APRIL 6, 1987

business insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $1.75 a copy; $68 a year

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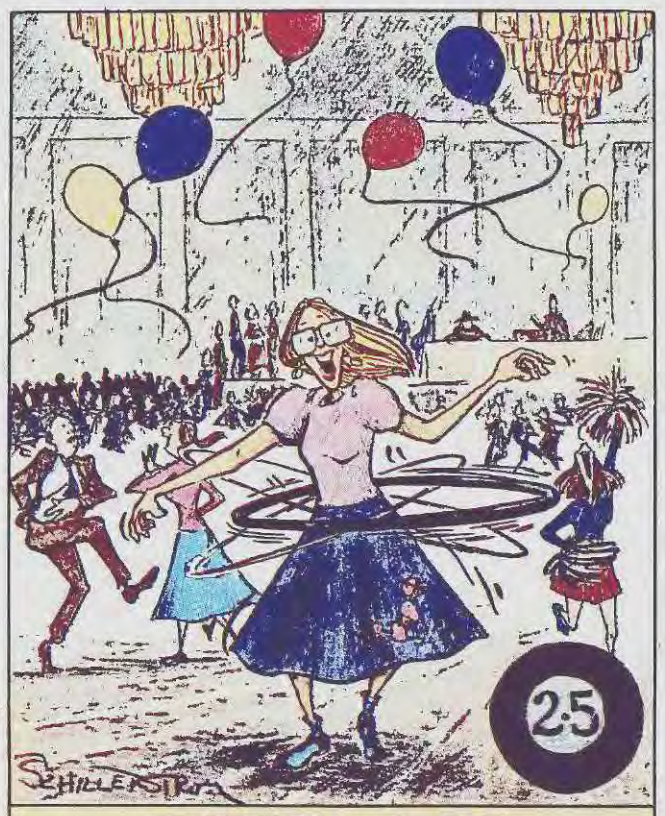
update

Hazell's syndicate facing premium capacity restriction

LONDON—Capacity for U.S. property risks won't be affected by Lloyd's of London's decision to restrict one of the market's largest writers of U.S. property insurance to 85% of its total premium income capacity this year, says the syndicate's underwriter.

"I do not think (Lloyd's decision) will affect capacity that badly. We think we have sufficient capacity

Continued on next page



RIMS at 25

The 25th Risk & Insurance Management Society conference opened with a party, "Where Were You in '62?" But, after "twisting and shouting," registrants quickly got down to business. Reports on benefit sessions begin on page 3; risk management sessions will be covered next week.

California ruling may trigger more employee comp suits

By STEPHEN TARNOFF

SAN JOSE, Calif.—Workers compensation experts fear a recent federal court ruling may further erode the exclusive remedy rule by allowing employees to sue their employers for exposing them to toxic substances, even though they have not exhibited any signs of illness.

U.S. District Court Judge Robert P. Aguilar ruled that a former Firestone Tire & Rubber Co. employee who was exposed to toxins and allegedly has suffered injuries to his immune system and his emotional state but has not exhibited symptoms of any disease can sue the company directly because his claim is not compensable under the California workers compensation law.

In addition, Judge Aguilar separately ruled in his March 18 decision that the employee, Harry Barth, also can sue Firestone for aggravating his injuries because of allegations that the tire company fraudulently concealed the nature of those injuries.

According to workers compensation experts, the decision allowing an injured employee who has no physical symptoms of illness to sue his employer may be unique, and some say it could result in many more suits against employers.

"It is a very significant exposure for employers. It could really be a very dangerous proposition," observed Randall Smith, an attorney with the San Diego firm of Hollywood & Neil.

"It opens a Pandora's box," said Donald Lieb, a vp of Zenith Insurance Co. and chairman of the Legal Committee of the California Workers Compensation Institute. "It strikes me as a tremendous expansion of potential liability."

"I think it could" open up employers to more suits, agreed Merton E. Marks, an expert on workers compensation law with the Phoenix, Ariz. firm of Lewis & Roca. "It could open up a new type of liability to employers."

However, Mr. Marks and the attorney for Mr. Barth say the decision may apply only to cases in which employees allege outrageous conduct on the part of an employer rather than just negligence.

"I'm not at all sure this ruling reaches that far," said Gordon Stemple, the plaintiff's attorney with the Century City, Calif., firm of Stemple & Boyajian. "I don't know if it would apply in a negligence case."

But, he added, the decision "sounds a bill of encouragement for victims exposed to toxins in the workplace, where you have these types of fact situations alleged."

He further noted that had Judge Aguilar held that Firestone employees' sole remedy was within the workers compensation system, victims theoretically would have to wait 10 to 15 years until a disease manifests itself before they could bring a workers compensation claim against the company.

A spokesman for Akron, Ohio-based Firestone said last week that the company would appeal the decision. Company officials would not discuss the ruling.

The suit was brought by Mr. Barth as a class action on behalf of himself and other production workers at a Firestone tire manufacturing plant in Salinas, Calif. About 7,000 Firestone employees are in the proposed class, which has not yet been certified.

The plant, which Firestone opened in 1963 and closed in 1981, used various chemical and industrial compounds, including the chemical benzene, in its operations.

Mr. Barth worked at the plant from 1963 until 1980, when he resigned. He sued Firestone in 1985.

In his complaint, Mr. Barth alleged that exposure to benzene and the other toxic substances could lead to several physical disorders, including leukemia;

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Delaware department OKs Beneficial's sale of ACIC

By DOUGLAS McLEOD

PEAPACK, N.J.—Beneficial Corp. will proceed with the sale of its American Centennial Insurance Co. unit to a management group following the Delaware Insurance Department's approval of the deal last week.

The management group, led by ACIC Chairman and Chief Executive Officer Robert Rothman, last month signed an agreement to buy ACIC and five other Beneficial insurance units in a deal that is scheduled to close before June 30 (*BI*, March 9).

A key factor in the Delaware department's approval of the deal is the management group's plan to write new business through a wholly owned subsidiary of ACIC.

ACIC may form the wholly owned subsidiary itself, may acquire an existing insurer or may move Wesco Insurance Co.—a New Mexico-domiciled Beneficial subsidiary that is also part of the sale—to Delaware, according to Andrew Kerstein, an ACIC senior vp and member of the management group.

"We are exploring a number of alternatives, including acquiring a company, forming a subsidiary or moving Wesco," Mr. Kerstein said.

ACIC will write new business until the subsidiary is licensed, after which ACIC will run off its book, according to Mr. Kerstein, who noted that profits of the new subsidiary could be used—if needed—to support the ACIC runoff.

Delaware Insurance Commissioner David N. Levinson noted that another key factor in the approval was Beneficial's commitment to add $200 million to ACIC's loss reserves in addition to the $165 million added on a statutory basis last year (*BI*, Sept. 1, 1986).

Although Mr. Levinson approved ACIC's sale last Thursday evening, the deal was not without opposition.

In a letter to the Delaware department last month, Wausau Insurance Cos., which ceded business to ACIC, expressed several concerns about the proposed sale, including questioning whether the sale was an "arm's length transaction."

In a reply to the Delaware department, ACIC's Mr. Rothman asserted that the deal was negotiated at arm's length and answered several other objections raised by Wausau, which claims ACIC owed it more than $6 million as of last Dec. 31.

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Strong 1986 results posted by U.S. reinsurers may signal further improvement, officals say
Page 2

German firms face AIDS-related losses

By STACY SHAPIRO

LONDON—Seven West German pharmaceutical companies and their insurers and reinsurers face as much as 400 million deutschemarks ($220.6 million) in losses from the distribution of AIDS-contaminated plasma products to West German hemophiliacs.

As many as 3,000 of West Germany's 6,000 hemophiliacs—who used the contaminated plasma products before mid-1984—may now be carrying the AIDS virus, according to reports.

To date, reports say that 56 hemophiliacs are known to be carrying the virus for acquired immune deficiency syndrome and that as many as 10 hemophiliacs have died from AIDS in West Germany.

The proteins contained in the plasma that spread the AIDS virus reportedly were imported from the United States, reports say, but no U.S. company has been implicated so far.

The hemophiliacs have threatened to sue the pharmaceutical companies and their insurers unless the companies provide the victims some form of compensation, confirmed Karl Harmen Schulte-Hillen, an attorney in Siegen, West Germany, who represents the 3,000 hemophiliacs.

But, the victims do not want to go to court because they fear they may die from AIDS before a settlement is reached, Mr. Schulte-Hillen noted.

"I want a settlement out of court because we do not have enough time," he said. "Going to court would take six or seven years. . . .But I will go to court if there is no other solution."

The pharmaceutical companies and their insurers also want to avoid a court battle, said a spokesman for the companies' trade association.

The hemophiliacs used plasma products manufactured by seven West German pharmaceutical companies that contained proteins

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update

Lloyd's restricts underwriting

Continued from previous page
(for this) not to affect us that much," said Lloyd's underwriter Richard Hazell.

Last week, the Committee of Lloyd's announced that non-marine syndicate 190 can only write 85% of its total 148 million-pound ($236.8 million) gross premium income capacity this year. Syndicate 190, also called the F.R. White syndicate, is managed by Three Quays Underwriting Management Ltd. and underwritten by Mr. Hazell, a Lloyd's Council member.

The committee said that unless this restriction is imposed, Mr. Hazell's syndicate is likely to exceed its underwriting capacity limit this year.

The restriction gives the syndicate an "oops factor" of 15% before it overwrites its capacity, said Lloyd's Chief Executive Alan Lord.

The syndicate had "grossly overwritten" its stamp capacity in 1984 and possibly in 1985, Mr. Hazell said. And, although it did not overwrite in 1986, it did exceed a self-imposed limit, admitted Mr. Hazell, who would not reveal figures.

Mr. Hazell says he did have a business plan for 1987 that would give his syndicate "elbow room" to maneuver within its stamp capacity, though he will not say if it matched Lloyd's dictate.

"We are distressed that there was a need for (Lloyd's move)," he said. "We have done a lot to control our premium income."

Lloyd's also is forcing other non-marine syndicates to only write 85% of their allocated premium income capacity: syndicate 396, with a stamp capacity of 17 million pounds ($27.2 million), underwritten by M. Gardner-Roberts and managed by MFK Underwriting Agencies Ltd.; and syndicate 839, with a stamp capacity of 64 million pounds ($102 million), underwritten by Alec Sharp and managed by Castle Underwriting Agents Ltd.

Lloyd's last year also ordered one of its largest non-marine syndicates, syndicate 799, underwritten by Robin A.G. Jackson and managed by Merrett Underwriting Agency Management Ltd., to write only 85% of its premium income capacity (*BI*, Sept. 29, 1986).

Panel rules on hotel fire suits

SAN JUAN, Puerto Rico—All pretrial proceedings for federal court cases stemming from the New Year's Eve fire at the Dupont Plaza hotel should be transferred to U.S. District Court in Puerto Rico, the Judicial Panel on Multidistrict Litigation has determined.

At least 42 separate suits—involving nearly 400 plaintiffs—stemming from the fire that killed 96 persons and injured more than 100 others have been filed in federal court in Puerto Rico (*BI*, Jan. 12). However, some attorneys have filed suits in U.S. courts.

Also, a plaintiff's litigating committee has been formed by nine attorneys, including six from Puerto Rico and three U.S. attorneys who were heavily involved in litigation from the 1980 MGM Grand Hotel fire in Las Vegas. The committee is headed by Wendell Gauthier of the Metairie, La., firm of Gauthier, Murphy, Sherman, McCabe & Chehardy.

Discovery in the litigation has been stayed, but the plaintiff's panel will propose a discovery schedule for the next three months at an April 7 hearing before a federal magistrate in Puerto Rico.

X.L. to open Bermuda office

BRIDGETOWN, Barbados—X.L. Insurance Co. Ltd. plans to open an underwriting office in Bermuda to ease access to the facility by Bermuda brokers, an X.L. official confirmed.

An application to open the office has been submitted to Bermuda's registrar of companies, but had not been approved last week.

Barbados-based X.L. is not changing domiciles, and its head office will remain in Bridgetown, noted Brian Walford, a vp at X.L.

Trenwick Services Ltd. of Bermuda currently provides underwriting services to X.L., although its contract with X.L. is set to expire at the end of the year.

Florida agency investigated

TALLAHASSEE, Fla.—The FBI and the Florida Insurance Department are investigating a Destin, Fla.-based insurance agency that sells long-haul trucking insurance in various states.

The FBI last week served a search warrant on Transportation Services Inc. to seize company records, a bureau spokesman said. The search warrant is part of a pending criminal investigation into allegations of violations of the federal wire fraud statutes and possibly other laws, the bureau spokesman said.

The Insurance Department is alleging that Transportation used unlicensed agents to accept premiums for long-haul trucking policies, and that the agency was not authorized to do business in Florida. The department, which has conducted its own probe, alleges the company had no licensed agents, a spokeswoman said.

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errors & omissions

- A photograph of David Ezekiel, president and managing director of International Advisory Services Ltd. in Bermuda, was misidentified in the March 30 issue. The person in the photograph was incorrectly identified as Robert A. Mulderig Jr., executive vp of Mutual Indemnity Ltd. in Bermuda.

- A story in the March 30 issue incorrectly reported that the Bahamas imposes a 1% tax on premiums written by non-resident insurers. There is no premium tax in the Bahamas.

- Associated Reinsurance Management Corp. is owned by various officers and directors of the company, with an investment interest held by Provident Life & Accident Insurance Co. Ownership was incorrectly stated in the directory of reinsurance intermediaries in the Nov. 10, 1986 issue.

Reinsurance executives see more improvement in 1987

By JUDY GREENWALD

U.S. reinsurance industry executives say vastly improved 1986 results could portend continued improvement for reinsurers in 1987.

But, they also point out that 1986 was an unusually mild year for catastrophic losses, while 1987 may not be.

And reserve adequacy remains a concern, as some reinsurers cast a nervous eye on signs of renewed competition in some lines of primary coverage.

The 71 reinsurers surveyed by the Reinsurance Assn. of America posted a 103.6% combined ratio for 1986, compared with a 121.4% combined ratio in 1985 for a similar, though not identical, group of reinsurers.

Nineteen companies reported combined ratios of less than 100% in 1986. In addition, the largest reinsurers based on net premiums written reported almost identical results as the industry as a whole, although their recovery was somewhat less dramatic. The Top 20 reinsurers posted a 103.5% combined ratio for 1986, compared with 1985's 117.3% combined ratio. Four reported combined ratios of less than 100% last year.

Results of the 18th-largest reinsurer, Putnam Reinsurance Co., which was organized by American International Group Inc. and began writing business last July, are not included in the Top 20 totals because there are no comparable 1985 figures (*BI*, July 28, 1986). Putnam Re posted a 99.7% combined ratio for 1986.

The reinsurance market tightened considerably at the end of 1984, and the momentum continued throughout both 1985 and 1986, resulting in the improved results, commented Paul Inderbitzin, executive vp of American Re-Insurance Co. in New York.

The fact that books of business were re-underwritten, prices increased and underlying business was written on a more conservative basis "made for a very attractive 1986," he said.

William D. Warren, chairman and president of National Reinsurance Corp. in Stamford, Conn., noted that as recently as 1984, the industry had posted a 128.2% combined ratio, and said he was surprised it "has been able to improve its results so rapidly. Obviously, premium volume has advanced very rapidly, which is why the results have improved significantly."

Net premiums written for all 71 reinsurers increased by 46% to $12.8 billion, while the Top 20 posted a 47% increase to $10 billion.

The 71 reinsurers posted a 78.3% loss ratio and a 25.3% expense ratio in 1986, while the Top 20 posted a 78.1% loss ratio and a 25.4% expense ratio.

The improvement in rates, tighter terms and the dropping of unprofitable business were among factors contributing to the improvement in reinsurance results, said James E. Dwane, president of Prudential Reinsurance Group in Newark, N.J.

"I believe the primary companies have strengthened their rating structures, and reinsurers have benefited as a consequence," said Don Smith, president and chief operating officer of Kemper Reinsurance Co. in Long Grove, Ill.

"It was the lowest catastrophe year in six years, so

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Amtrak sues Conrail to void indemnity pact

By DOUGLAS McLEOD

WASHINGTON—Amtrak is suing Conrail to void an indemnity agreement that could make Amtrak liable for most passenger claims arising from the Jan. 4 collision of two trains that killed 16 and injured about 170.

Under an agreement that allows Philadelphia-based Conrail to operate on Amtrak's rail lines, Amtrak agreed to indemnify Conrail for liabilities related to Amtrak passengers, employees and property. Conrail, meanwhile, agreed to indemnify Amtrak for liabilities related to Conrail employees and property, according to the prospectus for Conrail's recent public stock offering.

The agreement's indemnity provisions apply regardless of either party's negligence or fault, according to the prospectus.

The Jan. 4 accident occurred when a 12-car Amtrak train bound from Washington to Boston and traveling at about 100 mph

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Maryland legislation may cut comp costs

By DEBORAH SHALOWITZ and JOANNE WOJCIK

ANNAPOLIS, Md.—A controversial package of workers compensation reform legislation in Maryland expected to save employers an estimated $55.4 million per year is heading toward approval.

One bill, H.B. 238, which would replace the current prior approval rating system with competitive rating, is awaiting Gov. William Schaefer's signature, despite the objections of two insurer associations.

Meanwhile, a House-Senate conference committee is fine-tuning companion legislation, H.B. 239, after hammering out a compromise last week with labor representatives over benefit levels for particular injuries.

But, one provision in H.B. 239—a cost-of-living adjustment for workers receiving benefits for permanent total disabilities—is still being debated in conference committee.

The two bills, which the governor presented to the Legislature at the beginning of this session, reflect suggestions made in a report compiled by a workers compensation study commission.

The commission was formed last summer after studies by the state Department of Economic and Community Development showed the standard premium for workers compensation insurance in Maryland is 42% higher than the national average.

In 1985, Maryland employers paid $545.7 million in estimated earned premiums and self-insured costs for workers compensation coverage, according to Bob Schoeplein, the director of research at the Department of Economics.

That figure also includes approximately $55 million in premiums paid into the state accident fund, which will not be affected by the proposed legislation, he noted.

The governor's study commission report contained 25 recommen-

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inside

Noting a California court ruling that circumvents the workers compensation system's exclusive remedy doctrine, this week's editorial observes that employers' shield against lawsuits filed by injured workers is being pierced again. If an employee deserves compensation for a workplace injury, the workers compensation system—not the courts—should be the forum for his or her claim, the editorial asserts. **PAGE 8**

In International Issues, Jerome Karter, vp and manager of Johnson & Higgins' New York International department, considers the thriving maquiladora industry in Mexico and provides U.S. multinationals with a brief tour of the Mexican insurance market. **PAGE 40**

Myron M. Picoult, senior vp and senior insurance analyst at Oppenheimer & Co. in New York, reports that the complexity of the new tax law, along with recent Financial Accounting Standards Board activity, has made it difficult for insurance company managements to develop accurate long-term estimates of the impact of the legislation. This, in turn, is keeping managements mum about the tax law's impact on earnings. **PAGE 69**

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Vol.21, No.14—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611. Second-class postage is paid at Chicago, Ill. and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1611. Copyright 1987 by Crain Communications Inc.

RIMS benefit report

AFL-CIO supports health coverage mandate

By JERRY GEISEL

LAS VEGAS, Nev.—The AFL-CIO is throwing its support behind the growing drive to require all employers to offer group health care coverage.

"We have not come to this decision lightly. It is time for strong action," says Karen Ignani, assistant director of the AFL-CIO's Department of Occupational, Safety, Health and Social Security in Washington.

She stresses that advocates of federally mandated health care coverage only are seeking to require employers to offer a "minimum" health care coverage plan—not sweeping, comprehensive coverage.

While business groups have denounced the concept of federally mandated health care coverage, employers would have little to fear from such a proposal, Ms. Ignani said, because:

• Most employers already provide more coverage than a minimum benefit plan would require and thus would not be affected.

• Small employers for whom even a minimum plan could be costly would be able to buy coverage through special state pools.

These pools, with the buying clout of thousands of employers, would be able to secure coverage from commercial insurers—who would be asked to bid on contracts—at much better rates than individual firms.

• Because all employers would have to offer a health care plan, no company would be at a competitive disadvantage.

Speaking last week at the 25th annual Risk & Insurance Management Society conference, Ms. Ignani said a federal health care mandate would be a boon to those companies already providing coverage.

With more people covered under employer-provided plans, hospitals would be treating fewer charity cases—a cost that is now passed on in the form of higher charges to insured patients.

"Who pays for uncompensated care? You (employers with health care plans) do," Ms. Ignani said.

But during the same session, "Mandated Benefits: A Look Into the Future," a business lobbyist predicted that a minimum health care plan mandate would not stay "minimum" for very long.

"It would be so easy (for Congress) to keep adding benefits" warned Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers.

Taking a somewhat different approach to the issue of mandated coverage, Delaware Insurance Commissioner David N. Levinson said employers should be required to offer employees health care coverage that employees could purchase with no

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HMO networks link care across nation

By DONNA DiBLASE

LAS VEGAS, Nev.—In today's employee health benefits marketplace lottery, using health maintenance organization networks could be one way large, national employers can increase their chances of hitting the jackpot, according to benefits experts.

An effectively developed and administered HMO network offers many advantages to employers and their employees, observed benefit experts during the session "HMO Networking—Can it Work?" at the 25th annual Risk & Insurance Management Society conference, held March 29-Arpil 3 in Las Vegas.

"An HMO network is an interconnected string of HMOs developed to serve employees in many locations. But, because no one HMO company has HMOs in all locations, networks include pieces of various HMOs," explained Edwin C. Bass, a principal consultant in the St. Louis office of William M. Mercer-Meidinger-Hansen Inc.

Among the advantages HMO networks can provide employers are:

• Group data.

"Employers are hungry for group specific data from HMOs and this is a need I think networks can satisfy," noted Richard A. Kleinert, director of employee benefit plan administration for Detroit-based General Motors Corp.

"The national information and reporting systems necessary to effectively operate these networks would, in turn, be available to employers," he said.

"As a corporation, we favor HMOs and we offer them to our employees, but HMOs are an administrative burden. Networks offer potential advantages to employers," he said.

The automaker offers 147 HMOs to its employees nationally and works with five major chains or networks, according to Mr. Kleinert.

• Centralized enrollment and benefits eligibility reporting.

"This will decrease data processing time and costs," Mr. Kleinert explained.

• Coordinated premium payments.

"This would enable an employer to issue one premium check to that umbrella organization," he pointed out.

• A single point of accountability for the HMOs and the employer.

"HMOs routinely have questions about an employer's procedures and benefits eligibility requirements. Employers and HMOs have one contact to handle this in a network," Mr. Kleinert noted.

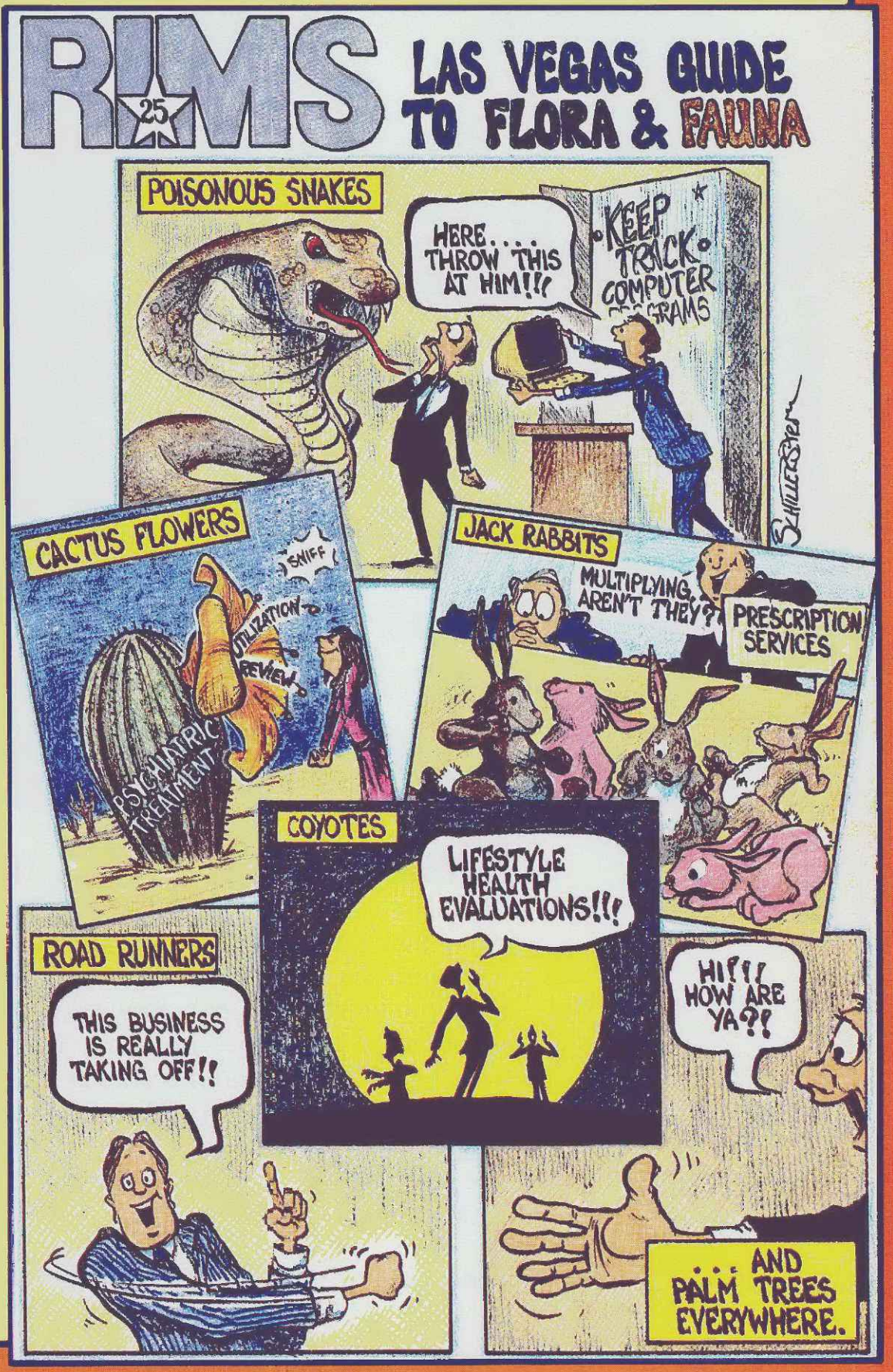
• Simplified employee communication.

Communicating several HMO options to employees could become more standardized under a network, "especially if all of the HMOs offered the same coverages and benefits packages," Mr. Kleinert said.

• Simplified open enrollment or membership periods.

Instead of having different annual enrollment dates for all of the HMOs offered by an employer, enrollment dates and procedures would be more easily coordinated under an HMO network, he said.

Continued on next page



HMO networks

Continued from previous page

• Coverage for health care services when employees are traveling or outside of their HMO's service area.

"This is one of the major concerns of employees when they are deciding whether to join an HMO," Mr. Kleinert observed.

Because a network has HMO affiliates in many locations, employees could receive coverage for needed health care services when they are traveling, he explained.

"From an individual employee's point of view, if a provider is a member of a national network, employees feel that there are national quality of care standards the provider must follow," said Sy Kaplan, executive director of Chicago-based HMO USA, a division of the Blue Cross & Blue Shield Assn.

• Open, ongoing dialogue between HMOs and the employer.

"It is vitally important that employers have constructive, creative dialogue with HMOs, and a network could facilitate this," Mr. Kleinert said.

But even with these administrative advantages of HMO networking, employers must be careful to evaluate and monitor the quality of care delivered through HMOs in a network, experts warn.

While there really is no formal mechanism to assess quality, employers must take steps to ensure that HMOs in the network deliver quality care, Mr. Kleinert said.

For example, General Motors and the United Auto Workers union developed a joint quality-of-care project, he said.

"We worked with a national consultant and designed a survey instrument with three components. We designed a questionnaire for HMOs that asked them about their staffing, selection criteria, reporting capabilities and other issues.

"We also used a medical records collection survey of the HMOs and found wide variances among the HMOs as to their quality control and their willingness to disclose this information," Mr. Kleinert pointed out.

"We also conducted a telephone survey of HMO enrollees and recent 'disenrollees'. This survey yielded the best results," he noted.

But, developing an HMO network can be tricky, the experts noted.

"Right now, because there is no one HMO with national capabilities, you have to work with more than one HMO, and this means there will be some crossing of organizational and administrative lines," Mr. Bass of Mercer said.

"But, with the number of HMOs fighting for market share, it's easy to find a group of HMOs that are willing to work together to put together a string of interconnected HMOs," he added.

For example, HMO USA, the BC/BS unit, recently worked with an employer to develop an HMO network to cover about 60,000 employees, Mr. Kaplan said. "We had one customer who discovered it had 157 HMOs nationwide for 60,000 employees. The employer had to deal with about 60 different executive directors and HMO medical directors.

"The employer came to us and said they wanted to set up a national network and that they wanted a single contact in the network for all of the HMOs," Mr. Kaplan explained.

The employer chose three HMO companies for the network: HMO USA; Hartford, Conn.-based CIGNA Corp.; and New York-based Prudential Insurance Co.

"To overcome the additional administrative burden of an HMO network, hire an outside administrator or managing partner," to act as a single point of accountability for the employer in dealing with the HMOs in the network, Mr. Bass suggested.

"Essentially, the managing partner stands between the HMOs and the employer and handles all necessary administration. The managing partner also serves as an unbiased third-party intermediary to handle relations between employees and the HMOs," he said.

"Another advantage of having a managing partner is that this administrator could help an employer to define its employee benefits objectives and HMO policy," Mr. Bass noted. "Once you have a clear-cut HMO policy, you'll have a better opportunity to integrate your HMOs with your traditional indemnity plan. You want to have an equal playing field between HMOs and indemnity plans," to avoid adverse selection and other problems, he added.

After developing an HMO policy, the administrator then can help the employer develop a request for proposal outlining exactly what the employer expects from the HMOs participating in the network and therefore assuring quality, cost-effective care, he said.

An employer's request for proposal should include not only an investigation into the reputation and financial status of the HMOs that wish to participate in the network, but also:

• Details of the criteria used by the HMO to choose physicians and hospitals.

"Be specific about your requirements. Check how hospitals are chosen with respect to financial solvency, cost efficiency, quality and the array of services they offer," Mr. Bass said.

• Details of how the HMO's provider selection criteria is documented and reported.

• How cost and utilization data and patient records are maintained.

"This is important information to be used to identify the cost and utilization experience of employees using a particular HMO—and whether savings from efficiency are being shared with the employer," Mr. Bass noted.

This information also may be used by the administrator to identify employees with high-risk illnesses or injuries who may be candidates for catastrophic case management. These cases then can be handled outside of the HMOs or the employer's indemnity plan in more appropriate, cost-effective settings, he said.

• How the quality of health care delivered in the HMO is monitored.

"Find out if member satisfaction surveys are performed periodically and how these are used to monitor quality," Mr. Bass noted.

• Details of ongoing evaluations of participating providers.

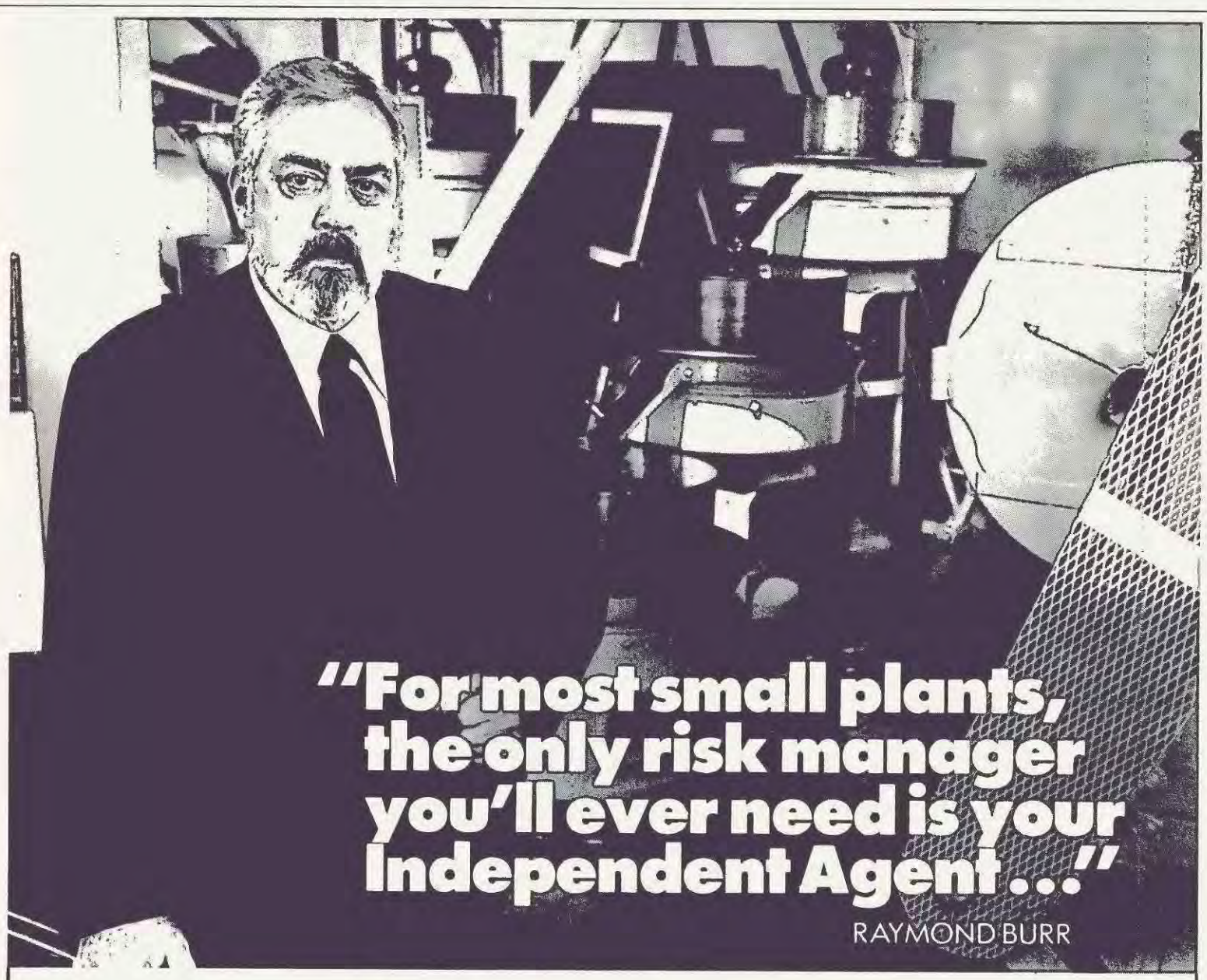
Mr. Bass also advised that "HMOs should not be chosen on the basis of rates and size of the provider network, as has been the case in the past."

While HMO networking may reduce administrative problems for employers, it remains to be seen whether benefit costs can be reduced through the arrangements, Mr. Kleinert said.

"As far as whether employers save money as a result of HMOs themselves. . .the jury is still out on this. HMOs haven't proven significant savings," he said.

"There continues to be a belief in the potential for savings due to HMOs and the competition generated by them in the health care marketplace. The point is that HMOs themselves do not represent a magic solution or a panacea. They can't work alone, but this is where a network could help," he predicted.

Alice Horner, risk manager for Syracuse University in New York moderated the session. ■



Here's why... • Most major manufacturers have a professional risk manager on the payroll—a person who advises on, selects and administers insurance programs. As a small plant, you have the same needs, but not the same budget. That's where we come in. We work with you to reduce risk, to set up safety programs and, because as an Independent Agent, we represent several fine companies, you get to choose the right policies at the right price.
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Since the 40's, A. O. Smith and Wausau have put on a lot of miles together.

Much of A. O. Smith's business serves the original equipment markets, including the auto industry.

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Burden of retiree health benefits growing

By JERRY GEISEL

LAS VEGAS, Nev.—The problems employers now face in providing and funding retiree health care benefits are likely to worsen in the future, experts warn.

Post-employment health care benefits are "mushrooming into a gigantic liability, growing twice as fast as inflation," says Jerold Mullane, director of corporate insurance at Jockey International Inc. in Kenosha, Wis.

Left unchecked, post-employment health care benefits not only can threaten corporate profits, but the corporation itself, Mr. Mullane added.

At a seminar last week at the 25th annual Risk & Insurance Management Society conference, Mr. Mullane and other benefit experts explained why employers' post-employment health care liabilities will increase, including:

- A growing elderly pool of retirees.

Today, there are about 32 million retirees over 65.

But, by the year 2011, there could be 55 million people age 65 and older as the baby-boom generation reaches retirement age, said Bernie Nash, assistant manager of business partnerships and community involvement for the American Assn. of Retired Persons in Washington.

- More cost-shifting by the federal government from the Medicare program to employer-provided retiree health care plans.

Many employer plans are designed to pick up what Medicare doesn't cover. As Medicare is reduced, employers pay more.

"As long as there are big budget deficits, Congress will keep chipping away at Medicare," said Anna Rappaport, a managing director in the Chicago office of William M. Mercer-Meidinger-Hansen Inc.

Medicare now pays less than half of retirees' health care costs, a percentage that keeps dropping.

While Medicare cutbacks so far have been limited, employers' ultimate nightmare is that Congress one day will pass legislation to make employer-provided health care plans the primary payer for retirees, Ms. Rappaport said.

- The growing tendency toward early retirement. The earlier employees retire, the longer they will be covered by retiree health care plans.
- Greater life expectancy.

"People are living longer," Ms. Rappaport notes, with the highest health care costs often incurred in the year before a retiree dies.

- Court decisions that have barred employers from terminating or reducing post-employment health care benefits.

"We are sitting on some kind of time bomb," summed up J. Douglas Wert, director of employee benefits at Kraft Inc. in Glenview, Ill, whose retiree health care expenses have about doubled to $10 million over the last five years.



Mr. Wert notes one way to reduce the mountain of unfunded retiree health care liabilities would be to give employers tax incentives to prefund those benefits.

The incentive to prefund retiree health care benefits was taken away by the Deficit Reduction Act of 1984. Under DEFRA, investment income on assets set aside to pay for retiree health care benefits are subject to current taxation.

"We need a tax-effective way" to prefund benefits, Mr. Wert says.

But, Mr. Wert observed, the Treasury Department has resisted offering such tax incentives because of the potential revenue loss.

However, he did call a Reagan administration proposal to allow employers to transfer surplus pension assets to special retiree health benefit trusts a positive step. Those assets would earn tax-free interest. However, assets only could be transferred to pay for current retirees' expenses (*BI*, Feb. 23).

And a Reagan administration proposal to put an annual $2,000 cap on retiree's out-of-pocket expenses for Medicare covered services won't make much of a dent in retirees' health care bills, Ms. Rappaport noted.

The Reagan administration proposal does not expand Medicare's very limited coverage for long-term expenses, like extended stays in nursing homes.

"Long-term expenses can wipe out families. That is where the greatest problem is," Ms. Rappaport says.

But Ms. Rappaport suggested ways employers can control retiree health care costs.

First, employers should be very careful not to reduce the percentage of plan costs paid by retirees.

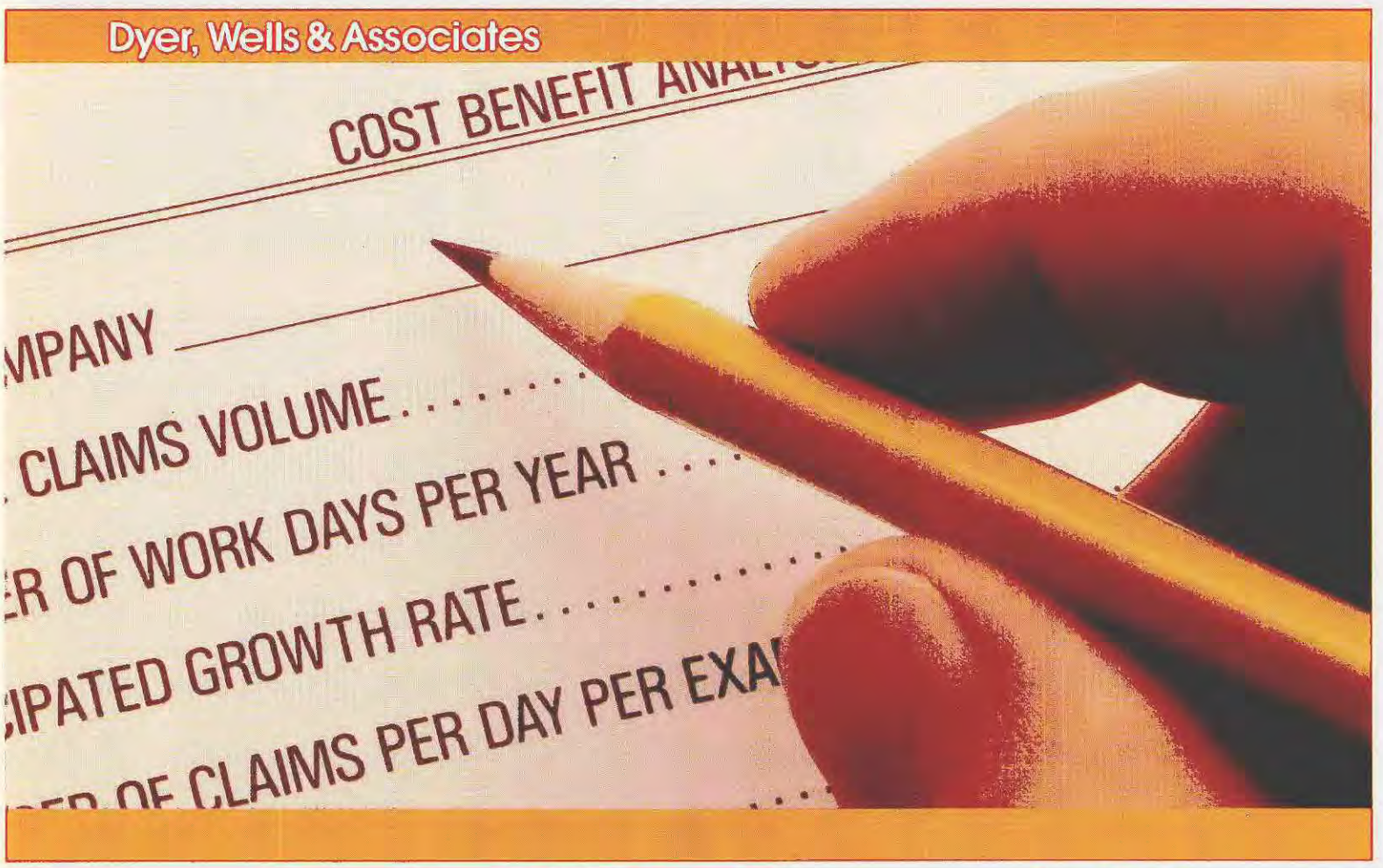
Companies, she notes, may require retirees to pay 25% of plan costs. As costs rise, employers may not increase premium contributions to keep retirees' share of costs at the 25% level.

"Don't let retiree contributions slip. The price you pay in the long run may be enormous," she said.

Also, companies should be cautious in explaining plan benefits. "Anything you say may be held against you," she said.

Courts have ruled against employers that tried to cut retiree benefits after evidence was introduced that the companies suggested—through oral or written communications—that employees had a permanent right to retiree health benefits. ■

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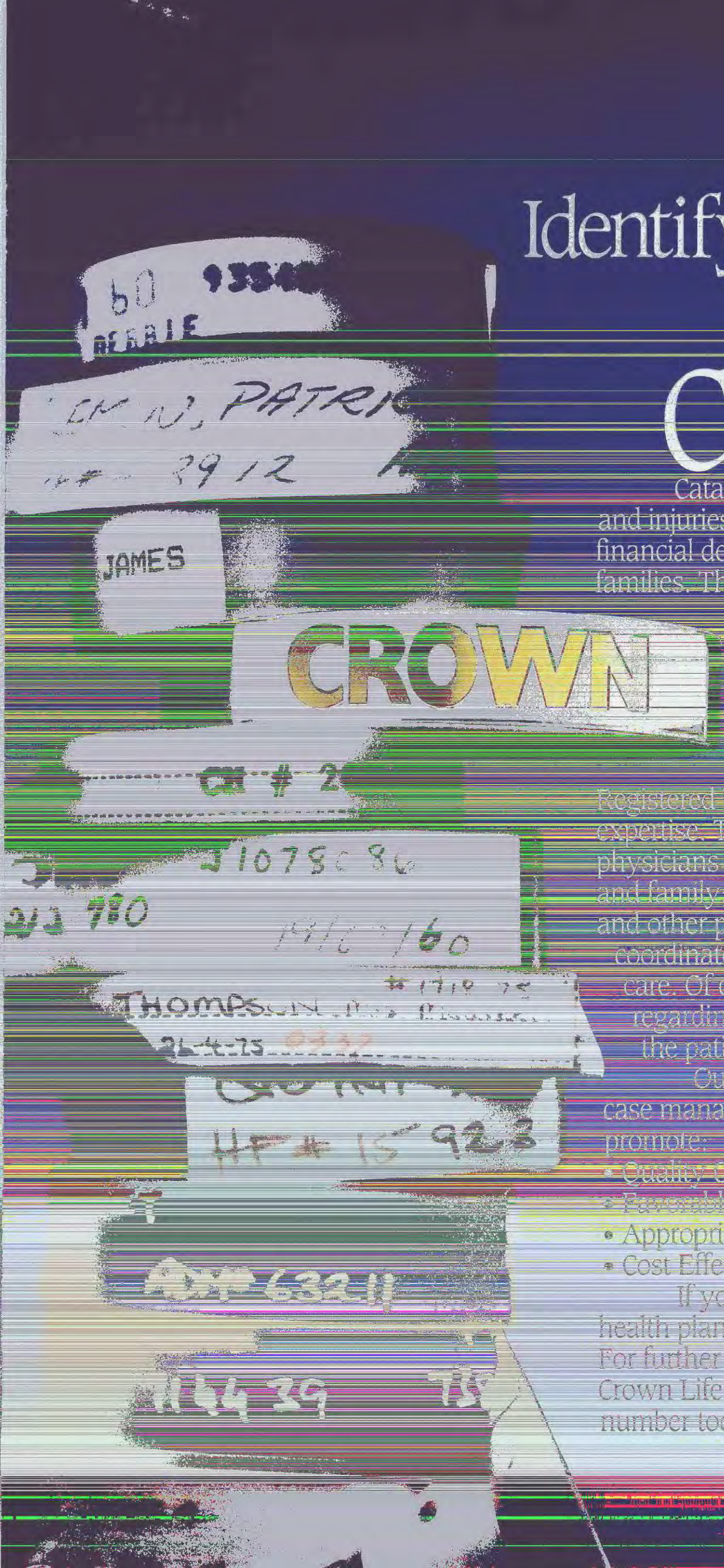
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opinions

Wither workers comp?

