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Update

Maxicare replaces management after more than $325 million loss

LOS ANGELES—In a management shake-up following 18 months of losses totaling some $327.2 million, Maxicare Health Plans Inc.'s board of directors last week replaced the health maintenance organization's chief officers who had founded the firm.

Co-founders Fred W. Wasserman, chairman, and Pamela K. Anderson, president, were replaced by another board member, Peter J. Ratican, who was elected chairman, president and

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Bonus bonanza

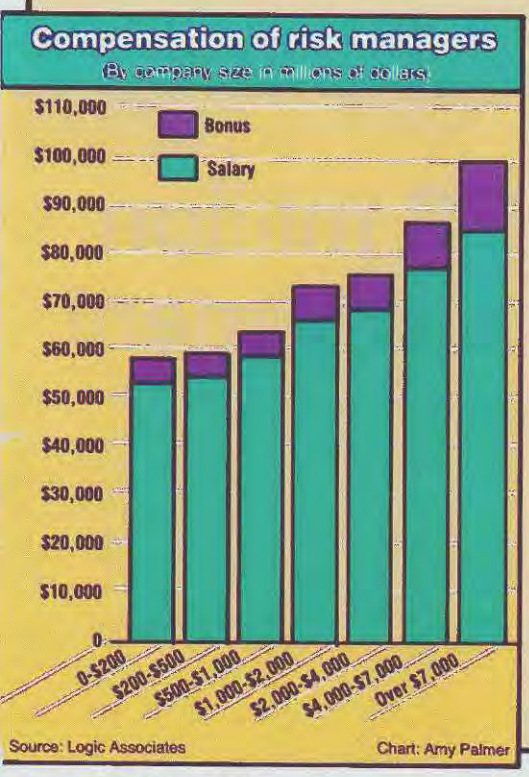
Bonuses shot up for most risk managers in 1987 and resulted in higher overall compensation last year, according to a survey by New York-based recruiting firm Logic Associates Inc.

The smaller companies that responded to the seventh-annual survey on the risk management profession reported the largest total compensation increases—up to 20%.

But, risk managers at larger companies—those reporting more than $2 billion in annual sales—reported either no change or even a reduction in their average total compensation.

Coverage of the Logic survey results begins on page 3. Charts compare risk managers' average 1987 compensation with 1986, as well as average compensation among similarly sized companies in 12 industry groups.

Next week, articles will report risk managers' responsibilities, educational backgrounds and the proportion of women in the risk management profession.



401(k) regulations damaging to plans

By JERRY GEISEL

WASHINGTON—New Internal Revenue Service regulations governing 401(k) salary reduction plans will further reduce the plans' appeal to employees as well as sock employers with new administrative burdens.

IRS regulations—published last week in the Federal Register, more than three years after they were supposed to appear—virtually will eliminate 401(k) plans as a convenient, tax-sheltered home in which employees can temporarily park their extra cash until they need it.

Employees still will be allowed to make in-service withdrawals of contributions for such traditional hardships as purchasing a home or paying for a child's college tuition, but the conditions attached are very tough: Either the employee must be truly needy or the employee must forgo contributing to the 401(k) plan for one year, among other things.

Faced with these hardship withdrawal restrictions that take effect Jan. 1, employees—especially lower-paid workers—are likely to reduce their salary deferrals. That would exacerbate problems that some employers already have in trying to pass the 401(k) non-discrimination tests established by the Tax Reform Act of 1986.

If lower-paid employees cut their 401(k) deferrals, employers will have to place new limits on contributions by higher-paid workers for their 401(k) plans to pass the non-discrimination tests.

And, employers that match workers' 401(k) deferrals and allow employees to make aftertax contributions—which are covered under Section 401(m) of the Internal Revenue Code—will face an additional problem in trying to pass the non-discrimination tests.

While employers have been able to use the most liberal non-discrimination formula—known as the "200% test"—to test for non-discrimination for both 401(k) deferrals and 401(m) contributions, the IRS is proposing to end the double use of the test.

Instead, the 200% test could be used only once. For example, if the employer used the 200% formula to test 401(k) salary deferrals, it would have to use a much tougher "125% test" to compare the 401(m) contributions of the higher and lower-paid employees for non-discrimination purposes.

While this portion of the regulations is only a proposal, it is unlikely that the IRS will back off from its position, experts say.

In addition, the regulations will take away a tactic employers now can deploy to give employees another incentive to make deferrals to their 401(k) plans: Under a proposed regulation that would be effective Jan. 1, employers will not be allowed to require 401(k) contributions as a condition to receive other benefits.

An employer could not, for example, reduce an employee's group health insurance benefits if the employee did not make a salary deferral to a 401(k) plan.

Aside from restrictions, the regulations add yet another layer of complexity to the operation of 401(k) plans.

"The IRS has given a great deal of guidance, but employers have to be careful not to run afoul of the

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BC/BS develops new strategies to reverse losses

By DONNA DiBLASE

CHICAGO—In the wake of a 1987 net loss of almost $2 billion among its member plans, officials at the Blue Cross & Blue Shield Assn. say the group of health plans is fighting back to profitability and growth.

Premium increases, managed care programs, new national products for employers—including nationwide managed care programs and centralized claims administration—and individual plan cost reductions are the Blues' weapons against future losses.

Premium increases in 1988—on top of increases ranging from 15% to 25% last year and 8% to 15% in 1986 among the 77 BC/BS member plans—are expected to reduce the collective loss this year, said BC/BS Assn. President and Chief Executive Bernard Tresnowski.

"We're beginning to see that what we priced for is coming true. I think our 1988 results will show that our underwriting cycle will begin to turn" toward gains instead of losses, he said.

However, "we're going to lose some money in 1988, although it's not yet clear just how much."

BC/BS Assn. could not estimate the range of 1988 premium

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National claims network available to BC/BS clients
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Republicans will gather at the Superdome today in New Orleans for the start of the GOP national convention.
Photo: AP/Wide World

Only victory not insured

By JUDY GREENWALD

NEW ORLEANS—The Republican National Convention will be no more short of insurance than it will be of rhetoric when it opens today.

In fact, about the only item not insured at either the Republican convention this week or last month's Democratic National Convention is victory in the November elections.

In both cases, brokers in each convention's host state placed the insurance: Coverage for the Republican gathering at the Louisiana Superdome in New Orleans today through Thursday was placed by Shreveport, La.-based Kouns & Green Inc.

Coverage for the Democratic convention, held July 18-21 at the Omni Center in Atlanta, was brokered by the Marsh & McLennan Inc. office in Atlanta, which worked in conjunction with minority-owned Atlanta-based Jenkins, Owens & Associates.

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Update

Ailing Maxicare reorganizes

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chief executive officer of the ailing HMO company.

The husband-and-wife team of Mr. Wasserman and Ms. Anderson will remain with the firm in a consulting capacity, said a company statement issued last week. Officials did not return phone calls.

Mr. Ratican, 44, has been a director of Maxicare since 1983 and most recently served as chief financial officer of De Laurentis Entertainment Group, a Beverly Hills, Calif.-based filmmaker.

Maxicare, one of the nation's largest HMO firms, expects to report a second-quarter 1988 loss of roughly $50 million, according to the statement. In the first-quarter, Maxicare posted a loss of $21.3 million. This follows a 1987 loss of $255.9 million, which created a negative net worth of $29.3 million.

