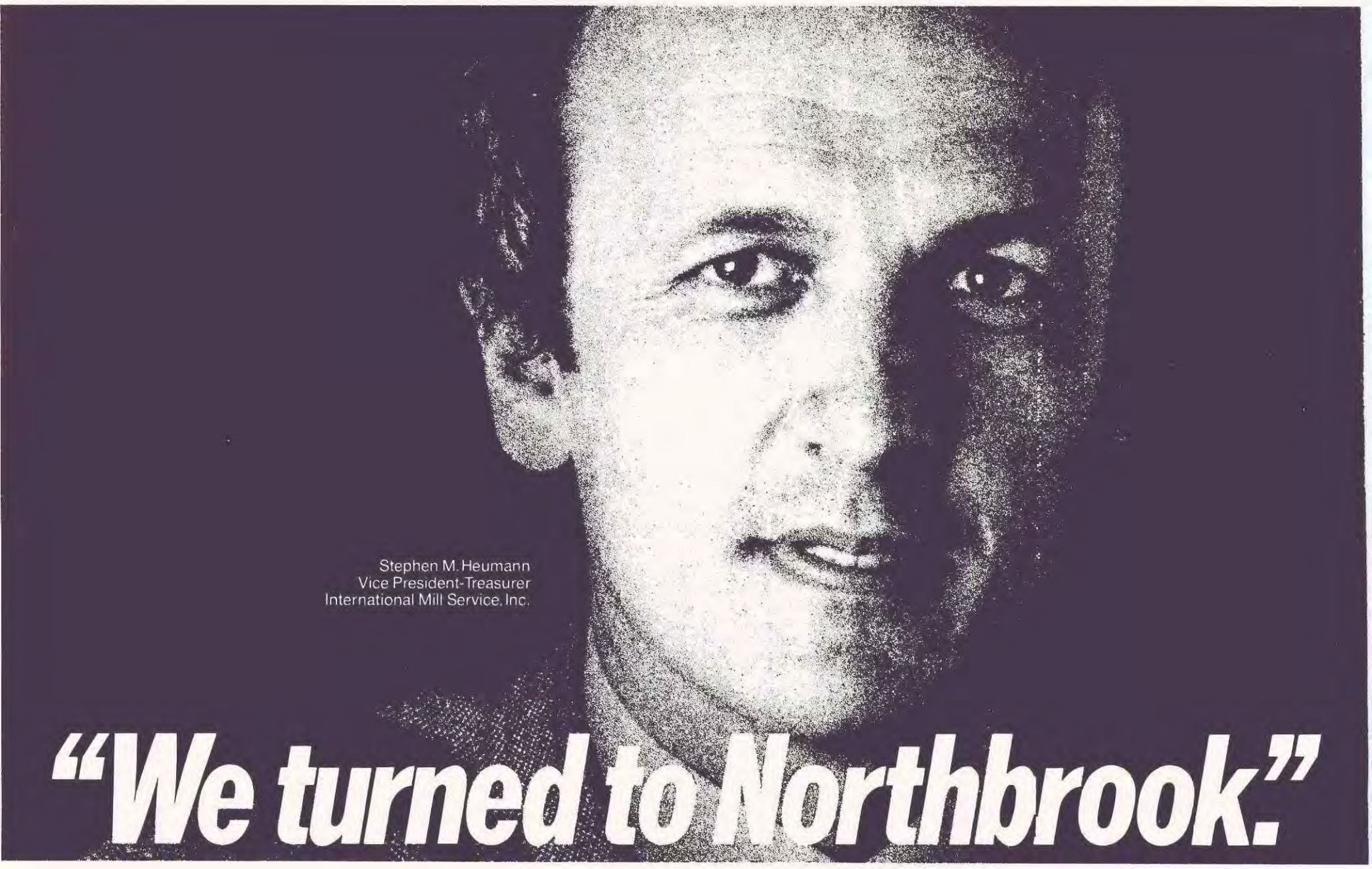

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