EMPLOYERS' SHIELD against lawsuits from injured workers is being pierced again.

A federal judge in California last month ruled that an employee exposed to benzene could directly sue Firestone Tire & Rubber Co., even though the man has not manifested any symptoms of a disease (see story, page 1). The plaintiff alleged he should be able to sue because his "injury"—alleged damage to his immune system that could make him more susceptible to cancer as well as emotional distress—is not compensable under the California workers compensation law.

While we agree that an employee should be entitled for compensation for employment-related injuries, we oppose further assaults on the exclusive remedy provisions of workers compensation laws. The workers compensation system was—and should continue to be—based on a true "no-fault" concept: Employers agree to compensate employees for workplace injuries, with employees barred from suing their employers for such injuries.

However, the no-fault concept has been continually eroded through the years by court decisions allowing employee suits for a plethora of reasons. Last month's decision is just another in a long line of rulings that go against the true purpose of the workers compensation system.

We believe the plaintiff in the California case should be compensated if he does manifest a benzene-related injury. But instead of allowing employees to sue for diseases that may never be contracted, states that have not already done so should modify their work comp laws to allow employees sufficient time to file a work comp claim after an employment-related disease manifests itself.

All this decision will do is prompt disgruntled workers, alleging all kinds of "latent" injuries, to file suit against their employers.

It is ironic that at a time many are suggesting the tort system be reformed and possibly replaced with a no-fault system, the workers compensation system is being transformed from a no-fault system into a tort system. If an employee deserves compensation for a workplace injury, the workers compensation system, not the courts, should be the forum for his or her claim.

letters

U.S.-Canadian trade pact warrants closer scrutiny

To the editor: The United States and Canada are currently pursuing a Free Market Pact, an arrangement enabling Canadian firms to sell their goods and services in the United States and American firms to do likewise in Canada, without paying tax on the goods and services going each way.

The pivotal situation involving the insurance relationship is whether profitable opportunities for insurance brokers and insurers would be relatively equivalent in both countries as a result of this possible arrangement.

Significantly, the insurance industry and aggregate premiums in both nations should continue to grow through economic expansion and the need for new and more extensive coverage.

The same insurance industry currently is expressing a much heralded upturn in premium rates, which has an immediate impact on insurance brokers' commission revenues. In addition to being a substantial improvement on the insurance broker's ledger, this growth is anticipated during a period where corporate profit growth is expected to be slow, hence making insurance brokers on both sides of the border quite attractive to the investor.

Aside from insurance, other service industries are banking, data processing and professional services. These industries do not produce goods or commodities and they have grown substantially during times of recession.

Trade-in services accounts for some 20%, or $24 billion, of all trade between Canada and the United States. Service industries, including insurance, generated about two-thirds of the Canadian and U.S. gross national products.

Yet, the major block to growth of service industries, inclusive of the insurance industry, is the right of American business to compete in a market on the same basis as local Canadian firms and vice versa for Canadian business in the United States.

For Canadian insurers, agents and brokers, it would be demoralizing if a "common market" environment were to spring up. There is no accurate prediction as to what it would engender. However, possible demands from American firms depending on their insurers to provide insurance for their operations in Canada would arise. Efforts by agents and brokers south of the border to follow their clients into Canada could be a natural result.

Doubtlessly, there would be pressure on the Canadian dollar to align itself more closely with the U.S. dollar, and confusion as to whether premiums and losses would be collected and paid in the same currency would arise.

Another point: What is the likelihood of Canadian policy forms reaching acceptability amidst the form standardization rampant throughout the United States?

The free trade pact would most likely stipulate that insurers on either side of the border transact insurance while meeting distinct financial requirements.

While none of the above speculations mean a change in the current method of conducting affairs in the isomorphic insurance market in the United States and Canada, the effect that the Free Market Pact may have bears more comment from major insurance companies.

Brian Kilgannon
Bayside, N.Y.

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System, not just plaintiffs' lawyers, 'obscene'

To the editor: An article in your Feb. 23 issue reported some of my remarks addressed to The Insurance Institute of London on Feb. 12. Without quoting me, the story observed:

"He described the present tort system —whose main aim, he said, is to pay plaintiffs' attorneys huge contingency fees—as obscene and called on the insurance industry to provide some type of system that ensures that those claimants who need money receive it."

I did not limit my criticism to plaintiffs' attorneys. I described the system as obscene because its primary economic function is to pass wealth to lawyers—for both sides of the conflict—and to pay for the legal apparatus. As you know, more of insurers' premium and investment income goes to attorneys than to the maimed.

Donald J. Greene
LeBoeuf, Lamb, Leiby & MacRae
New York

McCarran-Ferguson needs careful review

To the editor: In the March 23 Washington column, you misstate the National Assn. of Insurance Brokers' position on the congressional review of the McCarran-Ferguson Act.

You state that the NAIB believes that review of the McCarran-Ferguson should "proceed immediately." In fact, the NAIB said it recognized the review is "a valid public policy issue" that should proceed "deliberately."

The word deliberately was chosen to express the NAIB's concern that Congress, looking for a quick response to the insurance crisis, will act hastily without careful review of the impact of changes on the insurance marketplace and insurance buyers.

It should also be noted that the NAIB board of directors reaffirmed its support of the principle of state regulation in the same position statement.

David F. Lambert III
Executive director
National Assn. of Insurance Brokers
Washington

1985 growth year for both HMOs and PPOs

To the editor: The National Assn. of Employers on Health Care Alternatives has tracked HMO development since 1972 and PPO development since the early '80s. In contrast to some of figures in an article in the Feb. 16 issue, the greatest growth year for both HMOs and PPOs was 1985. The number of HMOs increased by 161 and the number of PPOs by 160. The total number of HMOs still exceeds the total number of PPOs.

NAEHCA's second annual "Blue Book" digest of HMOs, published in July 1986, included 682 operational HMOs and the second annual "Blue Book" digest of PPOs, as of November 1986, included 462 operational PPOs.

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Ruth H. Stack
Executive Director
National Assn. of Employers
on Health Care Alternatives
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Aide says business created COBRA problems

By JERRY GEISEL

LAS VEGAS, Nev.—A misguided business lobbying campaign is a key reason employers now are having so many problems coping with COBRA's health care continuation provisions, a congressional committee staffer says.

During the debate on COBRA—the Consolidated Omnibus Budget Reconciliation Act of 1985—some employer groups spent more time trying to kill a key provision in the legislation rather than work with staff to iron out technical issues, the staffer said.

Phyllis Borzi, pension counsel with the House Labor Management-Relations Subcommittee, said employer lobbying efforts centered on deleting a provision requiring companies to extend health care coverage to former employees.

Speaking last week at the 25th annual Risk & Insurance Management Society conference, Ms. Borzi said this lobbying effort was doomed to failure. It "had the same chance as hell freezing over," Ms. Borzi said.

Instead of working with congressional staff to straighten out problems before the legislation was enacted, employers focused on the "politically impossible," she said.

And some business groups didn't even take part in the debate—either because they didn't take the legislation seriously or because they were concentrating on tax reform legislation, Ms. Borzi said.

But as most employers now know, COBRA is having a tremendous impact on health care plans by requiring employers to open up their health care plans to millions of new participants.

COBRA requires most public and private employers to provide health coverage to employees' widowed or divorced spouses for up to three years. In addition, except when fired because of gross misconduct, former workers may purchase continuation coverage for up to 18 months after employment.

The only groups that are excluded from this broad federal benefit mandate are those with fewer than 20 full-time employees on a "typical business day" during the previous calendar year and religious organizations that operate so-called church plans.

Companies can charge former employees and spouses up to 102% of the cost of coverage.

Employers failing to abide by COBRA could lose tax deductions for health care expenses.

But employers say compliance with a loosely written law, for which there are no published regulations, can be difficult.

For example, the law provides little guidance on how a self-funded employer can calculate an "applicable premium" and thus determine what they can charge COBRA beneficiaries.

But, federal regulatory agencies and Congress are working to clear up some of the confusion, she said.

The Treasury Department, for example, is drafting regulations on the premium calculation issue, Ms. Borzi said.

In addition, Congress already has filled in some COBRA holes.

For example, under COBRA, an employer can cut off continuation coverage if a beneficiary fails to make premium payments in a timely manner. However, COBRA did not define "timely."

But in a budget bill—sometimes referred to as COBRA II—passed last October, Congress made clear that employers could stop coverage if beneficiaries failed to pay premiums within 30 days of the due date, Ms. Borzi said.

Also, she noted, COBRA II clarified the maximum length of continuation coverage when there are multiple qualifying events.

Under COBRA II, a beneficiary can have multiple qualifying events, but the total length of coverage cannot exceed 36 months, Ms. Borzi said.

For example, if a former employee dies during the 14th month of coverage, the spouse's coverage could be extended for 22 more months.

The original COBRA legislation did not specify the maximum length of coverage when there were multiple qualifying events.

In addition, Ms. Borzi said, COBRA II requires employers to give COBRA beneficiaries a choice between the company's so-called core benefits—medical and hospital coverage—and the core package plus health care-related benefits—like dental and vision care—that the company offers to employees.

Congress decided to give beneficiaries the right to choose between core benefits and a richer benefit package to curb potential abusive situations, Ms. Borzi said.

It was feared that employers might create such a rich and, thus, expensive package that COBRA beneficiaries would be unable to afford the premium, she said.

While the business community may see COBRA as another example of needless congressional interference, the reality is quite different, Ms. Borzi said.

"Members were concerned about access to affordable health care coverage" for spouses and former employees, Ms. Borzi said.

While the social objective may have been sound, COBRA is creating all kinds of administrative hassles for employers.

For example, Martin S. Brown, corporate employee benefits manager at The Clorox Co. in Oakland, Calif., said Clorox's six-person benefits department spends between 40 and 50 hours a month administering COBRA.

Among other things, time is chewed up keeping track of beneficiaries' premium payments and mailing out notices that a person is eligible for continuation coverage.

COBRA administration has forced the company to delay new benefit programs, Mr. Brown said.

"Employers can't offer new plans because they are snowed under by COBRA," he explained.

But, companies can reduce administrative problems.

For example, Mr. Brown advises companies to give beneficiaries pre-printed labels to enclose with premium checks. This will help the company route the premium check.

The session was moderated by Kathy Dupree, risk manager for MetroVision Inc. in Atlanta. Session coordinator was Don Caton, a senior consultant with William M. Mercer-Meidinger-Hansen Inc. in Atlanta. ■

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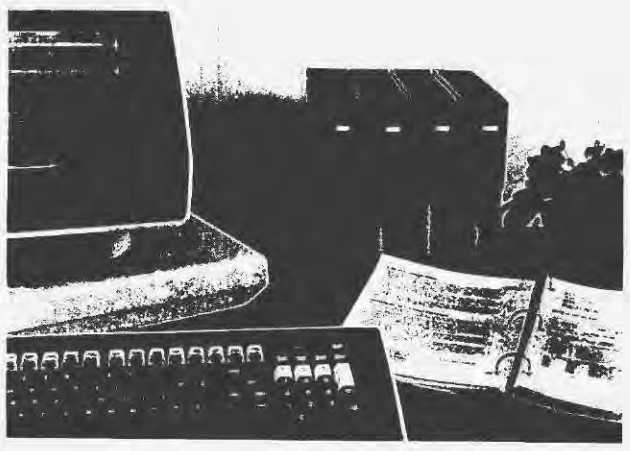
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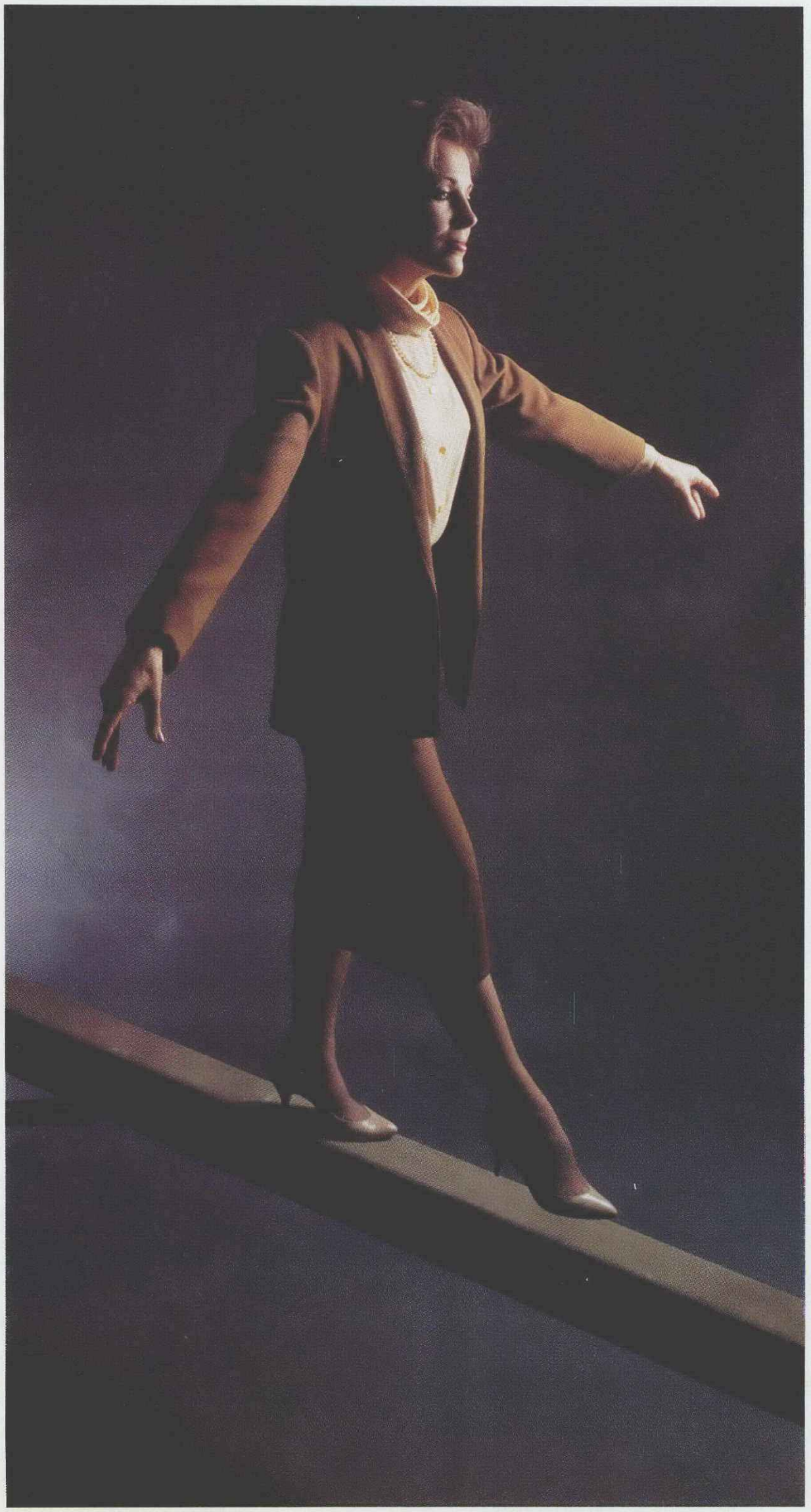
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Flexible plans can save money: Panel

By DEBORAH SHALOWITZ

LAS VEGAS, Nev.—Small and medium-sized companies can use flexible benefit programs to control costs, meet the needs of a diverse workforce and possibly save money, benefit experts say.

In the past, the high cost of flexible benefits put them out of reach of many companies with fewer than 5,000 workers. But, with the advent of low-price software programs—many of which are designed to be used on a personal computer—and special insurer plans marketed to small employers, any size company can now economically offer flexible benefits, said a panel at the 25th annual Risk & Insurance Management Society conference last week.

"Flex can work equally well for the small to medium-size companies as the Fortune 500 companies," said Suzanne M. Kidd, a senior consultant with the national benefit services division of Frank B. Hall Consulting Co. in Briarcliff Manor, N.Y.

While many companies will first begin to save money three to five years after instituting a flexible benefit program, flex plans immediately offer employers increased control over benefit costs and can offer both employers and employees tax savings, panelists agree.

On average an insurer-administered flexible plan for a 1,000-person group could cost an employer an additional $25 to $50 per employee for the first year, the panelists said after the session. This cost could be reduced by about 20% in succeeding years because start-up fees have been paid.

The simplest type of flexible benefit plan is a flexible spending account, in which employees are allowed to set aside money on a pretax basis to use for health care and dependent care expenses, said Joseph B. Reilly, III, another senior consultant with Frank B. Hall Consulting Co.

For instance, an employer could allow an employee to contribute an amount equal to his or her premium contribution to an FSA. Not only would the employee save both federal income and FICA taxes, but the employer also would not have to pay FICA taxes on the amount the employee contributes.

Flexible spending accounts also can be used by employees to spend pretax dollars on other health care and dependent care expenses, Mr. Reilly said.

He added that most of the employer's costs, such as administration costs, would be offset by savings on FICA contributions.

Modular benefit packages, which offer specific combinations of benefits, are a more complicated type of flexible benefit program.

The most popular flexible benefit program is the "core plus options" program, Mr. Reilly said.

Under this type of plan, a minimal "core" benefits package is provided to all employees at no cost. A typical core package might cover some of the costs of a catastrophic illness, long-term disability and a small life insurance policy, Mr. Reilly explained.

The employer then provides credits to allow employees to "buy" the additional benefits he or she wants. An employer also could allow employees to convert the credits into cash compensation.

The key to saving money through flexible benefit programs is to define the contribution the company will make toward benefits rather than to define the benefits employees are entitled to, said Raymond C. Linstrum, president of CIGNA Employee Benefits Services Inc. in Hartford, Conn.

By promising only a contribution to a benefit plan and allowing an employee to choose how to spend the contribution, the employer can better maintain control over its costs, Mr. Lindstrum explained.

One of the downside risks of flexible benefits, however, can be what is called adverse selection, which occurs when an employee chooses benefits he is most likely to utilize most frequently, Mr. Linstrum pointed out. He suggested limiting the number or combinations of options to mitigate this problem.

A flexible benefit plan can be administered in-house or through an insurance company, Ms. Kidd.

A communications program should measure employee attitudes before the pretax-enrollment period so an employer can tailor its efforts to its employees' needs, Mr. Linstrum advised. Then, at least three months before the effective date of the flexible benefit program, an employer should build awareness of and try to generate enthusiasm for the plan.

As the effective date of the flexible benefit program draws near, employees should receive detailed information kits, perhaps including worksheets to calculate options, Mr. Linstrum suggested.

The panelists agreed that flexible benefit programs will grow in popularity in the coming years. Mr. Linstrum said after the session that while flexible benefit programs now account for about 5% of CIGNA's group insurance business, the company expects that to grow to about 50% in five years.

John K. Hahn, director of risk management and insurance for Northville Industries Corp., Melville, N.Y., moderated the discussion. ■



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FAS 87 won't have great impact: Accountant

By KATHRYN J. McINTYRE

LAS VEGAS, Nev.—Only a minority of companies will be forced to show pension liabilities on their balance sheets under a new pension accounting rule, a pension accounting expert says.

Estimates are that between 5% and 20% of large companies will have to show a pension liability on their balance sheets as a result of Statement 87 by the Financial Accounting Standards Board, said Dale L. Gerboth, a partner with Arthur Young & Co. in New York.

"It will be far more than before, but it will be a distinct minority," he said.

Furthermore, compliance with FAS 87 generally will reduce the cost of pension plans as reported by companies, with more companies reporting a negative cost than before, he said.

"Very few companies will find their pension costs increasing under FAS 87," he said.

Mr. Gerboth, along with William M. Mercer-Meidinger-Hansen Inc. Principal Donald E. Fuerst, described FAS 87 and its effect on corporate financial statements during a seminar at the 25th annual Risk & Insurance Management Society conference last week.

Companies that most likely will have to report pension plan liabilities on their balance sheets are "Smokestack America," which are financially troubled companies—sometimes with underfunded pension plans. Such a disclosure will hurt these companies most, Mr. Gerboth noted.

The offsetting "intangible asset" required by FAS 87 will be ignored by financial analysts, he predicted.

FAS 87, Employers' Accounting for Pensions, requires companies to report pension plan liabilities on their balance sheets instead of merely disclosing them in footnotes to their financial statements.

The rule applies not only to qualified pension plans but also nonqualified plans that might not be subject to ERISA, noted Mr. Fuerst.

In addition, the information required in the footnote will be expanded, Mr. Gerboth noted.

The basis for determining any liability is governed by the rule, which permits only one actuarial cost method, called the attribution method. Companies also will be required to expense an amount during the year based on FAS 87.

That contrasts with the common practice before FAS 87 of using the actuarially calculated funding contribution (money contributed to the plan) for the charge for expense (amounts reported in the financial statements). Now, funding and expensing figures will be different.

"You simply can't use one calculation to do both jobs anymore," Mr. Gerboth said.

FAS 87 requires companies to use the projected unit credit actuarial method for pension accounting. This entails attributing benefits to various years based on the company's pension plan formula.

"It is absolutely essential that these be supplied by an actuary," said Mercer's Mr. Fuerst. "The actuary will allocate the liabilities applying the methodology that FAS 87 sets forth, and the cost applicable to a particular year and some of the amortization tables," he explained.

The minimum liability a company must show is the greater of either the unfunded accrued cost of the plan or the unfunded accumulated benefit obligation.

The accumulated benefit obligation is the total of the vested benefit obligation and the non-vested benefits for active employees, Mr. Fuerst explained.

Although compliance with the rule was not required until fiscal years beginning after Dec. 31, 1986, 112 companies already have complied, Mr. Gerboth said.

Of the 112, 69 had fiscal years ending from Dec. 31, 1985, to May 31, 1986, and 43 had fiscal years ending from June 30, 1986, to Dec. 31, 1986.

Before FASB Statement 87 was adopted, pension plan accounting was governed by Opinion No. 8 issued by the Accounting Principles Board, a forerunner to the FASB.

That opinion permitted a variety of cost-calculation techniques, generally resulting in accounting for pension costs based on pension funding, Mr. Gerboth said. In addition, there was very little balance sheet recognition of pension obligations.

The objectives of FAS 87, Mr. Gerboth said, were:

- To provide a measure of net pension costs that is more faithfully representative than those used previously. This was accomplished by reflecting the terms of the underlying plan and better approximating the recognition of the cost of a pension plan over the employees' service period.
- To provide a measure of the net periodic pension costs that is more understandable and comparable.
- To provide additional disclosures that would allow users of financial statements to better understand the extent and effect of an employer's undertaking to provide pensions.
- To improve reporting of financial position.

Financial statement users include investors, creditors, management, employees, suppliers, customers, government agencies, business researchers and teachers and students.

"It is interesting to note," Mr. Gerboth said, that in FAS 87 the board said: "Accounting for pension costs is still in a transitional stage."

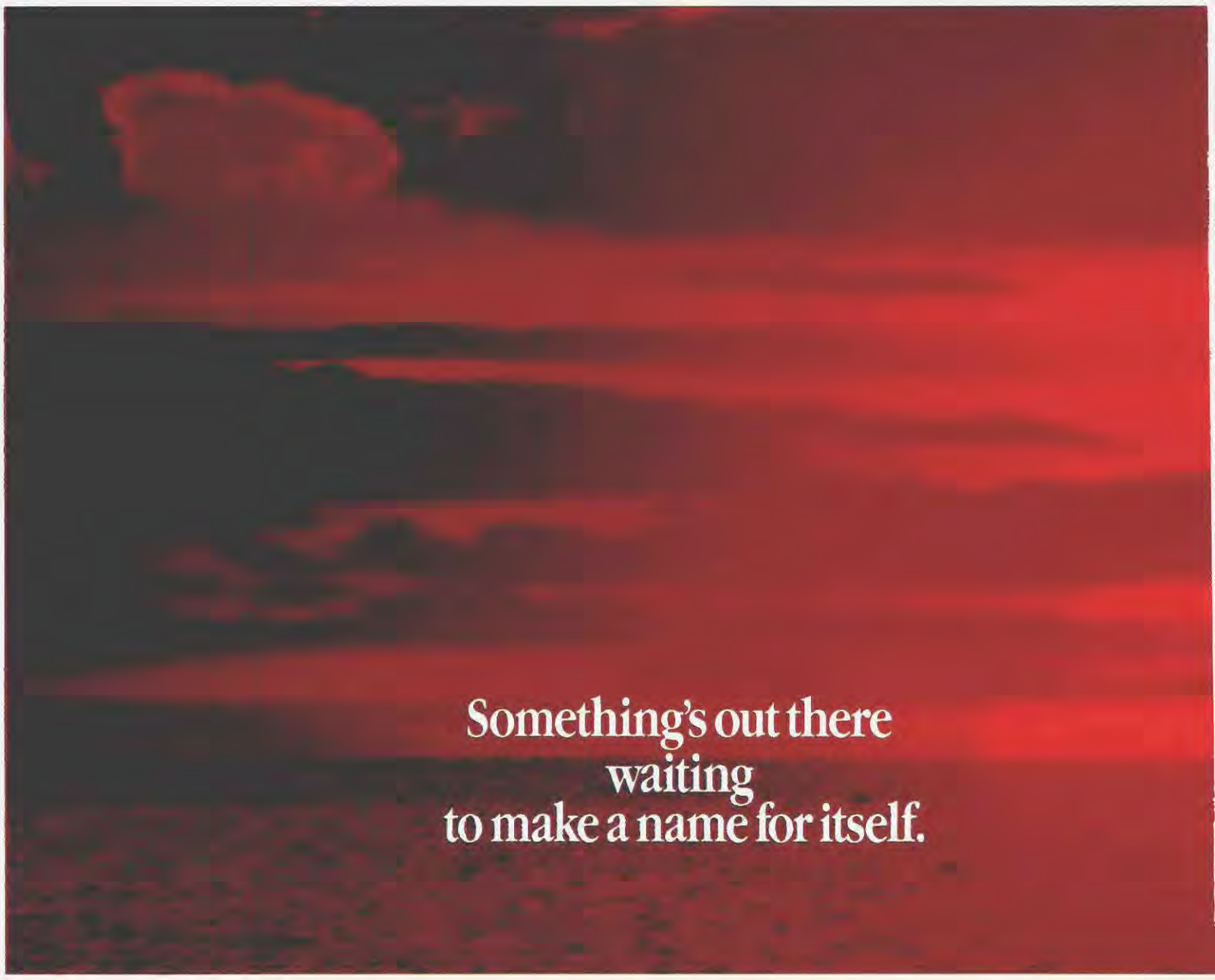
Therefore, FAS 87 "is not likely to be the final step in the evolution of pension accounting," he said.

For example, the board would have preferred to recognize an even more onerous requirement for putting an obligation on the balance sheet as a liability, he said. His outline noted the board would have preferred to require pension plan sponsors to recognize the net asset or liability for the difference between the projected benefit obligation, instead of the accumulated benefit obligation, and plan assets.

The projected benefit obligation adds to the accumulated benefit obligation the effect of future salary increases on past service.

Despite widespread opposition to FAS 87 when it was being deliberated, an "unusually large number of companies" is complying with it before they are forced to, Mr. Gerboth noted.

Moderating the panel was Gary L. Swinhart, director of risk management for Calmat in Los Angeles. ■



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Tax reform impacts benefit plan rules

By JERRY GEISEL

LAS VEGAS, Nev.—Five months after the Tax Reform Act of 1986 was enacted into law, questions about the act's sweeping benefit provisions keep rolling in.

Many of those questions, from both employers and employees, involve Individual Retirement Accounts and 401(k) salary reduction plans.

That interest is understandable given the enormous popularity of both IRAs and 401(k) plans and the complicated rules the Tax Reform Act imposes on both types of plans.

At a seminar, "Tax Reform: Coping With the Benefit Changes," at last week's 25th annual Risk & Insurance Management Society conference, a panel of benefit experts explained the fine points of the IRA, 401(k) and other benefit plan rules contained in the new tax law.

For example, most employers and employees know that only wage earners who are not active participants in a corporate pension plan retain the automatic right to contribute up to $2,000 annually on a tax-deductible basis to an IRA. The deductibility of IRA contributions by those covered by a pension plan now is tied to adjusted gross income.

Pension plan participants filing individual returns with adjusted gross incomes of less than $25,000 or participants filing joint returns with adjusted gross incomes under $40,000 still are allowed to make a $2,000 annual tax-deductible contribution to an IRA.

Individual filers who are participants in pension plans and earning more than $35,000 and joint filers earning more than $50,000, no longer can make tax-deductible IRA contributions.

In addition, a sliding scale determines the maximum deductible IRA contribution made by individual filers with adjusted gross incomes between $25,000 and $35,000 and by joint filers with adjusted gross incomes between $40,000 and $50,000 who also are pension plan participants.

But some individuals incorrectly believe that pension plan participants still can take the maximum tax-deductible contributions to an IRA if they are not vested in the pension plan, said Gerald Uslander, a principal in the Louisville, Ky., office of benefit consultant William M. Mercer-Meidinger-Hansen Inc.

A plan participant's vesting status is irrelevant in determining eligibility to make tax-deductible IRA contributions, he explained.

"It does not matter if a person is not vested. He still is an active pension plan participant" and thus his ability to make tax-deductible IRA contributions will be based on income, Mr. Uslander said.

On the other hand, Mr. Uslander noted, a retiree receiving a pension benefit could have the automatic right to make a tax-deductible contribution to an IRA.

This situation could occur if an individual retired from one company, began to receive a pension benefit and then started to work for another company that didn't offer a pension plan.

Mr. Uslander noted that the new annual $7,000 limit an individual can defer to a 401(k) plan is a radical reduction from the old $30,000 limit. The $7,000 limit went into effect on Jan. 1.

In addition, the new $7,000 maximum is an individual limit, while the old $30,000 maximum was a plan limit, Mr. Uslander explained. Prior to the Tax Reform Act of 1986, an employee changing jobs could defer up to $30,000 into each 401(k) plan in which he or she participated during a year. Now, with the new individual limit, the maximum an employee can defer into a 401(k) plan is $7,000 annually, regardless of the number of plans involved, he said.

Mr. Uslander noted that withdrawal of funds from 401(k) plans still is allowed for hardship—such as payment of a child's college expenses, down payment on a primary home and uninsured medical expenses—but access to the funds has been reduced.

Interest earned on salary withdrawals and matching employer contributions that were aggregated with deferrals for purposes of satisfying non-discrimination tests could not be withdrawn, he said.

Maureen Gorman, an attorney with the law firm of Mayer, Brown & Platt in Chicago, told listeners that many of the pension changes contained in the tax law were motivated by the desire of both Congress and the Reagan administration to increase the chances that participants will receive benefits.

Ms. Gorman noted that policymakers could justify the substantial tax breaks that pension plans receive only if benefits were available to a broad cross-section of employees.

For example, while definitive statistics are not available, there was a strong possibility that many people were not receiving benefits because they didn't stay on the job for 10 years—the normal minimum service period to become vested in a pension plan, she said.

As a result, Congress—to boost the number of people entitled to benefits—set new rapid vesting schedules, generally effective in 1989. Under the law, employers will have their choice of offering two new vesting schedules: 100% vesting after five years of service or 20% vesting after three years of service, with vesting continuing at a rate of 20% annually until a plan participant is 100% vested after seven years.

Changes in pension plan integration rules—laid down by the Tax Reform Act—also were motivated by administration and congressional desire to increase the chances that a person would receive a meaningful benefit, she said.

Under current integration rules, "People with small benefits could get (next to) nothing," Ms. Gorman noted. In fact, pension activists for years have charged that integration rules unfairly sliced retirees' pension benefits.

For example, many employers now reduce benefits payable under defined benefit plans by an amount equal to 50% of a retiree's Social Security benefit.

But under the new integration rules, which will go into effect in 1989, a pension benefit generally could not be reduced by more than 50%.

Also speaking at the seminar was John Stair Jr., manager of analysis and studies at E.I. Du Pont de Nemours & Co. in Wilmington, Del. The seminar moderator was Mark Hudson, director of risk management at Batus Inc. in Louisville, Ky. ■



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Mandated benefits

Continued from page 3

employer contribution. Employees with healthy lifestyles—no smoking, frequent exercise—would pay lower premiums.

"I want every American to live by a few rules: Stop smoking. Exercise. Pay them (in the form of lower health insurance premiums) to live healthier lifestyles," Mr. Levinson said.

While it isn't clear how the issue of mandated benefits will be resolved, congressional interest is intensifying, a veteran House committee staffer told the session.

"Members (of Congress) are increasingly concerned about access to health care coverage," said Phyllis Borzi, pension counsel for the House Labor Management-Relations Subcommittee.

"The people have been pushing this issue. . .and it is the role of Congress to come up with the least objectionable solution," said Ms. Borzi, adding that health care coverage is very much on the congressional front-burner.

'Everyone knows someone who is not covered (by health insurance) and has been hit with horrendous bills,' says Phyllis Borzi, pension counsel for the House Labor-Management Relations Subcommittee.

Indeed it is. Even before the 100th congressional session opened in January, benefit experts were predicting that this would be a "health care Congress."

That expectation already is being realized. For example, Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., is drafting legislation to require, much as the AFL-CIO's Ms. Ignani advocates, all employers to offer a minimum health care plan.

The Kennedy legislation now is expected to be introduced in May.

In the House, Rep. Fortney (Pete) Stark, D-Calif., chairman of the Ways and Means Health Subcommittee, has introduced legislation to expand the federal Medicare program and reduce the elderly's vulnerability to catastrophic health care bills.

In addition, Rep. Stark and ranking minority member Rep. Willis Gradison, R-Ohio, are preparing legislation to give the nonelderly greater access to health care coverage.

And, a group of congressional staffers, led by G. Larry Atkins, minority counsel with the Senate Special Committee on Aging, have been studying ways of improving health care coverage.

This surge of congressional interest in expanding health care coverage has been triggered by a number of factors, including an increase in the number of uninsured individuals—now estimated at about 35 million—and the high cost of medical care.

Ms. Borzi, for example, notes that in recent years the greatest growth in the economy has been by small service firms—a sector of the economy least likely to offer group health care plans.

As coverage has declined, medical care cost inflation has continued, exposing those without health insurance to huge bills.

"Everyone knows someone who is not covered (by health insurance) and has been hit with horrendous bills," Ms. Borzi observed.

At the same time, fundamental changes in the nation's health care delivery system have exacerbated the problem of uncompensated care, experts say.

Some large employers, with big market clout, have been able to negotiate price discounts with hospitals. Those discounts, in turn, make it more difficult for hospitals to absorb the cost of charity care.

In addition, the ability of hospitals to pay for uncompensated care is being threatened by cutbacks in federal and state health care programs, such as Medicare and Medicaid.

Requiring all employers to offer a minimum health care plan is a step toward solving the problem of uncompensated care, Ms. Ignani said.

First, a federal health care plan mandate would make a huge dent in the number of uninsured.

Ms. Ignani estimates that of the 35 million uninsured individuals, about 75% either are employed by companies without a group health care plan or are dependents of employees.

Employers already providing health care coverage would benefit in several ways if the federal government required all companies to offer a minimum plan, she said. For example, individuals who lack health care coverage are likely to neglect medical problems.

As a result, uninsured individuals are most likely to seek care at hospital emergency rooms, the most costly and least efficient method of treatment, Ms. Ignani notes.

By contrast, if individuals had health insurance coverage, they would be more likely to see physicians more regularly and have problems treated in a more cost-efficient manner. That, in turn, would hold down health care costs, Ms. Ignani said.

In addition, if more individuals had employer-sponsored health care coverage, hospitals would not be under pressure to boost bills of insured patients to pay for uncompensated care.

Employers with health care plans currently "cross-subsidize those who lack coverage," Ms. Ignani said.

And, as larger employers win price discounts, such as through preferred provider organizations, hospitals will have to raise charges even more for the remaining companies to subsidize uncompensated care, Ms. Ignani said.

"PPOs make the (cross-subsidy) situation even worse," she said.

Major employers should not feel threatened by a federal health care plan mandate, Ms. Ignani said.

While not laying out the details of a minimum plan, Ms. Ignani said a minimum plan would be "bare bones" and would be far below what most employers already provide.

In addition, an employer could offer the actuarial equivalent of a minimum plan rather than a fixed prescribed set of benefits, Ms. Ignani said.

"Flexibility would be allowed. You would not have to dot every 'i' or cross every 't,' " she said.

Employers, especially smaller firms with little market clout, would be allowed to buy coverage through state pools, Ms. Ignani said. Pool coverage would be supplied by insurers, or other providers, who won contracts as a result of competitive bidding, she said.

In addition, Ms. Ignani advocates separate health care pools for high-risk uninsured individuals who don't work for a company, such as those with pre-existing medical conditions.

But those pools for high-risk uninsured individuals would be

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Mandated benefits

Continued from page 16

funded through a broad financing mechanism, like general revenues —not just by employers, she said.

Offering a carrot to employers, Ms. Ignani said the minimum health care plan, if enacted, should pre-empt existing state mandated benefit requirements.

While Mr. Ugoretz of the ERISA Industry Committee, also known as ERIC, doubts if a congressionally mandated minimum health care plan would stay "bare bones" very long, ERIC is most concerned about the proliferation of mandated benefit laws at the state level.

As recently as 1974, there were 48 state mandated benefit laws. Now, Mr. Ugoretz says, there are some 680 laws, with many more proposals facing action.

These mandated benefit laws, which often require employers to offer certain coverage for alcohol and drug abuse, create an administrative nightmare for nationwide employers, Mr. Ugoretz noted.

'Mandating specific coverage may result in fewer dollars available for basics,' says Mark Ugoretz.

In mandating benefits, state legislators fail to consider that companies have limited resources to provide benefits, and that companies may be forced to cut back on popular, valued benefits, Mr. Ugoretz said.

"All employers have limited resources for their benefit programs," he said. "Mandating specific coverage may result in fewer dollars available for basic coverage forcing. . .employees to pick up a greater share of the cost of basic coverage in exchange for boutique arrangements."

Forcing companies to provide benefits sought by special interest groups could mean less coverage for health care, Mr. Ugoretz pointed out.

"If companies are forced by legislative fiat to provide for pediatric care, alcoholism and drug abuse, hospice care and a variety of other benefits—however laudable—and if they have to provide for the increasing costs of special providers, then fewer resources will be available for basic health care," he said.

Mr. Ugoretz noted that the proliferation of state mandated benefit laws is pushing more employers to self-fund health care plans.

That is because a 1985 Supreme Court decision allows states to impose benefit requirements on insured, but not self-funded, plans.

"Pre-emption (from state benefit rules) allows an employer to design a plan that provides coverage its employees want; it means that labor and management can work out a collective bargaining agreement on benefits," he said.

But not all employers have the financial resources to self-fund their health care plans.

As a result, employers hope that if the federal government does mandate benefits, then that federal standard would pre-empt varying state statutes and apply to all companies, Mr. Ugoretz said.

Mr. Levinson, Delaware's insurance commissioner, told the session that state laws mandating specific benefits are counterproductive.

Such laws inflate costs and reduce coverage because employers may terminate plans rather than provide forced benefits, he said.

Instead of mandated benefits, employers should make available group health insurance that employees could purchase.

As a key part to this proposal, which was defeated last year in the Delaware Legislature (*BI*, Aug. 25, 1986), employers would have to provide substantial premium reductions to employees who engage in "healthy lifestyles."

These healthy lifestyles would include no smoking, regular exercise, non-abuse of drugs and moderate alcohol consumption.

Mr. Levinson said 50% of health care costs are the result of conscious lifestyle decisions, such as smoking. As a result, those whose behavior is likely to lead to big health care costs should pay a higher premium than those with healthy lifestyles, he said.

"We should make slow suicide a little more expensive," he said.

The session was moderated by Galt Grant, director of risk management at Polaroid Corp. in Boston. Kathy Dupree, risk manager at MetroVision Inc. in Atlanta, coordinated the session. ■

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Stop-loss cover can trigger conflicts

By JUDY GREENWALD

LAS VEGAS, Nev.—Companies that self-fund their group health plans should be aware of discrepancies between their plan documents and their stop-loss insurance policies: They could prove expensive.

This was the warning sounded by a reinsurance broker at a seminar on stop-loss contracts at the 25th annual Risk & Insurance Management Society conference last week.

Employers that self-insure their group health plans can purchase two types of stop-loss coverage. Specific stop-loss insurance reimburses the self-funded plan when a covered individual has annual claims greater than the coverage's attachment point, which is based on the level of expected claims.

Aggregate stop-loss insurance reimburses the employer when total annual eligible claims for all employees are greater than the aggregate attachment point.

There already have been several errors and omissions claims made against third-party administrators that stem from discrepancies between employers' plan documents and their stop-loss coverage, said Milo W. Zidek, vp of Philadelphia-based broker IOA Re.

"You want to watch that the reinsurance document protects you as much as it protects them," he said during his presentation, referring to the stop-loss underwriters.

Mr. Zidek pointed to one stop-loss contract that excluded coverage in cases of injury from nuclear material. Typically, he indicated, such an exclusion may not be in an employer's plan document.

"That's a conflict. What happens if you have a Three Mile Island?" he asked. Mr. Zidek also noted that hospital employees could be injured at a hospital's radiation facilities.



"What you have to watch out for is conflicts between what you say, and what you intend to say," Mr. Zidek said, referring to plan documents.

Other potential areas of discrepancy, he said, include stop-loss contracts that exclude coverage for transplants when there is no such exclusion in the plan document.

Mr. Zidek also demonstrated an instance where a plan document included no provisions for a lifetime maximum for mental or nervous conditions, even though the stop-loss contract had a $50,000 maximum with a coinsurance provision.

Self-insurers also should avoid stop-loss contracts that grant the insurer the right to change deductibles, rates or attachment points at virtually any time, said Mr. Zidek.

Other potential problem areas for self-insurers occur when they decide to switch stop-loss insurers, said Bruce A. Carlson, assistant vp at North American Life & Casualty Co., based in Minneapolis.

For instance, Mr. Carlson noted most self-insurers have "paid contracts," which provide that all claims be paid within the plan year.

When an employer switches insurers, claims on these contracts incurred before the coverage is transferred to the new insurer—but paid later—may not be reimbursed by either insurer unless expensive special arrangements are made with the new carrier, he said.

Mr. Carlson noted this would not be a problem with "incurred contracts," which pay eligible claims incurred within the plan year, regardless of when the claim is actually paid. But, he added, these contracts are not frequently written by stop-loss insurers.

Another problem that faces employers that switch stop-loss insurers are disabled employees, said Mr. Carlson. Sometimes a new insurer will exclude coverage for disabled workers, though this point often can be negotiated, he said.

Another issue that should be discussed with a new insurer is its renewal philosophy, Mr. Carlson said. In particular, the new insurer should be questioned as to how employees who have become disabled are handled. Options, he said, include not renewing the policy, increasing rates, increasing the deductible, setting a higher deductible on the particular employee or some combination of the various options.

"These are questions you want to ask your carrier before you sign an agreement with them," said Mr. Carlson.

Another problem can arise when claims are incurred late in the plan year and paid in the next plan year. If the contract is written on a "paid" basis, the claim goes against the second year's deductible, instead of the first year's, which may have already been satisfied, he said.

Yet another problem can arise with some insurers that will not cover amendments to the health plan before they have received the signed amendment, Mr. Carlson said. For instance, if the employer amends the plan to cover chemical dependency and the insurer does not receive the signed amendment until 60 days later, the insurer could refuse to cover any chemical dependency claims, he said.

The No. 1 cost for stop-loss insurers is claim costs, which are determined by plan design, said Richard P. Shea, senior vp at Penn General Services in Philadelphia, a third-party administrator.

"Stop-loss insurance plans are probably the smallest cost items in your plan," said Mr. Shea, who estimated that they probably account for less than 5% of a self-insured employer's health care costs.

Mr. Shea also noted there are now as many third-party administrators as there are McDonald's franchises.

"A new industry has emerged," said Mr. Shea, adding that a "whole array" of services are now being marketed by TPAs that were handled provided only by group health insurers 10 years ago.

The session's moderator, Richard DoBell, vp-administration at Stow Manufacturing Co. in Binghamton, N.Y., noted the company felt it needed a good plan document when it began self-insuring in 1979.