The HMO, which has 2 million members in 26 states, attributed the losses to rising health care costs and expenses related to the consolidation of two major 1986 acquisitions: Nashville-based HealthAmerica Corp. and Orange, Calif.-based Health Care USA (*BI,* Aug. 4, 1987; July 21, 1987).

As a result of the loss, Maxicare was forced to restructure its $175 million in bank debts and has been selling assets to meet the terms of its bank agreements.

So far, Maxicare has sold HMOs in Florida; Kentucky; San Antonio, Texas; Atlanta; and Omaha, Neb. Pending sales include HMOs in Maryland, Virginia, Philadelphia and Pittsburgh (*BI,* March 21).

Maxicare stock closed Thursday at less than $1 a share.

Meanwhile, a shareholder suit was filed in Los Angeles County Superior Court July 15 charging several directors—including Mr. Wasserman, Ms. Anderson and Mr. Ratican—with selling Maxicare stock at artificially inflated prices based on inside information since 1985.

Panel OKs COBRA changes

WASHINGTON—Former employees with pre-existing medical conditions would have the right to obtain COBRA health care coverage even if they become covered under their new employer's health care program, under technical corrections legislation passed last week by the House Education and Labor Committee.

Former employees could opt for COBRA coverage from their previous employers if their health care claims were denied by the new employer because of a pre-existing medical condition, under the provision.

Currently, the Consolidated Omnibus Budget Reconciliation Act of 1985 does not allow a former employee to obtain COBRA coverage when he or she becomes covered under another employer's health care plan.

The measure also would encourage pension plan expansion and improve pension portability by allowing employers that do not offer pension plans to establish a Simplified Employee Pension plan with a salary reduction feature and by making it easier for employers to transfer pension benefits of employees who quit to individual retirement accounts.

Proposals encourage day care

WASHINGTON—Employers would have an incentive to create or expand day care centers under two new Congressional proposals.

Sen. Dave Durenberger, R-Minn., last week introduced S. 2690, a bill that would, among other things, grant employers that build or expand an on-site child care facility a 25% tax credit up to $100,000 annually.

The bill also would establish a federal fault-based system of liability for child care providers, reduce awards against child care providers by the amount of compensation plaintiffs receive from other sources, and strengthen the standard of evidence plaintiffs must provide to collect punitive damage awards.

And, Sen. Pete Wilson, R-Calif., plans to introduce a child care bill that would grant businesses with 50 or fewer employees a 25% tax credit up to $100,000 annually for expenses of building or operating an on-site or near-site child care facility. It also would grant states up to $100 million to establish shared-risk programs to decrease the cost of liability insurance for day care centers.

Meanwhile, the House Education and Labor Committee last week approved a bill to subsidize child care for families with incomes of up to 115% of the median income level in each state that receives the funds.

The bill, which would cost about $2.5 billion, is similar to S. 1885, a bill approved by the Senate Labor and Human Resources Committee earlier this summer (*BI,* Aug. 1).

Two rig owners file claims

LONDON—Part of the physical damage claim for two of the owners of the $790 million North Sea oil platform that exploded July 6 likely will be paid by the end of the week, sources say.

Brokers, underwriters and representatives of Union Texas Petroleum Ltd. and Thomson North Sea Ltd. "furiously" negotiated documentation last week of physical damage to the Piper Alpha rig. The explosion, which surveyors say caused a total loss, killed 167 people (*BI,* Aug. 1; July 18; July 11).

Union Texas and Thomson, which each owned 20% of the platform, have filed claims for physical damage to the rig, said John Turner, deputy managing director of the oil and gas division of Willis Faber & Dumas Ltd. Based on the platform's insured value, the two companies' share of the physical damage loss could total $296 million.

The two other owners, Occidental Petroleum (Caledonia) Ltd., with a 36.5% stake, and Texaco Britain Ltd., with 23.5%, are expected to submit their claims shortly, Mr. Turner said.

Lloyd's of London underwriters are using a special weekly claims settlement procedure to speed up payment, he noted.

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Firm suspends policy excluding AIDS claims

By GLENN HUNTLEY

PHOENIX, Ariz.—Circle K Corp. last Thursday suspended pending further review its controversial medical plan provision excluding coverage for lifestyle-related claims such as AIDS and drug and alcohol abuse.

The self-insured company's recently revealed policy, designed to control rising health plan costs, applied to employees hired after the policy's Jan. 1 effective date.

"A general misunderstanding of the policy has arisen that needs to be clarified," said a statement from the company. Company officials would not elaborate on the misunderstanding, but the statement said Circle K will "focus on clarification of language and of some conditional exclusions," with the review completed by the end of the month.

Circle K had recognized earlier that its policy to exclude claims resulting from "personal lifestyle" would be controversial and expected "in all probability it would be settled in the courts," Senior Vp Ray Cox, said earlier in the week.

No suits had been filed as of last week.

Circle K's policy also could spur activist groups to press Congress to amend the Employee Retirement Income Security Act of 1974 to prohibit self-funded health plans from excluding coverage for such claims.

Benefit consultants, meanwhile, say there are more effective ways to control health care costs.

Circle K, the country's second-largest chain of convenience stores, informed 8,000 employees late last year that it no longer would pay for health care claims that it determines—based on case-by-case examinations of medical records and employee interviews—were caused by "personal lifestyle decisions." Under the policy, AIDS cases caused by blood transfusions would be covered, whereas AIDS claims by homosexuals and drug users would not.

Also to control costs, the company extended effective Jan. 1 the waiting period for new employees to obtain health care coverage to six months from 90 days. Circle K has rapid turnover, with many employees staying only a few months, Mr. Cox said.

The company decided to exclude lifestyle-related health care claims after its health care costs nearly doubled in 1987, Mr. Cox said. Although he did not know what percentage of the company's health care costs was attributable to lifestyle choices, "for the long-term, we feel it would be substantial," Mr. Cox said.

No lifestyle-related health care claims have been filed this year, Mr. Cox said.

While the policy was implemented in January, it was first publicly revealed earlier this month when employees complained to civil liberties groups.

Circle K could face employment discrimination suits in states that have strict anti-employment discrimination laws, said Richard Gisonny, an attorney and technical consultant for TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. of New York.

Mr. Gisonny said some states may find Circle K's policy discriminatory against homosexuals with AIDS.

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Insurers to pay $50 million to FSLIC in E&O settlement

By DEBORAH SHALOWITZ

WASHINGTON—A Philadelphia law firm's record $50 million settlement with the Federal Savings and Loan Insurance Corp. over its representation of a failed Florida thrift is fully insured, according to the firm.

However, David Girard-diCarlo, managing partner of Blank, Rome, Comisky & McCauley, would not name the firm's professional liability insurers.

Among lawyers E&O insurers that confirmed they did not write Blank Rome's coverage are: Home Insurance Co.; St. Paul Fire & Marine Insurance Co.; and the Chicago-based Attorneys Liability Assurance Society Inc., A Risk Retention Group.

Among major underwriters of lawyers E&O insurance that declined to comment are: Shand Morahan & Co. Inc.; CNA Insurance Co.; and Crum & Forster Managers Corp.

Among other large E&O insurers of lawyers that did not return phone calls are: American International Group Inc.; CIGNA Corp.; and Chubb Corp.

"This settlement demonstrates that where violations contributing to insolvency are caused by the negligence or malpractice of professionals, including law firms, the Bank Board will hold them, as well as thrift management, fully responsible and accountable," said M. Danny Wall, chairman of the Federal Home Loan Bank Board, which oversees the FSLIC.

The agency routinely sues attorneys and accountants who have contributed to a thrift's insolvency, an FSLIC spokesman said. However, this is the largest settlement with a law firm.

The Blank Rome case involves Sunrise Savings & Loan Assn. of Boynton Beach, Fla., which the law firm's partners created in 1980 as a state-chartered stock association. The partners solicited the S&L's original investors and attended board meetings.

Sunrise increased its assets in five years to $1.5 billion in 1985 from $4.7 million in 1980, but was insolvent and placed in receivership July 18, 1985.

The FSLIC filed suit against Blank Rome in September 1986 charging, among other things, the firm acted negligently in advising Sunrise Savings, improperly closed loans and aided former Sunrise officials in violating several laws and banking regulations.

The FSLIC at that time also filed a lawsuit against the directors and officers of Sunrise.

The FSLIC sought a total of $250 million in damages in the suits, which were combined in the U.S. District Court for the Eastern District of Pennsylvania.

As a result of its settlement with the FSLIC, Blank Rome has been dropped from the suit.

Under the settlement, an insurance proceeds escrow account will be established that will accrue interest.

Of the $50 million total, $9.5 million will be set aside to pay any other claims against Blank Rome, and another $1.5 million will used to settle future stockholder suits. In addition, $10 million will be paid to Sunrise shareholders.

The FSLIC will receive $29 million of the settlement with Blank Rome. ■

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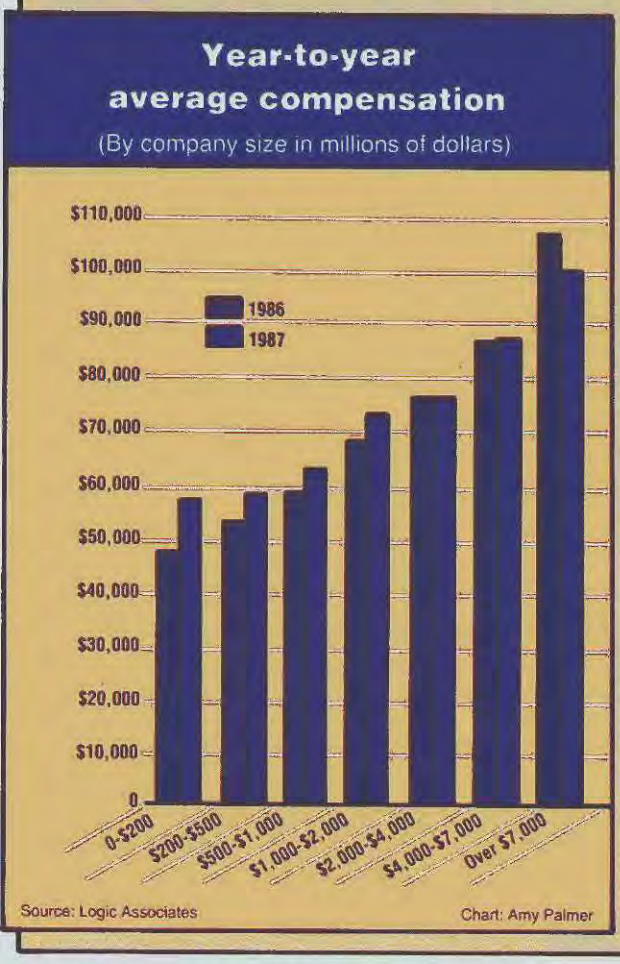
Bonus boom hikes risk managers' pay



By KAREN HUELSMAN

Compensation for risk managers, fueled by double-digit increases in bonuses, rose in 1987 at all but the largest companies, according to a new survey.

Risk managers at smaller companies benefitted from the bonus bonanza more than those at larger companies, according to the seventh annual salary survey by Logic Associates Inc., a New York-based recruiting firm.

Risk managers at the smallest companies surveyed—with revenues less than $200 million—received an average 20% increase in compensation, based on an 18% salary increase and a 63% bonus increase.

However, risk managers at companies with revenues of $4 billion to $7 billion received an average compensation increase of only 0.5% last year. Their average salaries actually declined by 1%, while their bonuses rose by only 15%.

Average compensation for risk managers at companies with sales of $2 billion to $4 billion was virtually flat in 1987 compared with 1986, with salaries declining by 2% and bonuses rising by 20%.

And, average compensation for risk managers at companies with more than $7 billion in sales decreased 7% last year. Salaries fell 6%; bonuses fell 11%.

Compensation increased more at smaller companies because there is increasing competition for risk managers at small to medium-sized companies.

"More and more companies are hiring professional risk managers. There is somewhat of a shortage," which pushes salaries up, said Bill Perry, an executive vp at Logic. "Corporations are looking for better qualified people—aware of the value of a risk manager."

More risk managers within the smaller revenue categories also change jobs, which can spur a 15% to 20% increase in total compensation for a comparable position.

"There's a market inducement in there that isn't normally seen on an annual review basis," said Richard Meyers, executive vp at Logic.

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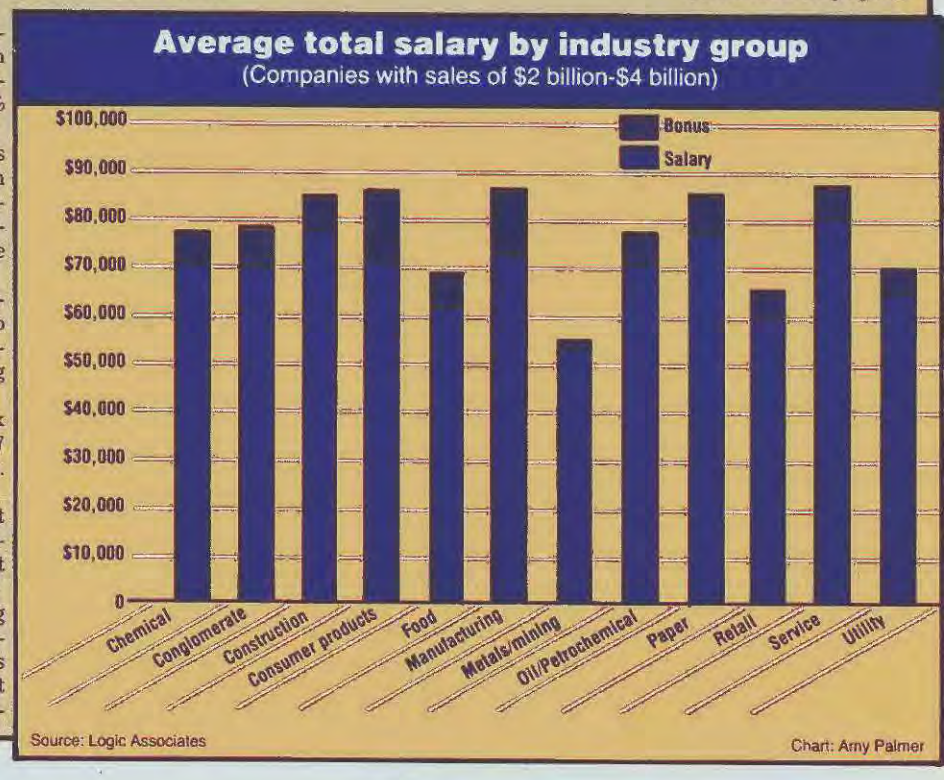

ATLA conference

Author blasts tort 'deform'

By STACY ADLER

KANSAS CITY, Mo.—U.S. manufacturers and their insurers have launched a two-pronged attack on the nation's judicial system by attempting to "deform" the tort system and by "fraudulent misuse" of the bankruptcy code, a well-known asbestos industry observer charges.