There were discrepancies and overlapping areas in its previous plans, which consisted of both Blue Cross hospitalization coverage and a major medical program, he said. To simply convert to self-funding without addressing these issues "would have been a bad, bad scene." ■



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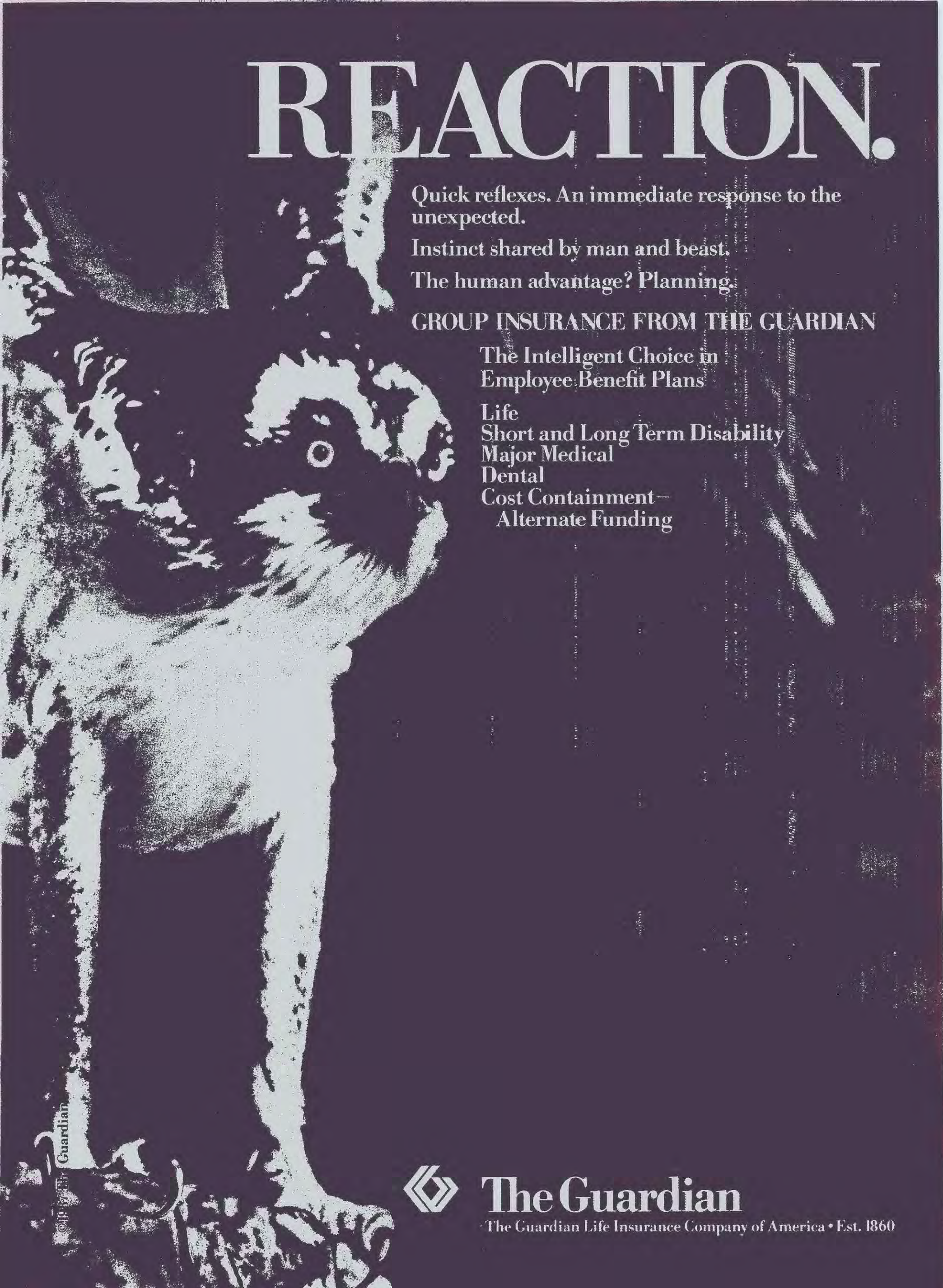
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Utilization review cuts firm's health care costs

By STEVE TARAVELLA

LAS VEGAS, Nev.—Between 1980 and 1985, Control Data Corp. watched its employee health care costs rise an average of 15% per employee, or about twice the rate of inflation.

But in 1986 and 1987, the Minneapolis employer projects it will be able to keep the increase in its health care costs below that of the inflation rate.

Control Data's success with a group of about 26,000 employees is but one illustration of how American business can cut its health care tab by using utilization review programs as the scissors.

Benefit managers attending last week's 25th annual Risk & Insurance Management Society conference were offered the insights of health care professionals experienced in "utilization management"—a tandem effort including utilization review and case management concepts—to attack corporate medical costs.

There's certainly no lack of room for cutting, the experts note.

Employers sometimes find that more than 30% of their plan enrollees' paid hospital days are medically unnecessary, according to Dr. Arnold Milstein, president of National Medical Audit in San Francisco, a unit of William M. Mercer-Meidinger-Hansen Inc. NMA has conducted some 200 audits of plan utilization and utilization review firm performance over the past 36 months.

In 1984, for instance, NMA was asked by a major oil company to examine the bills for 120 randomly selected hospital days incurred in the previous financial quarter. The company was considering contracting with a utilization review firm for $600,000 and wanted assurance that the service was warranted.

The audit concluded that 32% of the hospital days were not medically necessary, Dr. Milstein says.

As the petroleum company studied its options, Control Data was in the midst of reviewing the utilization of its own plans. In 1985, a third in a succession of internal task forces recommended—among other things—implementing 43 varied mechanisms over a three-year-period to control utilization.

Combined, these plan design changes and utilization review techniques worked to reduce Control Data's health care costs for these employees by 10% in the last 10 months of 1986, reports Byron E. Johnson, vp-corporate compensation and benefits.

The company expects to keep health care cost increases below the inflation rate in 1986 and 1987, he says.

Among the changes the company made were reducing the usual-and-customary rate of reimbursement to 85% from 95%; combining the home health care and visiting nurse care benefits into one; increasing the list of surgical procedures requiring a second opinion; and increasing the list of procedures that must be performed on an outpatient basis.

The company turned to Benefit Services Division, Control Data's Dallas claims administration affiliate, for help in selecting a utilization review service. Of five firms Control Data considered, the monthly, per-employee fee ranged from 93 cents to $1.70, says Mr. Johnson. It eventually narrowed its choice to the two with the lowest cost but did not make the final selection on price alone, he says.

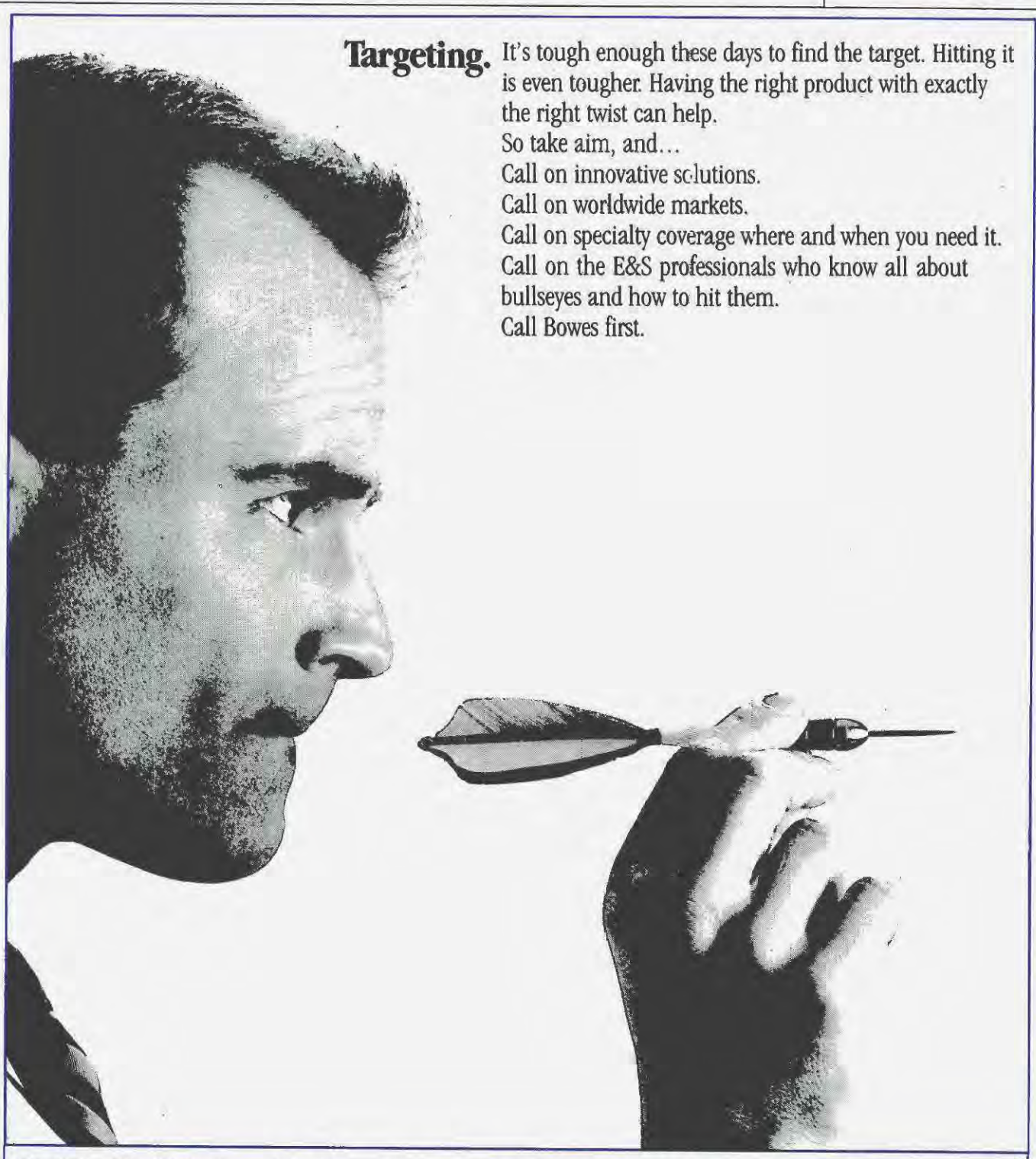
Rather, it focused its attention on the firms' sensitivity to employee needs. The more expensive of the two promised greater savings but appeared mechanical, cold and insensitive, Mr. Johnson notes.

By contrast, HealthCare COMPARE Corp.—the Lombard, Ill., firm retained by Control Data—seemed much more conscious of employees' particular concerns, he says.

"We didn't want to win the battle and lose the war," he explains.

Dennis G. Leibenson, vp-corpo-

Continued on page 24





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Utilization review

Continued from page 22

rate development at Federated Industries in Brisbane, Calif., commended this aspect of Control Data's decision-making.

"Sensitivity to employees has a unique importance, especially in the first years of the program," says Mr. Leibenson, who moderated the session.

Mr. Johnson suggests benefit managers ask utilization review candidates several questions, including: Are psychiatric cases handled by a doctor or a nurse? What is your employee turnover rate? How many physicians do you use? Are your nurses RNs or LPNs? What kind of access will employees have to a medical advice telephone hot line?

Benefit managers should not assume a utilization service is top-notch just because its fee is high; likewise, they should not presume that an inexpensive service would necessarily be less effective, Dr. Milstein advises.

'Sensitivity to employees has a unique importance in the first years,' says Mr. Leibenson.

"Performance differences among utilization review vendors are major," he says. "We do not at this point in the market see a good relationship between how much somebody is charging and the value."

Some very skilled review firms may charge $1.80 per employee per month, while some "dreadful" vendors may charge $2.40 per employee per month for the same service, he says.

To illustrate, he speaks of an insurer that, before deciding between two review firms, pitted the two companies against each other in "a horse race" for six months. The fees the firms quoted were within 10% of each other, yet their results were so disparate that the insurer stopped the project after just three months, he says.

The first review firm achieved a net savings of $359 per case, for a $5.50-to-$1 return on investment. By contrast, the second firm secured a net savings of $1,470 per case, for a return of $17.29 per investment dollar, Dr. Milstein says.

Similarly, a review firm that appears skilled in handling a particular type of case might not be adept at handling others, he points out.

Independent audits determined that one firm exhibited only a 3% error rate in reviewing charges for pre-operation hospital days but a 41.4% error rate in evaluating the necessity of continuing hospital stays.

Another firm demonstrated a 4.5% error rate in obstetrical and gynecological cases but a 47.5% error rate in evaluating hospital days for psychiatric care and substance abuse treatment, he says.

To put these numbers into perspective, Dr. Milstein points out that error rates as high as 10% to 12% are considered adequate because of the nature of medicine and because utilization review is still a new field. However, he said error rates close to 50% become "dismal"—tantamount to having no review at all.

Independent performance audits like these can yield the most conclusive and revealing evidence of a utilization review firm's true effectiveness, Dr. Milstein says.

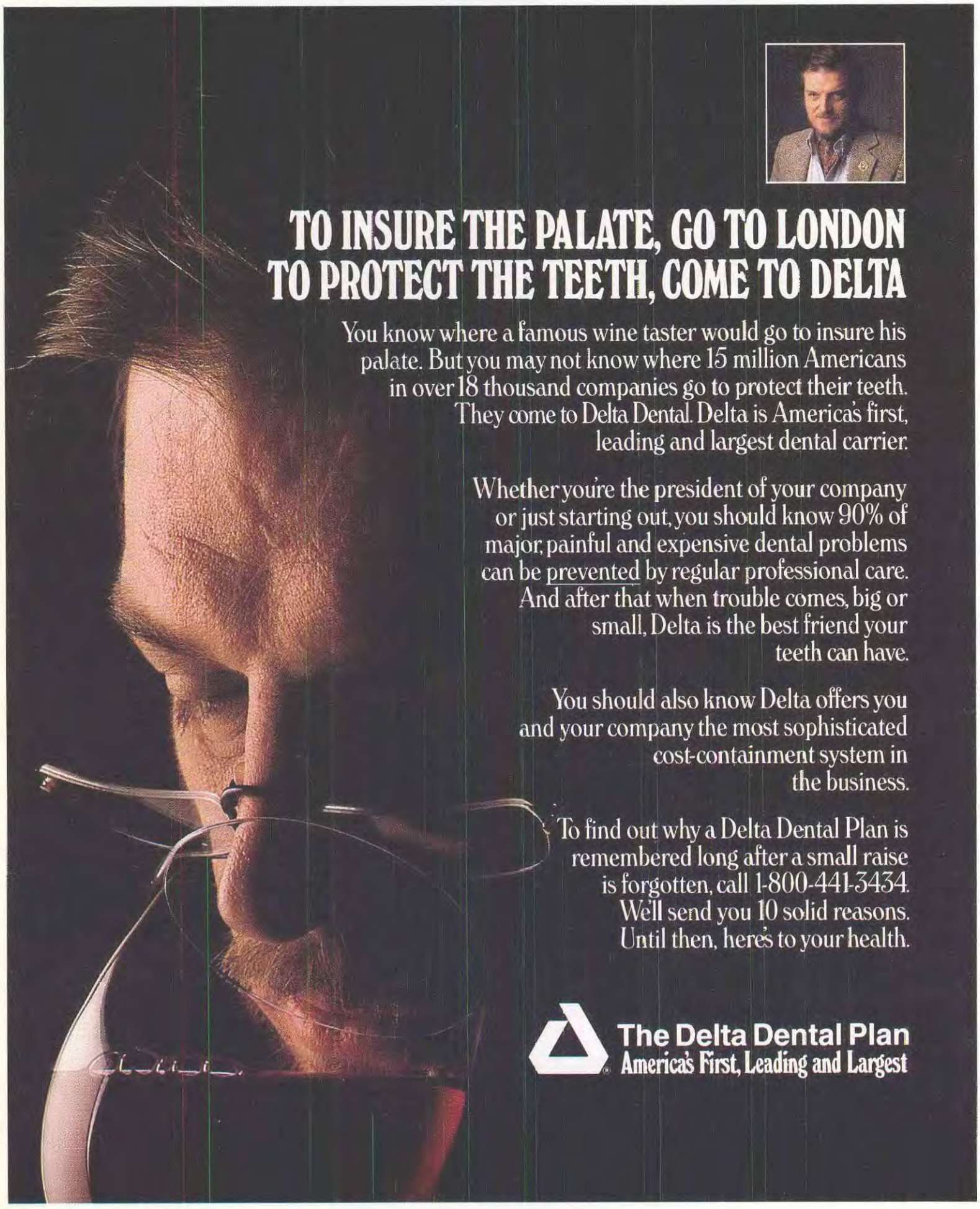
Dr. Robert J. Becker, chairman of HealthCare COMPARE, offered benefit managers evidence of how case management techniques can help make the most of utilization review.

In one case, an 11-year-old boy with head injuries sustained in a fall was moved from a pediatric intensive care unit—where he had been for 28 days at $1,980 per day—to a long-term care facility with coma rehabilitation at a total cost of $180 per day.

Not only did the change in treatment result in savings of $1,800 per day, but it also enabled the boy, after two months of rehabilitation, to return home, Dr. Becker says.

In another case, a 17-year-old youth suffering severe depression had been confined since age 13 in an adolescent psychiatric unit for behavioral disorders at a cost of $400 per day.

Through case management, the boy was transferred to a licensed halfway house that provides 24-hour supervision and outpatient therapy. The youth is now treated at a total cost of $62.80 per day, for a daily savings of $337.20, Dr. Becker says. ■



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PROVIDENT MUTUAL
SECURITY THROUGH FINANCIAL SERVICES

New laws complicating health benefits

By CAROLYN ALDRED

LAS VEGAS, Nev.—Group health insurance programs are becoming dramatically more complex, says an employee benefits consultant.

Doug Preston, managing director of Alexander & Alexander Consulting Group's western division in San Antonio, Texas, warned newcomers to the employee benefits profession at the 25th annual Risk & Insurance Management Society conference that changes in federal legislation and the legal environment have altered how benefits are provided by employers.

"The issue of providing health insurance benefits for employees is incredibly more complex than it was 10 or even five years ago," he noted.

While most of the complexity has been created by federal regulation, including tax reform and the Consolidated Omnibus Budget Reconciliation Act, "also legal issues and the whole legal environment has become hopelessly complex," Mr. Preston said.

"Problems exist that haven't even been identified yet," he added.

Tax reform also includes major changes affecting pension plans, noted Robert Epley, vp and senior actuary of Alexander & Alexander Consulting Group in Dallas.

"Washington has awakened to the (philosophy) of full portability of benefits, increasing the options available to employees while also increasing administration costs of employers," he said.

Tax reforms affecting contributions to Individual Retirement Accounts and the lowering of the 401(k) plan deferral limit to $7,000 from $30,000 have "lost a lot of what we can do for higher-paid executives, which will bring about an increase in supplemental benefit plans to replace those lost benefits," he noted.



Also, defined benefit pension plans will grow in popularity since recent tax reforms imposed more restrictions on defined contribution plans, Mr. Epley predicted.

"Benefits tend to be cyclical in nature and while defined contribution plans have been in favor lately, the recent changes in tax reform have made defined benefit (plans) more advantageous, and I predict a gradual change toward defined benefits," Mr. Epley noted.

However, defined contribution plans—which include 401(k) and profit-sharing plans—are often favored by employees, who find them easier to understand, he noted.

"In my experience, some form of combination of plans usually serves individual companies best," he said.

The increasing complexity of employee benefits and the increasing choices open to employees make the task of communicating a vital one, both speakers agreed.

"A pension plan is an unusually complex topic to explain," noted Mr. Epley.

"Communicating (benefits) to employees is a very important task which is often overlooked," said Mr. Preston.

Successful communication is necessary for several reasons, Mr. Preston noted, including:

- Tax considerations. If reasonable notice of tax benefits is not given to employees, those tax benefits could be lost, he noted.
- Legal considerations. If a company's communications efforts do not agree with plan documents, the company can be forced to offer what is communicated if those benefits are more generous than what is promised in the plan documents, he said.
- Improved employee understanding. "Improved understanding of benefit plans is going to lead to increased competency in using those plans, which in turn leads to increased satisfaction by employees," noted Mr. Preston.

The successful design of benefit plans is also a vital task for any employee benefits manager, noted Mr. Preston, Mr. Epley and Carmen Velez, assistant director of employee benefits for the Texas Municipal League in Austin.

For example, "the types of group life insurance plans available include term insurance, paid-up life insurance, ordinary life insurance and universal life insurance, and not all employees have the same needs," noted Ms. Velez.

In addition, she said companies:

- Have the option of offering accidental death and dismemberment coverage.
- Have various choices in financing life insurance plans, including whether to make the plan contributory or non-contributory.
- Can buy insurance from a commercial underwriter or self-fund.
- Can offer a choice of settlement options, including lump sums or monthly benefits.

And, for medical benefits, "the only limitations on plan design is your imagination and the ability to communicate the plan design to employees," said Mr. Preston.

"You have to look at the plan conceptually. What options do your employees require? How do you reimburse them? What exclusions can feasibly be included?"

Another vital question that has to be considered is how to fund the plans, said Mr. Preston. "In the early days of health insurance, plans were fully insured with the minimum of risk assumption by employers. That has gradually evolved to the concept of self-funding, which is now the most popular for major employers."

According to Mr. Preston, the advantages offered by self-funding include:

- Greater "unbundling" possibilities.
- More accountability from vendors. "If you don't have to buy a packaged plan, you have greater control over the vendors," he noted.
- Tax advantages.
- Reduced state regulation. However, some states are now attempting to regulate employers that self-insure health benefits, he noted.
- Varying levels of risk retention. "Stop-loss coverage can be made available at any level," he said.
- Maximum opportunity to control costs.
- Optimum cash flow.

The seminar was moderated by Jerry Todd, professor of risk management at St. Mary's University in San Antonio, Texas. ■



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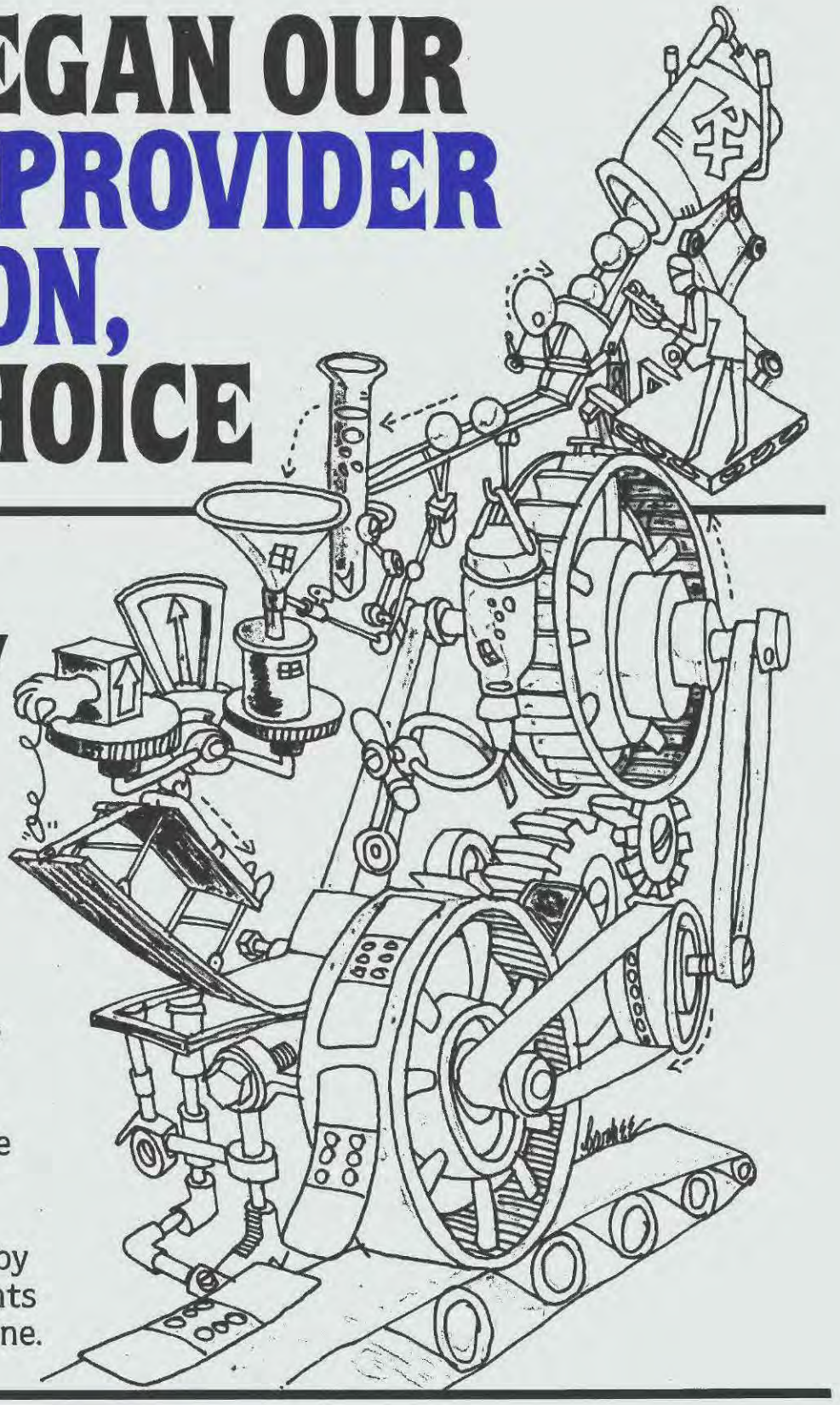
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MENTAL HEALTH/SUBSTANCE ABUSE
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Utilization review yields low-cost quality care

By DEBORAH SHALOWITZ

LAS VEGAS, Nev.—Health care cost containment does not have to jeopardize the quality of care and, in some cases, it can even improve it, benefit experts say.

"Properly designed cost-containment programs both control costs and enhance care," said James D. Motz, vp-group insurance for the Great-West Life Assurance Co. in Englewood, Colo.

David Rosenbloom, president of the Health Data Institute, a Lexington, Mass.-based health benefits management firm, agreed. "Managed health care is higher-quality care," he said.

As an example, Mr. Rosenbloom pointed out that while fewer and shorter hospital stays reduce expenses, they also minimize a patient's vulnerability to hospital-induced infections and illnesses.

"Hospitals are really a very dangerous place," he said. "If you can avoid being in a hospital for your medical care, you're probably better off."

Educating employees about how a cost-containment program works, why it is necessary and what the resulting benefits are is vital to the success of any program, said participants on a panel entitled "Is Cost Containment Endangering Health?" held at the 25th annual Risk & Insurance Management Society conference last week.

Other tools to cut costs while providing quality care include sharing some health care costs with employees and providing incentives to use the cost-containment program, said Mr. Motz.

He also suggested that utilization review, which involves interaction with a physician before any treatment is provided, can lower health care costs.

Mr. Motz says, a well-designed utilization review program should address the necessity of proposed treatment; whether hospitalization is necessary and, if so, for how long; and whether outpatient treatment could be provided.

Another tool an employer can use to control health care costs is to contract with preferred provider organizations. But it is an employer's "duty" to screen the providers it selects to make sure they will provide quality health care, said Mr. Motz.

One Columbus, Ohio, manufacturer of environmental support systems has been very successful in lowering its health care expenses.

Liebert Corp., which has 1,800 workers, saved about $375,000 in health care costs during the first year of its cost-containment program, said Linda G. Hellman, compensation and benefits manager.

In June 1985, Liebert started a Optimed preadmission certification program marketed by HDI.

Under the program, an employee's physician communicates with Optimed staffers via computer. A nurse or other health care practitioner asks the physician a series of detailed questions about the patient's condition and background. Based on the doctor's responses and HDI's data bases on illnesses and treatments, the nurse authorizes a certain type or length of treatment.

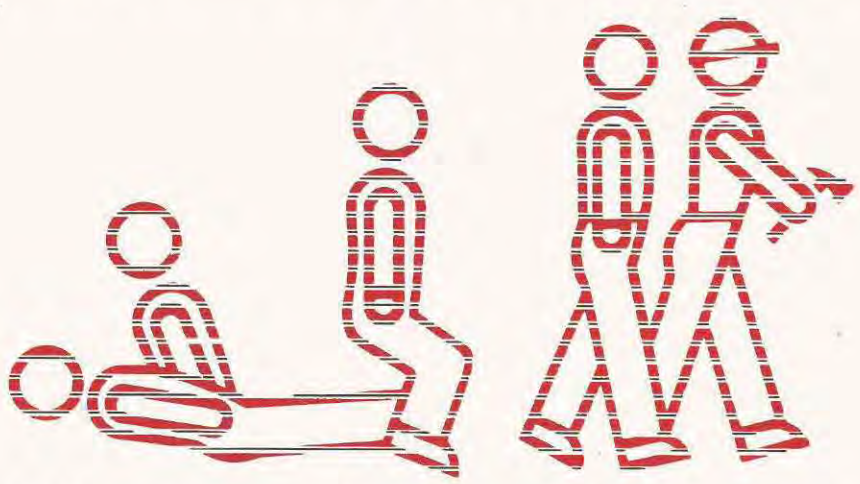
This exchange must take place prior to an employee's medical treatment or the employee pays a $250 penalty and can be assessed the cost of any unnecessary medical care up to $1,000. Emergency medical care must be cleared with Optimed the following day.

During the first year of the preadmission certification program, no surgeries or hospital admissions were denied, but 747 hospital days that physicians recommended were denied.

The Optimed preadmission certification program costs Liebert approximately $2 per employee per month, said Ms. Hellman.

Also participating on the panel was John D. Oswald, executive vp of the Swedish Medical Center in Englewood, Colo. Samuel Y. Fisher Jr., insurance manager for Hamilton Brothers Oil Co. in Denver, moderated the discussion. ■

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Tax Reform Act revises cafeteria plan definition

Q **What is the significance of the new definition of a cafeteria plan?**

A The Tax Reform Act of 1986 expanded the definition of a cafeteria plan. Before tax reform, the cafeteria plan definition encompassed only those plans that permitted a choice between cash and one or more non-taxable employee benefits (such as health insurance). When the new cafeteria plan definition becomes effective, it will include these plans, plus plans that permit a choice between two or more non-taxable employee benefits, but do not offer a cash option.

On the surface, this change appears to be a liberalization, favorable to plan sponsors. But the change may come back to bite some sponsors.

The new definition would appear to include health plans that offer employees a choice between the typical indemnity health insurance plan and a health maintenance organization. If a plan offering this choice is a cafeteria plan, many employers may become sponsors of cafeteria plans without realizing it when the new cafeteria plan definition becomes effective. If so, these sponsors will probably not have a written cafeteria plan document, as is required under Section 125 of the Internal Revenue Code. If a cafeteria plan does not have a written plan document, each employee is severely penalized: The entire value of the employer-provided health benefit is subject to income tax.

The new definition becomes effective for plan years beginning three months or more after regulations on this definition are published, but not later than Dec. 31, 1988. In the unlikely event that regulations are published before October 1987, the new definition becomes effective for plan years beginning after Dec. 31, 1987.

I hope that the regulations on the new cafeteria plan definition specifically exclude indemnity/HMO health plans. If not, some employees will undoubtedly have their health benefits taxed.

Offset pension plans soon may disappear

Q **Why are offset pension plans dead?**

A This question deals with a technical portion of the pension law, commonly referred to as Social Security integration.

A qualified retirement plan is integrated with Social Security when its benefits take into account the plan sponsor's contribution to an employee's retirement income through the employer's payment of Social Security (FICA) tax. This contribution toward an employee's retirement income is accounted for by providing benefits that discriminate in favor of high-paid employees—that is, by providing high-paid employees greater benefits (as a percentage of pay) from the qualified retirement plan than those benefits provided to the low-paid.

This discrimination in favor of high-paid employees is permitted because the FICA tax is not paid on all earnings of an employee but is paid only on earnings up to the Social Security wage base ($43,800 in 1987). Earnings above the wage base are also ignored for determining an employee's Social Security benefit, resulting in benefits (as a percentage of pay) that discriminate in favor of the low-paid employees. Since these earnings above the wage base are not taken into account in the Social Security program, Congress permits a qualified retirement plan to provide somewhat greater benefits for earnings above the wage base.

However, Congress and the Internal Revenue Service have historically laid out very detailed rules for determining the additional benefit that a qualified plan can provide to a high-paid employee. The purpose is to ensure that, on average, a low-paid employee receives benefits from the qualified plan and Social Security (as a percentage of his pay) that are comparable to the benefits from the same sources for a high-paid employee.

Before the Tax Reform Act of 1986, there were two methods for integrating a qualified defined benefit pension plan with Social Security—the "offset" method and the "excess benefit" method. Under the offset method, an employee's benefit was calculated as a percentage of his average pay at retirement; this amount was reduced (or offset) by a percentage of his estimated or actual primary Social Security benefit. The maximum offset that could be taken into account was 83.33% of the estimated primary Social Security benefit.

Under the excess benefit method, an employee's benefit is generally calculated as a percentage of average pay, plus a second percentage—the excess benefit percentage—of final average pay in excess of covered compensation. (Covered compensation is the average of the Social Security wage bases in effect during an employee's working career. For an employee reaching age 65 in 1987, covered compensation is $15,600.) The maximum allowable difference between the excess benefit percentage and the first percentage is generally 37.5%.

When the integration changes enacted by the new tax law take effect in 1989, there will still be two integration methods for defined benefit plans in theory. In practice, it is likely many sponsors will no longer integrate a plan using the offset method.

One change to offset integration provides that the maximum Social Security offset will be determined without any reference to an estimated or actual Social Security benefit. The offset appears to be limited to the lesser of: 0.75% of final three-year average compensation (not in excess of covered compensation) per year of service to a maximum of 35 years; or one-half of the participant's accrued benefit before reduction by the offset. Both limits make no reference to the Social Security benefit.

If a plan sponsor continues with an offset based on a percentage of the estimated or actual Social Security benefit and limited by the new maximums (assuming final integration regulations will permit this), the sponsor must check each benefit calculated to be sure the offset does not exceed the unrelated maximums, and must explain any differences to employees. As a consequence, these unrelated maximums add another layer of administrative complexity to a defined benefit plan. If the sponsor chooses to use an offset that is unrelated to the estimated or actual Social Security benefits (assuming final regulations permit this), the best rationale to explain to employees this reduction in benefits is no longer applicable—that is, the offset reflects the portion of the employee's Social Security benefit paid for by the employer.

These limits on the offset also create virtual parity between offset and excess plans—that is, an offset plan integrated to the limits of the tax law will provide virtually the same benefits as an excess plan integrated to the limit. The examples in the chart help illustrate these changes. The examples are based on final pay claims integrated to the limits of the law. Under each plan, 60% of final pay is used to calculate benefits. The benefit formula for an employee with at least 35 years of service at retirement are as follows. Using pre-tax reform rules:

- Excess benefit integration: 22.5% of highest average pay up to covered compensation, plus 60% of highest average pay in excess of covered compensation.
- Offset integration: 60% of highest average pay, less 83.33% of primary Social Security benefits.

Using post-Tax Reform rules:

- Excess benefit integration: 33.75% of highest average pay up to covered compensation, plus 60% of highest average pay in excess of covered compensation.
- Offset integration: 60% of highest average pay, minus the lesser of (a) 83.33% of primary Social Security benefit, or (b) the maximum offset amount described above.

As the examples illustrate, pre-tax reform differences between maximum offset and excess benefit integration disappear after the tax law takes effect. As a consequence, offset integration will likely disappear for some plan sponsors.

Annual benefits for retirement at age 65*

Highest five-year average annual pay	60% of highest average pay	Annual primary Social Security benefit	Pre-tax reform rules		Post-tax reform rules	
			Offset plan	Excess benefit plan	Offset plan	Excess benefit plan
$15,000	$9,000	$6,396	$3,670	$3,375	$5,063	$5,063
30,000	18,000	9,084	10,430	12,150	13,905	13,905
55,000	33,000	9,468	25,110	27,150	28,905	28,905
100,000	60,000	9,468	52,110	54,150	55,905	55,905

*Retirement in 1987. Benefit under life-only form of payment from a plan which provides no ancillary benefits. Employee has 35 years of service with employer. Highest five-year average annual pay earned in each of the last five years of employment.

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

Ask A Casualty Actuary, Ask A Benefit Actuary, Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues and actuarial problems.



Mr. Miner

This month's column, on actuarial issues in the benefits field, is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco answers risk management questions. And, Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefit management questions.

Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in June.

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.*

ACROSS THE BORDER

Check coverage before forming a Mexican maquiladora

By Jerome Karter

SOUTH OF THE BORDER, down Mexico way, the maquiladora industry is booming. Indeed, after petroleum, maquiladoras were Mexico's second-largest foreign-income earner during 1986.

Maquiladoras, also called "in-bond" plants, process imported materials and components into exportable products that are destined primarily for U.S. markets. Bilateral treaties permit the imported materials and components to enter Mexico duty-free because the reworked or finished product will not be sold in the Mexican market. Likewise, reciprocal U.S. tariff rules levy custom duties only on the value added in Mexico, primarily the cost of labor.

In recent years, the maquiladora industry has attracted foreign investment from labor-intensive manufacturing industries because Mexican wage rates are generally lower than those of other countries. Currently, Mexico's value-added exports are weighted heavily toward electronics (46%) and automotive products (25%). But future industry percentages are expected to be fueled by increasing foreign investment from Japan, the United Kingdom, Finland, Spain, Holland, Belgium and France.

By and large, the maquiladora movement is expected to sustain its explosive growth in the near future. Maquiladoras generated $1.6 billion in 1986 value-added earnings up from $1.3 billion in 1985. More importantly, U.S. multinationals contributed 85% of 1986 value-added earnings, as well as 80% of the industry's employment. U.S. investment in this booming sector, however, is forcing many multinationals to examine the mechanics of the Mexican insurance market before investing—not after.

So, hang on to your sombrero while we take a brief tour of the Mexican insurance market.

The National Banking and Insurance Commission regulates the insurance business in Mexico. In cases where the insurable interest is situated in Mexico, the law provides that all insurance must be written with insurance companies authorized to do business in Mexico. Non-admitted insurance premiums are not allowed as local income tax deductions.

Depending on the type and size of the maquiladora, construction typically takes 15 months from start to finish. During this time, the U.S. multinational's investment should be protected through both the construction and the post-construction phase.

The construction phase starts before breaking ground, when a contractor's "all-risk" policy is issued. This policy protects all parties against losses arising from either direct damage or third-party liability. A typical contractor's all-risk policy includes admitted coverage for physical damage to materials, structures and machinery, extra expense, debris removal, transit, storage and installation of machinery and equipment.

Typically, the general contractor purchases the insurance and builds the cost into the contract price. In Mexico, however, the U.S. multinational should purchase insurance directly because legal contractors usually do not understand the potential insurance expenses that a U.S. multinational can face. As a result, policy limits and conditions that are adequate for a Mexican contractor may be insufficient for a U.S. multinational.

international issues

A contractor's all-risk policy can be denominated either in Mexican pesos or U.S. dollars. But the policy's premium and any losses must be paid in the same currency in which the policy is denominated.

Even after construction has been completed, the contractor's all-risk policy will provide coverage for the installation and testing of all machinery and equipment. Yet, the post-construction phase should begin when the construction phase is about two-thirds completed. The post-construction phase allows the maquiladora investor to organize both an insurance and an employee benefits program, before construction and testing terminates.

The following recommendations should help U.S. risk managers to organize the components of a maquiladora insurance program:

✔ Fire insurance. Fundamentally, two fire insurance policies are critical to a post-construction insurance program.

First, a peso-denominated fire policy should be written to cover buildings and contents purchased in Mexico. The peso policy should include an inflation-guard endorsement to ensure that the policy's limits keep pace with Mexico's inflation rate (until the pre-selected inflation percentage amount has been used up).

Next, a U.S.-dollar policy should be written to cover imported raw materials, equipment and machinery. The U.S. multinational alleviates the risk of underinsurance arising from currency devaluations when imported goods are insured in U.S. dollars.

✔ Business interruption and extra-expense insurance. Since maquiladoras do not generate profits in Mexico, their interdependency exposure is best insured under the U.S. parent's program. Yet, continuing expenses and ordinary payroll are primary local concerns in the event of a loss. Thus, extra-expense coverage should be contracted locally to assist the maquiladoras after a major loss.

✔ Transit coverage. U.S. risk managers usually purchase a single policy that covers the entire transit cycle back and forth across the border. The policy can be either issued in the U.S. or in Mexico, depending on the terms of the sale. Mexican policies are available on a monthly reporting basis or on an annual sales-based rate. The latter method is very popular because it reduces the local client's administrative work.

✔ General liability insurance. Since maquiladoras generally export all of their products, the U.S. parent should maintain appropriate product liability coverage on all imports. Otherwise, a maquiladora's general liability policy should cover the usual third-party exposures.

What policy limit is appropriate in Mexico? The answer depends on the location, as well as on the assembly process, of the maquiladora. In general, U.S. multinationals are counseled to carry a minimum liability insurance limit equivalent of $200,000. But, when a U.S. multinational uses a worldwide casualty insurer to front a policy, the worldwide program limit should be maintained locally.

✔ Money and securities coverage. Payroll security is a big area of concern because Mexican law requires that most employees be paid in cash. However, a maquiladora should establish security procedures before considering a local insurance policy. For example, armored vehicles can be hired to deliver the payroll and, for an additional fee, guards will distribute the payroll for each employee.

Money and securities coverage is very expensive in Mexico due to poor underwriting experience. Also, coverage applies on a scheduled basis, so the policyholder must report new locations immediately. Some U.S. companies have found it less expensive to institute security measures rather than pay inflated tariff premiums for local money and securities insurance.

✔ Burglary coverage. Shift-operated businesses, such as maquiladoras, will always face the possibility of theft because large numbers of employees move around the plant at least three times per day. When adequate procedures are in place, however, the frequency and severity of such losses can be cut.

✔ Automobile insurance. To protect against automobile hazards, the maquiladora first must identify its exposure. Some questions to ask include:

- Are U.S. company-owned or leased vehicles traveling across the border to Mexico?
- Are U.S. employee-owned vehicles traveling across the border to Mexico on personal or company business, or both?
- Are maquiladora-owned or leased vehicles traveling in Mexico?
- Are maquiladora employee-owned vehicles traveling across the border to the United States?

Next, the policyholder must decide whether to cover all or some of its exposures—a decision that is often influenced by a strict tariff rating system. In addition, the tariff rating system prohibits fleet policies for less than 10 vehicles, and requires separate policies for trucks and automobiles.

✔ Workers compensation and employers liability insurance. In Mexico, workers compensation is handled directly by the social system and employers liability insurance is not usually purchased since the local exposure is minimal.

✔ Employee benefits. Many maquiladoras today offer a growing number of employee benefit plans to all levels of employees, from assembly line workers to executives. Local life insurance companies administer most of the employee benefit programs. These include life insurance policies that cover both natural and accidental death, as well as policies for permanent disability and group major medical benefits. Aside from tax advantages, maquiladoras expect employee benefit plans to improve workers' productivity while attracting and retaining qualified personnel.

The types of benefit plans instituted by many maquiladoras include: obligatory plans (i.e., Federal Work Law, Social Security and Housing Development fund); contractual plans based on the needs of individual contracts; and voluntary plans.

Timing is one main criteria for structuring an employee benefits program. For example:

- Short-term plans may include a savings fund, a grocery allowance tuition and scholarships, transportation allowances and productivity bonuses.
- Medium-term plans may include major medical and maternity expenses.
- Long-term plans may include retirement benefits, as well as coverage for permanent disability and death.

South of the border, down Mexico way, the forecast is sunny for maquiladoras, At year-end 1986, Mexico's maquiladora industry numbered more than 1,000 "in-bond" plants along its 2,000-mile northern border area. And the industry's dynamic growth pattern is expected to continue, spurred on by a plummeting peso, readily available industrial space and a general economic slump that has left many management personnel out of work.

If your corporation has plans to invest in a maquiladora, you must remember two rules: Review your insurance needs *before* breaking ground—not after, and don't leave home without your sombrero because the sun is now shining brightly on maquiladoras.



Jerome Karter is vp and manager of the New York International Department of Johnson & Higgins. His column appears the first Monday of every month.

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Benefits

Continued from previous page

"You should consider a resolicitation of participation in your 401(k) plan because many employees will lose the tax deduction on Individual Retirement Account contributions. They'll be looking for a tax-deferred savings plan," he suggested.

However, because of new tax rules governing the maximum percentage of salary that can be deferred to a plan, employers offering deferred savings plans have a new responsibility, he said.

"You now have a threat to the employee because he faces a double tax on excess funds, and the employer can lose its tax deduction on contributions if action is not taken within 12 months," Mr. Schoen said.

"The best way to work with the plan is to develop a checklist based upon who will do what to comply with required changes under the tax bill," he said.

"You also ought to determine who will note what changes will need to be made to plan documents once the completed tax regulations are issued," he added.

Employers' pension plan concerns include compliance with the "1,000-hour rule." Under this rule, any employee who works at least 1,000 hours in a year must be covered by the pension plan.

And, "if a terminated employee comes back to work for an employer, he earns back his benefit credits and vesting. Therefore, it is very important to keep good records of terminated employees," he said.

Employers that participate in multiemployer pension plans—in which a group of employers set up a trust to administer a pension plan for their employees—must be cautious.

"According to the U.S. Treasury Department, you're not only responsible for your employees' pension benefits, you are also responsible for the benefits of the employees of an employer that might be in default," he noted.

He added that employers must carefully consider the risks and benefits of such plans.

Employers also should be aware of the risks involved in offering life insurance coverage to employees, Mr. Schoen said.

Many employers have reduced the amount of life insurance they provide for employees, instead giving employees the opportunity to purchase additional life insurance if they so desire, he observed.

However, under the new tax law, employer-provided life insurance would have to meet certain nondiscrimination tests. Under these tests, the plan could not discriminate in favor of the most highly paid group of employees.

Some employers may have to amend their life insurance plans to meet these tests, he said.

But, along with these risks, there are other risks inherent in the design of some group life insurance policies, Mr. Schoen said.

For example, some group life insurance plans do not require covered employees who become permanently disabled to continue paying the life insurance premium even though coverage remains in force. However, these plans require the employer to pay 50% of the death benefit when the disabled former employee dies, he explained.

"It's actually cheaper for the employer to continue paying the premium the employee was paying instead of paying a 50% death benefit," Mr. Schoen said.

Also, when an employer changes life insurers, it is very important that the new insurer continue to cover these disabled policyholders who are no longer employees. This limits the employer's exposure to lawsuits over terminated coverage, he noted.

Employers also should make sure that the life insurance provides an opportunity for an employee to convert to an individual policy if the employer terminates the group policy with the insurer, Mr. Schoen said.

Employers must keep accurate, hard-copy records of employees' beneficiaries to limit exposure to lawsuits. "If you have more than one life insurer, these records are important" to determine exactly who the beneficiary is and which insurer is responsible, he said.