"Why are the nation's manufacturers and their insurance carriers so aware of the asbestos litigation, and why are they spending millions of dollars across this nation in a campaign to weaken the tort system?" asked Paul Brodeur, author of "Outrageous Misconduct: The Asbestos Industry on Trial," a book tracking the saga of the asbestos bodily injury litigation in the United States.

"Because they see the asbestos litigation as a precedent," answered Mr. Brodeur, who also is a staff reporter for New Yorker magazine, during a speech at the Assn. of Trial Lawyers of America's annual convention July 29-Aug. 5 in Kansas City, Mo.

Mr. Brodeur received a standing ovation for his message that manufacturers and insurers—through tort reform and new uses of U.S. bankruptcy laws—are attempting to create "a no-fault administrative system for compensating the victims of occupational and environmental disease."

"The captains of the chemical industry know that they have for 40 years dumped hundreds of millions of gallons of unlabeled, cancer-producing chemical waste into landfills across the nation and that this waste is seeping into the nation's drinking water supplies," he said.

"The insurance carriers for these manufacturers know they are on the risk for the disease that is now developing because of this indiscriminate dumping and they want desperately to get off that risk."

Together, these manufacturers and insurers are working to create a system in which the victims of occupational and environmental disease are paid based on a fixed schedule from a fixed fund, said Mr. Brodeur. Under this system they can "fold the costs of compensation neatly into the cost of production," he said.

"With such a no-fault system, the nation's corporations will be able to institutionalize occupational and environmental cancer as a way of life—albeit a shorter life," said Mr. Brodeur.

The total toxic waste problem in America is huge, with more than 265 million metric tons of hazardous waste produced annually and only 1% of that toxic waste actually destroyed, he said.

"The worst news of all is that the most promising preventive measure we have to fight cancer and other environmental disease is under massive and unprecedented assault," he said, referring

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Lawyers slow litigation: Judges

By ALISON KITTRELL

State and federal judges blame lawyers for slowing the wheels of justice and needlessly driving up legal costs, especially in such "high stakes" cases as medical malpractice and product liability litigation, a recent survey shows.

Abuse of the discovery process is the chief cause for the legal logjam, according to many of the 200 federal court judges and the 800 state court judges polled by Louis Harris & Associates for Aetna Life & Casualty Co. late last year for the survey, titled "Judges' Opinions on Procedural Issues."

For example, some 45% of the federal judges and 34% of the state judges blamed lawyers' abuse of the discovery process for delays in litigation.

Other factors the judges blame for driving up litigation costs and slowing the judicial process are a shortage of judges, the filing of frivolous suits and incompetent attorneys.

Some 21% of the federal judges and 27% of the state judges said there were too few judges to handle the caseload assigned to them, while 18% of the federal judges and 9% of the state judges said attorneys are filing too many frivolous lawsuits.

In addition, 27% of the federal judges and 36% of the state judges attributed the courtroom delays to incompetent and overzealous attorneys who take on too much work.

Attorneys contacted about the poll scoffed at the judges' allegations that lawyers are principally to blame for the legal logjam.

"That's factual garbage," asserted David Shrager, a plaintiffs' attorney with the Philadelphia firm of Shrager, McDaid, Loftus & Flum. "Of course there are some frivolous lawsuits, but for every frivolous lawsuit that is filed, one with merit is not."

Judges criticize the amount of litigation that attorneys file because "a lot of judges don't want to work too hard," Mr. Shrager said.

Eugene Anderson, a attorney with Anderson, Russell, Kill & Olick in New York who represents policyholders in insurance coverage disputes, also disagreed with the judges' opinions.

"The courts should be open to everyone," even those who on the surface appear to be bringing meritless suits, asserted Mr. Anderson, because suits often effect change.

For example, Mr. Anderson pointed out that the historic *Brown vs. Board of Education* lawsuit, which led to school desegregation, was considered frivolous when it was filed.

The survey also found that most of the judges believe attorneys' abuses of the discovery process are driving up litigation costs.

A whopping 86% of federal judges and 69% of state judges said a major cause of high legal costs was "lawyers who use discovery to 'turn over every stone' rather

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Initiative vote may resurrect Cal/OSHA

By GLENN HUNTLEY

SACRAMENTO, Calif.—The largely dissolved California workplace safety agency could be resurrected this fall if voters in the state approve a ballot initiative that would return oversight of all workplaces to the agency.

But, even if the ballot initiative fails, the California Division of Occupational Safety and Health, which now regulates the workplaces of only public employees, could be restored.

A Senate bill is pending that would restore state funding for Cal/OSHA.

And, the California Supreme Court has agreed to consider whether Gov. George Deukmejian exceeded his authority when he snuffed out $7 million of Cal/OSHA funds in June 1986 in a budget line-item veto, despite objections from employers and even some of the governor's traditional Republican allies.

The governor explained when he first announced his intention to veto spending for Cal/OSHA that it was a money-saving move (*BI*, Feb. 23, 1987).

The U.S. Occupational Safety and Health Administration took over responsibility for workplace safety for all but public workplaces, like schools and government facilities, in July 1987. But OSHA has drawn heavy criticism from labor groups, which charge that it is not as tough as the state program was.

Cal/OSHA's total budget for overseeing private sector workplaces had been $34 million. Besides the $7 million the state contributed, $10 million more in funding was derived from fines and fees the agency imposed. The federal government provided $17 million of the state program's funding.

A comparable figure for federal spending since OSHA took control in California was not available from OSHA because OSHA manages its budget on a regional, not a state-by-state, basis.

Cal/OSHA supporters believe their best shot to fully restore the program may be the ballot initiative. Proposition 97, approved by the secretary of state in June for the November ballot, would re-institute Cal/OSHA's

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New York probes surety insurer

NEW YORK—The New York Insurance Department is warning contractors that an unlicensed surety company is violating New York State Insurance Law by writing surety bonds in the state.

The surety insurer, United American Surety Co. Ltd., was never licensed as an admitted insurer nor approved to operate as a surplus lines insurer in the state, the department charges.

However, the surety insurer, an association-owned captive domiciled in the Bahamas, disputes the Insurance Department's allegations.

The Bahamas-based United American Surety has been illegally writing surety bonds for New York contractors through its parent, Boston-based United American Contractors Assn., according to a spokesman for the Insurance Department, which is currently investigating the insurer's activities.

In addition to being unlicensed, United American Surety also is ineligible to write as an excess insurer in the state, having failed to meet the minimum requirements of the department's Regulation 41, including the establishment of a $1.5 million trust fund, the department charges.

Any New York-licensed broker placing surety business with United American Surety is subject to license revocation and/or fines.

The Insurance Department warns that it has no control over the premiums charged or the terms and conditions of coverage offered by United American Surety and that parties accepting the insurer's bonds are not protected by the state guaranty fund.

Charging the New York Insurance Department with "attempting to regulate by adverse publicity," Thomas P. Carrigan, executive director of United American Contractors Assn., contends that the insurer "writes bonds for association members because brokers are unable to purchase them from insurers who are increasingly withdrawing from the marketplace."

Furthermore, Mr. Carrigan said, the New York Insurance Department "never issued a 'cease-and-desist' order" against United American Surety.

—By Collin Nash

Comings & goings: buyers

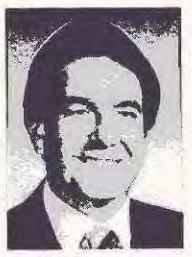
Winchell's McGuigan promoted to manage employee benefits

Kate McGuigan, 31, was promoted to director of administration at Winchell's Donut Houses L.P. in La Mirada, Calif. In this newly created position, Ms. McGuigan continues to oversee risk management and now is also responsible for employee benefits, human resources, employee relations and information resources for the chain of doughnut stores. Ms. McGuigan reports to Doug Felderman, vp and chief financial officer. Ms. McGuigan joined the Denny's Inc. unit in 1987 as director of risk management. Prior to joining Winchell's Donut Houses, she was director of risk management at Trans-Technology Corp. in Los Angeles. She holds a bachelor of arts degree from the University of Northern Colorado in Greeley. In addition, she is a member of the national Government Affairs Committee of the Risk & Insurance Management Society Inc. and a member of the Orange County Chapter of RIMS.

Also at Winchell's: **Rose Marie Goldman** has been named risk management administrator. In this newly created position she is responsible for all risk management and employee relations claims. She reports to Ms. McGuigan. Prior to joining Winchell's, Ms. Goldman served as risk management administrator at Lucky Stores Inc. in Dublin, Calif. Ms. Goldman is a deputy member of the Risk & Insurance Management Society Inc.

* * *

Laurence S. Brilliant, 39, has been named risk manager for the San Juan Unified School District in Carmichael, Calif. In this newly created position, Mr. Brilliant oversees property/casualty insurance, workers compensation and special insurance programs, as well as safety, loss control and waste management activities for the school district. He reports to Carl E. Thompson, assistant superintendent-business operations division. Prior to joining the school district—the eighth-largest in California—Mr. Brilliant was director of general claims for the Western Pacific Railroad Co. in San Francisco. He holds a bachelor of science degree in criminology from California State University at Fresno and a master of public administration degree from Golden Gate University in San Francisco. In addition, Mr. Brilliant is working toward earning the Associate in Risk Management designation.



Mr. Brilliant

* * *

D.A. (Chuck) Raetz, has been named director of administration at the International Foundation of Employee Benefit Plans in Brookfield, Wis. In this newly created position he oversees human resources programs, including employee benefits, as well as payroll, purchasing and other responsibilities. Mr. Raetz reports to John Altobelli, chief executive officer of the employee benefits educational association. Prior to joining the IFEBP, Mr. Raetz served as manager of human resources for Eaton Corp.-controls division in Wauwatosa, Wis. He holds a bachelor of science degree in economics from the University of Wisconsin in Madison. In addition, he is a member of the American Society for Personnel Administration and holds the Accredited Personnel Manager designation.

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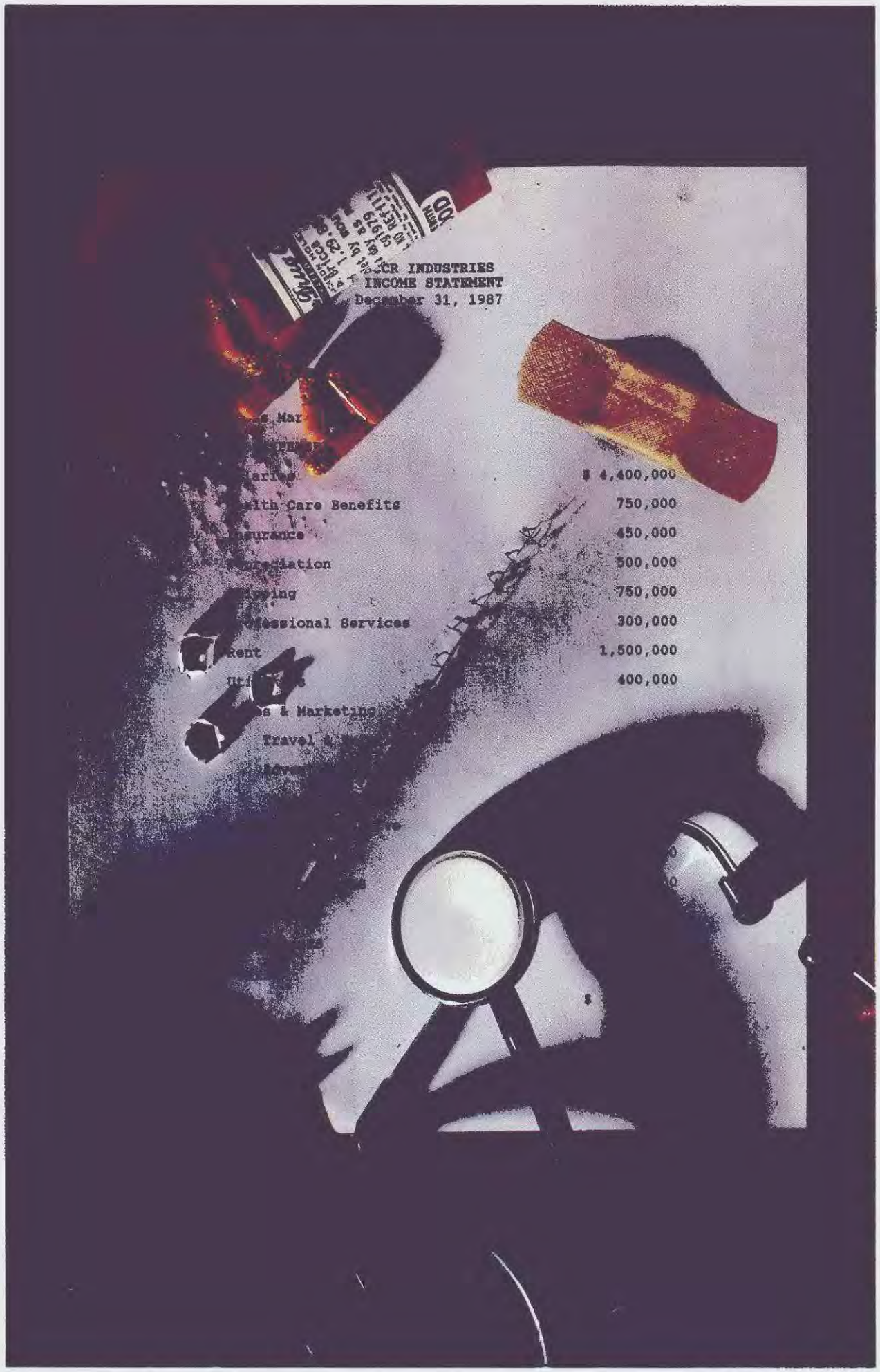

There's an epidemic sweeping the country that is causing considerable pain to upper management.

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Polaroid employees contribute to ESOP

By GLENN HUNTLEY

About 10,000 U.S. employees of Polaroid Corp. are contributing 5% of their annual salaries in exchange for company stock as part of a mandatory leveraged employee stock ownership plan.

The ESOP, which is part of the Cambridge, Mass.-based employer's program to cut costs over the next few years, will acquire up to $300 million in Polaroid common stock over the next 10 years, which would result in 14% employee ownership of the company, a Polaroid spokeswoman said.

By distributing stock to employees in lieu of pay and eliminating 500 to 800 jobs through an early retirement program, Polaroid hopes to cut expenses by about $50 million in 1989, the spokeswoman said.

Under a leveraged ESOP, a company sets up an ESOP by creating a trust fund, which then arranges for a bank loan to finance the purchase of company stock.

The company then makes regular, tax-deductible contributions to the ESOP, which the trust uses to repay the loan. As the loan is repaid, shares of stock are allocated to employees' accounts in the ESOP since it no longer must be used as security for the loan.