In addition, employers that offer group universal life insurance plans should have an agreement that the employer maintains control of employee records, Mr. Schoen noted.

"This way, you have the freedom to switch insurers and replace the coverage if you aren't satisfied with the insurer," he said. ■

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Growing benefits arena poses new risks

By DONNA DiBLASE

LAS VEGAS, Nev.—Administering an employee benefit plan can be risky business.

But, risk and benefit managers can limit an employer's exposure by applying basic risk management principles to managing benefit risks, advised a group of experts at the 25th annual Risk & Insurance Management Society conference last week.

These risk management principles include identifying the risk; quantifying the risk; deciding whether to avoid, assume or transfer responsibility for the risk; and financing the risk.

"Often, the most difficult part of risk management is identifying risk," noted Gary Yeaw, manager of group insurance for Morristown, N.J.-based Allied Signal Inc.

"The risks we don't see or know of can hurt us the most severely. In today's benefits environment, the many new products mean new risks. We still have many financial risks, but today there also are legal risks," he explained.

Today, employers are faced with high health care costs and inefficient utilization, growing costs under retiree health plans and legislative changes affecting retirement plans and even life insurance, experts observed.

"If we are going to preserve the corporation's profits and assets, there is much to be done" to both health care costs and the risks inherent in health care cost containment, noted Robert Schnuer, a national marketing executive in the New York office of Connecticut General Life Insurance Co.

"The days of the blank check are gone. But, pre-admission certification and other utilization review functions have brought us into an era of conditional benefits contracts," he added.



These conditional contracts say, "we'll cover this procedure if you follow this procedure," he explained.

"Communication is probably our biggest job in these programs. I don't think any employer goes into a utilization review program with the idea of penalizing employees or shifting a 50% cost to them. We want to eliminate that 100% unnecessary charge," Mr. Schnuer said.

However, there are risks to review programs. "We still have the problem of who's going to be blamed if something goes wrong," he observed.

Employers can limit liability exposures stemming from utilization review providers by "making certain you have 100% indemnification and that you are held absolutely harmless from any malpractice or errors and omissions claims," he advised.

When contracting with health maintenance organizations and preferred provider organizations, "be careful in assessing their permanency and solvency. Look at their marketing plans," Mr. Schnuer warned.

When offering these alternative plans to employees, employers should avoid endorsing one plan over another. "While we want employees to make an informed choice," the choice should be made only by the employee, he warned.

"There is a significant financial risk from adverse selection against indemnity plans when HMOs are offered," he added. Employers should work closely with consultants and insurers to limit or avoid this exposure.

And, "you must carefully reassess your risk assumption and your risk transferring mechanisms in light of the catastrophic costs now coming down for AIDS, care for premature babies and others," he suggested.

But, along with the risks prompted by offering health benefits to employees, employers also are facing significant financial and even legal exposures related to retiree health and life insurance benefits, Mr. Yeaw of Allied Signal noted.

To identify the financial risks of these plans, "start with good data. Identify the true costs of your retiree plan," he said.

"If your plan is experience-rated, split the experience of your active employees out from that of the retiree group. You can even split it further into the group below age 65 and the group older than 65," he explained.

However, in light of recent legal cases concerning termination or changes in benefit levels, employers must be extremely careful when making any plan changes to control retiree health care costs, Mr. Yeaw advised.

Clear, unambiguous communication of the employer's right to change a retiree plan is necessary to limit exposure, he said. "And, be sure that human resource managers communicate this clearly in direct communication with retirees. You want to dispel their fears, but you must also let them know that there is no permanency."

Employers can take steps in designing retiree health insurance plans to limit exposures, he said.

For example, "you must, in the future, take steps to insulate these programs from Medicare reimbursement by eliminating the typical Medicare carve-out," in which the employer's plan covers any costs Medicare does not.

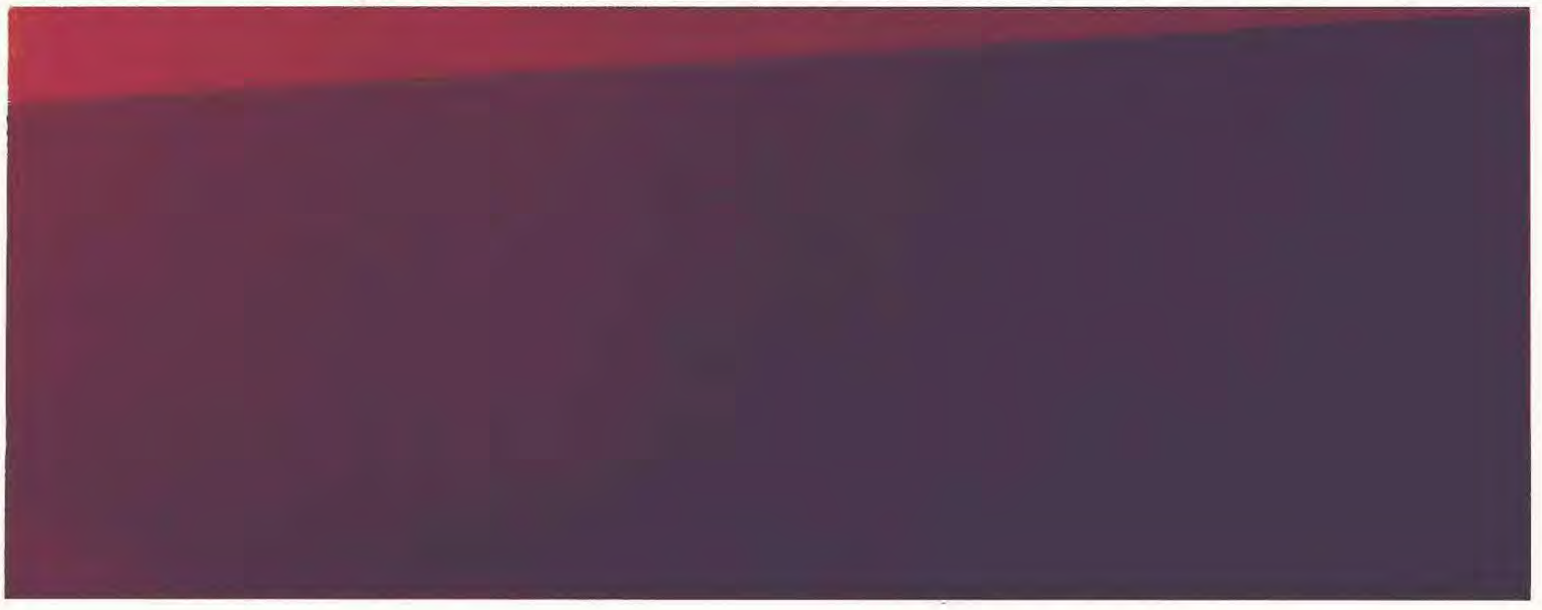
"With the reduction in Medicare payments to providers under the DRG system, these carve-out plans face increasing costs," he noted.

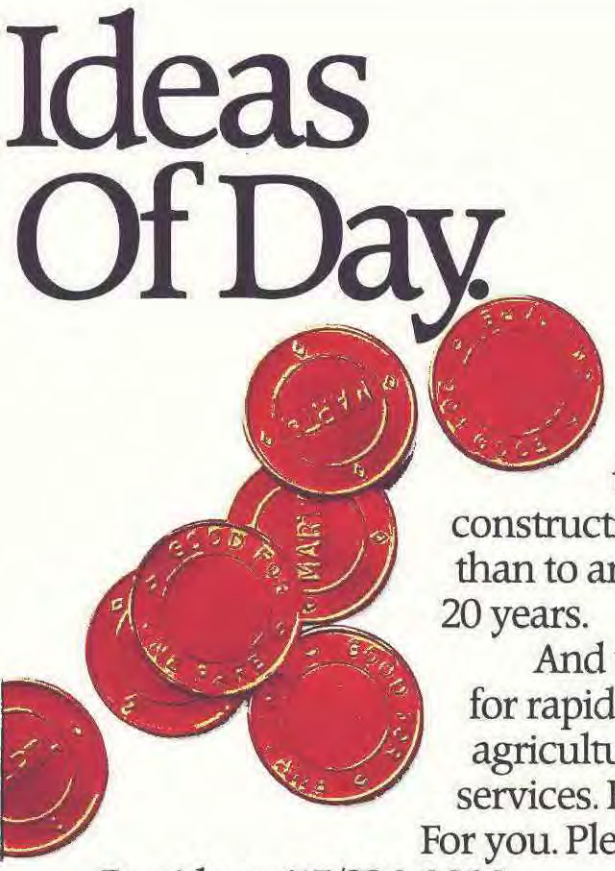
Employers that currently do not offer retiree health and life insurance plans must consider the long-term costs of these plans by "considering the health care costs of your workforce as it ages. One of the mistakes employers have made in the past is introducing a plan when the company only has two retirees," without taking into consideration future retirees, Mr. Yeaw explained.

Along with concerns over retiree health care plans, employers also have new concerns over pension and retirement savings plans as a result of the Tax Reform Act of 1986.

"We must communicate to employees that the original intentions of savings plans like 401(k)s have changed. They used to be thrift and savings plans, but Uncle Sam has changed them into retirement plans with penalties for early withdrawals," said Bernard Schoen, a vp in the Hartford, Conn., office of benefit consultant Johnson & Higgins.

Continued on next page





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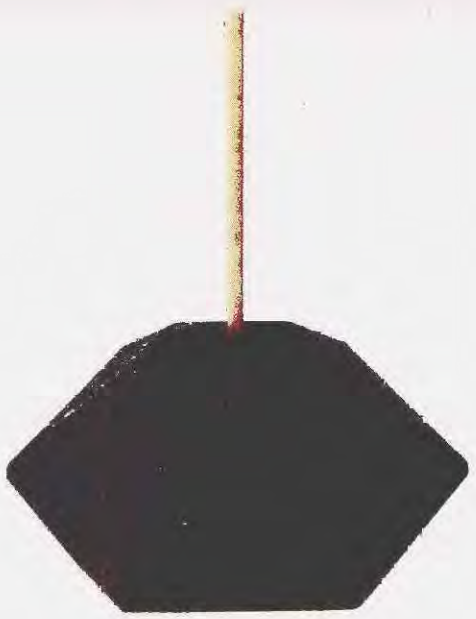
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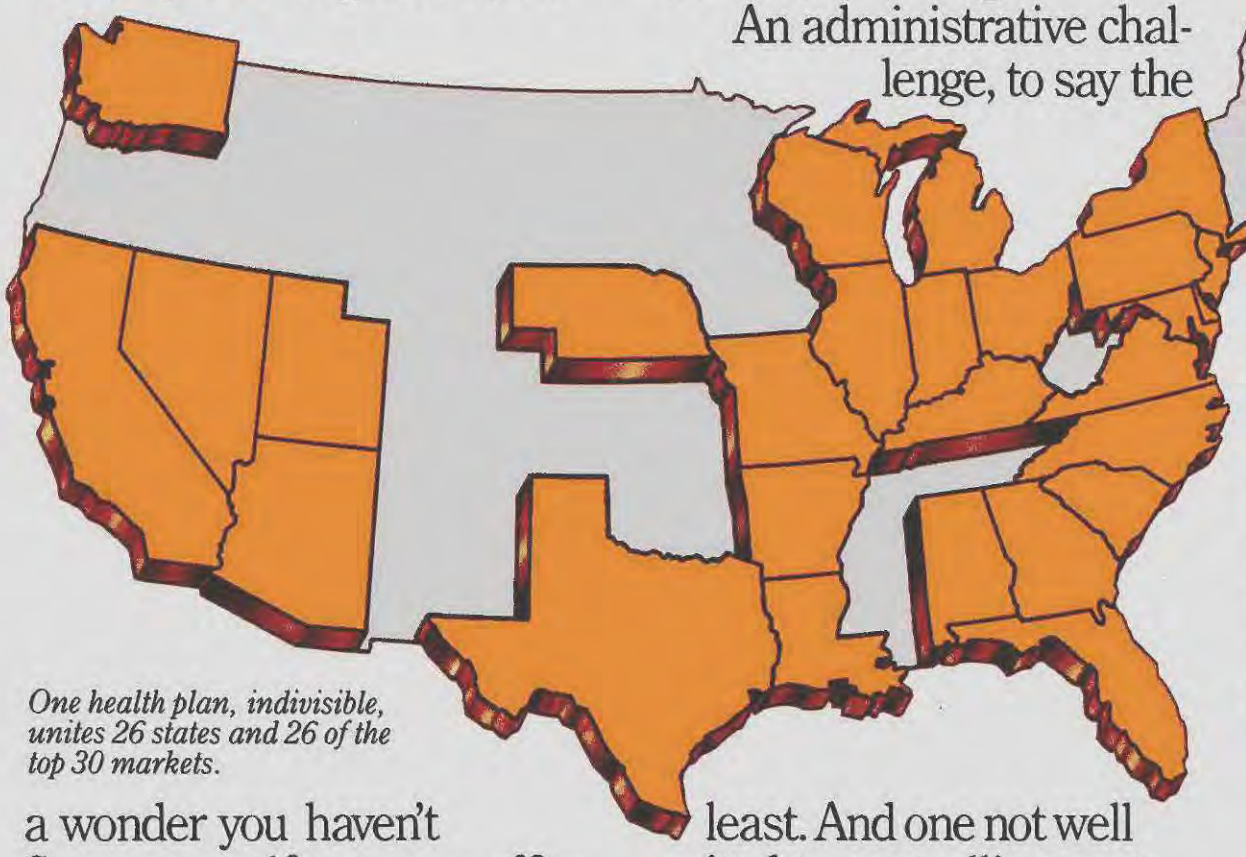


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Most HMO's treat the United States as if they aren't united.

Vendors deal cost-containment products

By DONNA DiBLASE

LAS VEGAS, Nev.—A full house of health care cost management products and services is being dealt to risk and benefit managers.

In hopes of reducing the high stakes of escalating health care costs, risk and benefit managers turned to dealers at the 25th annual Risk & Insurance Management Society conference in Las Vegas last week.

But, these were not blackjack or poker dealers, but dealers of utilization review and managed health care programs.

And, in addition to offering programs to control the costs of illness, some vendors displayed illness prevention and early detection programs that could control costs by helping employees to avoid serious health problems.

Other companies offered claims processing and management products and services to help benefit managers track and identify health care cost or utilization problems.

Many vendors of utilization review services increasingly are emphasizing case management for catastrophic and long-term illnesses.

These programs manage costs and improve the patient's quality of life by suggesting alternative settings for care that may not normally be covered under a benefit plan—such as home health care or hospice care.

For example, Corporate Healthcare Management, a subsidiary of New York-based Equicor, assigns a health care and an insurance benefits professional to these cases to work with the attending physician. Together, they work out an individualized treatment plan for the patients.

Corporate Healthcare Management also offers other services such as pre-admission certification, concurrent review, dental review, psychiatric consultation and a toll-free health information line for employees.

Pacific Review Services, a Cypress, Calif.-based cost-containment firm, also offers a comprehensive utilization review program that includes case management.

And, along with these services, the firm also helps employers to redesign their benefit plan to effectively support health care cost-containment programs.

Minneapolis-based Health Risk Management Inc. offers employers a full range of cost-containment services.

Along with its utilization review program, "ReviewPLUS," the company negotiates prices on a case-by-case basis with physicians and hospitals through its "HRM CarePASS" program.

HRM also offers health promotion programs, claims data reporting, "CareCALL"—a toll-free employee health information line—and individualized communication programs for employers.

Cost Care Inc., a Huntington Beach, Calif.-based cost-containment firm, currently is developing a new preferred provider network in Southern California.

"This will be a full-service network, integrating discounted fees and our current comprehensive utilization review services," said Kenlyn Boyd, a registered nurse and manager of medical alternatives for the firm. The PPO eventually will expand to Northern California and Tampa, Fla.

Cost Care also offers specialized review programs like "Maternicall," which helps to identify high-risk pregnancies through early evaluation of risk factors, and "PrescriptCare," a home delivery program for maintenance drugs like insulin.

Employers also can purchase review services from Lombard, Ill.-based Healthcare COMPARE. The company's services include pre-admission certification, concurrent review and mental health review.

U.S. Corporate Health Management of Santa Monica, Calif., also offers employers case management and review services.

In addition, the firm offers hospital bill auditing services and claims data analysis.

Large health insurers that exhibited products and services at the RIMS conference are helping employers contain costs and maintain quality health care for their employees through managed health care plans.

John Hancock Mutual Life Insurance Co. recently launched its "John Hancock Preferred" PPO program.

In addition to the PPO, the Boston-based insurer also offers employers a variety of cost management programs through its Managed Health Services division.



Along with hospital utilization review, the division also offers the "Absence Awareness Program," a short-term disability cost management program that requires employees to report work-related illnesses or injuries quickly. The employer then is aware of the reason for the employee's absence at the outset, said James H. Sang, director of the division.

Along with PPOs and utilization review programs, Travelers Corp. covers employers with benefits services all under one umbrella.

The Hartford, Conn.-based insurer demonstrated its new interactive video employee benefits communication system at the conference.

Housed in a kiosk, the system can be used to communicate health benefits, retirement plans, life insurance and a variety of other benefits. Employees simply touch the video screen to activate the system and to answer their benefit-related questions.

The system currently is being used by several major employers and is an expansion of the insurer's benefit communication software, said Stephen R. Booma, secretary of new business and marketing for Travelers' employee benefits division.

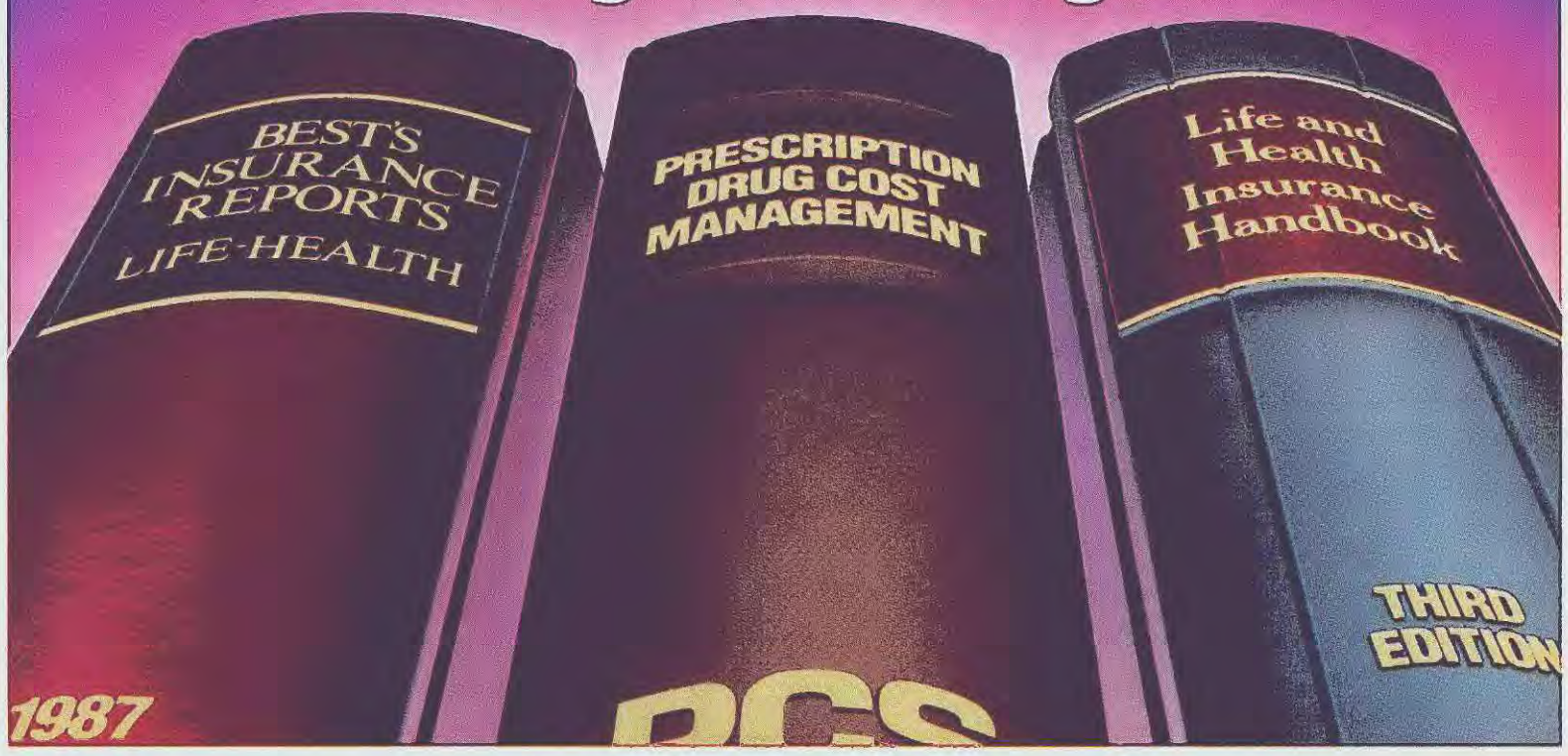
New York-base Metropolitan Life Insurance Co. also demonstrated its "Showcase" computerized employee benefits communication system.

Also housed in a kiosk, the system can be used to communicate various benefit. Workers enter employee identification numbers to use the system and then use numbered keys on a small keyboard to compute contribution and benefits amounts.

Along with medical managed

Continued on next page

PCS Continues to Write the Book on Rx Drug Cost Management



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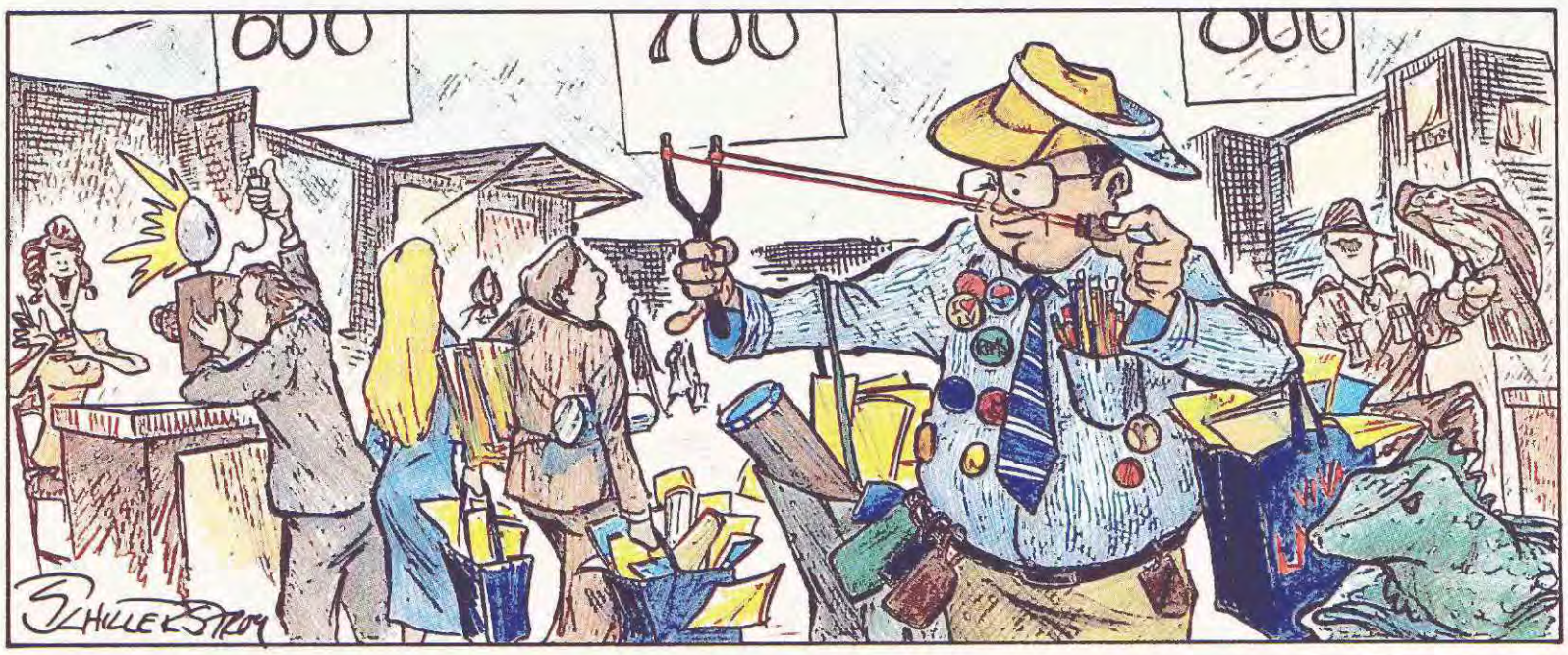
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Benefit products

Continued from previous page

care programs, Aetna Life & Casualty Co. also offers a prepaid dental plan called "Prevent."

Under one program arrangement, called the Shared Risk plan, dentists are at a financial risk to deliver only care that is necessary. This is similar to a health maintenance organization.

Under Prevent's Preferred Provider Arrangement, dentists contract to provide services for negotiated fees and also agree to utilization review of their services.

CIGNA Corp. offered risk managers a magnifying glass to read the fine print in their insurance policies, in addition to information about its multiple option benefit plan called "Flexcare."

Flexcare enables employers to offer traditional indemnity coverage and managed care through either a PPO, an HMO or both for one experience-rated premium.

CIGNA also offers employers a group universal life insurance product that gives employees the chance to purchase additional life insurance combined with savings for retirement.

Other exhibitors focused on health promotion and wellness programs.

"There is both a long-term and a short-term approach to health care cost containment," said Brian E. McCagh, a marketing representative for Washington, D.C.-based Health Management Strategies.

"Utilization review and similar programs are short-term approaches to controlling costs. Health risk appraisals are a level, long-term approach," he added.

Some vendors offered blood tests and health questionnaires to prove their point that prevention is the best cost containment.

Health Management Strategies helps employees to assess their current health and to take action to improve their overall health through an appraisal. Tests such as blood cholesterol levels, blood pressure screening and weight measurement are used to assess health.

However, the aggregate of a company's employee appraisals also are reported to the employer in aggregate form. This helps an employer to identify health risks.

Health Management Strategies then points the employer toward various programs provided by other consultants to reduce these risks, he said.

The Blue Cross & Blue Shield Assn. also offers employers a health risk assessment program designed to help reduce health costs through wellness and education programs.

Employees begin by filling out a computer-scored health questionnaire. The profile covers the areas of sleep habits, safety, exercise and eating habits.

The program, called "Your Healthy Best" also includes self-help handbooks, personal fitness diaries and a health newsletter.

The "Taking Care Program," offered by the Travelers Corp.'s Center for Health Promotion subsidiary emphasizes medical self-help for employees to avoid unnecessary visits to the doctor.

The program, which is utilized by the Travelers for its own employees, includes a "LifeScore" health risk appraisal and recommendations for improving health based on the results of the appraisal.

Also included are newsletters, self-help materials for health problems like dieting and alcoholism and educational materials to help employees use the health care system wisely.

Containing health care costs requires not only utilization review and managed care plans, but also analysis of health claims. ■



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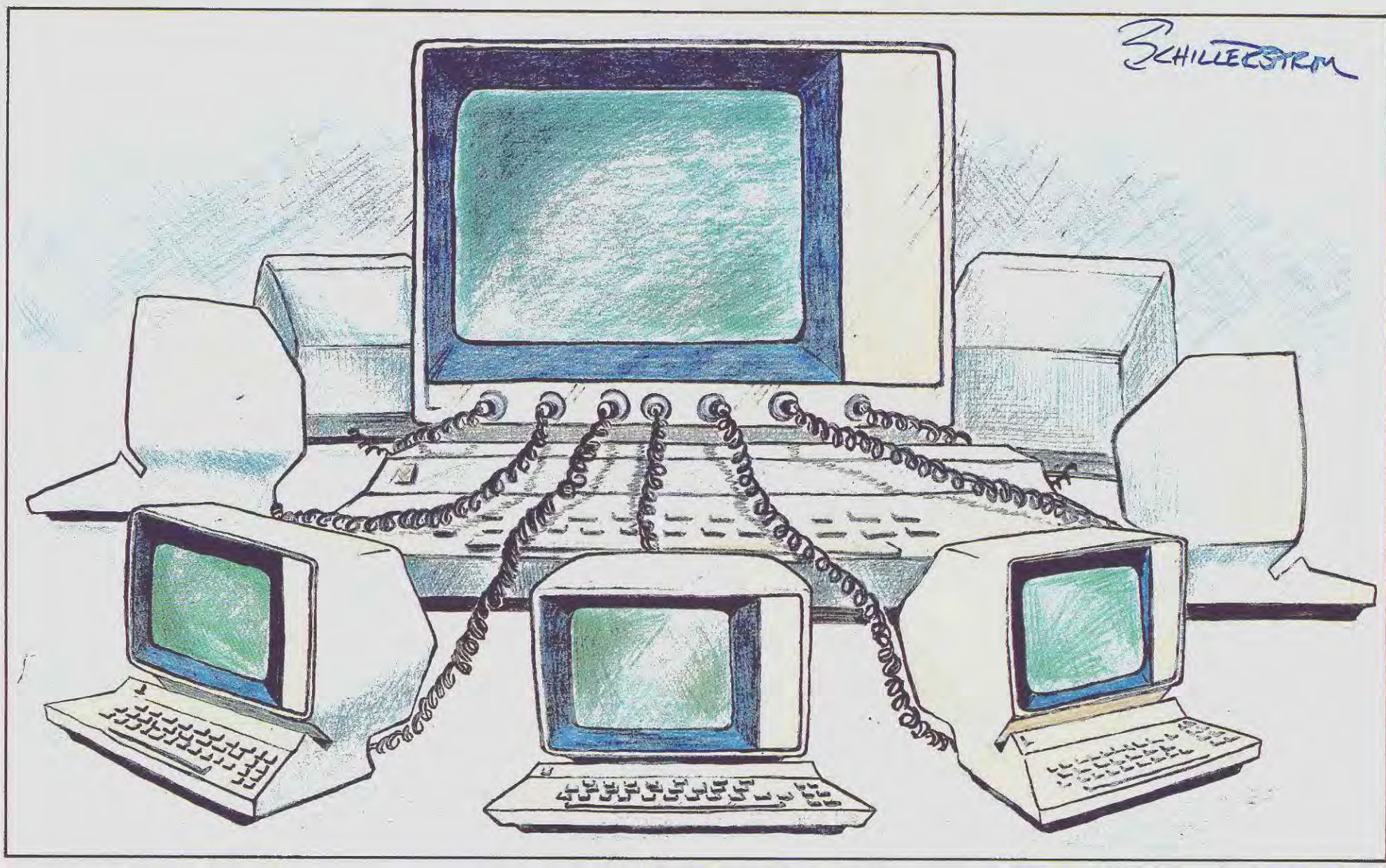
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agent/broker topics

A monthly editorial section sent exclusively to agents and brokers



Byte-by-byte

IVANS agency/insurer network progresses slower than anticipated

By LINDA J. COLLINS

WHITE PLAINS, N.Y.—The drive to establish standardized agency/insurer computer communications is taking longer than many agents had hoped.

"We have accomplished a lot," said Rita Waters, vp of the Insurance Value Added Network Service. "The problem was, everybody began to talk about interface years before it was ready, while it was still in the research phase."

When IVANS was established in 1983, it sparked hope among many producers that multiple agency/insurer interface soon would become commonplace.

The network, which is supported by producer associations and a number of insurers, can take information under an agency's computer format and translate it into a standard format, then route the information to insurance companies.

Thus, IVANS can permit agencies to interface with one or more of their insurers and with support service vendors.

Multiple-insurer interface has long been a goal of independent agents, who predict that when such a network is fully operational it will reduce agency paperwork, duplication of effort and processing costs.

In addition, single-entry, multiple-company interface should help agencies compete more cost effectively with direct-writer agents, who only communicate with one insurer, producers speculate.

But while about 3,300 agencies already have been signed up to use IVANS by at least one of their insurers, network activity has progressed more slowly than IVANS and producer associations originally projected when the facility was planned.

This is partially because of the magnitude of the project, and partially because of the recent hard insurance market, which forced many agencies and insurers to focus on survival rather than on beefing up automation activities, an IVANS official says.

With the large number of insurers and agents—roughly 3,500 property/casualty insurers and 60,000 independent agents—the effort of standardizing agency automation equipment, educating agents on how to get the most use of their equipment after they purchase it and getting insurers to cooperate in making the network operational has been no easy task.

Some large national insurers that were already involved in developing their own automation interface efforts with their agency forces have been reluctant to abandon those efforts and start all over again using IVANS standards.

In addition, during the hard market period from late 1984 through 1986, "A lot of agents were concerned simply with where they were going to place business, not how they were going to do so," said Ms. Waters.

On the other hand, many insurers that faced underwriting losses during that period were unable or unwilling to devote their resources to furthering agency automation.

But now that the insurance marketplace is stabilizing, insurers and agents are better able to focus their attention on agency/company interface. As a result, IVANS activity has begun to accelerate.

Ms. Waters predicts not only will more agents join the network, but that those currently using IVANS will increase their activity as they gain experience using the network.

IVANS, a non-profit service corporation, was founded to research and develop a communications network that could permit agents with a wide variety of automation systems to communicate with their insurers and with support service vendors.

The network communicates through IBM Information Network of Tampa, Fla., a unit of International Business Machines Corp.

And Ms. Waters stressed that while network participation has not grown as rapidly as some original projections, IVANS has significantly exceeded its initial three-year volume agreement with IBM. "We had until May 1, 1987, and we met our goal in July of 1986," she explained.

Through the interest that is now being expressed by agent associations, it appears that there will be substantial growth in network usage in the next several months, Ms. Waters said. "The agents who are automated are beginning to focus on interface, and those who are interfaced with one insurer are now considering multi-company interface. That is a critical expansion area."

Those agents and insurers who were skeptical about IVANS when it was founded are now giving the network a second look.

"A lot of top insurance companies and the industry in general are viewing IVANS as a success today. We are larger than any other insurance industry network," Ms. Waters said.

And not only does IVANS provide agents with a vehicle for

Continued on page 42C

Pilot study to probe multi-insurer interface

By LINDA J. COLLINS

WHITE PLAINS, N.Y.—IIR/ACORD is launching a pilot study to determine the potential costs and benefits of single-entry, multiple-insurer interface to both agents and insurers.

While IIR/ACORD and other industry associations have asserted that multiple-insurer interface can decrease errors, speed transactions and reduce processing costs for both insurers and agents, the premise has never been formally tested.

The IIR/ACORD research project, dubbed IMPACT, will explore and document the actual costs and benefits of multiple-insurer interface.

"We are looking for the ultimate system from the agency perspective," explained Arthur Pavelle, senior vp of IIR/ACORD. "Agents want to accomplish single entry of data and want to be able to transact business with multiple carriers in the same way.

"Participating in the IMPACT project is not supposed to cost the agencies money, but the agencies selected have already installed automation systems that support our automation standards," Mr. Pavelle added.

The association will work closely with agencies participating in the IMPACT pilot project and with software vendors that install their management systems.

Based in White Plains, IIR/ACORD is a non-profit association founded to improve the efficiency of the independent agency system and is supported by more than 100 insurance organizations.

Initially, five insurance companies—Aetna Life & Casualty Co., Harleysville Mutual Insurance Co., Royal Insurance Co. of America, SAFECO Corp. and Travelers Corp.—and about 10 agencies will participate in the project, though Mr. Pavelle said that more insurers and agents probably will join IMPACT as the project progresses.

Mr. Pavelle explained that IIR/ACORD asked for volunteers from among its insurer members who were "able to support single-entry, multiple-carrier interface."

After locating the five initial insurers, IIR/ACORD "asked each participating company to nominate a number of their agencies who were also representing at least one of the other participating companies," he said.

While they sought agencies for the project that already were automated, the agencies did not have to already be interfacing with an insurer to be selected for participation, according to Mr. Pavelle.

"We visited each agency recommended, along with representatives from two of the insurers. During this visit, we did an assessment of the appropriateness of the agency and its staff" for participation in the project, he said.



Mr. Pavelle

Some of the participating agencies will be involved in the project "as early as the first half of this year."

IIR/ACORD does not initially plan to reveal the identities of participating agencies, so the agencies can conduct their activities without the added strain of public scrutiny.

Agency automation software vendors that have installed the systems in the pilot agencies and are assisting in the project include: Aetna Technical Services (GEMINI systems), EBS Inc., HarTech, AGENA Corp. and McCracken Computer Inc. These vendors were already working with the agencies selected for the project.

Participating insurers and agencies will establish different prototype multi-insurer interface environments based on electronic standards for agency automation and agency/company interface previously developed by IIR/ACORD.

At first, IMPACT will concentrate solely on personal lines transactions—the only kind of interface that currently meets IIR/ACORD standards, Mr. Pavelle explained.

IMPACT was established to define the costs and benefits associated with two-way interface, he said. "A lot of what's going on" currently in agency/company interface is simply one-way transmission to companies from agencies, Mr. Pavelle said. "We're looking for electronic processing capabilities both ways."

After a "very detailed cost analysis to understand what the benefits and costs have been," the IMPACT project likely will expand to commercial lines transactions sometime in 1988, according to Mr. Pavelle.

One of the primary purposes of IMPACT is to evaluate the effectiveness of interactive and batch transmissions.

Interactive transmissions connect the agency directly with the insurer's computer, but the agency must re-enter the information to store it on its own computer system. And the agency incurs phone costs the entire time that data is being entered.

Batch transmissions can be stored in the agency's computer and then transmitted to insurers in short bursts, which reduce phone line costs.

"It's likely that agencies that are doing batch transmissions will also be doing interactive transmissions for some types of transactions and inquiries. One of the purposes of IMPACT is to find out if the agent is able to do both," Mr. Pavelle explained.

For example, "New business transactions might be batch from the agency to the company, but renewals and endorsements might be sent interactively. And there are still some technical processing difficulties in the batch mode, because it requires additional programming," he added.

Through the project, IIR/ACORD also will determine if there are certain transactions that simply cannot be conducted through electronic interface.

In that case, the IMPACT project will compile data to identify and analyze the work flow and costs necessary to maintain a mixture of interface and non-interface transactions.

IIR/ACORD has budgeted $600,000 for implementation of the IMPACT program in 1987. That figure covers administrative costs, operating expenses, travel and consulting expenses.

Mr. Pavelle explained that while the project does not have a formalized completion date, IIR/ACORD will issue periodic status reports on IMPACT as soon as it starts to develop solid statistical data.

Seminar links up people, computers

LINDA J. COLLINS

WHITE PLAINS, N.Y.—A new automation seminar teaches agents and brokers how to streamline in-house record keeping, processing and marketing functions.

And, while the seminar lasts only one day, agency personnel receive an ongoing support package as part of their fee.

"People and Computers: A Winning Team" was developed by White Plains, N.Y.-based IIR/ACORD, along with representatives from the American Assn. of Managing General Agents, the Independent Insurance Agents of America Inc., the National Assn. of Casualty and Surety Agents, the National Assn. of Insurance Brokers, the National Assn. of Insurance Women and the National Assn. of Professional Insurance Agents.

The course, designed for agencies or brokers of all sizes and with all mixes of business, teaches ways to maximize the use of any type of automation equipment.

"Even the non-automated agent is taken into account by the course," stressed Robert E. Merriman, executive vp of IIR/ACORD, adding that the course provides "common-sense information."

"The concepts we talk about in the seminar address the automation workplace rather than the insurance workplace," Mr. Merriman pointed out. The course is designed to shift the agency or brokerage's thinking from "old work/old way to new work/new way. Most people get bogged down in that transition," he explained.

An advisory committee of nine agents and three insurance company representatives worked for 15 months with IIR/ACORD to develop the seminar. Each producer association also sent one or two representatives to act as committee liaisons.

To determine what was most needed in an automation seminar, the committee surveyed 10,000 agents representing a "random population from among the IIAA, PIA and NAIB," Mr. Merriman said.

"We suggested a lot of topics in the survey. The respondents evaluated the topics according to need, and the key topics identified were incorporated into the content of the seminar," he added.

Topics identified by respondents as being most useful for agencies and brokerages of all sizes included: defining the role of the principal(s) in the automation effort; incorporating automation into the agency's business plan; involving the staff in the automation effort; handling paper files; managing the data base; adapting automation to fit the agency's work flow; automating suspense files, new business, renewal business, endorsements and claims handling; using word processing capabilities; potential marketing opportunities.

Two agency or brokerage representatives—a principal and a staff member who is involved in the automation process—must attend the course, which is limited to 20 agencies, or 40 attendees.



Mr. Merriman

Classes consist of agencies and brokerages of all sizes. "We thought briefly about marketing the course to separate-sized groups, but decided that the courses wouldn't work as well" if all classroom participants were homogenous, Mr. Merriman said.

After the automation committee and IIR/ACORD developed a preliminary curriculum based on the survey responses, they conducted five pilot seminars in different areas of the country. The business volume and automation level of the pilot group participants was deliberately varied. Some participants were not automated. The feedback of participants was used to re-evaluate and further modify the curriculum.

"We used the pilots to reshape what was being taught in the seminar and how. We found that the interactive teaching approach was very important in this type of course. We also saw that we should concentrate on the way that agencies are now doing their work and then try to eliminate duplication of effort," Mr. Merriman stressed.

Courses begin this month. More than 50 programs already have been booked in 15 states, Mr. Merriman said.

The seminars are not conducted by IIR/ACORD. They are sponsored by local associations or organizations that are responsible for securing and compensating course instructors and for promoting and registering attendees.

The sponsoring association also is responsible for ordering course materials from IIR/ACORD and arranging seminar facilities, refreshments and hotel accommodations for attendees. Specifications for the classroom setup and audio-visual equipment are furnished by IIR/ACORD.

While there is no formal course fee, IIR/ACORD does provide a suggested course fee ranging from between $195 and $250 per agency to cover the costs of the facility, instructor and course materials.

A National faculty list distributed by IIR/ACORD provides the names and phone numbers of certified course instructors. To be certified, instructors must attend an intensive two-day training program. And, prior to attending the training program, they study an instructor's guide developed by IIR/ACORD for the course.

The instructor training program "covers concepts, reinforcements and how to conduct the course philosophically. The instructor needs to determine early on in the class what the unfulfilled expectations of the group are," Mr. Merriman explained.

Depending on the group's needs, instructors then "have liberties in teaching the course to move in one direction or another," he added. Instructors learn how to examine the business functions of the agencies.

"At the end of the first day, after a broad discussion of the course concepts, the instructors are broken up into teams. The following day, each team practices teaching the group. We videotape this so that they have a chance to see their own performances," said Mr. Merriman.

IIR/ACORD acts as the administrative arm of the seminar advisory committee. It developed the curriculum, prepared the instructors' guides and materials, recruits and trains instructors and has developed marketing brochures and advertisements that organizations or associations can use when sponsoring courses in their geographic areas.

Each attendee receives a questionnaire to fill out and send back to IIR/ACORD prior to attending the course.

Agencies who submit the questionnaire to IIR/ACORD "before going to class will get their own confidential management report handed out to them during the seminar," Mr. Merriman explained.

The report measures an agency's income, commission per employee and per producer, average account size and personal and commercial lines production. It also analyzes the demographics of the agency's marketing area to make personal and commercial lines sales projections over the next three years and to determine where target marketing efforts would be most successful.

Accompanying instructions show the agency or brokerage how to analyze the customized report.

During the course, attendees are taught: how to delegate and monitor automation duties in the workplace; how to avoid duplication of effort; and how to get the best use out of their equipment.

In addition, each agency or brokerage attending the seminar receives:

- Access to a toll-free automation help line operated by IIR/ACORD from 8:30 a.m. to 5:00 p.m. EST.
- A free newsletter, "Postscript," which features interviews with seminar participants, general automation information and critiques on available software.
- A DeskTeam software diskette that acts as an office organizer. Functions include a memory clock, a calendar, a calculator, a phone dialer, a typewriter and a notepad.
- An agency office manual diskette through which an agency can create a live procedures manual that contains agency job descriptions, policies and procedures and work flow patterns.
- A 45-minute cassette tape discussion of agency automation featuring Dr. Richard Byrne, an expert on automation technology.
- A 25-minute cassette tape that discusses the IVANS network from an agent's point of view. The tape details current services provided by the network and why it is needed by the industry (see page 42C).

Attendees are asked to submit a course evaluation at the end of the day. "These evaluations will concern themselves with the conduct of the course and the benefits derived by attendees. We will also periodically audit the performance of instructors by sitting in on courses," Mr. Merriman said.

Mr. Merriman explained that while the course has been designed for independent agents and brokers, it is generic enough that direct writers also could benefit from attending.

The courses graphically illustrate the automation problems and concerns of agencies and brokerages, said Mr. Merriman.

"When you are dealing with representatives of just 20 agencies in a classroom who are baring their souls, what comes out is real-world concerns," he stressed. ■

IVANS network

Continued from page 42A

interface, but it can do so more cheaply than agents and insurers could do alone, she pointed out.

"Because of our combined volume with IBM, IVANS network users receive substantial discounts" on network usage, according to Ms. Waters.

The discounts, which are based on monthly IBM network usage, are included in the bill IBM sends to IVANS each month. IVANS retains a portion of the discount for operating expenses and passes the remaining discount to its members.

IVANS bills member insurance companies and support service vendors directly for the IBM network line charges. Those insurers and support service vendors then can decide whether to assume all of the transmission costs or pass some of them on to agencies.

In addition to the monthly usage fee, property/casualty insurer members are currently assessed a reimbursable $40,000 annual fee if they write more than $500 million in annual premiums, and $24,000 if they write less than $500 million in premiums. Then, based upon the insurer's own usage of the IVANS network, the network pays the insurer back a percentage of the assessment at the end of each year.



Ms. Waters

Ms. Waters explained that when enough agencies and insurers begin using the system, IVANS should be able to reduce or eliminate this assessment to insurers. The margin between the IBM monthly usage discount and the amount of that discount that is passed on to members "will eventually be what IVANS operates on," she said.

In addition to these costs, the agency or insurer would assume any phone line costs during data transmission. But IVANS has 226 local transmission sites—up from seven sites when the network first became operational—which service about 600 communities, so the majority of the agencies using the system would only pay the cost of a local phone call. Ms. Waters said that 80% of the agencies currently using the network are within a local dialing area.

And she explained that the maximum any agency would pay for a line charge would be $15 per hour, because if the long-distance costs were more, they could route their transmission through IVANS' toll-free number at that cost.

Agencies in the United States, Puerto Rico and the Virgin Islands have access to IVANS.

However, of the 3,300 agencies using IVANS, only 210 are currently interfaced with more than one insurer. The agency with the largest interface capability is communicating with six insurers via IVANS. The others are interfaced with two to five insurers.

Thus, while IVANS is beginning to improve agency automation interface efforts, the goal of multiple-carrier, single-data entry is still down the road.

Nearly 95% of the agencies now using IVANS only transmit data to insurers interactively, which means that the agency has a direct connection with the insurer's computer during transmission.

While this type of transmission is fine if the agency simply wants to provide information to an insurer, it does not accomplish single-data entry. The link is with the accessed computer only, and data must be reentered if the agency wants to store it in its own system or transmit it to another insurer.

And interactive transmissions increase phone line costs because the agency is directly connected with the insurer's computer during the entire transmission period.

Only about 5% of IVANS' agencies are now capable of making batch transmissions, which connect the agency's system to the network directly, rather than to an individual insurer. And at the present time, those agencies are only using batch transmissions for processing personal lines business.

"In the batch arena, it's personal lines only. In interactive, it's a mix" between personal lines and commercial lines, Ms. Waters said.

But batch transmissions are more advantageous in the agency/insurer interface arena for two primary reasons. They incur lower phone line costs because information is sent out and received in short bursts. And data can be stored in the agency computer at the same time it is being transmitted to an insurer through the network, eliminating the need for duplication of effort.

However, batch transmissions require special programming, and most IVANS agents now transmitting data through the batch mode "have been involved in some type of pilot activity," Ms. Waters explained.

Agents must be sponsored by an insurance company that is a member of IVANS to join the network. Currently 28 property/casualty insurers and 11 life/health insurers belong to IVANS.

In addition, there are "over 50 subscriber members who offer a service or product to the industry or are agency automation vendors," Ms. Waters said. The life insurers also are classified as subscriber members, although that may change, she added.

Some of the sponsoring insurers are buying support services, such as electronic access to motor vehicle reports, from vendors as a marketing benefit to their agencies. While the technical capability exists to offer vendor services directly through IVANS, the network has not yet worked out a structure for billing for those services, so they are not available to all users.

"I anticipate that we will begin offering support services through the network sometime this year," Ms. Waters said. "We don't see the billing function as an IVANS responsibility. We are a non-profit organization, and we do not want to become a collection agency."

Agents do not have to have a sophisticated computer system to access the IVANS network, Ms. Waters explained. Many computers —from the most sophisticated mainframe systems down to personal computers—are compatible with IVANS.

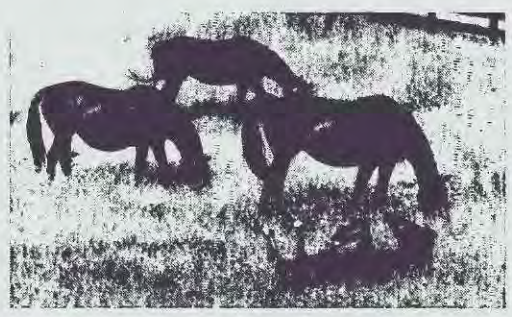
And, if an agency is not sure whether its automation system is compatible with the IVANS network, IVANS will test the system. If the system can communicate through the network, IVANS collects data on the system from the vendor so that its help desk can offer assistance to the agency if operational questions arise.

IVANS also distributes a monthly newsletter to network users that covers: technical information; products and services offered by vendor members; and administrative information, like procedural and billing changes.

Network users can obtain assistance from 9 a.m. to 5 p.m. EST by calling the hot line of IIR/ACORD, IVANS' sister corporation, which is housed in the same facility.

IIR/ACORD—a non-profit association supported by more than 100 insurance organizations—was established to improve the efficiency of the independent agency system. It designs agency automation products and services, electronic interface standards and standardized insurance application (ACORD) forms for different lines of commercial and personal property/casualty insurance. ■

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Rhulen AGENCY, INC.

Agents lobby legislators at Washington conference

By LINDA J. COLLINS

WASHINGTON—More than 600 independent agents descended on the nation's capital March 23-25 for the 11th annual National Legislative Conference of the Independent Insurance Agents of America.

The bulk of two days of the legislative conference was reserved for agents to visit their respective congressmen to lobby for industry-backed legislation.

Issues agents identified as their primary concerns included:

- Opposition to any legislation that would expand the powers of banks.
- Support for legislation that would close federal and state loopholes through which banks and bank holding companies have circumvented federal restrictions on bank activities.
- Opposition to any federally mandated employee benefit programs that would apply to small businesses with less than 50 employees, because of the hardships they could impose on those employers.
- Opposition to any legislative efforts to repeal or modify the McCarran-Ferguson Act.
- Support for a uniform national product liability law that eliminates the inconsistencies among state laws.
- Support for continued private-sector participation in Federal Crop Insurance Corp. programs and opposition to any legislative increase in insurance powers for lending institutions.

The conference began with an all-day meeting of the IIAA's national board of directors. Afterward, the IIAA held a legislative briefing at the White House.

Also during the conference, IIAA members were shown a political education film explaining the purpose of the legislative conference.

After the film, Sen. Christopher J. Dodd, D-Conn., a member of the Senate Banking Committee, discussed his views on pending banking legislation and other bills of interest to agents (see story, page 42E).

Sen. Dodd's speech was followed by a legislative briefing.

Also during the conference, Sen. Alan Simpson, R-Wyo., spoke on the McCarran-Ferguson Act, product liability and a number of other legislative issues.

During his address, he warned agents that the public may perceive a conflict between the desire to preserve state regulation of the insurance industry and the simultaneous push for federal product liability regulation.

"You want to watch your conflict there. You're talking about McCarran-Ferguson with fear and passion, and then over here you're trying to get a federal pre-emption of product liability," Sen. Simpson warned. "It can lead you to some problems."

"If you believe in McCarran-Ferguson, and I deeply believe in that, then states should also have the ability to determine what kind of tort laws they want to have" without being federally pre-empted, Sen. Simpson added. ■



Photo: Linda J. Collins

Historic Washington, D.C., was the site of the IIAA's 11th annual National Legislative Conference.

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Senate OKs temporary curbs on banks

By LINDA J. COLLINS

WASHINGTON—A banking bill that passed the Senate March 27 by a 79-11 vote contains a moratorium that would prohibit federal regulators from granting banks broader authority in the insurance, real estate and securities industries until March 1, 1988.

If adopted by the House, S. 790 would:

- Place a one-year moratorium on the chartering of new non-bank banks. At the end of that time, non-bank bank growth would be limited to 7% annually and non-bank banks would be prohibited from expanding their activities into other industries.

Non-bank banks are institutions that either accept deposits subject to withdrawal on demand, or make commercial loans, but do not do both. They are authorized by a 1970 amendment to the Bank Holding Company Act of 1956.

Non-bank banks have been set up by banks and others in attempts to circumvent prohibitions on bank involvement in the insurance industry.

- Clarify the limitations on the insurance activities of banks that were spelled out in the Bank Holding Company Act and the National Bank Act.

Title II, the second section of S. 790, would amend the Bank Holding Company Act by clarifying that the act also applies to any bank or non-bank subsidiary or affiliate of a bank holding company.

In addition, Title II would confine the insurance agency activities of national banks under the National Bank Act to towns of 5,000 or less and prohibit them from conducting insurance agency activities on a national basis.

The moratorium that applies to Title II would prohibit federal regulators from attempting to expand the intent of those two acts through loopholes in the legislation until March 1, 1988. This would give Congress time to enact a permanent law dealing with these problems.

Agent associations have lobbied extensively for passage of the bill in an attempt to keep banks from making further inroads into the insurance industry.

In an address to independent agents in Washington on March 24, Sen. Christopher J. Dodd, D-Conn., co-author of Title II, warned independent agents that they must maintain their current lobbying efforts and show their continuing support for the bill if they want it enacted.

Sen. Dodd pointed out that the banking community has "virtually swarmed" Capitol Hill in an attempt to kill the entire bill or to eliminate Title II.

Speaking before the 11th annual national legislative conference of the Independent Insurance Agents of America Inc., held March 23-25, Sen. Dodd explained the reason for the proposed moratorium contained in the bill.

"What we have done is to put everything on hold for a year in order to give the (Senate) Banking Committee an opportunity to try and deal with the whole set of issues that affect financial institutions in this country, including insurance," the senator stated.

Sen. Dodd supports the closing of the "South Dakota loophole," through which national banks have attempted to circumvent federal barriers to banks' insurance activities by acquiring state-chartered banks in states that allow those banks to sell and write insurance.

But while Sen. Dodd would have preferred to close the loophole immediately, he explained: "We're trying to deal with all of these issues, including the South Dakota loophole. I don't think I could have prevailed if I had argued on one hand that we needed a moratorium affecting bank powers on mortgage-backed securities, real estate and other securities activities and then, for the insurance industry, go for a permanent closing of that loophole."

The moratorium is a vehicle through which legislators can bring banks and other financial services players "back to the table" in a year, "so that we can settle what the financial services landscape ought to look like" in the future, he explained.

Sen. Dodd noted that if S. 790 is enacted, the moratorium will halt recent attempts by the Federal Reserve Board, the Comptroller of the Currency and the Federal Deposit Insurance Corp. to rely on regulatory loopholes to provide banks with routes to expand their insurance and securities powers.

"I think that it is important that the Congress of the United States set the policy in this country and that it not be set by people who are serving in bureaucratic positions," Sen. Dodd stressed.

While those agencies "are extremely important in implementing and setting the various measures or provisions that occur as a result of legislation that is adopted, I don't happen to believe that public policy in this country affecting financial institutions—both the providers and the users—should be set by the Fed or the Comptroller General. That's why we elect congressmen and senators," Sen. Dodd emphasized.

Following Sen. Dodd's address to the IIAA, S. 790 was amended—then passed—by the Senate.

One amendment to the bill reduced the length of the moratorium. The original language of the bill would have set the length of the moratorium at one year following the date the bill was enacted into law.

The moratorium is now effective only until March 1, 1988.

This is a disappointment for independent agents, according to Robert A. Rusbuldt, director of federal affairs for the IIAA, although not as big a disappointment as if the moratorium had been abolished.

Mr. Rusbuldt said the association "still supports the bill, but a little less strongly than we did before. This muddies the waters a bit," he explained, pointing out that if Congress doesn't act relatively quickly to enact the legislation, "the moratorium could come to mean virtually nothing" because of the March 1 cutoff.

Another amendment to the Senate bill was the insertion of a new paragraph into Title II that states: "Nothing in this title should be construed as limiting the powers of state-chartered banks."

The potential for ambiguity in interpreting the scope of Title II may arise as a result of this addition, Mr. Rusbuldt explained, which "further muddies the waters." ■

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Broker discovers power of suggestion

By JEFFREY MOSES

STUDIES HAVE shown that in Japanese companies, employees make an average of one suggestion every three days. In American firms, the average employee makes a suggestion once every five years.

This comparison may not completely explain Japanese productivity, but it certainly illustrates the comparative personal involvement American and Japanese employees have with their companies.

Realizing the potential benefits from encouraging employee suggestions, Financial Guardian Group Inc., the nation's 19th-largest insurance brokerage, has implemented a companywide suggestion system that has been very successful.

"No one understands an employee's job better than the employee," says Don Weber, chairman of Kansas City, Mo.-based Financial Guardian. "When employees who know their jobs inside and out start looking for ways to improve things, the company as a whole benefits."

Soon after starting the system, the home office coordinator was receiving between 50 and 60 suggestions a month. Within the first six months, nearly half of Financial Guardian's 300 employees in 15 offices had offered ideas.

While the suggestion systems of larger companies often require dozens of full-time staff to monitor incoming suggestions, such expense is beyond the means of a small or mid-size company. Financial Guardian hired a professional consultant to get the system off the ground.

The consultant designed a suggestion form, which was printed on 8½-by-11-inch pads and distributed to the offices. He then formed a network of coordinators and managers in the offices to keep suggestions flowing. His duties included the writing of a monthly company newsletter, "The Excellgram," which publishes the most widely applicable suggestions, along with company and office news.

The suggestion system is part of an overall campaign for quality. Top-level management continually encourages excellence in all aspects of employees' office activities. Insurance education and advanced certification are supported and financially rewarded.

Tom Peters' videotapes on excellence are shown, along with other educational and motivational films. The suggestion system is considered an integral part of the company's "Journey to Excellence," which for the last year has been the central thrust of the corporate plan.

Norb Koehs, general manager of the broker's Chicago office, believes the rapid acceptance and consistently high quality of the suggestion system has been a result of managers' quick response to suggestions.

"Managers have been encouraged to respond to each suggestion within 48 hours," he says. "That shows the employee that management cares and is interested. Sometimes I write a response right on the suggestion and give it back the same day. We make a copy and send it to the home office in Kansas City."

Each suggestion is reviewed by executive management. The company awards $50 for each suggestion implemented. Larger, more important ideas are awarded higher amounts. These dollar figures are small compared with awards from Fortune 500 companies, but Financial Guardian is focusing on the spirit of suggestions.

"We wanted to open channels of communication between all levels of the company," says Mr. Weber, company chairman. "The suggestions have been excellent, and the program has given everyone a chance to feel like a real part of the organization. We wanted to increase the quality of the company, and the only way to do that is through our people. To be a company of excellence, we need excellent employees and excellent operating systems. The success of the suggestion system has helped move us toward these goals."

A number of major innovations have originated from the suggestion system:

- A program named "Circles of Excellence" has started in several of the larger offices. Once a week, employees within a department meet to discuss ways to improve their own operations and productivity, as well as ways to enhance communication between departments.
- The capacity for speed dialing was found to exist in the company telephone system. The special dialing greatly speeds calls among the 15 offices, and can be used for frequently called local numbers as well. The suggestion leading to use of this system is especially interesting, because the telephone capacity only needed to be brought to light.
- Special bright red files were designed for producers who need quick action from customer service representatives. This is only one of dozens of office procedures that have been implemented.
- Several offices now invite employees of local insurance company branch offices to brokerage offices. Also, an Underwriter of the Year Award has been established.
- Seminars for clients are being held to discuss the new commercial general liability claims-made and occurrence forms, the Consolidated Omnibus Budget Reconciliation Act and other timely subjects. To date, three seminars have been held, with attendance averaging nearly 100.

Response to the suggestion system has been extremely positive. Recently a companywide poll was taken in which 100% of employees rated the suggestion system either excellent or good. None rated it fair or poor.

Typical responses were:

- "Seems to be a real morale-booster."
- "Shows that management is interested in employee suggestions."
- "Lets employees feel like a part of the decision-making process."
- "Lets a person express ideas that could help the company."

Experience has shown that with the support of management, a successful suggestion system can be started quickly. The success of the suggestion system is difficult to translate into actual dollar figures, but the high quality of suggestions, along with the positive response among employees, have led management to feel that the system has been worthwhile for the entire company.



Jeffrey Moses is a Kansas City, Mo.-based business writer and advertising consultant. He coordinates Financial Guardian Group Inc.'s suggestion system and newsletter.

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California judge affirms anti-rebating statutes

SAN FRANCISCO—A California Superior Court judge has upheld the constitutionality of the state's anti-rebate statutes.

The judge denied a request by Consumers Union—the non-profit publisher of Consumer Reports—that the court declare California's anti-rebate statute unconstitutional.

Consumers Union filed its request last fall, after the California Legislature added Section 750.1 to the state insurance code.

The section clarifies the intent of California's anti-rebate statute, which prohibits producers from rebating to their clients a portion of the commission they earn on an insurance policy (*A/BT*, Aug. 4, 1986).

Consumers Union argued that the law was an unreasonable exercise of the state Legislature's authority.

The judge disagreed with this argument and ruled that the legislation was within state legislative authority.

A different conclusion was reached by the Florida Supreme Court in June 1986, which determined that Florida's anti-rebate statute was unconstitutional.

Following its decision, the Florida Department of Insurance issued a memo warning producers that while the ruling applies to the statutory prohibition of commission rebates, other prohibitions against such inducements still exist.

Prohibited inducements include one barring insurers from charging different premium rates for life and health insurance to policyholders in the same actuarial class, another prohibiting discrimination and a third prohibiting many methods of sharing or dividing commissions.

The department memo said that other statutes also apply to premium rebating. It urged producers to carefully consider all of those provisions before engaging in any rebating activities.

Electronic etiquette

NEW YORK—The agency contracts committee of the Independent Insurance Agents of America Inc. is designing a provision that will spell out the responsibilities of agents and insurers when they develop an automated electronic relationship.

The provision will identify:

- The responsibilities of each party for the security of information entered into the system.
- The responsibilities of each party regarding specific automation expenses, such as modem and line costs.
- Which party would own the automation equipment if the agency/company relationship is terminated.

The committee also is reviewing the errors and omissions exposures that potentially could arise as a result of interface, particularly when the insurer and agent share a data base.

Agents should send their suggestions to Shirley Lukens, IIAA's director of automation, 100 Church St., New York, N.Y. 10007.

Unigard Security

SEATTLE—Unigard Security Insurance Co. has developed a new agency business planning program.

Through the program, called "Planning for Value," Unigard branch management and agency principals will work together to draft a business plan document in which each party makes commitments to achieve specific goals.

The company designed the plan to develop long-range marketing strategies for the mutual benefit of Unigard and its agents. For details on the program, Unigard suggests that agents contact their local Unigard branch office.

a/bt briefs

New office

SPRINGFIELD, Ill.—The Illinois Assn. of Professional Insurance Agents has relocated to 955 Durkin Drive, Springfield, Ill. 62704; 217-546-7700. ■

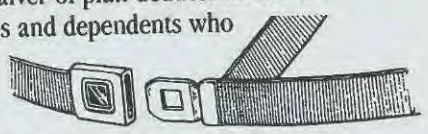
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Benefit trends trigger EBIS development

By MICHAEL BRADFORD

LAS VEGAS, Nev.—The growing need to control health care costs and benefit managers' changing role are triggering the development of several "generic" employee benefit information systems, a consultant says.

Mary Lou Maxie, a consultant with Towers, Perrin, Forster & Crosby in New York, explains that benefit managers have responded to management's desire to cap health care costs by becoming more demanding purchasers of health care services.

Speaking as a member of a panel at the 25th annual Risk & Insurance Management Society conference last week, Ms. Maxie explained that "early attempts at controlling health care costs involved the employer assuming all or part of the risk that traditionally was covered by an insurance company."

But unfortunately that solution was short-lived and eventually, Ms. Maxie noted, an employer's health care costs "started going up again."

At that point, "senior management went to their benefit managers and said, 'What's happening? What can we do? We've got to do something.' "

That's when the benefit manager's job started to change, she remarked. "No longer was just buying or financing the health insurance coverage through an insurance company contract enough."

Benefit managers began to shop around, she noted, and became concerned not only with the price of benefits, but also with whether plans would meet the company's needs and objectives.

And benefit managers became especially concerned with making sure benefit plans, once they were in place, operated effectively.

"The way you do this is by constantly monitoring it, you fine-tune it," said Ms. Maxie. "And this is how the new industry of employee benefit information systems sprung up."

Isurers and independent vendors began developing data processing services to help benefit managers continually "fine-tune" their plans, Ms. Maxie explained.

Today, there are six "generic" types of employee benefit information systems, she said. However, "there's a little bit of blurring of the dividing lines between the types of systems."

A simple, straightforward system used by some benefit managers is one Ms. Maxie called a "claims management system."

The system categorizes information about claims paid on behalf of individuals, families and all employees. It also provides information relating to deductibles and other data.

A second system, which Ms. Maxie called a "data or expense analysis system," helps identify trends in claims payments. For example, a subsidiary in one city that has higher health care costs than other units can be identified and made to pay a higher share of the overall cost of benefits, she explained.

A "utilization review system" does not focus as much on costs as how much a benefit plan is being used, Ms. Maxie pointed out. "These types of EBIS measure one employer's results against something else."

She explained that results might be compared with "normative data" like that compiled by a health care coalition or even the previous year's utilization information.

"When you use a utilization review system, you are trying to find efficient providers" and providers that not only get employees well, "but get them well quicker. You're trying to find the hospitals where the average length of stay is a little bit shorter. You're trying to find cost-efficient providers."



An employee benefit information system that "helps you play 'what-if' games" is one Ms. Maxie called "benefits modeling."

Such a system allows a benefit manager to ask hypothetical questions and see answers that show whether certain changes in a benefit plan would result in savings.

For example, a manager could ask the computer program to show whether money could have been saved by raising deductibles or by offering a preferred provider organization.

One of the most recently developed employee benefit information systems is one that combines property/casualty claims experience with employee benefit costs.

An advantage to this combined system is that it helps identify "double dippers," said Ms. Maxie. She explained that some workers receive double benefits by having a claim paid both by the employer's health plan and its workers compensation insurer.

She also referred to an "audit system," that reviews physician charges and hospital bills to make sure the costs are in line with nationwide norms.

If discrepancies are found, the employer can review the charges and possibly make adjustments.

Panel member Larry Tucker, a consultant with Hewitt Associates in Los Angeles, said benefit managers can receive information from a data system in three ways.

"Paper output is the one you're most familiar with," he said. The system simply involves receiving reports from an insurer or outside computer services vendor that operates the employer's EBIS.

Mr. Tucker said, "The up and coming way to get data is going to be something like a (personal computer) hooked to a mainframe" operated by an insurer or vendor.

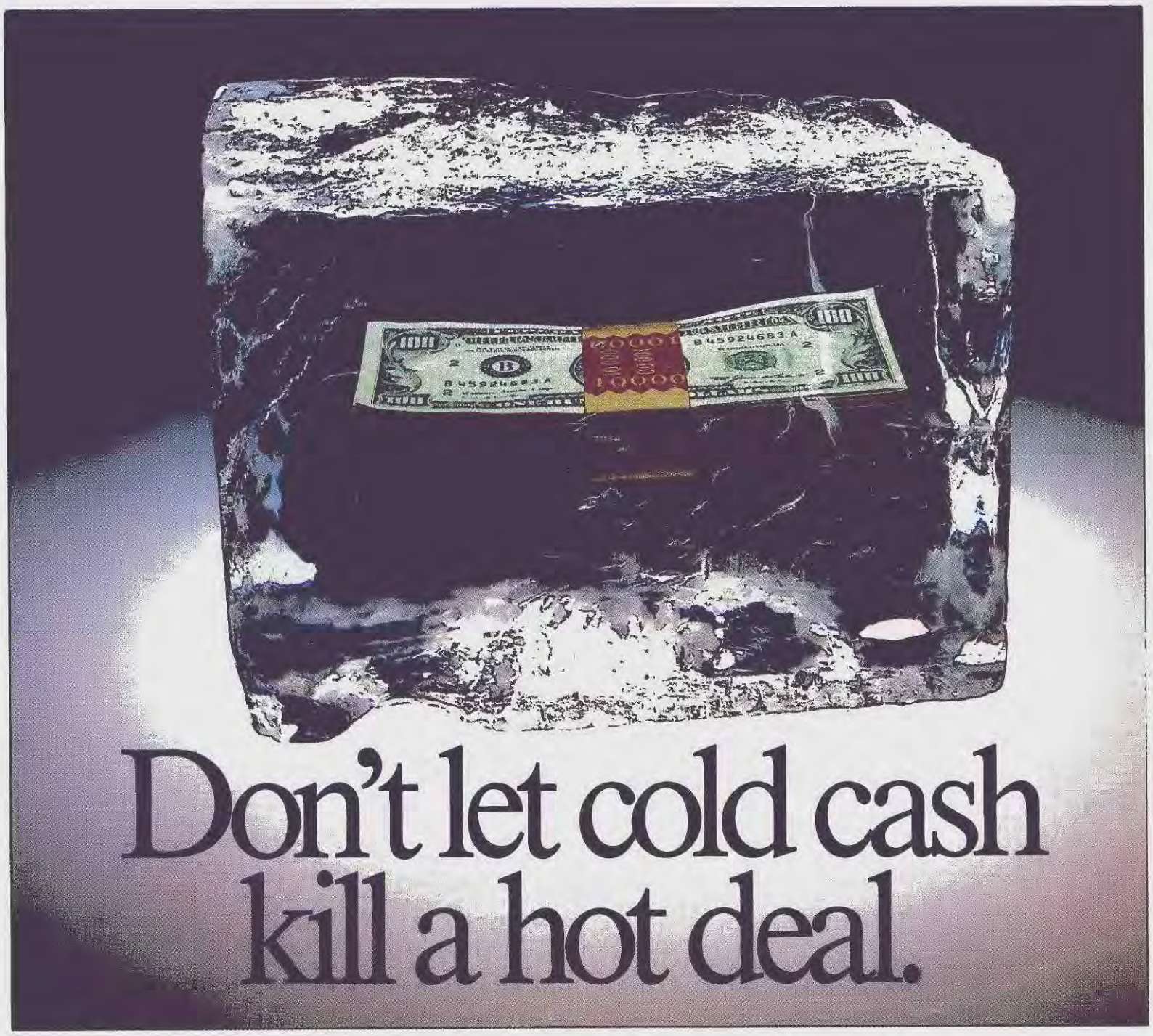
It also is possible for an employer to install its own mainframe system, said Mr. Tucker.

Kent Peterson, medical director of Health Examinetics Inc. in Charlottesville, Va., said he believes an EBIS can help contain costs by identifying diseases that are preventable.

And, he said, "once people are ill," an EBIS can help reduce the demand for health care services by identifying proper utilization review techniques.

The system also should improve the efficiency of administration and restrain future price increases, Mr. Peterson noted.

The panel was moderated by David L. Broadway, director of risk management at Carnation Co. in Los Angeles. ■



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Experts warn employers: Review doctors' charges

By MEG FLETCHER

LAS VEGAS, Nev.—An employer needs to adopt utilization and claim review strategies before it can identify the doctors wearing "white hats" from those clad in gray or black, experts say.

Categorizing doctors is important because although doctors receive only about 30% of all medical expenditures by commercial insurers, they are responsible for generating about 80% of all health care costs by ordering tests and hospital admissions.

"The best physicians—and hospitals—do not charge the most," Dr. W. Bryan Latham, president of InforMed Inc. in Coral Gables, Fla., said at a session on doctors' costs at last week's 25th annual Risk & Insurance Management Society conference.

His conclusion, which was supported by other panelists, resulted from a survey of local doctors done for Miami, Fla.-based Ryder System Inc. Ryder has made the computerized information, which included doctors' background and credentials, available to employees who requested it.

"Employers and employees can save substantial amounts of money without sacrificing quality," Dr. Latham contends.

But, that cannot be accomplished unless employers adopt effective claim and utilization review strategies, panelists said.

Early strategies were mere Band-Aids and not cures, said Dr. Robert K. Maddock, medical director of the Salt Lake City-based Medical Review Institute of America.

"Crooks often do paperwork better than honest people," he said, noting that reviewers were sometimes not skilled enough to understand how a doctor was milking the system.

The best traditional solution may be to invite "white hat" doctors—those with good methods of practicing medicine—to join a preferred provider organization or health maintenance organization, Dr. Maddock said.

But, employers also must take steps to cope with doctors who are charging too much either because they think the market will bear it, or because they are trying to bilk employers and insurers, panelists say.

The first step in controlling doctors' charges is to identify the doctors who deserve "black hats" because of abusive billing, Dr. Maddock said.

His company has found cases where doctors made phony diagnoses to keep the patient coming back for treatment or surgeons who have charged an additional fee for taking a patient's history, which should be included in their general fee.

Some teaching hospitals may submit general bills for an experimental procedure that, while legitimate, is not covered by the employee's health plan. "Don't trust the ivory towers not to fool you," he cautioned.

Once a "black hat" doctor is identified, all the procedures performed by that physician should be reviewed using the American Medical Assn.'s book on Current Procedural Terminology, which specifies what services are necessary for a particular procedure, he said.

Dr. Robert Hertenstein, medical director of group insurance for Caterpillar Tractor Co. in Peoria, Ill., noted that his company recodes more than half of the claims it receives with the help of sophisticated medical technician reviewers. Caterpillar handles all of the nearly $2 million in annual claims submitted under its self-insured medical and dental programs.

About 95% of Caterpillar's problems come from doctors who graduated from foreign medical schools, Dr. Hertenstein said.

Small employers cannot do this type of review in-house, but they can hire a good third-party administrator to do the work, suggested panel moderator Joseph G. Charles, Ryder's director of employee benefits.

In addition, a small employer could get help from a local health care coalition, he pointed out.

Continued on next page

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Continued from previous page

"Across the board, when you've got a black hat, they are ripping you off in every area," he said.

A tricky problem emerges when a group of affiliated doctors bill twice for taking and reading X-rays for the same patient injury, Dr. Maddock said.

"Once you spot that, the best thing to do is review everything that comes out of that house. It will slow down their payment schedule so much that they will scream 'Uncle' " and stop submitting duplicate claims, he said.



"You are perfectly within your rights to do this once you have caught them upcoding on you because it is a form of fraudulent billing," he said. However, employers need to realize that sometimes patients are the problem, not the doctor. One patient bilked the system for $250,000 over 10 years by adding procedures and fees to an honest doctor's bill, Dr. Maddock added.

The services of claim reviewers can be cost-effective, Mr. Charles said. Dr. Maddock's services save Ryder about $12 for every $1 spent for his services, he added.

After determining that a doctor is charging for a legitimate service, an employer then should consider what the usual and customary fee should be.

"The worst disease in health care today is usual and customary (fees)," said Samuel X. Kaplan, chairman U.S. Administrators Inc. in Los Angeles, a third-party administrator.

If a doctor manages to figure out how to charge $300 more for a procedure and gets an insurer to pay it, the word spreads, other doctors copy his example and the elevated fee eventually becomes customary, Mr. Kaplan complained.

While Caterpillar's Dr. Hertenstein said he doesn't blame doctors "one iota" for such practices, employers must fight against it.

Caterpillar goes to court about eight times a year over disputed fees submitted by doctors in areas where the company has a significant number of employees, he said. The company usually wins and the sentinel effect is significant on other doctors in the area, he said.

Caterpillar has found it useful to go directly to the local community before it introduces a tough fee plan. Describing the company's problems with doctors in advance helps create some support and circumvents some opposition, he said.

Ryder often pays doctors at 75% of usual and customary fees, Mr. Charles said.

However, that approach still means that doctors' fees will continue to creep up over time, Mr. Kaplan said. Employers need to go back to a fee schedule and let doctors know in advance what they can expect in payment, he urged.

That approach requires a hold-harmless agreement in the employee medical plan to protect employees from doctors who seek to recover the balance of their requested fee from them, he added.

In one case, a Florida doctor sent a $5,000 bill for a procedure for which other doctors typically billed $2,800, Mr. Kaplan said. U.S. Administrators sent a letter asking if there were any extenuating circumstances to justify the excessive bill. There were none, and the doctor turned to the patient for the difference.

The employer notified the employee of the hold-harmless clause and he did not pay the excess charges. U.S. Administrators lined up several surgeons to testify that $2,800 was the customary fee and called an investigative reporter. The doctor backed down and accepted the $2,800 fee, Mr. Kaplan explained.

Another leverage-gaining technique for an employer can be to pay bills slowly or to refuse to pay for the presence of assistant surgeons for many procedures, panelists said. Employers also can help employees keep doctors' fees in line through a patient education program like InforMed Inc.'s.

The data base includes information about a doctor's location, specialty, credentials, fees for basic services, hospital affiliations and any disciplinary actions taken by state medical review boards, Dr. Latham said.

The company's Miami-area survey found that foreign-trained and non-board-certified doctors sometimes charged thousands of dollars more for a procedure than doctors with better credentials, Dr. Latham said.

While controlling doctors' fees is important, it is more important for employers to control a doctor's utilization of medical procedures and drugs, Mr. Kaplan said. "The health care system is a utilization-driven system and not a fee-driven system," he said.

"The mundane is where they are getting by with murder," he said, classifying doctors not as "white hats" and "black hats," but as "varying degrees of gray hats." ■

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Catastrophic illness costs can be managed

By DONNA DiBLASE

LAS VEGAS, Nev.—Employers must reassess their risk assumption and transfer strategies to effectively manage the costs of catastrophic illnesses, benefit experts warn.

"Actual medical costs represent only one of the benefit costs of a catastrophic illness," observed Wilmer E. Hough, corporate risk manager for Mack Trucks Inc. of Allentown, Pa.

Catastrophic illnesses like acquired immune deficiency syndrome or spinal injuries also can be costly to an employer's disability and group life insurance plans, he added.

Benefit experts at the 25th annual Risk & Insurance Management Society conference last week discussed the costs of catastrophic illnesses and strategies for controlling these costs through effective medical case management programs and communicating these programs to employees.

The majority of these costs are incurred by a small percentage of the population, experts noted.

Some 80% of health care benefits dollars are used by only 20% of the covered population, noted Jackie Mazoway, a registered nurse and a product manager for Intracorp, a Wayne, Pa.-based cost-containment firm and a subsidiary of CIGNA Corp.

"Three percent of that 20% of the population use 40% of benefits dollars" for illnesses like cardiovascular disorders, neurological disorders and transplants, she added. "The remaining 17% of that 20% of high utilizers use another 40% of benefits dollars for chronic illnesses," like birth defects, respiratory illnesses and Alzheimer's disease, Ms. Mazoway added.

And, the high cost of AIDS will inevitably confront employers, said Tom Billet, a senior consultant in the New York office of benefit consultant Johnson & Higgins.

"The Centers for Disease Control in Atlanta estimates that there are over 30,000 cases of AIDS now and that there could be 270,000 cases by the year 1991," he pointed out.

It is estimated that AIDS patients, form the time of diagnosis to the time of death, have an average of three hospital admissions, with an average length of stay of about 23 days each. The CDC estimates that the average treatment cost per patient is about $140,000 during this time, Mr. Billet said.

"The implication for employers is that about 35% to 55% of all AIDS patients are employed and could be covered under a benefit plan," he pointed out.

"The reason catastrophic health care is a substantial cost is that most employers don't know how to deal with it," he added.

For example, requiring employee cost-sharing through deductibles and co-payments does not control the costs of a catastrophic illness or injury. This is because once an employee reaches his or her annual maximum out-of-pocket expense, any additional costs must be covered by the benefit plan, he said.

And, many discount arrangements with providers do not get at the real cause of catastrophic costs, because there is no control over utilization and because most chronically or catastrophically ill patients are not willing to change to alternative delivery systems since they already have their own doctors or hospitals, Mr. Billet said.

In addition, smaller companies that self-insure their health care benefits must be even more concerned with controlling catastrophic health care costs, because "one catastrophic case could literally wipe out a small- or medium-sized self-insured employer," Mr. Billet said. "And, the majority of all employers do not have case management or utilization review to manage catastrophic illness costs."

Catastrophic case management is one of the best strategies for managing these costs, Mr. Billet and Intracorp's Ms. Mazoway asserted.

Case management involves suggesting more appropriate and often less expensive treatment and settings—which may not normally be covered by a benefit plan—for catastrophically ill patients.

Good candidates for case management include high-cost, high-volume cases like hysterectomies and high-cost, low-volume cases like organ transplants, Mr. Miller explained.

Case management usually takes over when a patient reaches a certain dollar or length-of-stay limit. However, early intervention is the most effective method of controlling catastrophic health care costs, the experts said.

"The pre-admission certification process usually picks up or identifies the high-risk patient, but employers must decide when to get involved in managing the case," said Laird Miller, president of the Minneapolis-based health care consulting firm of Health Systems Management Inc.

Following pre-admission certification, "the patient and family should be notified that you have a voluntary case management program available," Ms. Mazoway of Intracorp noted.

Then, a case manager—preferably with psychological training—should meet with the patient, family and attending physician to determine how each person views the illness and possible care, she said.

Appropriate, feasible care should then be coordinated. For example, if home health care is suggested, the case manager should ensure the proper personnel are available to manage the patient's care.

In addition to case management, effective benefits communication is a valuable technique for managing costs, according to Bonnie Gellas, a vp of Marjorie Gross & Co., a New York-based employee benefit communications consultant.

"The problem is employees are passive users of the health care system. We have to get employees to realize that the best medical care isn't necessarily the most expensive," Ms. Gellas said.

By implementing a strong employee benefit communication program, employers can attain goals like increasing employees' participation in health care cost control programs and impacting better utilization of health care services by employees, she said.

An effective communications program raises employees' awareness of general health care costs and the employer's objectives in implementing cost-control programs, Ms. Gellas noted.

Mr. Hough of Mack Trucks moderated the panel discussion. ■

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Absent employees hike employers' costs

By STEVE TARAVELLA

LAS VEGAS, Nev.—When Janice M. Jones speaks about the "habitual absentee," she's not talking about the employee who misses five days of work each year to nurse the flu.

Rather, Ms. Jones, benefit manager for Eaton Corp. in Cleveland, is talking about the person who calls in sick three or four days a month, if not more.

Frustrated at what they say is a drastic rise in casual absenteeism, benefit managers attending the 25th annual Risk & Insurance Management Society conference last week discussed ways to combat excessive absenteeism and make the most out of short-term disability claim management.

Tracing the beginning of the recent rash of absenteeism is difficult, Ms. Jones said.

"We do know it's growing. We don't know how fast," she said. "Somewhere along the way, this particular work ethic just diminished."

To illustrate, she cited the experience of one employer whose incidence of absenteeism doubled between 1985 and 1986; between 1980 and 1985, absenteeism rose only about 1% annually.

Employers that already have gotten a grip on their pension, group health and long-term disability benefit costs frequently overlook the need to better manage their short-term disability and salary continuance plans, Ms. Jones and other panelists said.

Most employers spend 2% to 6% of their payroll on short-term disability payments. At major corporations a 1% increase in absenteeism could easily cost the company $1 million in salary alone, Ms. Jones noted.



Those are the kind of numbers that can make even the biggest companies, like Ford Motor Co. in Dearborn, Mich., pay attention.

By using impartial medical exams on a massive scale, the Ford/UAW Group Life and Disability Program is seeing substantial savings in its short-term disability expenditures, reported Maurice Shapiro, benefits research manager at Ford.

IMEs are scheduled for about one-third of all of Ford's short-term disability claimants. Performed at medical facilities nationwide—Ford uses 12 sites in Michigan alone—the examinations are designed to provide a fast, independent determination of whether a true disability exists, nothing more, he said. Claimants do not receive treatment, nor are they always diagnosed.

In 1986, Ford scheduled IMEs for 12,499 of about 33,000 claimants. Of the 5,981 individuals who appeared for exams, 1,251 were determined not to be disabled, resulting in a savings for the company, Mr. Shapiro reported.

Last August alone, for example, the automaker conducted 799 IMEs. Of those, 141 persons were found able to work and had their disability claims terminated. Ford saved money in 114 of the cases.

The company realized a net savings of $40,000. That was achieved by subtracting the $28,000 cost of the exams from the $68,000—or 230 weeks' worth—in benefit payments avoided.

But businesses need not establish anything on such a grand scale to make a dent in their short-term disability expenditures.

James H. Sang, director of the Managed Health Services Group Sales Department at John Hancock Mutual Life Insurance Co., says it's "absolutely essential" that employers formulate a written policy on absenteeism. He says the policy should include information like:

- At what point should employees notify the company about their illness?
- Will family members or others be permitted to call in on the employee's behalf?
- To whom should they report—their supervisor, the personnel director, the plant manager?
- How long will salary continue during absence before the employee is required to see a physician?

Richard A. Lewis, president of Thomas L. Jacobs & Associates Inc., a Chicago claims manager and consultant, offers the following approaches to improve short-term disability claim management:

- Early intervention for rehabilitation.

"Everybody in the business has learned the hard way that the only way (rehabilitation) works in a cost-effective manner is to get in early," said Mr. Lewis.

Often, this means beginning rehabilitation while an injured person is still hospitalized. This also necessitates developing guidelines for detecting and screening cases suitable for rehabilitation.

- Close coordination with workers compensation and medical case management professionals.

"Everybody involved should be involved in a closed loop; there should be information passed back and forth and joint decisions should be made," he advises.

- Identify and then measure overutilization of short-term disability benefits. This would involve setting up a program to deal with employees suspected of taking advantage of absence or disability policies, either by offering them counseling, imposing disciplinary action or both.
- Commence psychological disability case management programs. Many companies are now experiencing a huge increase in psychiatric disability cases, he said. "It's a national problem and one that deserves special attention."
- Establish a modified-duty program, in which injured employees can remain motivated and active while contributing in some lesser capacity to the company.

Mr. Lewis related the experience of a telephone company that was spending about 2.4% of its payroll on short-term disability benefits. The business, with about 26,000 employees, adopted a strong salary continuation management program that shaved 18%—or about $1.1 million—off its 1986 short-term disability benefit bill.

Starting the program involved, among other things, automating claims functions, introducing detailed forms to track physician-supplied information and significantly beefing up rehabilitation efforts. It cost the company about $100,000 to implement the program, Mr. Lewis said. ■

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'87 PRIMA conference to 'reach new heights'

WASHINGTON—Risk management professionalism will be the emphasis of this year's Public Risk & Insurance Management Assn. conference to be held May 17-20 in Seattle.

The annual conference, entitled "Risk Management Reaches New Heights," will show "how risk managers have survived the insurance crisis, how they have introduced new, innovative risk financing into their organizations and how their programs have grown stronger and more self-sufficient," said Natalie Wasserman, PRIMA's executive director.

Following a reception May 17, a panel of experts will discuss how the risk management approach is gaining momentum among public entities as both a survival technique and a permanent, long-range method for protecting governmental units, their employees and the public from loss.

Following the opening session, conference participants will be able to choose from more than 40 concurrent sessions discussing risk management and employee benefit issues.

Session topics include: evaluating risk management programs; risk management information systems; loss control, including coping with disasters; reinsurance; and the commercial general liability form. Other topics include how to read service contracts; lobbying legislators; industrial hygiene; motor vehicle fleet safety; privatization of public services; and coping with civil rights and pollution claims.

Other sessions will focus on topics of interest to schools, airports, recreational facilities and health care facilities.

Benefit-oriented topics include multiple-option health care plans; short- and long-term disability programs; and the effects of the Consolidated Omnibus Budget Reconciliation Act.

New this year will be a special afternoon session in which advanced risk managers will discuss innovative solutions they found to their problems.

The board of directors of PRIMA's pooling section is planning sessions on starting a pool.

"We'll have experts helping each other," Ms. Wasserman said.

In addition, the board of directors of PRIMA's pooling section is planning sessions on starting a pool, financing pools and what maturing pools need to do to stay viable. Also scheduled are the pooling section's annual meeting and a session for pool participants to exchange information.

Attendees also will be be able to meet with software specialists in a risk management information systems exhibit hall, who can describe the capabilities of their microcomputer programs on a one-to-one basis.

In addition, newcomers can attend a three-part series of "how-to" sessions devoted to the basics of risk management.

Individual fees for public entity registrants are $265 for the first representative of a member government and $225 for each additional registrant. The fee for non-member public entities is $330, which includes a PRIMA membership fee. Industrial affiliates and non-member private sector attendees can contact PRIMA to obtain their fee schedule.

All fees will increase after April 10.

Included in a registration fee are the cost of continental breakfasts, luncheons, coffee breaks and a cruise to the Tillicum Village in Puget Sound for a salmon feast and an exhibition of Northwest Indian dancing.

Other events include tennis and golf tournaments.

PRIMA is banning smoking during all presentations in response to the complaints of non-smokers, although smoking will be allowed in hallways.

For more information, contact PRIMA at 1120 G. St. N.W., Suite 400, Washington, D.C. 20005. ■

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Rand Corp. study

Frequency, size of punitive awards grow

By STEPHEN TARNOFF

SANTA MONICA, Calif.—The frequency and size of punitive damage awards has increased significantly during the 1980s, but the biggest growth has been in business and contract disputes, not personal injury cases, the most recent study on punitive damages says.

The study by the Rand Corp.'s Institute for Civil Justice says that punitive damages have been minimal for personal injury cases, which includes those involving product liability claims.

And even with the growth in frequency and size of punitive awards, almost 50% are reduced either by settlement, by the trial judge or on appeal.

Punitive damages are awarded to punish defendants for engaging in outrageous behavior and to deter them from engaging in similar future conduct.

The study, the latest in a series on the civil justice system by Rand, was based on data of punitive damage awards in San Francisco County, Calif., and in Cook County (Chicago), Ill., between 1960 and 1984 and also other California jurisdictions between 1980 and 1984.

The study looked at the awarding of punitive damages in three areas:

- Personal injury cases, including negligence and strict liability but not personal injuries from assaults and other intentional torts. This category includes product liability cases.
- Business/contract cases involving claims for monetary damages for fraud, business torts and unfair business practices. These include bad-faith claims against insurance companies, employers and other businesses.
- Intentional torts including claims for defamation, discrimination, violation of civil liberties and assaults.

In general, the study found that the frequency of punitive damage awards has jumped significantly during the 1980s compared with the previous 20 years.

Such awards almost doubled in Cook County between the late 1970s and early 1980s and the number also increased significantly in San Francisco County in the 1980s.

In addition, the amount of money awarded in punitive damages also has increased significantly. For example, the amount awarded increased by 800% in Cook County during the 1980s, compared with the late 1970s, even after adjusting for inflation, the study notes.

In San Francisco, excluding a 1975 award for $13.4 million, the total of punitive damage awards more than tripled from the late 1970s.

The study points out that the perception that big awards are handed down frequently is a myth. "Despite the widespread perception to the contrary, most punitive damage awards are modest," the study says.

According to the study, prior to the 1980s, half of all punitive awards in Cook County and San Francisco were less than $31,000, while during the 1980s the median increased in Cook County to $43,000 and in San Francisco to $63,000.