Under the Polaroid ESOP, which is being financed by Morgan Guaranty Trust Co. in New York, stock allocations will be made to employees twice annually, the spokeswoman explained.

Employees' shares earned through the ESOP can be collected directly in stock or sold back to the company for cash upon retirement.

The Polaroid stock, for which the ESOP paid $30 per share on July 11, was trading at $41.38 per share last week.

In addition to the ESOP, Polaroid is offering employees early retirement incentives as a further belt-tightening move.

Polaroid employees 45 years of age or older who are fully vested in the company's defined benefit plan are now eligible to retire with reduced benefits.

Previously, only vested employees over age 55 were eligible for early retirement.

In addition, Polaroid employees who retire early will receive one month's pay for every two years of service up to a maximum of one year's salary.

Hospital charges

Negotiated hospital rates under preferred provider contracts helped reduce average hospital charges for major Los Angeles-area employers, according to an annual employer-sponsored survey.

The study compared the health care costs and utilization of 14 large Los Angeles-area employers with the aggregate experience of California health claims paid by Aetna Life & Casualty Co. of Hartford, Conn., San Francisco-based Blue Shield of California and Newark, N.J.-based Prudential Insurance Co. of America.

The study, funded by the Employers Health Care Coalition of Los Angeles, found daily hospital charges averaged $864 among the employers in the survey group, or about 15% less than the $1,013 reported by major health insurers. The majority of the surveyed employers—10 of 14—had negotiated price contracts with hospitals.

Inpatient hospital care accounted for 35% of all charges reported by the surveyed California employers, compared with 41% of costs among the insurers.

Participating employers had implemented cost containment measures including unlimited home health care coverage, chemical dependency treatment limits of $50,000 or less during each employee's lifetime, unlimited hospice coverage, medical case management, mandatory second surgical opinions, ambulatory surgical incentives and hospital preadmission certification.

"The study shows that effective cost containment can definitely reduce inpatient charges. That should be of interest to anyone who has responsibility for benefit plan costs," said Monica Desmond, chairwoman of the Employers Health Care Coalition of Los Angeles and director of employee benefits for Denny's Inc. in La Mirada, Calif.

"The gist of the survey is that cost containment works, at least for large employers," Ms. Desmond said.

Despite the lower inpatient charges, the number of admissions reported by the employers participating in the study shows room for improvement, said Joan Holmes, vice chairwoman of the health care coalition.

Hospital admissions in the employer group totaled about 90 per 1,000 covered lives last year, compared with fewer than 80 per 1,000 covered lives among the insurance companies, the study found.

"The high rates of admissions especially for psychiatric treatment, shown in the study indicate that employers must work with their employee assistance plans and utilization review organizations to ensure that care is rendered in the most appropriate setting," Ms. Holmes said.

The study also found that hospital charges for normal maternity care varied widely among employers, indicating the need for employers to shop for maternity care just as they would shop for other health care services.

The companies participating in the survey included many of California's largest employers such as Lockheed Corp., Hughes Aircraft Co., General Telephone Co., Los Angeles County, Denny's and Computer Sciences Corp.

The companies, which employ about 139,000 people in the Los Angeles area, provide group health care coverage for 343,000 lives.

The employers reported more than $378 million in covered charges under their benefit plans in 1987, resulting in $324 million in paid claims after copayments.

The survey data was analyzed by Garner Consulting of Pasadena, Calif.

•

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 Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3710.

Benefit beat

Falling revenues trigger loss for Hall

By LINDA J. COLLINS

BRIARCLIFF MANOR, N.Y.—Falling revenues caused Frank B. Hall & Co. Inc. to lose $7.1 million in the second quarter, despite stringent expense control measures initiated last fall.

Hall, the sixth-largest U.S. insurance broker, reported declines in both second-quarter and first-half gross revenues, indicating that it has lost market share in comparison with the other publicly traded brokers, all of which reported revenue gains in both periods (*BI*, Aug. 8).

In addition,Hall—which reported net losses for the second quarter and the first half—is the only publicly held broker to report a loss in either period.

Also, Rollins Burdick Hunter Co., a unit of Aon Corp. and the seventh-largest U.S. broker, last week reported large gains in revenues and income.

Hall's $7.1 million net loss in the second quarter of 1988 compares with a $2.2 million net loss in the second quarter of 1987. Hall's net loss in the first half totaled $1.4 million compared with net income of $5.6 million during the first half of 1987.

Hall's gross revenues—including investment income—fell 7.7% in the second quarter to $96.9 million from $97.9 million in the second quarter of 1987. First-half gross revenues fell 5.4% to $191.2 million in 1988 from $202.2 million last year.

Net commissions and fees alone plunged 8.8% in the second quarter and 5.9% in the first half.

Analysts say Hall's poor performance is not a surprise.

"Considering what the company has gone through in the last couple of years, its results are not that bad," said John E. Keefe, vp-research for Drexel Burnham Lambert Inc. in New York, referring to problems that have plagued Hall since 1984 stemming from discontinued underwriting operations, its now-defunct truck leasing subsidiary and resulting litigation and media attention.

"The loss was larger than I had expected, but I'm not surprised that the company reported a loss. I expect the company to continue to lose a significant amount of money for the balance of 1988 and all of 1989," said analyst Thomas G. Rosencrants, senior vp at Johnson Lane Space Smith & Co. Inc. in Atlanta.

"It looks like they are participating in a losing-market-share game," observed Michael A. Smith, research analyst for Shearson Lehman Hutton Inc. in New York.

"Their whole problem was on their revenue line," Mr. Smith said.

"Our problem is on our top line," agreed Joel Kornreich, vp-corporate development. "Rate reductions in the property/casualty marketplace were far and away the most important factor in our revenue decline."

However, in addition to rate reductions, "there were a fair amount of (account) cancellations and rewrites and a decline in contingency commissions from the first quarter," observed Samuel G. Liss, vp of Salomon Bros. Inc. in New York.

Ira H. Malis, securities analyst with Alex. Brown & Sons Inc. in Baltimore, noted that one reason Hall is feeling rate competition so dramatically is that two of its strongest marketing areas—aviation and marine insurance—are among the lines of coverage that "are seeing the biggest rate decreases."

Hall's "challenge is. . .to change its revenue mix and bring in more new business," Mr. Keefe stressed.

Other factors contributing to Hall's decline in revenues included "a good amount of lost business" and less new business than anticipated for the quarter, Mr. Kornreich conceded. "Our new business was acceptable but not in line with our expectations."

But, Hall reduced expenses 1.1% in the second quarter to $96.9 million from $97.9 million in 1987 and by 0.4% in the first half to $190.8 million from $191.5 million in 1987.

The expense reduction is attributable to a substantial cost-cutting effort launched by Hall Chairman and Chief Executive Officer Saul P. Steinberg in the fall of 1987 that included the elimination of about 500 employees and the sale or restructuring of unprofitable operations (*BI*, Aug. 24, 1987).

John Addeo, Hall's senior vp-finance, predicted that "expenses will run basically flat" for the remainder of 1988. He said that while Hall is satisfied with its expense-cutting efforts at this point, "that's not to say we won't continue to monitor and keep a close eye on expenses."

Hall's expenses were inflated by a new-business incentive program established last fall and enhanced this year, Mr. Addeo said.