Nevertheless, because the size of the largest awards had increased in recent years, average awards have increased significantly, including a quadrupling during the 1980s in Cook County.

Concerning the types of cases in which punitive damages are awarded, the study found that few punitive damage awards occurred in personal injury cases over the entire 25-year period surveyed.

The Rand Corp. study points out that the perception that big awards are frequently handed down is a myth. 'Despite the widespread perception to the contrary, most punitive damage awards are modest,' the study says.

Only 10 such awards occurred in San Francisco and 50 in Cook County. The larger number in Cook County reflects the greater number of personal injury trials there, according to the study.

While the number of punitive awards for personal injury cases increased during the 1980s, this amounted to only about one per year in San Francisco and three per year in Cook County.

Even in the 1980s, punitive damages were still awarded in only 1% or 2% of personal injury trials, which is far less frequently than in intentional tort or business/contract cases, the study says.

Despite the few punitive damage awards in personal injury cases, the amount of punitive awards in these cases increased greatly in Cook County—from $1 million between 1975 and 1979 to $27 million during the 1980s, the study notes.

This increase was due primarily to several very large punitive awards, including a $9.3 million medical malpractice award against a hospital in 1980 and a $13 million award in 1984 in a case involving both medical malpractice and product liability.

In San Francisco, which did not have any huge awards, the amount of punitive damages for personal injury cases remained modest and changed little over the 25-year period, the study says.

In fact, the largest punitive award for a personal injury case in San Francisco took place in the early 1960s and had a 1984 value of $1.6 million.

For product liability cases, a subsection of personal injury awards, the frequency of awards was very minimal, the study says.

Punitive damages were awarded in only four product liability trials in San Francisco and in only two in Cook County over the entire 25-

Continued on next page

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Rand study

Continued from previous page

year period.

But the study does note that there is some indication of a growing frequency of punitive damages in product liability cases because three of the four product liability cases in San Francisco occurred between 1980 and 1984.

While punitive damages are not a very significant factor in personal injury cases, they are much more significant in cases involving business and contract disputes, the study found.

Punitive damages were rarely awarded for these cases during the 1960s.

Yet between 1980 and 1984, they were awarded in 23 business/contract cases in Cook County—twice the number during the previous five-year period.

In San Francisco puntive damages were awarded in 34 business/contract cases between 1980 and 1984, three times the number of the previous five years.

The sharp upward trends in frequency and amount of punitive awards in business/contract cases reflect in part a growing number of jury trials in this area and expanding litigation in both Cook County and San Francisco, the study notes.

There was also a sharp increase in the size of punitive awards in these cases.

During the first five years of the 1980s, for example, juries awarded about $14 million in Cook County and $17 million in San Francisco—about three times more than was awarded during the previous 10 years.

The sharp upward trends in frequency and amount of punitive awards in business/contract cases reflect in part a growing number of jury trials in this area and expanding litigation in both Cook County and San Francisco, the study notes.

The trends also seem to reflect increased availability of punitive damages for bad faith in insurance contracts, wrongful termination of employees and unfair business practices, the study adds.

For intentional tort claims, including those involving claims for assault, defamation and discrimination, the study found that punitive damages increased sharply in Cook County during the 1980s but experienced little change in San Francisco.

This was because prior to 1980, jurors in San Francisco imposed punitive damages in these types of cases much more frequently than did jurors in Cook County.

The increased rate of awards during the 1980s in these cases in Cook County brought that jurisdiction to the higher San Francisco rate, according to the study.

In Cook County, punitive damage awards in intentional tort cases rose to 38 between 1980 and 1984 from 16 between 1975 and 1979.

By comparison, in San Francisco there were 20 such cases between 1975 and 1979, down to 11 between 1980 and 1984.

However, the study reports that most punitive damages in the intentional tort area were small, with the median under $30,000 between 1960 and 1984.

In addition, there were a few multimillion-dollar punitive awards in this area.

Commenting on the frequency of awards, the study says: "Punitive damages are an issue primarily in intentional tort and business/contract cases, where they have traditionally been awarded to punish intentional injuries or fraudulent or unfair dealings.

"Although intentional tort and business contract cases constituted only a small proportion of trials in both jurisdictions, they accounted for 88% of all punitive awards in San Francisco and 81% in Cook County during the 1980s."

According to Mark Peterson who headed the Rand study on punitive damages, "a substantial number" of the business/contract suits involved plaintiffs that were businesses or individuals engaged in business, such as sole proprietors.

Moreover because punitive damages are a bigger threat in business/contract disputes than product liability cases, businesses involved in providing services might face a bigger exposure to punitive damages than manufacturers of products.

The study also was able to follow up on 68 trials concluded between 1979 and 1983 and found that in almost 50% of the cases, punitive awards were reduced either through settlements, post-trial motions or on appeal. In 35 of the 68 trials, defendants paid the original trial award.

Considering all of the post-trial action, about one-half of the punitive damages awarded by juries in the cases was actually received by the plaintiffs.

The study also found that bigger punitive awards were less likely to stand than smaller ones. In addition, although business/contract awards were paid at close to the original award, in personal injury cases large reductions were typical.

On average, 38% of an original punitive award was paid in personal injury cases, according to the study.

"Most large punitive damage awards were reduced by post-trial activity, and only half of the money originally awarded by juries in the sampled cases eventually ended up in plaintiffs' hands," the study sums up.

The study also reinforced the view that businesses rather than individuals had to bear a large share of punitive damages.

In California, 57% of all liable defendants were businesses and in Cook County, businesses were one-third of the defendants found liable.

Moreover, when found liable, businesses were assessed far larger punitive damage awards than individual defendants.

In Cook County, the average punitive award against businesses was $1.3 million, or 33 times the average against individuals.

In California, the average punitive award against businesses—nearly $1 million—was five times that against individual defendants.

Most punitive awards were much more modest, even when assessed against businesses, however.

Half of all the awards against businesses were less than $100,000 in California and $143,000 in Cook County.

Other areas that will be addressed by Rand in the future include the effect of the potential for punitive damage awards on settlement outcomes, the costs associated with the post-trial settlement and the appeal process, the role punitive damages play in deterring unsafe practices, whether they deter innovation and how they affect economic and social behavior.

•

The report, "Punitive Damages: Empirical Findings," numbered R-3311-ICJ, may be purchased for $7.50 from Rand's Publication Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90406-2138.

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Spanish merchants face trial for selling deadly cooking oil

MADRID, Spain—Thirty-eight Spanish olive oil merchants and industrial chemists are on trial for allegedly causing the deaths of 584 people and injuring at least 24,992 others by preparing and selling deadly cooking oil.

Considered the "trial of the century" in Spain, the court will hear evidence that the defendants allegedly sold imported rapeseed oil—intended for industrial use—stained with aniline dyes as "pure olive oil," which caused the deaths and injuries.

The defendants allegedly distributed more than 110 metric tons (121 short tons) of the oil in early 1981.

Some or all of the plaintiffs are charged with manslaughter, causing grievous bodily harm, fraud and falsification of trademarks and business documents.

None of the plaintiffs or their companies—which were closed by the Spanish government—carries product liability insurance to pay compensation to the victims, according to Julian Lopez, reinsurance manager for insurance group Plus Ultra in Madrid. "Perhaps the victims had some individual health (insurance) policies, but there was no product liability insurance," said Mr. Lopez.

However, following the deaths and injuries caused by the sale of the oil in 1981, the Spanish government passed the Consumer Law on July 19, 1984, to force strict liability on manufacturers for the products they sell, he confirmed.

Under the law, Spanish manufacturers are strictly liable for the losses caused by their products. Certain companies that sell food and pharmaceuticals, as well as other products named in the law, are required to buy at least 500 million pesetas ($3.9 million) in product liability insurance to pay for the losses.

The Consumer Law is similar to the European Community's product liability directive.

However, Spanish companies are waiting for the government to pass regulations that accompany the law to force most Spanish companies to buy product liability insurance, said Mr. Lopez. "We have been waiting for two years (for the regulations) and, knowing this country, we will wait two more," he said.

As a result, not as many product liability insurance policies have been sold as the Spanish insurance market expected after the law was passed, Mr. Lopez said.

"The big companies have the insurance, but they bought the insurance before the law," he said. "There is not an important number of policies."

—By Stacy Shapiro

Reinsurance market

ZURICH, Switzerland—The reinsurance industry is keeping pace with growth in the world insurance market despite reports that the world reinsurance market has contracted, according to Swiss Reinsurance Co.'s recent review of the insurance and reinsurance industry from 1965 to 1985.

"Despite structural changes in direct insurance business—larger and larger concerns being formed by amalgamations, acquisitions and by companies raising their own capital—reinsurers have been able to maintain their own position and to some extent also strengthen it," said the Swiss Re report.

Swiss Re's report claims that the insurance market's premium volume in countries belonging to the Organization for Economic Cooperation and Development grew 10.7% annually to $265.1 billion in 1985 from $38.5 million in 1965.

worldwide

At the same time, reinsurers in OECD nations have seen their premium volume increase 10.9% annually—about the same growth rate as the insurance industry—to $40 billion in 1985 from $5.6 billion in 1965.

The reinsurance premium volume includes premiums ceded to reinsurance subsidiaries of insurance companies.

Altogether, there were 376 professional reinsurance companies in the Western world in 1985, double the number there were in 1965, according to the Swiss Re report.

North America's reinsurance market grew the most in the period, with 31.5% of reinsurance companies being based there in 1985 compared with 16% in 1965.

The reinsurance market, however, is constantly changing, the report noted. "The whole environment of the industry has altered over the past few years," said the report. Liability problems in the U.S., the sharp increase in underwriting losses and the advent of new risks such as acquired immune deficiency syndrome and environmental pollution have all added to

Continued on next page

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worldwide

Continued from previous page
this changing climate.

Swiss Re's report also claims that the growth rate of premium volume in both the insurance and reinsurance market has been generally greater than the gross national product in most countries.

—By John Parry

Belgian insurance report

BRUSSELS, Belgium—The Belgian insurance industry is inefficient, inflexible and does not cater to the needs of its customers, according to a recent report issued by the Belgian consumer association Test Achats.

Each branch of Belgian insurance industry needs to be overhauled, the report concludes.

For example, the Belgian life insurance industry is lazy and there is no real competition between companies, the report says. Premiums charged by Belgian life insurers are up to three times higher than their British counterparts and up to 30% of the premium is needed to cover administrative costs.

In the non-life areas of insurance, there have been recent changes in the Belgian insurance law with consumers in mind, according to the Office de Controle d'Assurance, the government body in charge of monitoring the industry. But, Test Achats asserts that OCA is controlled by the large insurance companies and the insurers are consulted before any changes in the law are made. However, consumer groups and the smaller insurance companies are not consulted, Test Achats says.

—By Denise Claveloux

Council of Europe

BRUSSELS, Belgium—The Council of Europe, which represents 21 European nations, has adopted a new agreement to strengthen cooperation between countries when natural or technological disasters occur that are hazardous to all European nations.

The agreement includes guidelines on the efficient use of European resources in the event of a disaster, a policy for issuing immediate warnings to the population of Europe, standardization of the vocabulary relating to disasters and the establishment of seven research and training centers.

Further meetings will be held in June and October to discuss how to implement the guidelines and to determine a budget.

—By Denise Claveloux

Jardine acquisition

SINGAPORE—Jardine Insurance Brokers Asia Ltd., the Hong Kong-based company that oversees the Asian operations of Jardine Insurance Brokers Group, has acquired Bergvall Far East Pte. Ltd., a Singapore-based insurance broker.

Bergvall Far East, which is a specialist marine insurance broker, has merged with Jardine Insurance Brokers Asia's subsidiary in Singapore, Jardine Matheson Insurance Brokers Pte. Ltd.

The new company will be called Jardine Bergvall Insurance Brokers Pte. Ltd.

Olaf Stokken will serve as managing director of Jardine Bergvall and Terence Tan will serve as general manager.

—By Stacy Shapiro

New York proposing risk retention rules

NEW YORK-The New York Insurance Department is proposing legislation to implement provisions of the federal Risk Retention Act (*BI*, Oct. 20).

Under provisions of the federal act, a risk retention group that is chartered in one state is free to operate nationwide without having to obtain prior rate and policy form approval from every state in which it does business.

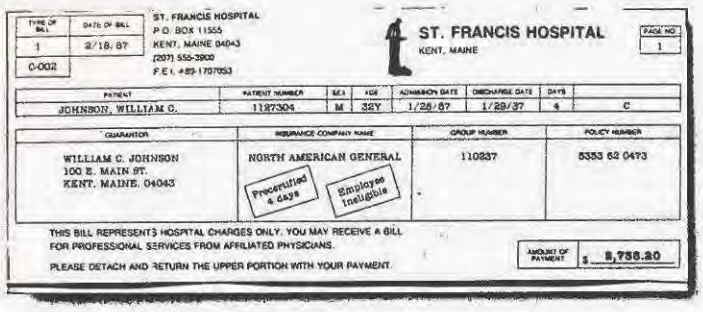
The proposed New York legislation, which is based on a model risk retention legislation adopted by the National Assn. of Insurance Commissioners, would introduce some restrictions on risk retention group operations.

For instance, one provision would prohibit New York public entities from obtaining a liability insurance policy from a risk retention group not chartered in the state or through a purchasing group.

"Because of insufficient safeguards, like unauthorized insurers, risk retention groups and purchasing groups present a real danger to public entities as well as to members of the public who may be injured as a result of municipal activities," says a statement issued by the Insurance Department in support of the legislation.

The bill also includes a provision that states that if statutory requirements cannot be satisfied by obtaining coverage from an insurer not authorized to do business in the state, these requirements cannot be satisfied either by purchasing insurance from a risk retention group not chartered in the state. ■

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Dole introduces new legislation to overhaul Medicare program

By DEBORAH SHALOWITZ

washington

WASHINGTON—Sen. Robert Dole, R-Kan., is sponsoring legislation that modifies the Reagan administration proposal to expand Medicare to cover catastrophic health care by reducing the cap on the beneficiary's annual out-of-pocket expenses to $1,800 from $2,000 (*BI*, March 23).

The bill—co-sponsored by Sens. John Danforth, R-Mo., Pete Domenici, R-N.M., David Durenberger, R-Minn., and John Chafee, R-R.I.—also would:

- Eliminate copayments for inpatient hospital services and eliminate the lifetime limit on inpatient hospital days.
- Modify the home health care benefit to permit up to 21 days of continuous care. The Reagan proposal does not include coverage for home or hospice care.
- Request that a study be done by the Institute of Medicine to determine which prescription drugs used by the elderly should be included in a list of drugs for which the cost would count toward an individual's out-of-pocket expenses. The Reagan proposal does not cover any prescription drugs.
- Ensure that an increase in the Medicare Part B premium in future years will never result in a reduction in Social Security benefits.

However, the bill does not address the financing of long-term care.

Sen. Dole said that according to the Congressional Budget Office, the increase in the Medicare Part B monthly premium—which covers physician services for inpatient hospital stays—needed to cover the Reagan administration's proposal would be $6.40, not $4.92, as originally proposed (*BI*, March 23). And if the $6.40 figure is used as a base, then the bill would result in a monthly premium increase of $8.70, to be added to the current Part B premium of $17.90.

PBGC funds

Fears that record deficits at the Pension Benefit Guaranty Corp. will deplete the agency's assets are confirmed in the PBGC's recently released annual report.

According to the report, the PBGC will use up all of the funds for its single-employer programs meeting benefits obligations in fiscal year 2003.

Based on two assumptions about the size of future claims, the report projects that the PBGC's revolving fund, which includes premium revenue plus investment income on the funds, would be available to pay benefits only through fiscal year 1989. When the revolving fund is depleted, the PBGC would have to begin using assets in its trust fund to meet benefit obligations. By 2003, assets in the fund would be depleted.

In fiscal 1986, which ended Sept. 30, the PBGC had a record deficit of $3.8 billion. Liabilities were $5.6 billion and assets were $1.8 billion.

This deficit could rise to $10 billion in the next few years, according to members of the PBGC Advisory Committee (*BI*, March 23).

"The PBGC is running out of money," warned Kathleen P. Utgoff, executive director of the agency. "Its financial crisis poses a serious threat to the future of the pension insurance program."

To address these problems, the Reagan administration has proposed legislative changes in minimum funding standards and the premium structure (*BI*, March 30).

In fiscal year 1986, the PBGC became the trustee of 120 terminated single-employer plans. A total of 1,345 single-employer plans are now in trusteeship or pending trusteeship.

The agency's single-employer program paid approximately $260.5 million in benefits to 90,750 retirees and participants of plans that have terminated; another 3,250 retirees received a total of $3.3 million in benefits from the PBGC's multiemployer program in 1986, according to the report.

Product liability bill

Rep. Stewart B. McKinney, R-

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washington

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Conn., introduced federal product liability legislation similar in many respects to a package of reforms proposed by the Reagan administration in its trade competitiveness package, but it also includes a $250,000 cap on non-economic damages, including punitive damages.

The Reagan proposal has a cap of $200,000 on non-economic damages, including punitive damages (*BI*, March 2).

Rep. McKinney's bill, H.R. 1599, would:

- Adopt an "unreasonably dangerous" standard of liability for manufacturers. However, a manufacturer's liability would be mitigated by "unreasonable misuse" of the product, and could be absolved entirely if the damage was the result of the injured party's negligence.
- Eliminate joint and several liability, except if defendants acted in concert.
- Offset awards by collateral sources of income, including workers compensation benefits.
- Limit plaintiffs' attorneys' contingency fees according to a sliding scale.

Under the scale, fees would be limited to 25% of the first $100,000 of an award, 20% of the next $100,000, 15% of the succeeding $100,000 and 10% of any amount exceeding $300,000.

IRS reforms

Sen. David Pryor, D-Ark., plans to introduce legislation in late April that would encourage small businesses to establish pension plans by amending current Internal Revenue Service rules.

The legislation would:

- Give small businesses a tax credit for maintaining qualified pension plans.
- Repeal the top-heavy rules of Internal Revenue Code Section 416.
- Extend the effective dates for certain provisions of the 1986 Tax Reform Act.

The IRS code would be amended to provide an administrative cost tax credit to employers with 250 or fewer employees, according to Jeff Trinca, a legislative aide to Sen. Pryor.

Mr. Trinca explained that the tax credit would help alleviate the higher administrative costs associated with running a small business and give those employers an incentive to set up employee pension plans.

The tax credit would either be $3,000 ($4,500 for defined benefit plans) or an amount equal to 4% of contributions to non-highly compensated employees, whichever is less.

A non-highly compensated employee cannot be an owner of the business, earn more than $70,000 per year or earn more $50,000 per year if he is among the highest-paid 20% of employees. Also, the plan would have to offer three-year vesting to be eligible for the tax credit.

The credit would not be available for salary reduction plans such as 401(k) plans, unless the employer matches an employee's contribution.

The bill would repeal the top-heavy rules of the IRS code that were adopted in 1982 to prevent employers from setting up a pension plan that excludes non-highly compensated employees.

Mr. Trinca said that Sen. Pryor supports that policy, but said provisions in the 1986 Tax Reform Act will have the same effect.

Pension deadline

Eligible former spouses of federal employees will lose their retirement and health benefits unless they sign up for them before May 9.

According to the Pension Rights Center, a non-profit education group based in Washington, eligible, former spouses have a one-time chance to apply for "widow's pensions" thanks to a little-known provision in the Civil Service Retirement Spouse Equity Act.

This law—which went into effect on May 7, 1985—mainly protects those divorced after that date, but also allows spouses divorced before that time to sign up for survivors benefits.

To be eligible, women must:

- Be at least 50 years old and not remarried before age 55.
- Have been married for at least 10 years during the federal employee's government service.
- Have been married to a federal employee that retired or was eligible to retire before May 7, 1985.
- Have been divorced after Sept. 14, 1978. If the divorce occurred before that date, this special pension is payable only if the federal employee did not choose someone else to receive the survivor pension.

Those questioning their eligibility for this program can contact the U.S. Office of Personnel Management, Employee Service and Records Center, Attention: Spouse Equity Act Coordinator, Boyers, Pa. 16017; 412-794-8442.

AIA changes

Two former Senate staffers have been elected to join the American Insurance Assn.

David J. Pratt, U.S. Senate secretary to the majority, will join the AIA as vp-federal affairs and Richard S. Fitzsimmons, former legislative assistant for Sen. J. James Exon, D-Neb., will become a legislative assistant for the organization.

Mr. Pratt was elected by the Senate to be secretary of the minority in 1985 and secretary of the majority in 1987.

Before his tenure as a Senate staffer, Mr. Pratt directed legislative activities in the office of Sen. Robert C. Byrd, D-W.Va., currently minority leader of the Senate. In his four years there, Mr. Pratt concentrated on issues involving taxes, energy and commerce.

Prior to 1979, Mr. Fitzsimmons was deputy director of the Nebraska Department of Agriculture.

New ECFC head

Donald F. Crowley has been elected president of The Employers Council on Flexible Compensation.

Mr. Crowley is a senior vp at the Chemical Bank in New York, where he supervises compensation, benefits, medical personnel systems and operations and European personnel. Previously, Mr. Crowley worked in the personnel department at Xerox Corp. in Stamford Conn.

In addition, Susan Ward Mink, vp and director of human resources services for Morgan Stanley & Co. Inc. in New York, was elected vp of the ECFC.

Prior to working at Morgan Stanley, Ms. Mink was the manager of worldwide benefits administration for Avon Products Inc. in New York.

The ECFC is a Washington-based non-profit membership organization of more than 190 employers who provide their employees with 401(k) plans, cafeteria plans and other elective employee benefit arrangements. ■

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New Deere pact includes benefit changes

A new contract between Moline, Ill.-based Deere & Co. and the United Auto Workers union includes pension improvements, an early retirement plan and changes in health benefits.

The agreement, which is effective until Sept. 31, 1988, covers about 12,000 active workers and about 10,000 laid-off workers in six states.

The agreement was ratified by 84% of the members of 14 union locals.

Under the agreement, workers who retired prior to May 31, 1986, will receive a monthly benefit increase of $1 per year of credited service under the company's defined benefit pension plan over the term of the agreement.

They also will receive two lump-sum payments of $200 each in April and December of this year, said Stephen B. Clark, administrator of deferred compensation plans for Deere.

Workers who retire after May 31, 1986 will receive a monthly pension benefit increase of $3.05 per year of credited service.

The union also negotiated a special early retirement benefit for workers who are at least 55 years old and whose combination of age and years of service total 84. The early retirement program also would apply to employees who are age 60 and have 10 or more years of service, Mr. Clark said.

Under the program, workers must decide whether to accept the early retirement offer between Aug. 1 and Sept. 1. If they accept the offer, they will receive their current accumulated pension credits and a special supplementary benefit of $18 per month for each year of service, up to a monthly maximum of $540. The supplementary benefit will be paid until workers reach age 62 and become eligible for Social Security benefits.

In addition to pension changes, the company and the union also negotiated changes in health benefits.

Under the first-dollar self-insured plan, workers now will be required to have pre-admission tests performed in a physician's office, said Mel Scott, manager of health benefits.

Previously, workers had tests performed in hospital outpatient centers.

And, beginning June 1, Deere will implement changes to its prescription drug plan, he said.

Currently, workers pay a $2 deductible if they use a generic equivalent to their prescription drugs. If they use brand-name drugs, they pay a $3 deductible.

Under a new system, Deere will rank prescription drugs according to their regular prices. If workers choose a brand name drug in the lower 80th percentile of the ranking, which are the lower-priced drugs, they will pay a $2 deductible. However, if they choose drugs above this percentile, they will pay a $5 deductible, Mr. Scott explained.

Also beginning in June, Deere will implement a mail-order drug program for maintenance drugs that are purchased in 100-day supplies. These types of drugs include insulin or high blood pressure medication.

Final details of this plan have not been worked out, Mr. Scott said.

The Deere benefit plan now will cover speech therapy and glucose monitors for diabetics.

The company also implemented a new "birthday rule" under the benefit plan. "Normally, when two spouses work and have health coverage, the responsibility for covering dependent children usually is assigned to the male spouse's coverage. Now, we will consider which spouse's birthday occurs earliest in the year and assign the dependent coverage to that spouse." Mr. Scott said.

The company currently has a voluntary second surgical opinion program. Deere does not have a pre-admission review program, but the company is considering implenting a program in the future, he said.

benefit beat

Utilization review

Standard Oil Co. in Cleveland hopes to realize substantial health care cost savings by implementing a utilization review program.

The company's ReviewPLUS program applies to more than 15,000 employees covered under three different benefit plans nationwide, said Thomas Emerick, manager, insurance plans for the company. The program is administered by Minneapolis-based Health Risk Management Inc.

Included in the program is pre-admission review, concurrent review, a second surgical opinion program and hospital bill review, he said.

In addition, ReviewPLUS includes case-by-case fee negotiations with physicians and hospitals before an employee enters the hospital.

Employees pay a penalty or their coverage is reduced if they do not follow the procedures of the review program, Mr. Emerick said.

For example, if employees do not have a non-emergency hospital admission reviewed, they pay a $200 penalty.

In addition, if an employee enters the hospital after a reviewer determines the admission is unnecessary, the employee could be responsible for paying 50% of the costs, up to a maximum out-of-pocket expense of $2,000, he said.

The benefit plans covered by the review program have varying deductibles and copayments, Mr. Emerick said.

The company used a comprehensive communication program to introduce ReviewPLUS last year, which was effective last October, he said.

"We also implemented some special health education programs," Mr. Emerick said.

While Mr. Emerick would not reveal annual costs of the three benefit plans covered by the review program, he said he expects the plan to help employees become more educated health care consumers.

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Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Donna DiBlase, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

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Employers Give PPOs Good Marks for Cost Effectiveness.

PPO penetration seen nearly doubling by 1988.

An average of 15 percent of the nation's employers utilized Preferred Provider Organizations in 1986 and an additional 12 percent plan to offer employees a PPO option in 1987, according to a survey of 1,466 employers in 36 states conducted by the Johnson & Higgins HealthGroup.

Corporations offering PPOs report reductions in total hospital costs averaging 11.4 percent nationally. The average reduction in total physician cost was 9.5 percent. To motivate employees to use a PPO, 85 percent of respondents utilized some form of financial incentive.

The findings on PPOs contrast sharply with employer attitudes toward the cost effectiveness of Health Maintenance Organizations. A total of 58 percent of employers either disagreed with the statement that "HMOs are effective in controlling costs," or were unable to form a positive opinion.

The 1986 J&H HealthGroup survey, conducted with the assistance of 62 business coalitions, also uncovered significant regional variations in the approach of employers toward utilizing alternative health care delivery systems. For example, 37 percent of employers in the Pacific Region contract with PPOs compared with a low of 7 percent in the mid-Atlantic Region.

The survey suggests that employers most successful in controlling and reducing health care expenditures are those that aggressively arrange an integrated package of finance and delivery systems. J&H Benefit Consultants can assist as follows:

- Evaluating cost effectiveness of PPOs and HMOs.
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- Negotiating cost-effective contracts with providers.
- Actuarial analyses of plan utilization patterns.
- Interpreting HMO and PPO legislative developments.

For more on PPOs, HMOs and other health care issues, call a Benefit Consultant at your J&H office, or Rich Murdock at the J&H HealthGroup, 609-520-2292.

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Insurer insolvency stings nightclub

By STEVE TARAVELLA

LOS ANGELES—Some businesses that purchase coverage from insurers that later go broke may suffer because of the insurer's insolvency for several years to come.

That's the experience of Chippendales, the Los Angeles nightclub known nationally for its male dance revues. Chippendales purchased general liability insurance from Bermuda-based Mentor Insurance Ltd. in 1983 and 1984 and still is suffering from that decision.

Mentor, a captive of Ocean Drilling & Exploration Co., was placed in liquidation in 1985. Mentor's insolvency could be as large as $474.2 million, according to a recent report from its liquidators.

Mentor's inability to respond to liability claims submitted by Chippendales was one reason the club's parent—Easebe Enterprises—recently sought Chapter 11 bankruptcy protection, says Steve Banerjee, Easebe's president.

Mentor provided Chippendales with comprehensive general liability coverage in 1983 and 1984 with $500,000 limits per occurrence. The coverage, arranged by Michael A. Hanen, a Beverly Hills independent broker, was issued by Worldsurance Inc., a Financial Guardian Group unit that discontinued wholesale brokerage operations two years ago.

"I wasn't sophisticated enough to know this could happen to me," says Mr. Banerjee. "I'm stuck with all the exposure I paid premium for."

Because of Mentor's inability to pay, Chippendales faces about 20 claims seeking several million dollars, not to mention legal fees, he estimates.

Chippendales drew a heavy volume of liability claims, says Mr. Banerjee, who suspects its high-profile name "definitely made it a target" for lawsuits. Mr. Hanen says that, at times, one or two claims were being filed monthly.

Among the claims Chippendales has been hit with are: a slip-and-fall suit by an elderly woman who fell on a stairwell; a suit by an employee who, battered by a co-worker, charged the club with providing unsafe working conditions by hiring an employee it should have known was violent; and discrimination suits by men who sought entrance to the traditionally women-only club.

Besides the flagship club in Los Angeles, there are Chippendales clubs in New York and Dallas. The company also performs its trademark shows in Denver and San Francisco.

Until Mentor's financial problems became severe in early 1985, the insurer paid out on many claims submitted by Chippendales, Mr. Hanen says. But many claims remain and since Mentor was not an admitted or approved insurer in the states, Chippendales cannot turn to state property/casualty guaranty funds for payment. Chippendales has since found replacement insurance placed by North Hollywood broker, Booth & Simpson.

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comings & goings: industry

Cheek named senior vp at Crum & Forster Corp.

Leslie Cheek III has been named senior vp-federal affairs at Crum & Forster Corp. in Washington.


Mr. Cheek

Mr. Cheek, formerly vp-federal affairs, will continue to represent the insurer before Congress and regulatory agencies.

In other insurer changes:

Richard J. Williams elected senior vp-staff underwriting for Allendale Mutual Insurance Co. in Johnston, R.I. Mr. Williams joined the company in 1984 as vp-regional operations from American International Group Inc. in New York.


Mr. Williams

Also at Allendale, **David E. Blake**, **Kenneth E. Devlin** and **Brian J. Hurley** elected senior vps of the southern region, western region and Canadian operations, respectively. Previously, Mr. Blake was a vp and regional manager of the southern region, which is based in Atlanta. Mr. Devlin was a vp and regional manager of the western region, based in Woodland Hills, Calif. Prior to his promotion, Mr. Hurley was vp and manager of the Canadian operations in Toronto.


Mr. Blake


Mr. Devlin


Mr. Hurley

Nicholas K. Moy appointed vp in the general obligation, leases and special tax division of the risk underwriting area at Bond Investors Guaranty Co. in New York. Previously, Mr. Moy served as vp municipal underwriting of AMBAC Indemnity Corp. in Milwaukee.

Frank Ceraolo promoted to senior vp at Beaver Insurance Co. in San Francisco. Previously a vp, Mr. Ceraolo will be responsible for operations in Southern California. He joined the company in 1979 as Southern California region marketing manager.

Also at Beaver in San Francisco, **Robert M. Hunt** joined as resident vp of the northern region. Most recently, Mr. Hunt was regional manager of Cypress Insurance Co. in Pasadena.

John F. Kirby joined Continental Insurance Co. in New York as senior vp in the brokerage and special operations group. He is responsible for the staff functions of the operating group. Most recently, Mr. Kirby served as senior vp-reinsurance for Chubb & Son Inc. in Warren, N.J.

Agents/brokers

Thomas J. Sklens named executive vp and chief operating officer of Fred S. James & Co. Inc. of New York. Previously senior vp-marketing, Mr. Sklens now will oversee all operating divisions of the New York branch.

Since joining the company in 1972, Mr. Sklens has held management positions in the marine, production and marketing divisions.

Paul Weitz appointed vp and account executive in the research division of Frank B. Hall & Co. of Massachusetts Inc. in Boston. The research division provides professional and technical expertise to large, corporate clients. Previously, Mr. Weitz was chief executive officer of Bayly, Martin & Fay of Massachusetts Inc. and later executive vp of the parent company, Bayly, Martin & Fay International Inc.


Mr. Weitz

David R. Smith named senior vp of Marsh & McLennan Inc. in St. Louis. Previously, Mr. Smith was vp and treasurer for Lawton-Byrne-Bruner and served on the broker's executive committee. Lawton-Byrne-Bruner merged with Marsh & McLennan in January.

HMOs/PPOs

Dr. Bertram S. Brown, formerly president and chief executive officer of Hahnemann University in Philadelphia, has been named senior vp of U.S. Healthcare Inc. in Blue Bell, Pa. Dr. Brown will oversee the development of new products. U.S. Healthcare operates HMOs in Pennsylvania, New Jersey, New York and Connecticut.

Thomas C. Kahler promoted to vp-underwriting and actuarial services of Delta Dental Plan of New Jersey Inc. in Parsippany from assistant vp-actuarial services. Mr. Kahler joined the company in 1978 and also serves on the National Actuarial and Product Development Committee of the Delta Dental Plans Assn. Delta Dental is one of New Jersey's largest providers of prepaid group dental coverage.

Excess/surplus

Roger A. Quigley joined Crum & Forster Managers Corp. in Chicago as senior vp and chief underwriting officer. In addition, Mr. Quigley will serve as a director of International Surplus Lines Insurance Co. Previously, Mr. Quigley was vp-excess and special risk underwriting at the Basking Ridge, N.J. office.

Other suppliers

James F. Cerone named director of the newly formed claims management department at Milliman & Robertson Inc. in Chicago. Prior to his appointment, Mr. Cerone served as vp and consultant to the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. and Kramer Capital Consultants Inc.

Thomas Coulter and **Mindy Fox** have joined Coopers & Lybrand Actuarial, Benefits and Compensation Group in New York. Previously, Mr. Coulter was a vp and consulting actuary for Johnson & Higgins in New York. Ms. Fox previously was vp-national accounts for Blue Cross & Blue Shield in New York. ■

comings & goings: buyers

Victor F. Weaver Inc. names risk manager

Thomas Verghese has been promoted to director-credit and risk management at Victor F. Weaver Inc. in New Holland, Pa. In this position he will direct property/casualty insurance, financial credit and accounts receivable activities for Weaver, which produces convenience foods and poultry products. Mr. Verghese reports to R. James Lafferty, vp-finance and treasurer. Most recently, Mr. Verghese served as manager of credit and collections. He joined Weaver in 1977 as production supervisor. Mr. Verghese received a bachelor of business administration degree from Eastern Mennonite College in Harrisonburg, Va., and a master of business administration degree from James Madison University, also in Harrisonburg. He is a deputy member of the Risk & Insurance Management Society.



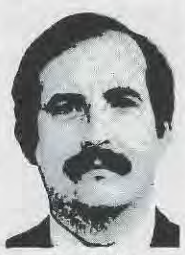
Mr. Verghese

* * *

Timothy M. Walker, 35, named corporate risk control manager at Denny's Inc., the national restaurant chain based in La Mirada, Calif. In this newly created position he will be responsible for loss prevention and loss control programs at Denny's and its subsidiaries. This includes supervising Denny's self-insured property, liability and workers compensation programs, as well as developing safety programs. Mr. Walker reports to Norma Baker, director of risk management. He was previously senior safety and health consultant at Zenith Insurance Co. in San Diego. He received a master of science degree in industrial safety management from West Virginia University in Morgantown.

* * *

Richard S. Wells, 35, has been named risk management administrator at Service Merchandise Co. Inc. in Nashville, Tenn. In this position, he will focus on the identification and analysis of risk exposures and the marketing of insurance coverages. Mr. Wells replaces **Randy Hindman**, who left Service Merchandise to join Batus Corp. in Louisville, Ky. Mr. Wells reports to Thomas A. Ainsworth, director of risk management. Prior to joining Service Merchandise—which is a national retailer of toys, sporting goods, housewares, gift goods and jewelry—Mr. Wells served as a commercial production underwriter with the Reliance Insurance Co. in Nashville. He received a bachelor of science degree in business administration from David Lipscomb College in Nashville. He holds the Certified Insurance Counselor designation and is working toward the Associate in Risk Management and Chartered Property & Casualty Underwriter designations.



Mr. Wells

* * *

Linda Zingsheim, 44, has been named insurance administrator in the corporate risk management department of Ryder System Inc. in Miami. In this position she is involved in workers compensation, surety bonds and coordination and expansion of Ryder's self-insurance programs. She replaces **Diane White**, who has transferred to one of Ryder's managing general agents, Southern Underwriters Inc., and reports to Richard R. Cote, corporate risk manager. Previously Ms. Zingsheim was supervisor-insurance administration at Jartran Inc. in Miami.

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We'd like to report on staff changes in your company's risk management, safety or employee benefits department. Contact Paul Winston, assistant copy editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5442. Please send a photograph, too.

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update

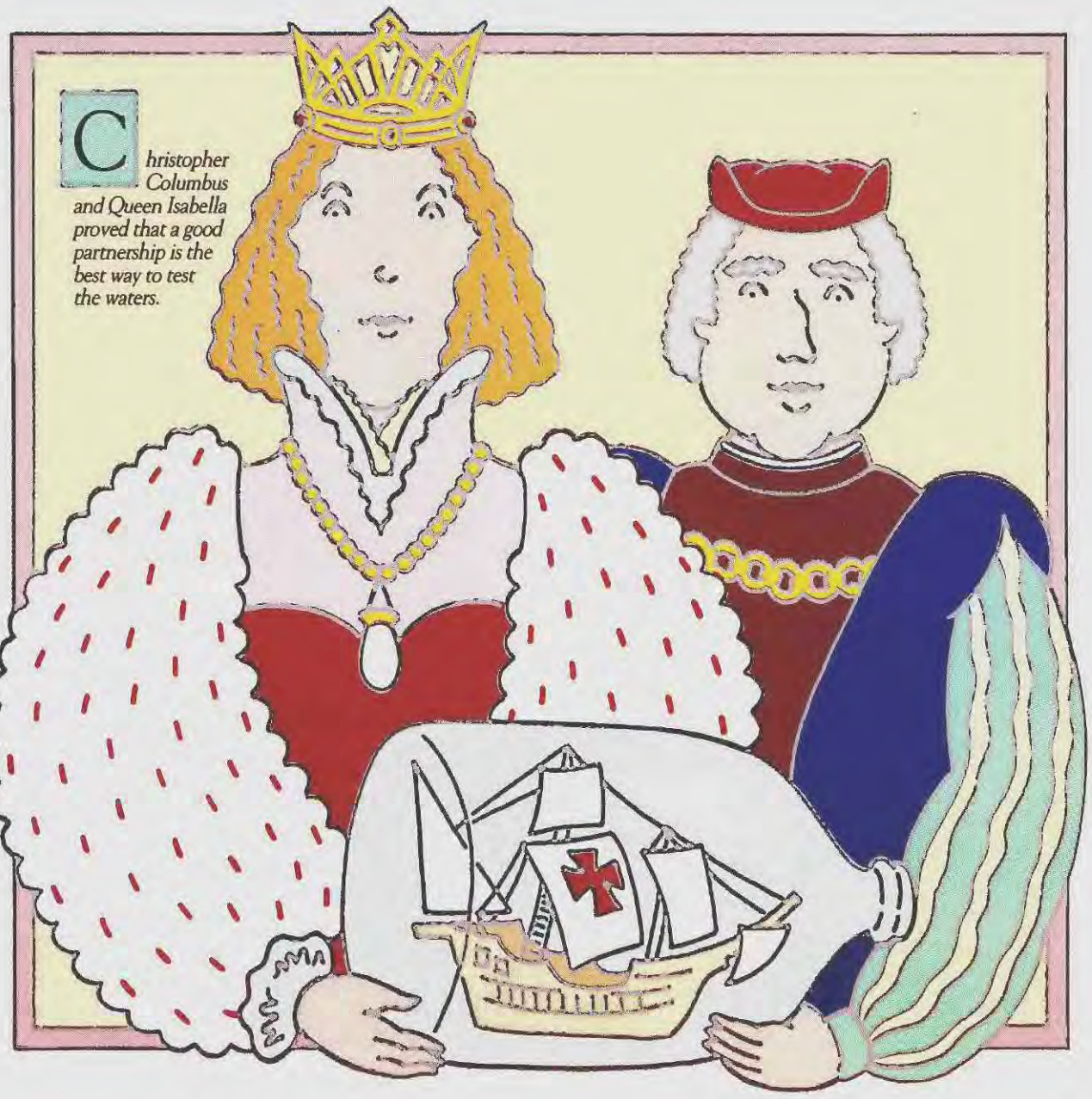
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Cover tight, pricey: Studies

By DOUGLAS McLEOD

NEW YORK—Two studies released last month confirm what risk managers have known for some time: While the commercial insurance crisis may have hit its peak, it has left insurance buyers with significantly more restrictive and expensive coverage.

A survey by the Risk & Insurance Management Society has found more corporations moving away from the conventional insurance market, while some long-tail liability coverages placed with commercial insurers are increasingly written on a claims-made form.

A separate study by the U.S. Department of Justice blames the liability crisis primarily on the tort liability system and suggests that state legislatures make further tort reforms.

The RIMS survey found that although some signs of improvement emerged in the second half of 1986, insurance market conditions generally continued to deteriorate last year. Results were based on 1,128 responses—29% of those receiving questionnaires—with responding companies ranging in size from $10 million to $10 billion in annual revenues.

Among the survey's findings:

- "Significant" availability problems continued for environmental impairment liability, directors and officers liability, umbrella/excess liability and flood and earthquake coverages.
- More companies moved away from the conventional insurance market: Overall, 18% of the respondents joined alternative risk financing vehicles, including 49% of the water and gas utilities and 47% of the chemical, oil and rubber manufacturers. Formal self-insurance programs for general liability were introduced by 8% of the respondents, while 6% introduced self-insurance programs for workers comp.
- The number of respondents with claims-made coverage in their excess liability programs increased to 33% last year from 17% in 1985. Claims-made excess coverage was purchased last year by 77% of the chemical, oil and rubber companies, 74% of non-electrical utilities, 72% of electrical utilities and 51% of agricultural, forestry and mining companies.
- Some 32% of U.S. respondents and 21% of Canadian respondents saw premium increases of more than 100% for umbrella/excess coverage, while 48% of U.S. respondents and 57% of Canadian respondents saw premiums jump more than 100% for D&O coverage.

The Justice Department study found that while insurance problems have ameliorated, the cost of liability coverage remains high. Greater availability and price stability, however, have resulted in part from increased self-insurance, higher deductibles, lower coverage limits and more restrictive policy conditions.

The Justice Department study, an update of a February 1986 report, also concluded that state tort reform legislation has a direct impact on the availability and affordability of insurance, based on a comparison of the malpractice insurance market in California—which has adopted a "rigorous" malpractice reform statute—with those in Florida and New York, which have not. ■

datebook

APRIL 6-8. Property Loss Managers Conference in San Diego, Calif., sponsored by the Property Loss Research Bureau; $75 for PLRB member company personnel; $200 for others. Judith Bollman, Property Loss Research Bureau, 1501 Woodfield Road, Suite 400W, Schaumburg, Ill. 60173-4978.

APRIL 6-10. Safety in Chemical Operations course in Chicago, sponsored by the Chemical Section of the National Safety Council, Industrial Division $655 NSC members; $815 non-members. National Safety Council, 444 N. Michigan, Chicago, Ill. 60611; 312-527-4800.

APRIL 6-10. Modern Safety Management course in Boston, sponsored by the International Loss Control Institute; $695. **Also April 27-May 1** in Atlanta. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

APRIL 7. The Risk Bearing Phenomenon—Alternatives to Traditional Insurance workshop in Schiller Park, Ill., sponsored by the Society of Chartered Property & Casualty Underwriters; $125 for Society members; $150 for non-members. **Also April 15** in Tampa, Fla., **May 5** in Pittsburgh. Mari Jennings, The Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

APRIL 7-10. Joint Meeting of the Independent Reinsurance Underwriters Assn. Inc. and Reinsurance Brokers in Wesley Chapel, Fla.; $250 plus room deposit. Robert L. Sias, Convention Manager, Independent Reinsurance Underwriters Assn., 210 Canterbury Circle, New Smyrna Beach, Fla. 32069; 904-427-2231.

APRIL 8-9. Latest Developments In: Arbitrating and Litigating Disputed Insurance and Reinsurance Agreements conference in New York, sponsored by Executive Enterprises Inc.; $875 for first registrant; $775 for second registrant from same organization; $650 for third or more registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

APRIL 8-9. How to Use the Risk Retention Act of 1986 symposium in San Francisco, sponsored by the Risk Management Section of the Chartered Property & Casualty Underwriters; $200 for society members; $250 for non-members. **Also April 21-22** in New York, **May 13-14** in Chicago. Julie Ann Juliana, The Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2735.

APRIL 8-10. Financial Aspects of Contracting or Provider Services seminar in Chicago, sponsored by the Group Health Foundation, the educational affiliate of the Group Health Assn. of America; $370 for GHAA members; $445 for GHAA non-members. Group Health Foundation, 1129 20th St. N.W., Washington, D.C. 20036; 202-778-3228.

APRIL 9. ISO Commercial Property Rating workshop in Blue Bell, Pa., sponsored by the Insurance Society of Philadelphia and Delaware Tech; $105 for members; $120 for non-members. **Also April 21** in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

APRIL 9. How to Use the Risk Retention Act of 1986 symposium in San Francisco, sponsored by the Society of Chartered Property & Casualty Underwriters; $20 for Society members; $250 for non-members. **Also April 21-22** in New York, **May 13-14** in Chicago. Julie Ann Juliana, The Society of CPCU, Kahler Hall, 720 Providence Road CB#9, Malvern, Pa. 19355; 215-251-2735.

APRIL 13-14. Health Care Cost Containment workshop in Orlando, Fla.,sponsored by the Health Research Institute; $495. **Also May 11-12** in Houston; **June 1-2** in Chicago; **June 22-23** in Philadelphia; **July 27-28** in Honolulu; **Aug. 17-18** in San Diego; **Sept. 14-15** in Cleveland; **Oct. 5-6** in Boston; **Oct. 26-27** in San Francisco; **Nov.9-10** in New York; and **Dec. 7-8** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 13-14. Health Policy Conference in Washington, sponsored by the American Medical Care & Review Assn.; before March 23: $375 AMCRA members, $475 for non-members; after March 23: $425 for AMCRA members, $550 for non-members. American Medical Care & Review Assn., 5410 Grosvenor Lane, Suite 210, Bethesda, Md. 20814.

APRIL 15. Advanced "Post Graduate" Cost Management workshop in Orlando, Fla.,sponsored by the Health Research Institute; $250. **Also May 13** in Houston; **June 3** in Chicago; **June 24** in Philadelphia; **July 29** in Honolulu; **Aug. 19** in San Diego; **Sept. 16** in Cleveland; **Oct. 7** in Boston; **Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 15. ISO Commercial General Liability Policy workshop in Blue Bell, Pa., sponsored by Insurance Society of Philadelphia and Delaware Tech; $105 members; $120 non-members. **Also May 14** in Philadelphia. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

APRIL 16. Assessing Vendors (HMOs, PPOs, Utilization Review Firms, etc.) workshop in Orlando, Fla., sponsored by the Health Research Institute; $250. **Also June 4** in Chicago; **June 25** in Philadelphia; **July 30** in Honolulu; **Aug. 20** in San Diego; **Sept. 17** in Cleveland; **Oct. 8** in Boston; **Oct. 29** in San Francisco; **Nov. 12** in New York; and **Dec. 10** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 16. Coping with COBRA seminar in Springfield, Ill., sponsored by the Ilinois State Chamber of Commerce; $45 for ISCC members; $70 for non-members. **Also April 30** in Chicago. Carol Jensen, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

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APRIL 16. Cost Containment Through Communications and Education workshop in Orlando, Fla., sponsored by the Health Research Institute; $250. **Also June 4** in Chicago; **June 25** in Philadelphia; **July 30** in Honolulu; **Aug. 20** in San Diego; **Sept. 17** in Cleveland; **Oct. 8** in Boston; **Oct. 29** in San Francisco; **Nov. 12** in New York; and **Dec. 10** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 16-17. Labor/Management Cost Containment workshop in Orlando, Fla., sponsored by the Health Research Institute; $495. **Also June 4-5** in Chicago; **June 25-26** in Philadelphia; **July 30-31** in Honolulu; **Aug. 20-21** in San Diego; **Sept. 17-18** in Cleveland; **Oct. 8-9** in Boston; **Nov. 12-13** in New York; and **Dec. 10-11** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

APRIL 21-22. Advanced Safety Management seminar in Phoenix, Ariz., $295. Dr. Rick Summers, Waite Hill Services Inc., P.O. Box 5816, Kingwood, Texas 77325; 713-358-0949.

APRIL 21-22. Insurance Claims for Environmental Damages: Technical and Legal Considerations conference in Washington, sponsored by Executive Enterprises Inc.; $875 for first registrant; $775 for second registrant from same organization; $650 for third or more registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

APRIL 21-23. Laboratory Safety course in Chicago, sponsored by the Research & Development Section of the National Safety Council, Industrial Division; $415 for NSC members; $520 for non-members. National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

APRIL 21-24. Reinsurance Accounting and Finance for Ceders and Assumers seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,295 (includes lodging and meals). **Also Sept. 8-11.** Robert W. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 914-832-9384 or 212-677-5974.

APRIL 23-24. New Issues in Public Sector Employee Benefits conference in Washington, co-sponsored by Pension Commission Clearinghouse and Johnson & Higgins Edward H. Friend & Co. division; $250. Laura S. Horvath, J&H/Edward H. Friend & Co. Division, 1800 K St. N.W., Suite 500, Washington, D.C. 20006; 202-785-9080.

APRIL 26-29. Sixth Annual Conference on Employee Benefits in Scottsdale, Ariz., sponsored by the State and Local Government Benefits Assn.; $120 for State and Local Government Benefits Assn. members; $140 for non-members. George L. Morawski, State of Arizona, 1831 W. Jefferson, Phoenix, Ariz. 85007; 602-255-5482, ext. 263.

APRIL 28. Questions on the New CGL and CP Policies? Ask the Claims Department! workshop in Ashville, N.C., sponsored by the Society of Chartered Property & Casualty Underwriters; $80 for society members; $95 for non-members. Mari Jennings, professional services coordinator, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

APRIL 28. Surety Claims '87 Conference in Chicago, sponsored by the CMA Consulting Group; $195. **Also May 1** in San Francisco, **May 5** in Philadelphia. Beverly Loughlin, CMA Consulting Group, Box 2287, Morristown, N.J. 07960; 201-267-7171.

APRIL 30-MAY 1. Workers Compensation: The Changing Character of State Systems conference in Storrs, Conn., co-sponsored by the University of Connecticut, Cornell University, Rutgers University and Syracuse University; $150. The University of Connecticut, Non-credit Programs, U-56, 1 Bishop Place, Storrs, Conn. 06268.

APRIL 30-MAY 1. SEC Accounting & Financial Reporting for Property/Casualty Insurance Companies conference in New York, sponsored by Executive Enterprises Inc.; $875 for first registrant; $775 for second registrant from same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 within New York; 800-831-8333 outside New York.

MAY 3-6. Corporate Benefits Management Conference in Dallas, Calif., sponsored by the International Foundation of Employee Benefit Plans; if received 60 days prior to meeting date: $560 for IFEBP members, $635 for non-members; regular rate: $605 for IFEBP members, $680 for non-members. **Also June 22-25** in Lake Tahoe, Nev. International Foundation of Employee Benefit Plans, Registration Department, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

MAY 4-5. Insurance Ratings conference in Hilton Head Island, S.C., sponsored by Standard & Poor's Corp.; $500. Standard & Poor's Corp., 25 Broadway, New York, N.Y. 10004

MAY 4-5. Recovering Uncollectable Reinsurance conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for additional registrant from the same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7880; 800-223-0787 outside New York; 800-831-8333 within New York.

MAY 5. Flood Insurance: The Neglected Market workshop in Philadelphia, co-sponsored by the Insurance Society of Philadelphia and Delaware Tech; $55 for members; $65 for non-members. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

MAY 5-8. 50th Anniversary Annual Meeting of the National Assn. of Independent Insurance Adjusters: Golden Year-Investment in Excellence convention in Orlando, Fla.; $200 for National Assn. of Independent Insurance Adjusters members/guests; $100 for spouse. National Assn. of Independent Insurance Adjusters, 222 W. Adams St., Chicago, Ill. 60606; 312-853-0808.

MAY 6. Workers Compensation Course in New York, sponsored by The College of Insurance; $195 for college sponsors; $215 for non-sponsors. The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

MAY 6-7. Hurricane and Windstorm Catastrophe workshop in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 373.75 pounds (approx. $590.50). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175.

MAY 6-8. Insurance Coverage, Practice & Risk Management seminar in Chicago, sponsored by the Defense Research Institute Inc.; $395 for Defense Research Institute members; $420 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

MAY 6-8. The Future of Voluntary Benefits conference in Washington, sponsored by the Assn. of Private Pension and Welfare Plans; before April 22: $400 for APPWP members, $500 for non-members; after April 22: $425 for APPWP members, $525 for non-members. Sue Ransom, Assn. of Private Pension and Welfare Plans, 1331 Pennsylvania Ave. N.W., Suite 719, Washington, D.C. 20004; 202-737-6666.

MAY 7. Facultative Reinsurance-An Update (How to Succeed in the Current Market) workshop in Hartford, Conn., and Los Angles, sponsored by the Society of Chartered Property & Casualty Underwriters; $125 for society members; $150 for non-members. **Also May 14** in Kansas City, Mo. Mari Jennings, professional services coordinator, Society of Chartered Property & Casualty Underwriters, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

MAY 11. Employee Benefit Plans seminar in Chicago, sponsored by the Illinois State Chamber of Commerce; $90 for Illinois State Chamber of Commerce members; $135 for non-members. **Also April 30** in Chicago. Carol Jensen, Illinois State Chamber of Commerce, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

MAY 13. Health Improvement/Wellness workshop in Houston, sponsored by the Health Research Institute; $250. **Also June 3** in Chicago; **July 29** in Honolulu; **Aug. 19** in San Diego; **Oct. 7** in Boston; **Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

MAY 13. Fundamentals of Insurance course in San Diego, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. Fran Jordan, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MAY 13-15. Techniques of Loss Control course in New York, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. **Also June 3-5** in Honolulu. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

MAY 14-15. Brief Course in Reinsurance in New York, sponsored by The College of Insurance; $165. The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

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Satellite success won't cut rates: Broker

By CAROLYN ALDRED and STACY SHAPIRO

london

LONDON—The successful launch of an insured satellite late last month will not have any major impact on launch insurance rates, says a London satellite broker.

Rates will remain between 25% to 30% of the insured value until there are a few more successful launches, confirmed Brian Moore, managing director of Bowring Space Projects Ltd.

"If it had been a loss, it would have had a dreadful impact (on the satellite market)," he said. "But, because it is successful, it doesn't have the same impact.

"One would like to think successful launches are the norm. It was a relief after so many problems. . .what we need is a few more successes."

On March 19, the National Aeronautics and Space Administration successfully launched on a Thor Delta rocket the Palapa B-2p communications satellite owned by Indonesian government-owned Peruntel.

Sources say the satellite was insured for $73 million, led in London by Lloyd's of London's Ariel syndicate, and placed by Bowring and Lloyd's broker Leslie & Godwin Aviation Ltd.

The satellite's launch insurance has a 120-day policy period, so underwriters could still face a loss if the probe malfunctions.

The Palapa B-2p replaces the $75 million Palapa B-2 satellite, which failed to reach proper orbit after a January 1983 space shuttle launch. It was later salvaged by another shuttle mission in November 1984. The Palapa B-2 was sold by underwriters for $18 million to Sattel Technologies Inc. in Van Nuys, Calif. (*BI*, Sept. 22, 1986).

The launch last month is the first time an insured satellite has been launched since May when Arianespace, the European space agency's Ariane rocket carrying an $82 million satellite malfunctioned (*BI*, June 9, 1986).

It is also the first successful launch by NASA since the space shuttle Challenger exploded Jan. 28, 1986, killing the seven people aboard and shutting down the U.S. satellite launch program (*BI*, Feb. 3, 1986).

Last month, NASA also hoped to launch an $83 million uninsured military satellite on an Atlas Centaur rocket, but the rocket was destroyed with the satellite after the booster malfunctioned.

"That was a nasty situation for NASA," said Mr. Moore. "If the (insurance) market is asked to insure a satellite on an Atlas Centaur rocker, underwriters will wonder what the problem was."

Also, last month another uninsured satellite was destroyed when its launch rocket at Sriharikota space center in India failed.

Queen Mother to tour

Queen Elizabeth, the Queen Mother, will visit Lloyd's of London this week to tour the new building and lunch with members of the Council of Lloyd's.

The Queen Mother, the only female honorary member of Lloyd's, inaugurated work on the new building in November 1981 and performed a "topping out" ceremony in July 1984 when the building was nearly completed.

She opened the previous Lloyd's building in November 1957.

Lloyd's Council

Four non-Lloyd's of London members will join Lloyd's Council in July.

They will replace four Lloyd's members who work in the market, in compliance with recommendations made in a British government report led by Sir Patrick Neill.

It will be the first time in Lloyd's history that Lloyd's market has been governed by a majority of non-Lloyd's members.

The four appointees, approved by Lloyd's and the Bank of England late last month, include the first woman to sit on Lloyd's Council: Elizabeth Mary Freeman, a trial lawyer and lecturer in law at Cambridge University.

The other appointees are Sir Maurice Hodgson, former chairman and chief executive and now non-executive chairman of British Home Stores P.L.C.; Jeremy Morse, chairman of Lloyd's Bank P.L.C. and past president of the British Bankers Assn.; and Brian Pomeroy, a partner at the accounting firm Touche Ross & Co. and a member of the Neill committee.

Tax troubles

The government's decision to alter tax requirements for Lloyd's of London syndicates may discourage new members from joining Lloyd's, warns Peter Rawlins, managing director of Sturge Holdings P.L.C.

Members face higher taxes following the government's proposal to treat funds syndicates set aside to cover future claims similarly to insurance companies' loss reserves (*BI*, March 23).

Currently the funds—known as reinsurance-to-close—are tax-deductible, but they are not subject to Inland Revenue review because Lloyd's says they are reinsurance contracts rather than reserves.

The Inland Revenue is concerned that some of the syndicates are "overcautious" in their estimates and is anxious to have some sort of review power over the contracts, sources say.

"The situation means that you have effectively got one group of taxpayers able to determine the size of their own tax deductions," said an Inland Revenue spokesman.

However, Mr. Rawlins argues that the money put aside by syndicates is estimated by using "sound underwriting judgment" based on experience and available evidence.

"No agent is going to determine reinsurance-to-close premiums for tax reasons," he said, adding that the amount put aside by his own syndicates would not be altered by the government's plans.

All syndicates' accounts are examined by independent auditors who verify the size of the reinsurance-to-close premium, he added.

Also, because Lloyd's members are subject to unlimited liability and the members' list for each syndicate changes from one year to the next, any reduction in the amount of money earmarked to pay outstanding claims may deter future entrants to Lloyds, other underwriters argue.

Jeremy Scott, tax partner with the Price Waterhouse accounting firm, does not expect syndicates to reduce their reinsurance-to-close premiums even if it means they face higher tax bills.

"Lloyd's has a much bigger capacity for long-tail coverage than an average insurance company, so it is much more difficult to judge how much to put aside to meet outstanding claims," he said. "If underwriters reduce reserves simply for tax purposes, it would present a great danger for the market and I don't think that would happen."

However, although he agreed Lloyd's would be "unhappy" with the government's decision to back the Inland Revenue over reinsurance-to-close, he did not believe it would have a serious impact on capacity in the market.

Meanwhile, five of Britain's largest insurance companies could face an additional tax bill of 168.4 million pounds ($269.44 million) if the government enforces discounting of loss reserves, according to a report published last month by Morgan Grenfell Securities Ltd.

The figure is based on the 1985 loss reserves of Commercial Union P.L.C., General Accident P.L.C., Guardian Royal Exchange P.L.C., Royal Insurance P.L.C. and Sun Alliance & London Insurance P.L.C. For example, Commercial Union's loss reserves of 362.5 million pounds ($580 million) discounted at 5% would be subject to a tax payment of 41.5 million pounds ($66.4 million), says the report.

The discounting of loss reserves has been the subject of a two-year debate between the British insurance industry and the Inland Revenue, with many insurers arguing that the tax agency is proposing to introduce discounting merely to boost tax revenues (*BI*, Feb. 23).

"The U.K.'s Inland Revenue have, for the last year or so, been trying to milk the non-life insurance industry. The basis of their argument is about the time value of loss reserves. The impetus is given by the substantial taxable gains that would be thrown up in a year by the move from the traditional "prudent" basis (of providing for all losses in full) to the less prudent basis of discounting," says the report.

Passenger liability

The British government is pro-

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Continued from previous page

posing to raise liability limits for ship lines carrying passengers in the aftermath of the ferry disaster off the Belgian coast last month, which killed more than 130 people.

International liability limits set under the Athens Convention of 1972 and incorporated in the British Merchant Shipping Act of 1979 are too low, British Shipping Minister Michael Spicer told members of a House of Commons committee last month.

The convention, which is already British law and becomes international law on April 28, sets a liability limit for owners of 38,000 pounds ($59,645) per passenger for death or personal injury (*BI* March 16).

However, ship owners and insurers' views will be sought on the possibility of raising the limit to 80,154 pounds ($128,246), which is British airlines' liability limit for passenger injuries and deaths, said Mr. Spicer.

The Athens Convention limits were set 13 years ago but there was no straightforward mechanism for adjusting them to account for inflation, which is why the British government is proposing to raise the limits, he added.

Britain also proposes to press the International Maritime Organization to review the limits, he said.

Meanwhile, a steering committee of lawyers acting for claimants contends that another convention, the Convention on Limitation of Liabilities for Maritime Claims of 1976, which is also included in the Merchant Shipping Act, takes precedence over the Athens Convention.

"We believe the limits that apply in this case are those of the 1976 convention rather than the Athens convention according to our interpretation of the act," said Mark Mildred, a lawyer with the firm of Pannone Napier.

The 1976 convention provides aggregate liability limits for ship owners for losses that include death or personal injury, property damage and losses caused by delay and contractual rights. Passenger claims are limited to a total of about 20 million pounds or $31.5 million (*BI*, March 16).

Townsend Thoresen's lawyer, John Maskell, a partner with the firm of Norton Rose, refused to discuss under which convention, if any, claims will eventually be settled.

"At this stage it is much too early to comment on the final settlement of claims. Only one completed claim has been filed so far," he said.

Merrett acquisition

Merrett Holdings P.L.C. is acquiring loss adjusters Graham Miller & Co. (Northern) for 7.6 million pounds ($12.2 million) in cash.

Graham Miller & Co. has 15 offices based principally in north and central England and has annual revenue of about 3.5 million pounds ($5.6 million), according to a Merrett statement.

The adjuster, whose business comes mainly from major British insurance companies, reported net income of 1.13 million pounds ($1.8 million at $1.60) for the year ending April 30, 1986.

Merrett is financing the deal by selling its headquarters to Pearl Assurance P.L.C. for 8.5 million pounds ($10.4 million). It will then lease the space.

"The acquisition continues our expansion into loss adjusting and complements the specialist activities of the Robert Bishop Group which we acquired last year," according to Chairman Stephen Merrett.

Merrett Holdings now offers a full range of adjusting services, including insurance investigations, said the statement.

Willis Faber

Lloyd's of London broker Willis Faber P.L.C. is celebrating its 10th year on the London Stock Exchange with a 17% increase in pretax profits to 74.8 million pounds in 1986 ($110.7 million at year-end exchange rates) from 64 million pounds ($91.5 million at year-end 1985) in 1985.

The company's net retained brokerage and fee revenues increased to 136.6 million pounds ($202.2 million) in 1986 from 107.5 million pounds ($153.7 million) in 1985.

"The results show continued strong overall growth in our mainstream insurance broking activities in the U.K. and around the world," said Chairman and Chief Executive David Palmer.

Losses for the company's insurance company subsidiaries fell to 1.9 million pounds ($2.8 million) from 3.6 million pounds ($5.1 million), after a provision for a further increase in reserves relating to earlier years, said Mr. Palmer.

Water plant disaster

Damage claims from 31 victims of an underground explosion in a Lancashire water pumping station will be awarded in the next two months—nearly three years after the disaster that killed 16 people and injured 28.

The resolution of the 31 claims, expected to reach just over 2 million pounds ($3.2 million), follows a ruling of liability at Lancaster High Court, said David Arkwright of Cyril Morris Arkwright & Partners, which represents a consortium of 31 of the survivors and relatives.

Justice Rose ruled Binnie & Partners, the designers of the Abbeystead water plant, to be 55% responsible for the accident, which was caused when methane gas ignited during a public tour of the station.

The North West Water Authority, operator of the plant and employer of three of the people killed, was judged to be 30% to blame, while the plant's contractor, Edmund Nuttall Ltd., was held to be 15% responsible.

Binnie & Partners and its lawyer refused comment on the company's insurance.

"We are dissappointed with the judgment and are considering appealing against it," said a spokesman for the company.

The North West Water Authority carries employers liability insurance with Iron Trades Employers Insurance Assn. Ltd., said a spokesman for the authority.

The authority retains the first 100,000 pounds of third-party liability risk per incident, he added.

Sun Alliance & London Insurance P.L.C. writes a 400,000-pound layer excess of 100,000, while Legal & General Group P.L.C. write a 500,000-pound layer excess of 500,000 pounds. Prudential Corp. P.L.C. then writes a 49 million-pound layer excess of 1 million pounds.

The lead insurer on Edmund Nuttall's third-party liability insurance policy is Aegon Insurance Co (UK) P.L.C., said a spokesman for Edmund Nuttall. Both he and the insurance company refused to comment on the policy.

Outhwaite defense

Lloyd's of London underwriting agency R.H.M. Outhwaite (Underwriting Agencies) Ltd. has been given the right to defend a High Court action brought against it by syndicates managed by Philip N. Christie & Co. Ltd.

A call for a summary judgment from underwriter Norman Compton over $627,094 that he claims the Outhwaite syndicates owe on a $5 million runoff insurance policy was denied in the High Court last

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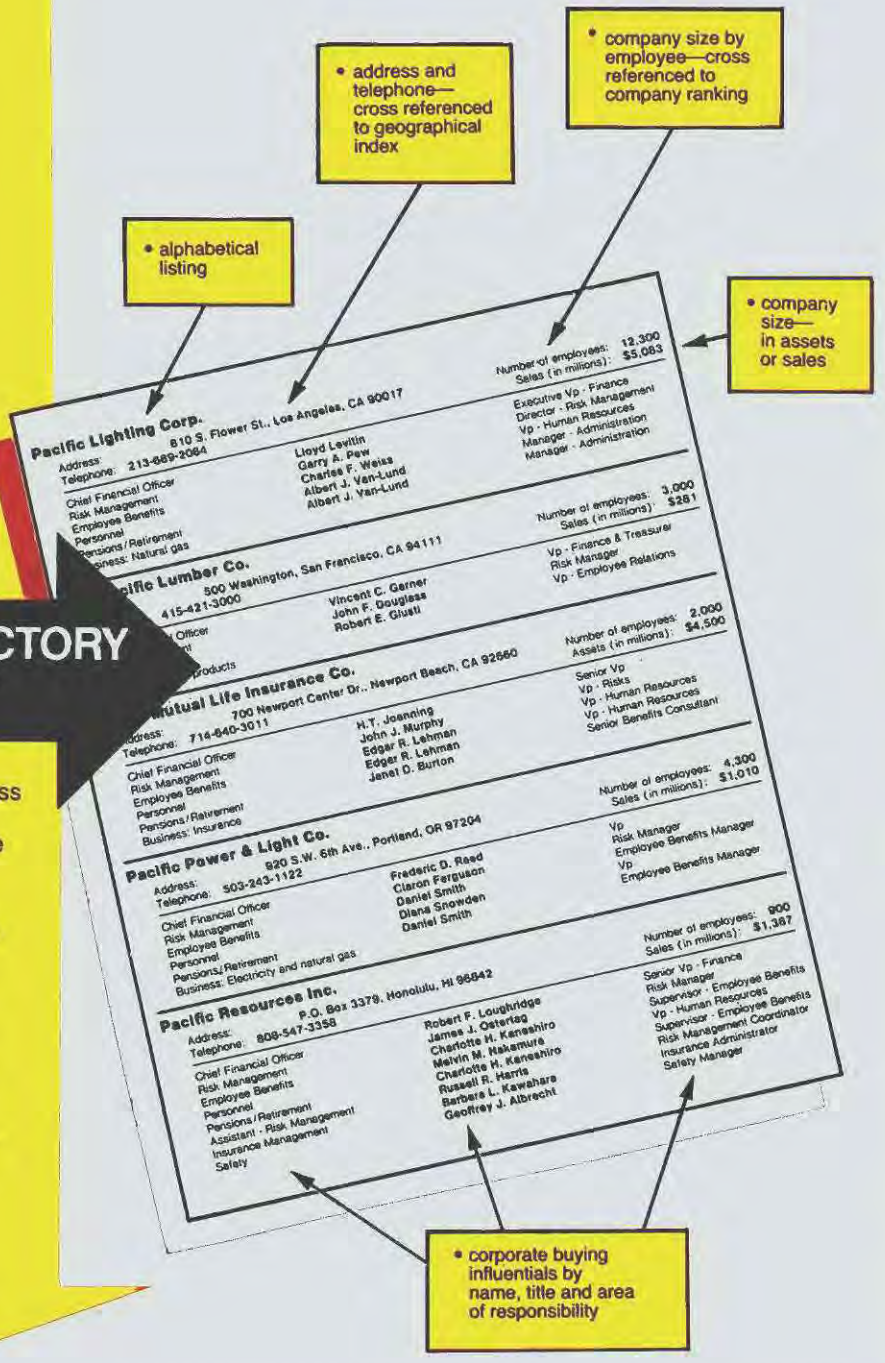
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london

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month (*BI*, Feb. 16).

Outhwaite Chairman Maurice Hussey said underwriter Richard Outhwaite has denied liability for the claim and will defend its action should the case go to trial.

Mr. Outhwaite is refusing to pay claims on several other syndicates' runoff policies until he recieves further information about the risks underwritten, confirmed Mr. Hussey.

However, the other policies include arbitration clauses, though none of the disputes have gone to arbitration, said Mr. Hussey.

"The problem would be in finding suitable people within Lloyd's who are not involved with any of the syndicates in dispute" to serve as arbitrators, he said. However, he would not comment on how many syndicates have runoff policies or have filed claims with Outhwaite syndicates.

Christie's lawyer could not be reached for comment.

New parent gains

Former employees from the North American division of Lloyd's of London broker C.E. Heath P.L.C. have contributed about 2.5 million pounds ($4 million) in revenues to Stewart Wrightson Holdings P.L.C. since they joined Stewart Wrightson in August.

Although Stewart Wrightson Chairman David Rowland would not comment on how much revenue the former Heath employees have generated, sources say the figure is around 2.5 million pounds.

Last August, three directors of Heath's North American division, including division Chairman Nigel Chamberlain, joined Stewart Wrightson. The resignations were expected to cost Heath as much as 8 million pounds ($11.8 million) in North American brokerage revenues (*BI*, Jan. 19).

The ex-Heath directors have formed Stewart Wrightson Development Ltd., which employs about 15 people including other employees from Heath, to place North American risks in the London market that are not produced by Stewart Smith Holdings Inc., Stewart Wrightson's U.S. surplus lines broker. ■

Amtrak

Continued from page 2
rammed three Conrail locomotives from behind near Chase, Md. An investigation found that the Conrail train had run a stop signal and that an alarm in the Conrail train's cab had been deactivated. The two Conrail crewmen operating the train also tested positive for marijuana use (*BI*, Jan. 12; Jan. 26).

Amtrak notified Conrail earlier this year that it would seek to hold Conrail liable for all deaths, personal injuries and property damage stemming from the accident, arguing that the indemnity agreement is not enforceable in this case, according to the prospectus.

On Feb. 4, Conrail filed a notice of its intention to arbitrate the dispute before the National Arbitration Panel, noting that Conrail has asked the panel to find Amtrak liable to indemnify Conrail for liabilities to Amtrak passengers, employees and property. On the same day, Amtrak filed suit against Conrail in U.S. District Court for the District of Columbia, seeking a declaratory judgment of its obligations under the agreement with Conrail, according to the prospectus.

Amtrak claims in the suit that the indemnity agreement should be voided in this case because of Conrail's allegedly "reckless, wanton, willful or grossly negligent" conduct, the prospectus says. Amtrak also claims that it should not be obligated to indemnify Conrail for any punitive or exemplary damages.

Conrail has filed a motion to dismiss the declaratory judgment action. The lawsuit and the motion to dismiss are pending, according to an Amtrak spokesman.

The spokesman said that the two sides have agreed to wait for the court to decide whether the dispute can be arbitrated before proceeding to the NAP.

Meanwhile, Conrail filed a motion before the Judicial Panel on Multidistrict Litigation in Washington to consolidate crash-related lawsuits against the railroad, the prospectus reported.

'While Conrail believes that under the agreement it cannot be held liable . . . no assurance can be given as to the ultimate outcome . . . ' the prospectus says.

"While Conrail believes that under the agreement it cannot be held liable as asserted by Amtrak, no assurance can be given as to the ultimate outcome of the arbitration, the declaratory judgment action, the proceedings before the Multidistrict Panel or the ultimate liability of Conrail," the prospectus says.

The prospectus also notes that the Federal Railroad Administration or Amtrak itself may require Conrail to install automatic speed control devices on its trains at a cost of about $6 million.

Conrail, a freight railroad currently 85%-owned by the government, has $190 million in liability coverage excess of a $10 million self-insured retention. Lloyd's of London syndicates and California Union Insurance Co. of Los Angeles led a layer of $40 million excess of $10 million. Railroad Assn. Insurance Ltd., a Bermuda-based excess liability facility, provided the next layer of $50 million excess of $50 million, while A.C.E. Insurance Ltd. provided $100 million excess of $100 million. Amtrak self-insured the first $50 million in liability losses, but also has coverage with RAIL for losses excess of $50 million. ■

Maryland work comp

Continued from page 2
dations, including slashing payments for "minor" permanent partial injuries by nearly $20 million in the first year by freezing wage scales used to compute benefits.

However, the cuts were modified after meeting opposition from various labor organizations. Vincent Raymond, president of the local International Assn. of Bridge, Structural and Ornamental Ironworkers, argued the commission's proposal would roll back the weekly permanent partial injury benefits to 1975 wage levels.

Although the governor has said he "absolutely" supports the two bills in concept, he is reserving final judgment until he has seen their amended versions, said Bob Frierson, an assistant legislative officer in the governor's office.

While the intent of H.B. 238—which would make Maryland the 11th state in the nation to require insurers to file their own workers compensation insurance rates—is to reduce rates by encouraging competition, the Alliance of American Insurers believes it may have the opposite effect.

Kathleen Boone, a government affairs representative in the Alliance's New York office, said the bill actually could increase employers' workers compensation costs because of the extra expense each insurer would incur in completing its own actuarial computations.

"We think that (H.B. 238 and H.B. 239) will not have any positive effect," concurred Grover Czech, mid-Atlantic regional vp of the American Insurance Assn. in Washington, D.C.

H.B. 238 also requires additional data reporting, which Ms. Boone contends is duplicative and costly. Most of the information required in the bill already is reported by insurers in other forms, such as annual statements or various rate filings, she says.

As a prior approval state, insurers in Maryland have used workers compensation insurance rates filed by the National Council of Compensation Insurers.

However, H.B. 238 will create "a modified file-and-use system," explained Chris Costello, director of industrial relations for the Maryland Chamber of Commerce and a member of the governor's study commission.

While the NCCI will continue to calculate the pure premium and maintain a data base, insurers will be able to file any rates above the pure premium rate without seeking prior approval, he added.

In addition, the bill contains "wording to explore the possibility of creating a ratemaking bureau," noted Tom Saquella, president of the

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Continued from previous page

Maryland Retail Merchants Assn. and chairman of the governor's study commission.

Mr. Saquella said insurers are "nervous" about "being painted as the bad guys" if the projected savings do not materialize. As a result, "they're trying to lower expectations."

However, JoAnn Porter, a regional director of government, consumer and industry affairs at NCCI, said it's not really possible to quantify the effects of increased rate competition. "You can't pinpoint how much you're going to save or if you'll have increased rates," she said.

"We already had competition" in Maryland, she added, explaining that insurers could raise or lower rates based on an employer's experience.

While she was unable to quantify the effects of H.B. 238, Ms. Porter could put an approximate price tag on the companion bill affecting benefits: The original House version of H.B. 239, which set a higher cost-of-living adjustment and higher benefit levels for workers with certain injuries, would cost the state 1.9% more than the current system, according to the NCCI's calculations. In contrast, the more frugal Senate version would decrease workers compensation costs in the state 2.4%.

Originally, the House version of H.B. 239 provided for a 5% cost-of-living adjustment, based on the Baltimore/Washington-area Consumer Price Index, which would be compounded annually. The Senate, however, was less generous, allowing for a simple 2% cost-of-living increase, which also would be tied to the area CPI.

In addition to providing the yet-to-be-determined cost-of-living adjustment, H.B. 239 would:

- Establish a three-tiered system of paying claims for permanent partial injuries.
- Require that doctors use American Medical Assn. guidelines in evaluating injuries.
- Impose penalties on insurers for late payment of claims.

Currently, workers compensation awards in Maryland are divided into two tiers: awards up to 249 weeks, and 250 weeks or longer.

Under H.B. 239, an additional tier, for "low, minor permanent partial injuries"—injuries from which there is no significant permanent disability, such as bruises, scratches and strains—would cap awards at $80 per week for a maximum of 74 weeks.

Full-time public safety workers, such as professional firefighters, would be exempt from the first tier.

The second tier, for "high, minor permanent partial injuries," would limit the award to two-thirds of the employee's average weekly wage, not to exceed one-third of the state average weekly wage, for 75 to 149 weeks.

The average weekly wage in Maryland currently is approximately $360.

The third tier—for permanent partial injuries that keep a worker off the job for periods of 250 to 500 weeks—would set awards at two-thirds of the employee's average weekly wage, not to exceed three-quarters of the state average weekly wage. Also, the injured worker's award would be increased by an amount equal to 33.3% of his total compensation.

While the current version of H.B. 239 would lower the maximum weekly benefit for "low, minor permanent partial injuries" to $80 from about $120 the bill provides an "escape clause" that states that if the injury affects a worker's ability to do his job, he will be "bumped up" into the second tier, explained the chamber's Mr. Costello.

This provision was strongly supported by the state's labor organizations, confirmed Ed Lamon, president of the Maryland and Washington, D.C., AFL-CIO. Its purpose is to shift the emphasis from minor injuries to more serious injuries, he explained.

'We do believe that as a result (of the AMA guidelines) doctors will no longer be sending in these flimsy exams that say this guy is 20% disabled,' says Chris Costello of the Maryland Chamber of Commerce.

Permanent partial injuries accounted for nearly $85 million of the total $380 million in workers compensation indemnity payments made in 1985, according to the Maryland Department of Economic and Community Development.

Of that amount, $69.7 million was paid for minor injuries, while $15.8 was paid for more serious injuries.

H.B. 239 would reduce indemnity payments for permanent partial injuries to approximately $73 million, using 1985 dollars, explained Pradeep Ganguly, senior economist for the department.

Of that amount, $23.7 million would be paid for first-tier injuries; $33.2 million for second-tier injuries; and $16.1 million for more serious permanent partial injuries, Mr. Ganguly said.

Under another provision of H.B. 239, doctors who treat injured workers will be required to use AMA "mobility" guidelines for determining the severity of injuries that occur after July 1. The bill stipulates that the state Workers Compensation Commission decide by July 1, 1988, whether to retain the AMA guidelines or adopt its own set of injury evaluation standards.

Currently, an employee who is injured on the job receives two opinions on his injury—one from his personal physician, the other from a doctor selected by his employer. The commission then refers to the two diagnoses when determining an award.

"What we have now is a system that doesn't work properly," complained the chamber's Mr. Costello. The attending physicians "give the commission conclusions, not facts," he added.

However, with the AMA guidelines, "we do believe that as a result doctors will no longer be sending in these flimsy exams that say this guy is 20% disabled," Mr. Costello said.

The guidelines "standardize the way you do your evaluation" by establishing "medical impairment ratings" for particular injuries, explained Mr. Saquella, chairman of the governor's study commission.

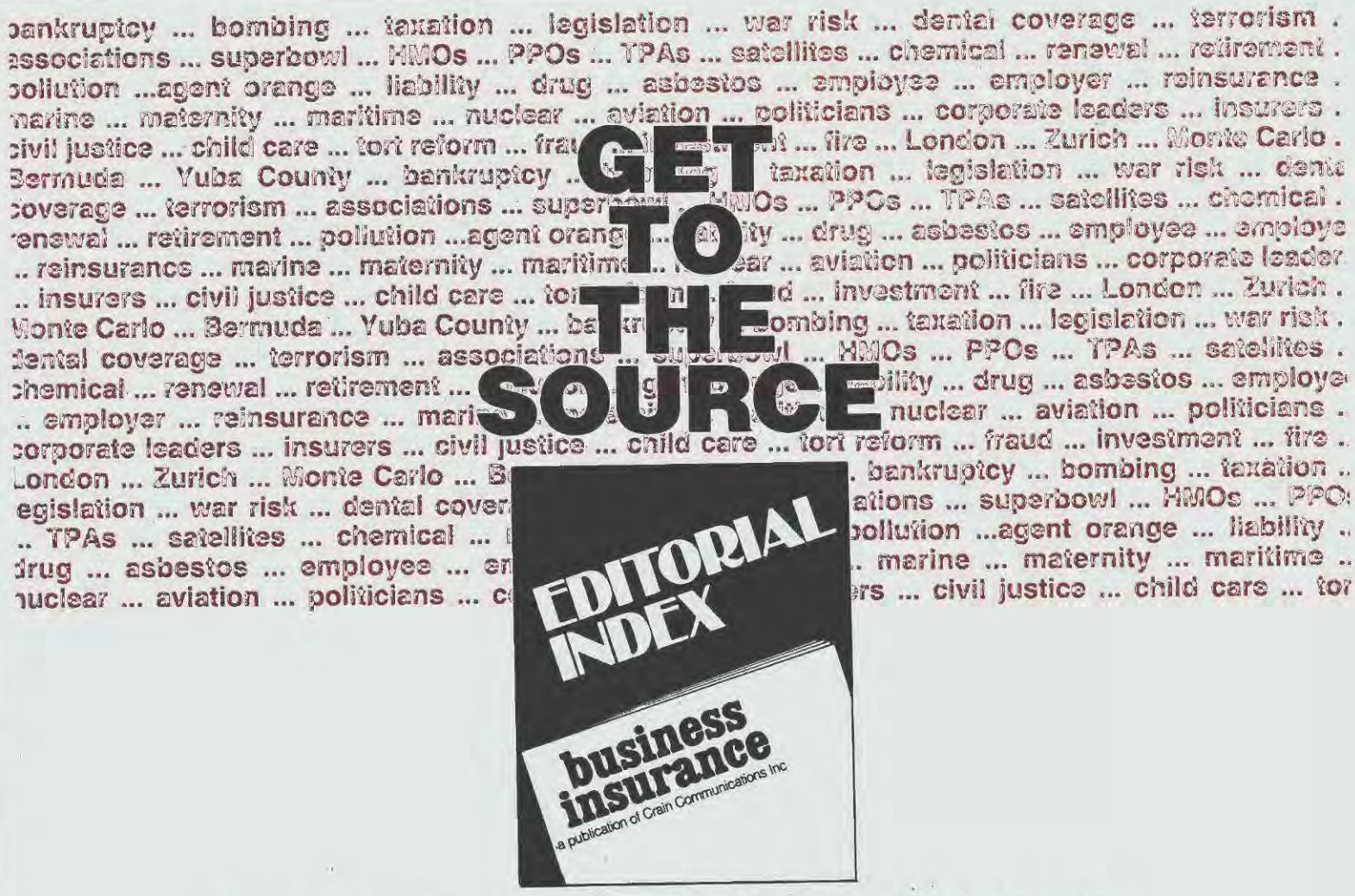
Another provision of H.B. 239 encourages prompt payment of workers compensation awards by imposing fines on procrastinating insurers.

If a workers compensation insurer does not pay benefits within 21 days of an award, it is slapped with a 20% fine. And, if payment is not made within 30 days, that penalty rises to 40%.

"It's trying to encourage earlier payment of a claim after an award is made," explained the NCCI's Ms. Porter.

Currently, an insurer is fined 20% if the workers compensation award is not paid within 30 days.

If the package of workers compensation legislation is passed during this session, it would become law on Jan. 1, 1988. ■



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Secretaries, Treasurers, controllers and other Financial Personnel 4,888

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Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,144

Sub-total 21,277

Associations 506
Government, Unions and Educational Institutions 1,400

Commercial Consumers

Sub-total 23,183

Insurance Agents and Brokers 11,009
Insurance Companies 7,111
Financial Institutions 989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 5,560
Others Allied to the Field 1,442
TOTAL 49,294

* Source Business/Occupational breakdown of qualified circulation, November 24, 1986 issue, as submitted to BPA for December 1986 BPA Publisher's Statement.

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Largest U.S. reinsurers' 1986 results

(All amounts in thousands of dollars) (Ranked by net reinsurance premium written)

Reinsurers	Policyholders' surplus (reinsurers only)	Percent change (decline) '85-'86	Net reinsurance premiums written 1986	Percent change (decline) '85-'86	Net reinsurance premiums earned 1986	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1986	Combined ratio 1985
General Re	$1,840,258	69.2%	$2,476,849	56.1%	$2,221,292	$1,768,856	79.6%	$586,734	23.7%	103.3%	110.8%
Employers Re	678,707	25.7	1,211,829	59.4	1,094,805	917,340	83.8	255,872	21.1	104.9	115.8
American Re	404,607	40.1	947,495	29.8	906,842	666,784	73.5	232,165	24.5	98.0	116.3
North American/Swiss Re	442,442	97.3	736,916	25.4	684,177	520,133	76.0	231,755	31.4	107.4	130.5
Prudential Re	383,534	45.4	678,947	31.2	640,931	468,693	73.1	188,695	27.8	100.9	119.2
Munich Re	389,427	94.9	671,799	46.2	600,996	409,933	68.2	197,713	29.4	97.6	106.2
Kemper Re	247,803	68.4	405,991	37.5	407,697	342,211	83.9	77,390	19.1	103.0	114.5
National Re	149,606	23.6	352,127	59.8	329,857	290,247	88.0	56,335	16.0	104.0	114.3
USF&G	N/A	N/A	333,563	205.7	270,174	163,193	60.4	114,673	34.4	94.8	111.0
INA Re	161,587	19.9	256,773	17.0	248,265	194,014	78.1	70,616	27.5	105.6	137.5
Continental Re	118,703	23.8	260,714	31.3	244,374	160,019	65.5	86,000	33.0	98.5	113.0
Transatlantic Re	111,941	11.9	251,955	30.9	233,690	194,749	83.3	64,252	25.5	108.8	124.7
St. Paul Re	N/A	N/A	233,002	45.2	220,311	160,028	72.6	65,107	27.9	100.5	110.8
Constitution Re	119,745	51.8	225,283	58.7	191,620	146,961	76.7	54,403	24.1	100.8	108.1
Constitution State Mgt.	N/A	N/A	222,581	148.5	186,677	157,064	84.1	53,228	23.9	108.0	119.3
New York Ins. Ex.	N/A	N/A	195,628	(2.7)	203,529	202,806	99.6	66,462	34.0	133.6	152.3
Skandia America Group	269,252	95.5	193,602	38.9	192,146	158,543	82.5	61,366	31.7	114.2	130.6
Putnam Re	95,789	N/A	187,584	N/A	136,116	124,773	91.7	15,035	8.0	99.7	N/A
Home Re	94,182	91.8	174,954	90.8	140,780	114,865	81.6	32,179	18.4	100.0	112.6
Continental Cas	N/A	N/A	168,710	47.9	179,394	149,808	83.5	42,515	25.2	108.7	114.9
Totals for top 20*	**5,411,794**	**59.7**	**9,998,718**	**46.7**	**9,197,557**	**7,186,247**	**78.1**	**2,537,460**	**25.4**	**103.5**	**117.3**
Total for all companies	**7,449,544**	**41.9**	**12,786,436**	**46.2**	**11,750,633**	**9,198,919**	**78.3**	**3,231,387**	**25.3**	**103.6**	**121.4**

*Top 20 totals do not include Putnam Re

Source: Reinsurance Assn. of America

Reinsurance report

Continued from page 2

that certainly improved the property results," added Jim Stannard, senior vp of F&G Re Inc. in Morristown, N.J., a wholly owned subsidiary of USF&G Corp.

INA Reinsurance Co.'s results were boosted in part because of a good catastrophe year, said a spokesman for its parent company, CIGNA Corp. INA Re posted a 105.6% combined ratio compared with a 137.5% ratio in 1985.

Paul F. Butler, president of St. Paul Reinsurance Management Corp., which manages the reinsurance business of St. Paul Fire & Marine Insurance Co., said: "I think it's generally conceded that '86 was a pretty good year for everyone, and we'd all like to see it continue."

However, improvement on par with last year is unlikely, he added, "since there was a lot of catching up that was done in '86."

Reinsurers in general were optimistic, however, about 1987 results. "I wouldn't doubt people wouldn't show even better results" this year compared with last, said National Re's Mr. Warren.

"I think in 1987 you'll see a lot more (reinsurers) with combined ratios under 100%," said Michael Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo.

"The major companies, I think, must be pretty satisfied with results," and this year "should be a pretty good year for reinsurers" as well, said Nigel Harley, chairman of Continental Reinsurance Corp. in New York.

Referring to reserves, Mr. Harley said, "It would appear a lot of work has been done on this by reinsurers in the past year. There's been a lot of improvement."

Reserves have been strengthened "tremendously" over the past few years," said Don Smith, president and chief operating officer of Kemper Reinsurance Co. in Long Grove, Ill.

"I think that the excellent results for the coverage year 1986 has allowed companies that have reserve problems to play catch up," said F&G Re's Mr. Stannard.

"I would guess the reserves are stronger now than they were at the beginning of the year by a lot. As to whether they have hit the magic number of being adequate or not, I don't know. That's obviously going to differ company by company," Mr. Stannard said.

Others, though, contend the industry still has a ways to go before reserves are adequate. "As far as we're concerned, we put up a tremendous amount of strengthening in 1986," which is why Employer Re's 104.9% combined ratio is somewhat higher than average, said Mr. Fitt. Its 1985 combined ratio was 115.8%.

Other companies are "all over the lot" as far as reserves are concerned, he said. "I still think there are a lot of companies out there with a very weak reserve position."

"I think there'll be the need for continued strengthening on the part of the industry overall," said American Re's Mr. Inderbitzin. There has been "substantial improvement," he said, "but not to the point of total adequacy."

The industry is well-reserved "within the context of what's known," said St. Paul Re's Mr. Butler. As for areas such as asbestos and toxic waste where the losses may still be unknown, "we'll just have to see as they develop."

"I still think there is needed reserve increases in some areas," said Pru Re's Mr. Dwane. Asbestos property damage and pollution liability are among the areas that still have to be addressed by the reinsurance industry, he said.

Continued on next page

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Reinsurer results

Continued from previous page

Some reinsurers said they are worried about a return to price competition.

F&G Re's Mr. Stannard said he is concerned about the slipping in primary prices, both in property and casualty lines, that he has observed over the past couple of months.