Another reason Hall's expenses have not dropped farther is that the broker has been "seeking out and hiring top production people" to beef up its new sales effort. In the past few months, Hall has been "extremely successful" in this endeavor, Mr. Addeo said.

For example, several new producers have been hired to enhance Hall's capabilities in marketing products to the financial services industry (*BI*, Aug. 1). But Mr. Addeo pointed out that while these new hires should bolster Hall's results in 1989, some are still bound by non-compete covenants with former employers and will not have a significant impact on new business production in 1988.

Gross revenues from Hall's employee benefit operations totaled $14.2 million in the second quarter, compared with $14.3 million in the second quarter of 1987. Other brokers reported growth in benefits business for the quarter.

While Hall's international benefits revenues grew 15% in the quarter, domestic benefits revenues were down about 12%, Mr. Addeo said.

Hall consolidated its domestic and international employee benefits operations earlier this year under the name Godwins International Holdings, headed by David J.D. McLeish, formerly chairman of the overseas operations.

Mr. Addeo acknowledged the domestic operations "have needed some work," but he predicts revenues will improve because of the consolidation.

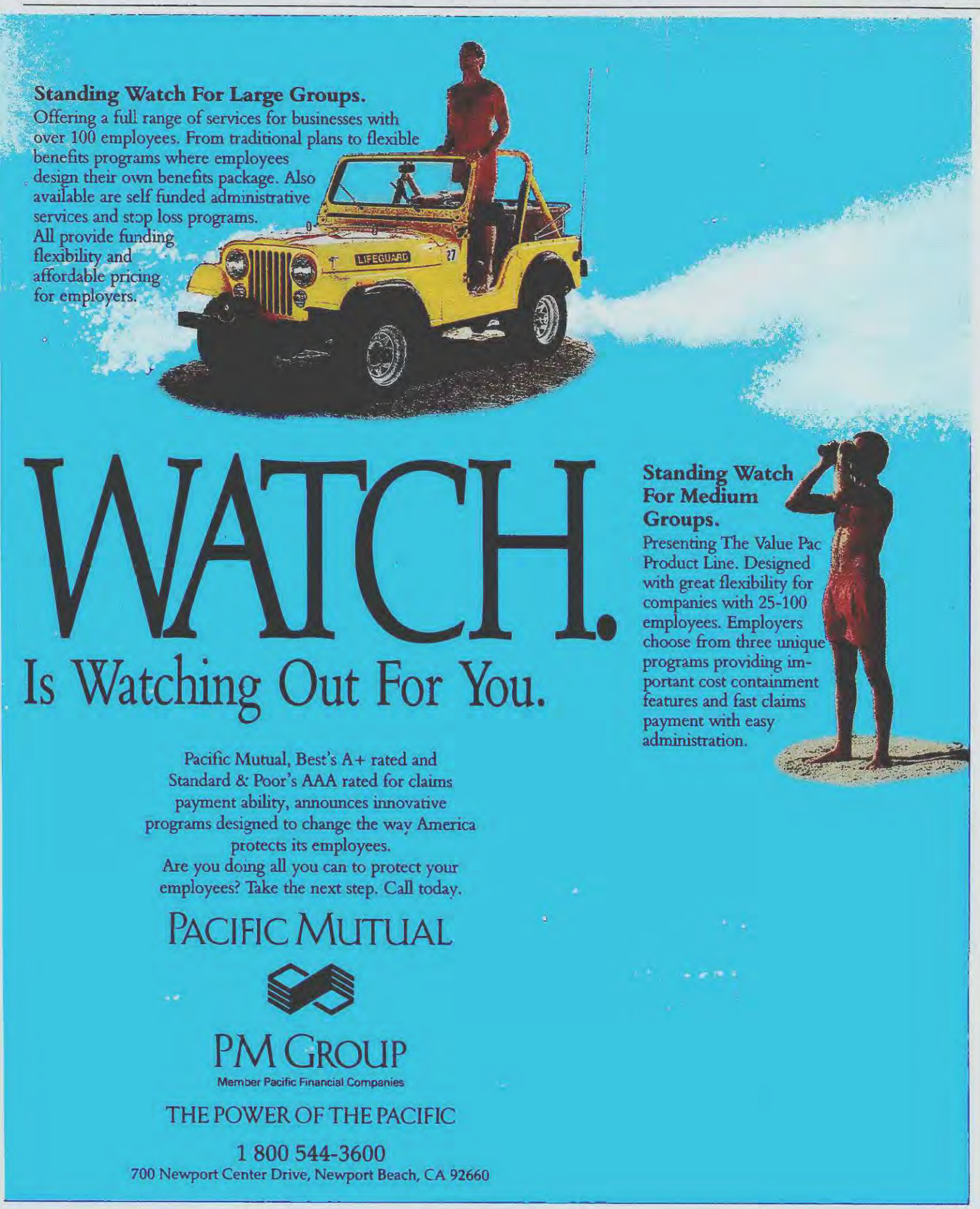
To respond to decreasing revenues, Hall also "plans to seek out acquisitions, especially in terms of acquiring existing books of business," before the end of the year, he said.

Separately, Chicago-based RBH reported second-quarter 1988 revenues of $67.5 million, a 22.7% increase from $55 million in the corresponding quarter of 1987.

RBH's second-quarter pretax operating income rose 22.3% to $10.2 million from $8.4 million.

In the first half, RBH's revenues totaled $133.4 million, a 25.1% jump from $106.6 million in the first six months of 1987. First-half pretax operating income rose 19.7% to $21.1 million from $17.6 million.

Several former Hall executives joined Aon and RBH in the first half of this year, including former Hall Chairman John F. McCaffrey and former Hall Executive Vp George E. Corde. ■



Opinions

Unreconcilable differences

PLAINTIFFS' ATTORNEYS AND consumer advocates are on the warpath against insurers and businesses.

Previous engagements between the opposing camps were only skirmishes compared with what's about to come.

While plaintiffs' attorneys and consumer advocates seldom have agreed with insurers and businesses on the issues of corporate culpability or damages deserved for injurious acts, the hostilities between the two camps are at an all-time high.

Our coverage of the speeches at the annual convention of the Assn. of Trial Lawyers of America vividly portray the distrust and disdain plaintiffs' attorneys and consumer advocates harbor for insurers and businesses.

As we reported last week, the trial lawyers attending the meeting were urged to hit the insurance industry with a barrage of lawsuits, now that insurers are already down on one knee from the blow of antitrust suits filed by 19 state attorneys general. The suits—charging fraud, false advertising and bad faith—will aid the effort to repeal the McCarran-Ferguson Act, they say (*BI*, Aug. 8).

And this week's report on other discussions at the ATLA convention reveals the conviction with which plaintiffs' attorneys and consumer advocates are preparing to go into battle.

On tort reform, plaintiffs' attorneys and consumer advocates preach that businesses and insurers are merely trying to deny consumers their rights and to escape liability for their purposeful acts of hurting people and polluting the environment. On liability insurance costs, plaintiffs' attorneys and consumer advocates see greedy insurance companies manufacturing an insurance crisis simply to increase their profits.

The articles from the ATLA convention no doubt will anger many risk managers and insurance company executives, and some perhaps will be bewildered that a publication for the commercial insurance consumer would report these viewpoints.

The reason: Risk managers and insurers need to know what is being said about them in the opposing camp to map their own strategies for the more ferocious battles over tort reform and insurance regulation that surely will ensue in the months and years ahead.