"It concerns me about the potential for continued good results like this," he said.

Facultative business may begin to level off, with no growth, or even a growth decline, this year because of rate cutting, commented Kemper Re's Mr. Smith. However, prices are "still holding up" on the treaty side, he said.

Reinsurers must beware that business does not become underpriced, said Pru Re's Mr. Dwane. "There are some things we have to pay attention to. We need that sustained recovery."

'I would guess the reserves are stronger now than they were at the beginning of the year by a lot. As to whether they have hit the magic number of being adequate or not, I don't know,' says Mr. Stannard.

However, American Re's Mr. Inderbitzin said despite some price declines in the primary market, "I don't think there's going to be that much slippage in reinsurance pricing in '87. I don't think it'll have a real negative impact on reinsurance."

Reinsurers said they were encouraged by their own results, and optimistic about continued improvements this year.

"I think we had a good year" in 1986 and a good year is projected for 1987 as well, according to Pru Re's Mr. Dwane, adding the reinsurer plans to further bolster its reserves.

Pru Re posted a 100.9% combined ratio for 1986, compared with a 1985 ratio of 119.2%.

St. Paul Re is "quite pleased" with its results "and would like to be able to continue it," said Mr. Butler. It reported a 100.5% combined ratio, compared with a 110.8% ratio in 1985.

"We had a very good year, and we were fortunate that we didn't have to play catch-up on our loss reserves," said F&G Re's Mr. Stannard, noting the subsidiary only started writing business in late 1983. It posted a 94.8% combined ratio compared with an 111% combined ratio in 1985.

"Basically, I guess '86 was a very successful year," said American Re's Mr. Inderbitzin. American Re posted a 98% combined ratio for the year compared with a 116.3% ratio for 1985.

Joseph Fahys, president and chief executive officer of the New York Insurance Exchange, said "There's been a substantial improvement" in the exchange's results.

The exchange posted a 133.6% combined ratio for 1986, compared with a 152.3% combined ratio for 1985. The combined ratio did not include results for Burt Syndicate Inc., First New York Syndicate Corp., Heartland Group Inc. and Realex Group N.V., all of which have been declared insolvent, as well those of the Syndicate of Wall Street Investors N.V., which have not yet been submitted (*BI*, Nov. 17, 1986).

Mr. Fahys noted the exchange's combined ratio would have improved by an additional eight points had it reflected 1986 loss portfolio transfers. However, exchange syndicates can not take credit for these transactions under New York Insurance Department regulations, he noted.

Continental Re's Mr. Harley said his company is pleased with its improvement.

The reinsurer posted a 98.5% combined ratio, compared with a 113% combined ratio in 1985.

"A large part of our account is non-U.S., and therefore the general progress of the international market is reflected in results," he said.

Because the international market's downturn was never as bad as the U.S. market's, Continental Re's Mr. Harley said, "its improvement was not as dramatic either."

Mr. Harley said he anticipates satisfactory results in 1987 as well. "From what we can see, the signs are encouraging."

Kemper Re posted a "great improvement" in 1986 compared with 1985, noted Mr. Smith. The reinsurer reported a 103% combined ratio compared with a 114.5% ratio in 1985.

"Barring major catastrophes, there will be continuing improvement in our combined ratios," according to Mr. Smith.

He added, "I'm encouraged by what we've seen in the past two years, and hopefully, it will continue for another two years—hopefully." ■

Workers comp ruling

Continued from page 1

cancer; respiratory diseases and injury; diseases of the central nervous system, kidneys, liver and other organs; injuries to the immune system; and injuries to the reproductive systems of the workers, possibly leading to birth defects in their children.

He also alleged there is an extended latency period between exposure to the substances and development of clinically diagnosable symptoms.

Mr. Barth contended that Firestone failed to comply with federal and state laws and regulations that prohibit the company from exposing unprotected workers to the hazardous substances at the plant and that require the company to provide workers with protective clothing, safety devices and safe premises.

He also alleged that Firestone:

- Fraudulently concealed information and intentionally misinformed employees about the danger of exposure to the chemicals.
- Disguised hazardous substances and denied that the company was using toxic substances.

In his suit, Mr. Barth does not seek compensation for any injury that currently can be clinically diagnosed.

Instead, he seeks the creation of a medical monitoring program for himself and other Firestone employees exposed to the chemicals. Physicians in the program would have information relating to the diagnosis and treatment of any diseases that may result from workers' exposure to the toxins.

Mr. Barth is asking the tire company to bear the cost of maintaining the program and the cost of locating other Firestone employees who where exposed to the chemicals.

Mr. Barth also seeks equitable relief and $100 million in punitive damages.

A major issue in the ruling was whether Mr. Barth's alleged injuries, coupled with the fact he had no physical symptoms of a disease, are compensable under the California workers compensation law.

Although Mr. Barth did not allege that he suffered from a currently diagnosable physical injury, he contended he sustained injury to his immune system, rendering him more susceptible to developing various forms of cancer. He also alleged that he is suffering from fear and emotional distress.

But Mr. Barth argued that his injuries are not compensable under the California workers compensation statute because they do not stem from a present impairment of earning capacity and because he has no clearly perceptible physical dysfunction or disease.

Therefore, Mr. Barth contended, he should be permitted to sue Firestone directly.

Firestone, however, contended that the Legislature intended to include this type of situation in the workers compensation system, and said the system would provide an adequate remedy.

In his decision, Judge Aguilar agreed with Mr. Barth, ruling he could sue Firestone directly because the injuries and the emotional distress he suffered, coupled with his lack of physical symptoms of a disease, did not constitute a claim covered by the state's workers compensation law.

Judge Aguilar noted that state case law excludes certain injury claims from the workers compensation system.

Non-physical injuries, such as the intentional infliction of emotional distress, are not "injuries" under the state workers compensation law and, thus, do not fit into the framework of the workers compensation system, Judge Aguilar said in ruling that Mr. Barth's case fell into this category.

" . . . The court need not and should not distinguish between a non-physical injury and an alleged injury for which symptoms are not clinically diagnosable," he noted.

"Neither situation presents an injury which is compensable under the workers compensation system, because that system was not designed to remedy the type of injury there asserted," he ruled.

"California law provides for exclusive workers compensation coverage for physical injuries which are accompanied by emotional distress," Judge Aguilar noted.

"In this case, however, the plaintiff's physical injuries do not fit within the definition of injury provided in the workers compensation system and are not therefore remediable," he said.

Judge Aguilar also ruled that Mr. Barth could sue Firestone for its alleged fraudulent concealment of the dangers of the toxic substances, thereby aggravating his injuries.

This allegation falls within the exceptions to the workers compensation system in California as the exclusive remedy for employee injuries, Judge Aguilar pointed out.

But Judge Aguilar did not agree that Firestone's alleged actions constituted a "willful physical assault" against Mr. Barth, which is another exception to the exclusive remedy rule.

Judge Aguilar also ruled that Mr. Barth could pursue his claim on behalf of the class to establish a medical monitoring program for workers at the Firestone plant.

Various workers compensation experts last week questioned Judge Aguilar's decision.

According to Duke University Law Professor Arthur Larson, the injury to Mr. Barth's immune system is a physical injury and therefore should be compensable under the state's workers compensation system.

"I think the court is dead wrong on that," he said.

Those injuries considered outside the system—such as emotional distress, defamation, humiliation and discrimination—generally have no physical component, Professor Larson noted.

Workers compensation attorney Mr. Marks pointed out that under workers compensation laws in some states, Mr. Barth's claim would be compensable, thereby precluding him from suing his employer directly.

Mr. Smith of Hollywood & Neil called the decision "somewhat schizophrenic." He noted that while the court found injury to allow Mr. Barth to sue the company for fraudulent concealment of the toxins, it did not find injury for purposes of covering Mr. Barth's claim under the workers compensation system.

Other attorneys noted another question the decision raises: What happens if a suit and recovery is allowed against a employer and then years later symptoms of a disease appear that would be compensable under the workers compensation system?

Some attorneys also noted that because the decision was handed down by a federal court judge who was interpreting California law, it is possible the decision would not prevail after state appellate court judges address the issue.

Mr. Stemple said that the decision should send a warning to the minority of companies that engage in the type of conduct to which the decision applies. ■

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American Centennial sale

Continued from page 1

Meanwhile, in accepting the management buyout proposal, Beneficial rejected an offer for ACIC and one other insurance unit from a group led by former Georgia Insurance Commissioer James Bentley.

An initial proposal from Mr. Bentley's group was made in January and was rejected as being "vague" when Beneficial announced its deal with the management group in early March, sources say.

A second proposal from the Bentley group was made last month after the agreement with the management group had been signed, sources report.

Andrew C. Halvorsen, Beneficial's chief financial officer, said the second proposal was not formally rejected, but could not be accepted since Beneficial had already signed a definitive agreement with Mr. Rothman's group.

"It was the best of all the alternatives we could have considered at the time," Mr. Halvorsen said of the Rothman proposal. "There were discussions with several parties and we chose the best deal for Beneficial."

Under the agreement, the management group will acquire ACIC, Wesco, Bermuda-based Beneficial International Insurance Co. and three of its subsidiaries: Consolidated Marine & General Insurance Co. P.L.C. and Consolidated Life Assurance Co. Ltd., both profitable British-based credit insurers; and Benico Insurance Co. of Cayman Ltd., a Cayman Islands insurer.

Beneficial will receive $10 million in cash along with a package of 10-year notes with a face value of $98 million for the companies. About $60 million of the notes are related to the sale of ACIC and Wesco, while the remaining $38 million relate to Beneficial International and its subsidiaries, Mr. Halvorsen said.

The ultimate value of the notes related to the ACIC sale, however, will depend on ACIC's future market value.

Beneficial also will have the option to acquire at a nominal price 9.9% of the equity of the two British credit insurers.

As part of the complex deal, the management group recently established two new holding companies: First Delaware Holdings Inc., which will acquire ACIC and Wesco and operate as a subsidiary of Beneficial International; and RCK Holdings Ltd., a Bermuda-based corporation acting as parent of Beneficial International.

Delaware Commissioner Levinson said a key factor in the approval was Beneficial's commitment to add $200 million to ACIC's loss reserves.

Mr. Rothman is chairman of both First Delaware and RCK Holdings.

First Delaware will be capitalized with $35 million from Beneficial International, $10 million of which will be paid to Beneficial Corp. on closing of the ACIC sale and $25 million of which will be contributed as capital to ACIC, according to the agreement.

Before the ACIC sale is consummated, Beneficial will also have to complete several other transactions, including:

- A capital contribution to ACIC of $135 million, $15 million of which may, at Beneficial's option, consist of all outstanding stock of Beneficial Building Corp.
- Payment of $40 million cash in lieu of a $40 million letter of credit issued by Beneficial in favor of ACIC.
- Payment in full of promissory notes of Beneficial and Beneficial Insurance Group Holding Co. held by ACIC in the amounts of $30 million and $15.8 million, respectively.

In approving the deal, the Delaware department required Beneficial to boost ACIC's reserves by $200 million, reflecting "worst-case" estimates of loss development on its current business. The $200 million consists of the $135 million capital contribution, the $40 million contributed in lieu of the LOC and the $25 million contributed by First Delaware, according to Mr. Kerstein, who also is president of First Delaware and RCK Holdings.

The remaining payment on the promissory notes reflects Beneficial's buyback of affiliated assets held by ACIC, Mr. Kerstein said. As part of the restructuring, the management group also has negotiated commutations of two financial reinsurance contracts ceded by ACIC, which will produce a surplus gain of about $30 million to ACIC.

The large increase in ACIC's loss reserves required in the deal has made the reinsurance contracts unnecessary, he explained.

The sale agreement also calls for Beneficial to indemnify ACIC's new owners for any liabilities and costs related to three lawsuits that grew out of business produced for ACIC by one of its former managing general agents, The Underwriters Inc. of Parsippany, N.J.

ACIC's new owner will have control over this litigation until Dec. 31, 1988, at which time Beneficial has the option of assuming control, according to the agreement.

Beneficial also has agreed to indemnify ACIC for 50% to 100% of the liabilities and costs connected with 10 other lawsuits arising from defaults on guaranteed loans, the agreement says.

While the Delaware department found that First Delaware met all of the statutory conditions required for the ACIC acquisition, Wausau objected to the approval in a March 18 letter to the department.

Requesting additional time to study the proposed transaction, W. Craig Olafsson, Wausau's associate counsel, expressed several concerns about the deal. In addition to questioning whether the deal represented an arm's length transaction, he questioned:

- The adequacy of ACIC's accounting records.

Pending litigation and arbitrations concerning ACIC have called into question "the adequacy and accuracy of accounting records of the MGA business which are now being relied upon by ACIC and others making studies and reports regarding the financial condition of ACIC," the letter says.

- The adequacy of information about Beneficial International.
- "Uncertainty" regarding the outcome of recision actions by ACIC reinsurers on business produced by The Underwriters and another MGA, Dar Allen Reinsurance Agency Inc.

In a response to the Delaware department on March 20, Mr. Rothman asserted that the transaction was arm's length. Replying to Wausau's other points, Mr. Rothman noted:

- That allegations about inaccurate accounting records relate only to one MGA and are not widespread "as implied in Wausau's letter." In addition, Mr. Rothman says, ACIC's records have been reviewed in the course of a recent triennial exam, and "distortions" have been adjusted for in further reviews by the Tillinghast division of Towers, Perrin, Forster & Crosby and by accountant Price Waterhouse.

"It therefore appears that a number of objective parties have made themselves comfortable with the current status of the records," the letter says.

- That First Delaware submitted six years of audited financial statements for Beneficial International with its submission to the Delaware department, and that Wausau rejected offers by First Delaware management to explain the structure of the acquisition.
- That ACIC has adequately considered the effects of recision actions by reinsurers on the two MGA books of business, and that all pending litigation and arbitration was reported to the Delaware department.

Wausau also noted in its letter that it is owed more than $6 million in reinsurance payments by ACIC, net of "recent payments which were received only after commencement of litigation/arbitration collection proceedings."

Mr. Rothman responded that ACIC has paid Wausau $3.9 million since Jan. 1 under a reservation of rights and that Wausau has refused requests by ACIC for an audit of its records. In addition, Wausau—which reinsured ACIC on business produced by The Underwriters—has not paid balances due ACIC, the letter says.

"In any case, this hearing is not the forum to resolve claim disputes between ACIC and Wausau," Mr. Rothman's letter says.

Before announcing the management buy-out, Beneficial received another proposal from Mr. Bentley, sources say.

Under the proposal submitted in January, the group led by Mr. Bentley would acquire ACIC and Beneficial International only. No cash would be paid for the companies, though Beneficial would receive a note maturing in 10 years and entitling it to 50% of the insurers' statutory surplus, sources say.

This offer was rejected as being "vague," according to one source.

Mr. Bentley then submitted a second proposal last month after Beneficial had announced the sale of the companies to the Rothman group, sources say.

Under the second offer—similar in some respects to the Rothman proposal—the Bentley group would pay Beneficial $3 million in cash and $10 million from Beneficial International funds. The group also would provide a note with a face value of $65 million whose ultimate value would depend on ACIC's profitability, sources say.

In addition, the Bentley group—which would have redomesticated ACIC in Georgia—would not have insisted on any further contributions to ACIC's reserves by Beneficial and would not have required Beneficial to indemnify ACIC for liabilities related to The Underwriters business or the loan default litigation, sources say.

These conditions—along with the rest of the deal—would have had to be approved by the Georgia and Delaware insurance departments, however.

E. Hugh Edenfield, deputy commissioner of the Georgia department, said that the department was informed of Mr. Bentley's plans but that the deal never got far enough for the department to consider specific terms of the offer.

"There was no serious discussion on that phase because it would have been premature," Mr. Edenfield said.

The Bentley group was represented by the New York law firm of Cravath, Swaine & Moore, which also represents Commonwealth Insurance Co. of Vancouver, British Columbia.

Commonwealth, one of ACIC's reinsurers, is disputing claims on business produced by two of ACIC's managing general agents. ■

update

Florida agency investigated

Continued from page 2

She added it is possible some of the trucking companies that bought insurance through Transportation may not have coverage in force because the agency may not have placed the policies with insurance companies. "That is our concern," she said.

The investigation began after complaints and questions were received from policyholders and the Interstate Commerce Commission, the spokeswoman said.

She noted that trucking companies in several states may be affected. The Florida department has talked with regulators in Oregon, Texas, Indiana, California, Illinois and North Carolina, which are among the states where Transportation sold insurance.

A receptionist at Transportation said the company would have no comment on the matter.

Raymark to pay $46 million

WICHITA, Kan.—Raymark Corp. will pay more than $46 million to settle an asbestos injury class-action suit involving approximately 17,000 plaintiffs.

U.S. District Court Judge Patrick Kelly has tentatively approved the settlement, which will provide plaintiffs with an average of $2,821 each, although the actual amounts awarded will vary depending on the particular plaintiff, said Frank Heap, a Raymark outside counsel.

Last year, Raymark, a subsidiary of Raytech Corp., said it may have to file for reorganization if it cannot settle asbestos claims for about $2,000 each and obtain uninterrupted insurance coverage from its insurers for defense and claim costs (*BI*, April 21, 1986).

Mr. Heap, with the Chicago firm of Bell, Boyd & Lloyd, said the settlement amount could range between $46 million and $52 million depending on whether another 4,000 asbestos plaintiffs are permitted to join the settlement.

The money will go into a trust fund to be administered by a special master appointed by the federal court in Wichita.

Insurers on Raymark's third and fourth layers of coverage—including Aetna Casualty & Surety Co. and Northbrook Excess & Surplus Insurance Co.—are expected to fund the settlement, subject to a resolution of the trigger of coverage of those policies.

Raymark currently is litigating with its insurers in various courts and is awaiting a decision by the Illinois Supreme Court on various coverage issues, including the trigger of coverage and insurers' duty to defend.

Medicare solvency assessed

WASHINGTON—Tax increases or significant benefit reductions are necessary to ensure continued longevity of the Medicare Hospital Insurance Trust Fund into the next century, according to a government report released last month.

However, if the system is used efficiently and health care inflation is moderate, the Medicare trust fund will remain solvent through the year 2002, said the annual report of the Social Security and Medicare trustees. Last year, the trustees said the fund would go broke by 1996.

Hospital benefits under Medicare—the federal health program for the elderly—will have to be reduced 13% or contributions increased 15% for the Medicare rust fund to remain solvent over the next 25 years, the report said.

PBGC settles class-action suit

WASHINGTON—The Pension Benefit Guaranty Corp.'s deficit will increase as a result of a settlement of a class-action lawsuit brought by workers who were denied PBGC guarantees of benefit improvements required by the Employee Retirement Income Security Act of 1974.

The settlement, announced last week, will affect between 16,000 and 30,000 workers and will cost the PBGC between $28 million and $61 million, according to Mark Borenstein, a lawyer with Tuttle & Taylor in Los Angeles, who represents the claimants.

Under ERISA rules, PBGC guarantees of plan amendments that boost benefits are phased in at the rate of 20% per year. For example, if an amendment boosts a worker's benefits by $100 a month, PBGC would guarantee only $20 of the increase one year after the amendment became effective.

However, in one of the cases comprising the class action—*Rettig, et al vs. PBGC*—the vesting provisions of the employer's pension plan were amended to comply with ERISA guidelines less than a year before the plan was terminated and taken over by the PBGC (*BI*, March 8, 1982).

The PBGC later refused to pay some workers' benefits under the underfunded plan, saying that the amendment improving vesting provisions was in effect for less than one year before PBGC became trustee. The workers sued the PBGC, arguing that the amendment was required by ERISA.

The settlement—which affects hundreds of plans that were amended to comply with ERISA between Jan. 1, 1976, and Dec. 31, 1981—would guarantee payment of 65% of the additional pension benefits resulting from vesting improvements that would otherwise have been guaranteed if not for the ERISA phase-in requirement.

Briefly noted

The California Insurance Department is attempting to sell **Mission American Insurance Co.** or portions of its book of business, says Assistant Insurance Commissioner Richard J. Roth Jr. The department placed Mission American in conservation in February (*BI*, Feb. 9; March 2). . . .Dennis M. Kass, head of the U.S. Department of Labor's **Office of Pension and Welfare Benefit Programs,** will resign next month. Mr. Kass was a key architect of the administration's recent pension funding reform proposal.

Liquidators' lawsuit improper: Pinnacle

By ROGER SCOTTON

HAMILTON, Bermuda—Pinnacle Reinsurance Ltd. contends the liquidators of the insolvent Mentor Insurance Co. P.L.C. improperly filed a lawsuit in a U.S. District Court in Louisiana that names Pinnacle as a defendant.

Mary Arden, a London-based attorney for Pinnacle, told the Bermuda Supreme Court last week that the suit had been filed in the names of joint Mentor liquidators Charles Kempe and Michael Arnold in violation of the Bermuda Companies Act of 1981, which empowers liquidators to bring legal proceedings "in the name and on behalf of Mentor."

"Under the Bermuda Companies Act, the liquidators have no power to prosecute a cause of action in their own names which they allege belongs to the company," Ms. Arden.

Ms. Arden's claim emerged on the fourth day of the liquidators' motion to dismiss Pinnacle's "originating summons," a British legal term describing Pinnacle's request that the court declare the liquidators lack legal standing to bring their suit.

'If Pinnacle thinks there is nothing in the fraud claim, let it take the appropriate steps open to it in Louisiana. . . .It is quite clear that Pinnacle is seeking to prevent the liquidators from continuing in the United States,' Mr. Crystal says.

The suit filed by Mentor's liquidators in U.S. District Court in New Orleans last year seeks about $700 million in compensatory and punitive damages to cover Mentor's insolvency, which could be as large as $474.2 million, according to reports by the liquidators.

The suit charges that Pinnacle conspired with officers and directors of Mentor and its parent company, Ocean Drilling & Exploration Co., to defraud Mentor and its policyholders by issuing misleading financial statements. Pinnacle had provided Mentor with reinsurance contracts that served to reduce Mentor's reported loss reserves (*BI*, Dec. 22, 1986; March 24, 1986).

Pinnacle, a subsidiary of Lloyd's of London broker C.E. Heath P.L.C., has denied the allegations.

Ms. Arden said that Bermuda law governs the powers of the Supreme Court-appointed liquidators of Mentor and she stressed that "the statute is quite specific: The liquidators only have power to sue in the name of the company."

"The words of the act cannot be declared redundant and cast aside simply when it is convenient to do so. . . .The liquidators are exercising the power they do not have," she said.

The Pinnacle attorney alleged that the liquidators were already aware of their mistake but had done nothing about it because it was "unanswerable and inarguable."

"I invite this court to infer that nothing has been done about this for good reason—because it is a knockout point."

Earlier in the week, Michael Crystal, a London-based attorney representing the liquidators, told the court that under English and Bermuda laws, Pinnacle is not allowed to challenge the liquidators' behavior and described Pinnacle's action as fundamentally misconceived.

"The originating summons was intended to raise the question of the liquidators' authority to commence their proceedings in the United States," he noted. "On the winding up of a company by a court, a statutory scheme comes into force whereby the liquidators are charged with getting in the assets of the company for distribution.

"Pinnacle, being neither a creditor nor a contributory, has no place in the statutory scheme. It is a stranger to the winding up and is not entitled to issue an originating summons to seek relief against the liquidators. That right is reserved for creditors and contributories of Mentor."

Mr. Crystal referred to judgments by the British House of Lords and Court of Appeal that he said show that a defendant in litigation brought by liquidators cannot argue the liquidators have abused their powers.

"That is a matter for those interested in the estate of the company and the distribution of assets," Mr. Crystal said. "A mere busybody and stranger such as Pinnacle has no interest in law over the distribution of assets in liquidation against it."

Pinnacle is "truly the last person who ought to be or is permitted to interfere and, in law, has no right to do so."

Nor, he said, could Pinnacle claim to be an "aggrieved person" —an individual or party allowed under Bermuda law to complain to the court about a liquidator's action.

"Pinnacle is not and cannot be aggrieved by the bringing of proceedings in Louisiana because it is not a creditor or contributory and it is not interested in the winding-up scheme—and I mean aggrieved in the legal sense rather than merely disappointed."

He added, "If Pinnacle thinks there is nothing in the fraud claim, let it take the appropriate steps open to it in Louisiana to convince the judge of its case. It is quite clear that Pinnacle is seeking to prevent the liquidators from continuing in the United States and this court ought to be astute enough not to permit this."

Mr. Crystal also produced copies of aggregate excess-of-loss reinsurance contracts written by Pinnacle for Mentor between 1982 and 1984, along with copies of what he alleged were "secret side letters" to the contracts.

"The documents are prima facie evidence of fraudulent behavior on the part of Pinnacle and Mentor and they well justify the complaint made in Louisiana," Mr. Crystal said. The side letters change the meaning of the reinsurance contracts so that they afforded Mentor no coverage and were nothing more than funding arrangements.

"Why have a secret side letter unless you have something to hide?" he asked the court.

Mr. Crystal also noted that Pinnacle has claimed that Mentor's auditor, Peat Marwick Mitchell & Co., should have "spotted something before they did."

But, he contended, "Whether Peat was bright enough to spot something or not does not answer being a party to a fraudulent scheme."

Ms. Arden replied that the letter of credit securing each reinsurance contract written by Pinnacle for Mentor made the terms of the contract perfectly clear.

Mr. Crystal urged the court to dismiss Pinnacle's request for a declaratory judgment and to lift a restraining order that prevents the Mentor liquidators from taking any action that would interfere in the consideration of the originating summons.

The hearing is scheduled to continue this week. ■

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AIDS contamination lawsuits

Continued from page 1

that allow blood to coagulate, sources confirmed. In mid-1984, the AIDS virus was discovered in plasma but manufacturers also learned then to kill the virus with heat before the products were distributed.

The seven pharmaceutical companies involved are Alphatherapeutic; Armour & Farmer; Behringwerke; Biothestfarmer; Immuno; Travenol; and Troponwerka, confirmed a spokesman for Bundesverband der Pharmazeutischen en Industrie, the West German pharmaceutical association.

Travenol is an affiliate of Baxter Travenol Inc. in Northbrook, Ill., according to a company spokeswoman.

Under West German law, pharmaceutical companies are strictly liable for any losses caused by their medical products, no matter who caused the loss, the spokesman confirmed.

Under the law, called Gesetz zur Neuordnung des Arzneimittelrechts of 1978, the pharmaceutical companies must buy insurance for each drug they manufacture with limits of 500,000 deutschemarks ($275,800) per person and 200 million deutschemarks ($110.3 million) per drug.

Also, under the law and under West Germany's civil code, claims must be filed within three years of the time the loss occurred, which means that claims from AIDS-infected hemophiliacs would have to be filed by midyear.

However, last week, the pharmaceutical companies, their insurers and reinsurers agreed with Mr. Schulte-Hillen that the three-year limitation on claims should be waived until March 1988 so that all parties can discuss compensation for the victims without going to court.

All of the pharmaceutical companies' first 10 million deutschemarks ($5.5 million) of product liability coverage is written by West German insurers, and the next 190 million deutschemarks ($104.8 million) of the coverage is reinsured with Pharmapool, a group of 50 or 60 West German reinsurers managed by Munich Reinsurance Co. in Munich.

Some of the major underwriters in the Pharmapool include Gerling-Konzern Allgemeine Versicherungs A.G., Allianz A.G. Holdings and Alte Leipziger Versicherung A.G., said the pharmaceutical association spokesman.

The pharmaceutical companies, their insurers and the hemophiliacs cannot agree on how many AIDS-contaminated drugs are involved in this case and therefore how much may be paid in compensation to the AIDS-infected hemophiliacs.

However, one West German underwriter involved in the case told *Business Insurance* that two drugs are involved, which means that the pharmaceutical companies would be be insured for a total of 400 million deutschemarks ($220.6 million) in losses.

The underwriter, however, believes the maximum amount of claims will total less than 100 million deutschemarks ($55.2 million).

"In the whole country, they do not know how many people have been hit," he said. "Claims are estimated to be less than 100 million deutschemarks."

One suggestion to compensate victims is to set up a "foundation" that would be sponsored by the pharmaceutical companies, the insurers and the West German government, said one German underwriter involved in the loss.

The underwriter speculates the West German government would contribute to any compensation for the victims because it allowed the products to be distributed.

However, Mr. Schulte-Hillen is not enthusiastic about such a foundation.

"To build a foundation needs a long time," Mr. Shulte-Hillen complained.

For example, he said, a 150 million-deutschemark foundation set up in 1961 to compensate babies born with deformities because their mothers took the drug thalidomide to prevent miscarriages has paid thalidomide victims settlements totaling 297 million deutschemarks ($162.5 million) as of year-end 1986. Mr. Shulte-Hillen's son is a thalidomide victim.

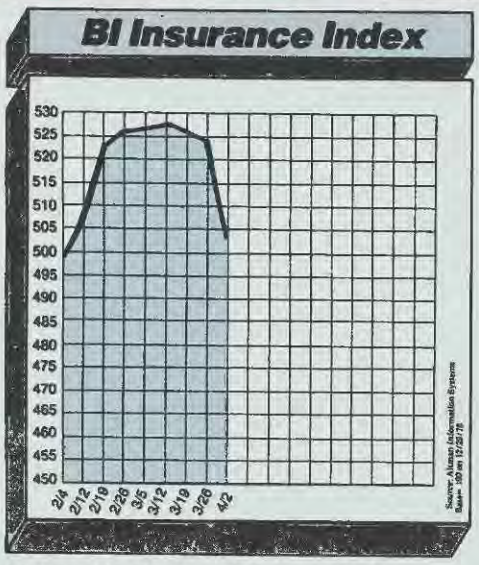
"But we do not have a long time," Mr. Shulte-Hillen said, referring to the AIDS victims.

"We hope to have good discussions with the pharmaceutical companies and insurers about compensation" for both physical loss and pain and suffering, Mr. Schulte-Hillen said.

The pharmaceutical companies also want to avoid a court battle over compensation, the pharmaceutical association spokesman said.

"We are searching for an unbureaucratical solution to the whole problem," the spokesman said. "The pharmaceutical industry agreed with insurance companies that there is no problem with the time limit (for claims to be filed). We have time now to discuss all the problems.

"Compensation is not clear. . .but there will be talks in the future. We hope that we will find a solution without going to court, and we want to compensate the hemophiliacs," the spokesman said. ■



Last week's stock market slump hit insurance industry issues hard, as the *Business Insurance* stock index plummeted 20.7 points to 504.0 on April 2 from 524.7 on March 26. Only four of the 63 issues tracked by the index posted gains during the trading period, while 52 stocks declined and seven remained unchanged. The only stocks to rise during the week were: Tokio Marine & Fire Insurance Ltd., up 6.6%; The Hartford Steam Boiler Inspection & Insurance Co., up 6.4%; Zenith National Insurance Corp., up 4.5%; and Nobel Insurance Ltd., up 1.7%. The largest declines were posted by: Aneco Reinsurance Co. Ltd., down 25.7%; CNA Financial Corp., down 12.5%; Orion Capital Corp., down 10.6%; General Re Corp., down 9.2%; and Fireman's Fund Corp., down 9.1%. The *Business Insurance* index dropped 3.9% during the week, a much larger decline than the major stock market averages. The Standard & Poor's 500 index fell 2.4%, the New York Stock Exchange composite declined 2.3% and the Dow Jones 30 Industrials dipped 2.2% during the same trading period.

British Issues

March 31 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence
Commi Union	320	15.9	18.3	5.7	333—320
Genl Accident	944	15.6	39.4	4.2	957—942
Gdn Royal Exch	904	14.8	46.5	5.1	930—899
Royal	952	9.0	43.7	4.6	952—932
Sun Alliance	777	15.5	30.3	3.9	807—777
Brokers					
CE Heath	479	13.7	34.5	7.2	479—455
Hogg Robinson	393	14.6	16.2	4.1	393—380
JH Minet	266	11.8	12.0	4.5	266—258
Sedg Grp	328	15.0	16.9	5.2	338—328
Slew Wrightson	459	16.4	18.3	4.0	473—457
Willis Faber	422	16.2	15.1	3.6	432—422

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Impact of tax reform law on insurers not yet clear

By MYRON M. PICOULT

Special to Business Insurance

THE TAX REFORM Act of 1986 and its impact on the property/casualty insurance industry is proving to be a confusing issue for both insurance company managements and investors.

With deference to all parties involved, the complexity of the new tax law, together with current Financial Accounting Standards Board activities relating to deferred tax accounting, has made it difficult for managements to develop accurate long-term estimates of the impact of the legislation.



Mr. Picoult

This has manifested itself in a profound decrease in management articulation about the tax law and its impact on earnings. This, in turn, has compounded the inability of investors to find out which end is up.

For the industry as a whole, loss reserve discounting, inclusion of the 20% of unearned premium reserve, proration of tax-exempt interest and the dividend-received deduction in taxable income—along with the alternative minimum tax—will result in tax payments that will reduce cash flows and the level of growth in statutory surplus. But, the full impact of these changes will not likely be felt by the industry until after 1988 when most companies will have exhausted their operating losses.

The tax changes also imply that from the basis of both economics and generally accepted accounting principles, it makes sense to emphasize tax-exempt securities at this time unless there is a meaningful shift in spreads between taxable and tax-exempt instruments. The reason for this relates to the impact the law has on the taxing of underwriting losses. In the past, underwriting losses were used to shelter taxable income. In effect, the new law produces a tax cost!

One of the unique provisions of the new law was the adoption of a "Fresh Start" provision. It is basically an exclusion from income of the difference between discounted and undiscounted reserves at the end of 1986.

"Fresh Start" is basically a double deduction for undiscounted loss reserves in 1986 while being permitted to record the accretion of the 1986 year-end loss reserves discount in tax returns for 1987 and beyond. The "Fresh Start" figure, which apparently will represent an average of some 10% to 20% of a company's reserve base (particularly those with long-tail books of business), will be used to reduce taxable income. Although the adjustment can last over a 15-year period, the bulk of the benefit is skewed over the first five to six years.

Insurance company managements are beginning to provide, on a piecemeal basis, some ranges on the size of their "Fresh Start" figures. The fact that their 1987 tax rate may be a moving target makes accurate forecasting moot. Nonetheless, it is becoming obvious that the 1987 first-quarter reported operating earnings will benefit from the inclusion of the "Fresh Start" provisions and investors should be aware that some distortions are in the making.

When analysts began to develop their 1987 and 1988 earnings "guesstimates" about a year ago, no one had the foggiest idea about "Fresh Start." Hence such a figure was not in quoted estimates.

Discussions with the management of several major companies indicate that many are viewing "Fresh Start" as an added earnings increment that will be reported in addition to expected operating earnings. A few others expect to meet Wall Street earnings expectations, but the operating number will include the "Fresh Start" provision. In essence, this says that the real reported operating earnings figure will be below "Street" projections!

Still, managements are being non-committal until they can get a sense of which way the wind is blowing. We wonder just how many companies might opt to include the "Fresh Start" number into consensus earnings estimates, or use the figure to write off some reinsurance recoverable problems, fund some inadequate reserves or finance the growth of certain business segments. One also would think that there might be a public relations problem if the industry apparently showed too fast an earnings recovery.

The provision seems to have more validity than the "Fresh Start" provision recorded several years ago by the life insurance industry. Although the provision has a one-time impact, it is occurring over a period of years.

Nonetheless, we are puzzled as to how or whether the "Fresh Start" provision should be capitalized. The one-time forgiveness will be more than offset in subsequent years with the higher tax payments. Perhaps the best thing to do is not to capitalize the increment but to let it flow into net worth with the belief that this figure will receive recognition over time.

It will be interesting to see just how the industry makes this "Fresh Start." The industry will either be conservative or it will return to its "self-destruct" mode.

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.

United HealthCare

United HealthCare Corp. in Minneapolis more than doubled its revenues and earnings in 1986.

Revenues increased 114% in 1986 to $216.2 million from $101.3 million in 1985.

Likewise, United HealthCare's 1986 net income increased 155% to $7.2 million from $2.8 million in 1985.

Much of the earning increase occurred in the fourth quarter of 1986 and was due to several factors, including a pretax gain of $2 million resulting from the sale to Lincoln National Life Corp. of 49% of UHC's Share-Nebraska and Share-Colorado health maintenance organizations; and one-time pretax write-offs of approximately $1.4 million due to the closing of several development-stage HMOs.

Enrollment in UHC's HMOs rose 41% in 1986 to 1.2 million.

Also in 1986, the number of physicians in the UHC network rose 63% to 23,500, a factor the company views as a sign of future market growth.

Hartford Steam Boiler

The Hartford Steam Boiler Inspection & Insurance Co. in Hartford, Conn., announced an agreement to purchase from Travelers Corp. 600,000 shares of Hartford Steam Boiler stock at $60 per share. Travelers will retain 200,000 shares.

"The purchase is an attractive investment for the company and should be beneficial to our shareholders in future years," said Wilson Wilde, president and chief executive officer of Hartford Steam Boiler.

The Home Group

The Home Group Inc. of New York has been approved for listing on the New York Stock Exchange. Trading of the company's common stock began March 31 under the symbol HME.

The Home's stock had been traded on the American Stock Exchange.

"Being on the Big Board will provide a broader market for our stock," said Marshall Manley, president and chief executive officer.

Warwick Insurance

Warwick Insurance Managers Inc. in Morristown, N.J., reported operating income for 1986 of $2.5 million, up from $1.2 million in 1985.

Net income for 1986 totaled $3.1 million up from $1.7 million in 1985, while net premiums written increased 58% to $34.9 million from $22.1 million in 1985.

Maxicare Health Plans

Maxicare Health Plans Inc. in Los Angeles reported revenues in 1986 soared, but net income dropped.

Revenues increased 75% to $914.4 million from $523.3 million in 1985. Meanwhile, net income in 1986 dropped to $4.3 million from $20.4 million in 1985.

Enrollment in the company's HMOs more than doubled in 1986 to 2.2 million from 695,886 in 1985. ■

BI Industry Stock Report

April 2, 1987 3/27/87 thru 4/2/87

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	30.50	-0.8	29.3	1.00	3.3	31.00	30.00	791.0
Baldwin & Lyons Inc	OTC	21.00	-4.5	9.1	0.20	1.0	22.00	21.00	6.8
Corroon & Black Corp	NYSE	33.38	-5.0	14.8	0.84	2.5	34.88	33.38	244.0
Gallagher Arthur J & Co	OTC	23.50	-3.1	16.8	0.40	1.7	24.50	23.50	48.5
Hall Frank B & Co Inc	NYSE	13.63	-1.8	0.0	0.00	0.0	14.00	13.63	161.7
Marsh & Mclennan Cos Inc	NYSE	64.63	-2.6	19.6	1.90	2.9	66.50	63.25	1,195.0
Poe & Assoc Inc	OTC	13.25	0.0	16.8	0.40	3.0	13.25	13.25	33.5
AGENTS/BROKERS	AVERAGE			16.8		2.5			
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	10.25	13.9	0.0	0.00	0.0	10.25	8.50	2,042.1
Berkley W R Corp	OTC	33.25	-8.3	13.9	0.24	0.7	35.50	33.00	661.6
Berkshire Hathaway Inc Del	OTC	3420.00	-2.8	233.9	0.00	0.0	3470.00	3360.00	1.4
CIGNA Corp	NYSE	61.63	-5.2	9.7	2.80	4.5	63.63	61.50	1,445.0
CNA Finl Corp (CNA)	NYSE	54.38	-12.5	13.5	0.00	0.0	60.00	54.38	260.8
General Re Corp	NYSE	59.50	-9.2	21.7	1.00	1.7	63.25	59.00	3,491.8
ITT (Hartford Group)	NYSE	60.63	-5.1	17.2	1.00	1.6	62.50	59.75	3,510.4
Sears Roebuck & Co. (Allstate)	NYSE	53.00	0.7	14.6	2.00	3.8	53.00	50.13	4,993.7
Transamerica Corp (Occidental)	NYSE	33.38	-4.0	9.3	1.76	5.3	34.50	33.25	1,229.8
CONGLOMERATES/HOLDING COS.	AVERAGE			86.7		0.2			
Insurers									
Aetna Life & Cas Co	NYSE	62.13	-6.0	10.1	2.76	4.4	64.13	61.50	2,694.0
American General Corp	NYSE	40.00	-7.5	11.1	1.25	3.1	42.00	40.00	1,717.2
Amern Heritage Life Invt Co	NYSE	42.50	0.0	14.7	1.32	3.1	42.75	42.50	1.0
American Indty Finl Corp	OTC	17.25	-0.7	0.0	1.12	6.5	17.25	16.75	15.5
American Intl Group Inc	NYSE	72.13	-7.7	17.9	0.25	0.3	76.25	72.13	2,009.3
Aneco Reins Ltd	OTC	3.25	-25.7	0.0	0.00	0.0	4.38	3.25	156.1
Avemco Corp	NYSE	40.50	-8.5	17.9	0.50	1.2	44.00	40.50	42.7
Business Mens Assurn Co Amer	OTC	28.00	-1.8	0.0	1.10	3.9	28.00	27.00	30.7
Chubb Corp	NYSE	65.25	-4.7	11.6	1.68	2.6	68.75	65.25	917.1
Combined Intl Corp	NYSE	53.88	-5.7	9.8	2.40	4.5	55.75	53.13	349.9
Continental Corp	NYSE	48.38	-8.7	13.4	2.60	5.4	52.13	48.38	637.0
Crown Life Ins Co	OTC	309.75	-4.8	10.7	6.40	2.1	325.25	309.75	0.0
Durham Corp	OTC	44.25	-0.6	14.8	1.36	3.1	44.75	44.25	22.7
Farmers Group Inc	OTC	46.25	-4.1	15.0	1.20	2.6	48.00	46.00	1,023.1
Fairmont Finl Inc	AMEX	18.13	-2.0	12.5	0.00	0.0	18.38	18.00	26.6
Fireman Fd Corp	NYSE	36.38	-9.1	15.5	0.40	1.1	38.00	36.38	1,436.6
Fremont Gen Corp	OTC	19.50	-1.3	0.0	0.48	2.5	19.75	19.13	144.8
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	0.00	0.00	0.0
Home Group Inc	AMEX	21.63	-6.0	5.8	0.20	0.9	22.63	21.38	461.1
Hanover Ins Co	OTC	72.50	-0.3	11.0	0.56	0.8	72.75	72.00	33.3
Harleysville Group Inc	OTC	17.13	-4.2	5.5	0.40	2.3	17.63	16.75	143.6
Hartford Steam Boiler Insptn	OTC	72.50	6.4	17.0	2.00	2.8	72.50*	68.50	152.4
Kans City Life Ins	OTC	27.75	-1.8	10.7	0.96	3.5	28.00	27.75	9.7
Kemper Corp	OTC	33.75	-8.2	13.4	0.60	1.8	36.25	33.75	965.3
Liberty Corp S C	NYSE	40.50	-2.4	14.3	0.72	1.8	41.75	40.50	10.0
Lincoln Natl Corp Ind	NYSE	49.50	-2.5	10.9	2.16	4.4	50.13	49.50	348.9
Mission Ins Group Inc	PAC	2.50	0.0	0.0	0.00	0.0	4.38	0.69	16.1
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Mac Re Corp	OTC	30.00	-4.8	46.2	0.00	0.0	31.25	30.00	64.8
Nobel Ins Ltd	OTC	15.00	1.7	11.3	0.37	2.5	15.00	13.50	103.4
Northwestern Natl Life Ins	OTC	25.38	-7.7	7.6	0.86	3.4	26.75	25.38	533.9
Ohio Cas Corp	OTC	45.25	-7.2	15.0	1.68	3.7	47.50	44.75	215.6
Old Rep Intl Corp	OTC	27.13	-3.1	11.3	0.80	2.9	27.75	27.00*	109.1
Orion Cap Corp	NYSE	25.25	-10.6	0.0	0.76	3.0	28.00	24.50*	113.6
Protective Corp	OTC	17.25	-2.8	11.1	0.70	4.1	17.25	16.63*	99.7
Provident Life & Acc Ins Co	OTC	23.38	-5.1	10.9	0.84	3.6	24.38	23.13	157.0
St Paul Cos Inc	OTC	46.88	-5.8	13.6	1.76	3.8	49.00	46.75	1,896.1
SAFECO Corp	OTC	54.50	-4.8	11.3	1.70	3.1	56.75	53.75	698.3
Scor U S Corp	OTC	14.75	-1.7	23.4	0.00	0.0	15.25	14.75	228.1
Seibels Bruce Group Inc	OTC	19.00	1.3	0.0	0.80	4.2	19.00	17.50	141.2
Selective Ins Group Inc	OTC	24.00	0.0	11.1	0.92	3.8	24.00	23.13	95.2
Statesman Group Inc	OTC	4.88	-2.5	5.6	0.05	1.0	5.00	4.88	170.3
Tokio Marine & Fire Ins Co	OTC	76.88	0.0	86.4	0.17	0.2	76.88	76.88	15.3
Torchmark Corp	NYSE	29.00	-4.9	10.7	1.20	4.1	30.50	29.00	332.8
Travelers Corp	NYSE	47.75	-5.7	10.7	2.28	4.8	49.63	47.00	5,398.6
Trenwick Group Inc	OTC	16.50	-5.7	42.3	0.00	0.0	17.50	16.50	37.7
United Fire & Cas Co	OTC	27.50	-0.9	10.6	0.80	2.9	27.50	26.50	52.0
United States Fid & Gty Co	NYSE	42.00	-7.9	11.6	2.48	5.9	43.88	41.75	2,475.7
Unum Corp	NYSE	25.00	-1.0	10.0	0.40	1.6	25.25	24.25	1,916.8
Uslife Corp	NYSE	41.88	-0.9	10.7	1.20	2.9	41.88	40.75	358.8
Washington Natl Corp	NYSE	28.38	-4.2	13.4	1.08	3.8	29.88	28.25	34.2
Zenith Natl Ins Corp	OTC	23.25	4.5	17.7	0.80	3.4	23.25	21.25	332.9
INSURANCE COMPANIES	AVERAGE			13.0		2.6			

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