Letters

Louisiana cases prove argument

To the editor: It certainly supports Maurice Greenberg's arguments against state regulation of insurance when the former insurance commissioner and former deputy insurance commissioner of Louisiana are not able to pass the state's licensing exams (*BI*, July 25). Or maybe Mr. Greenberg should have stated that his comments only applied to Louisiana.

Deborah J. Hertzog
Manager-Marketing and
Product Development
Wright & Co.
Washington, D.C.

HMO accountability must be improved

To the editor: I have admired your editorials over the years and on most occasions I find no pressing urge to comment one way or the other.

However, your editorial "Stop the Bickering" (*BI*, July 11), causes me to offer a comment. Simply, any employee benefits manager who is conscientiously fulfilling the responsibilities of his job would be remiss if he did not insist that the HMO with which he has contracted be held accountable. I am still bewildered why the HMOs continue to enjoy the statutory privilege of unaccountability for the manner in which they spend the employer's money. Until the leadership of the HMO cabal comes to grip with the necessity to account to their clients as they do to their stockholders, the "petty sniping" and "diatribes" should continue —unrelentlessly—until HMOs tell us where the money goes. Anything less than full disclosure is simply reminiscent of days long gone.

I am afraid that you are still on the wrong side of the issue.

Ralph N. Galascione
Consultant
La Jolla, Calif.

■ *Editor's note: We fully agree that HMOs must be accountable for how they spend employers' money. Our point was that the intellectual level of discourse between HMOs and employers must be elevated.*

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

Nader's business is to create myths

To the editor: I enjoyed reading the letters to the editor about Ralph Nader's report on Lloyd's of London, especially the one from Joanne Doroshow (*BI*, Aug. 1).

There was a time when Ralph Nader and his colleagues puzzled me, but they no longer do so. When they were capable of puzzling me, I would have read their report on Lloyd's underwriters, noted the subsequent remarks of various personalities and would have drawn my own conclusions. And, like the chairman of Lloyd's, I would have called the report "utter nonsense" and, also like him, I would have been quite wrong.

On the face of it, what Mr. Nader and his colleagues have published is manifestly absurd. But neither he nor his colleagues are stupid and must have been under no illusion whatever as to how their work would be greeted. So, why publish a report that could be demolished so easily, not only by the targeted organization but by many of its purported victims: insurance buyers?

To my mind, the answer is simple: Ralph Nader is not in the business of publishing verifiable facts but of creating myths. There is nothing unusual about this, people and organizations with their own agenda have spent endless time and effort attempting to superimpose their myths on those currently in vogue in society. And if facts happen to get in the way, then so much the worse for facts.

We should never underestimate the power of myths; in fact, we live by them as Ms. Doroshow's letter so clearly illustrates. Indeed, it is not difficult to give a thousand examples of this, ranging from creation myths to the political myths of recent centuries. We often recognize these myths when scientists and revisionist historians weaken or demolish them by reciting what they deem to be the true facts relating to them. As an example of this, just look at the way the Soviet Union continues to demolish its myths about the Stalin era.

It is evident to me, at least, that the real movers and shakers of this world, the ones who successfully exercise power, are those who create the best myths and make use of them. And Ralph Nader wants to be among that number.

To a limited extent, he has already succeeded in this objective. His mythologizing is published on many op-ed pages and

Continued on page 10

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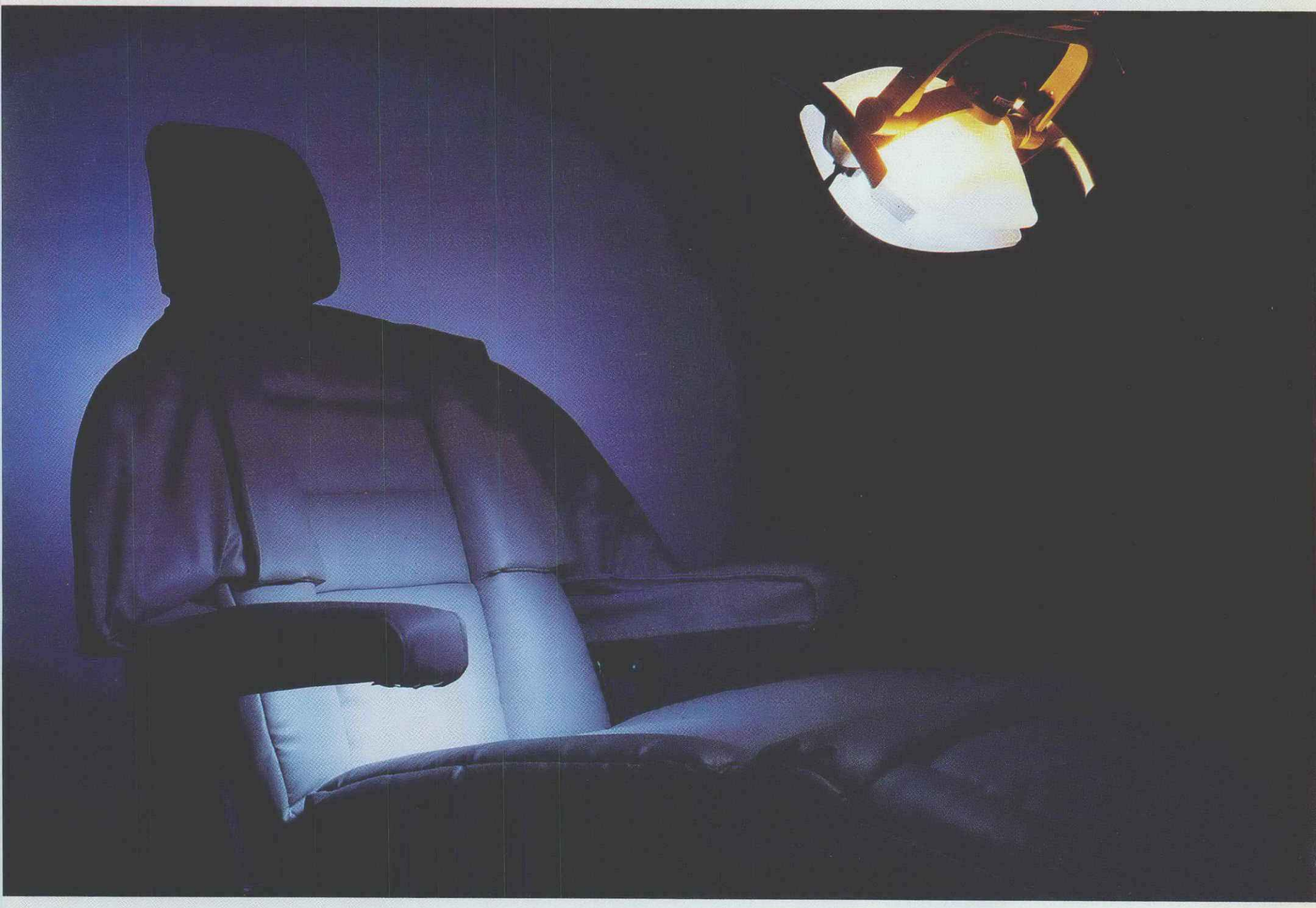

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Letters

Continued from page 8
reaches a quite large public. And, as he has demonstrated in his report on Lloyd's underwriters, he shows a fine disregard for truth when it suits his convenience. Apart from his one success against auto manufacturers, however, he seems to have accomplished little.

For myself, I feel that he deserves a sobriquet that will describe him more perfectly. "Ralph Nader: The Consumer Advocate" does not accomplish it for me. I suggest "Ralph Nader: The Myth Manager."

Peter Downes
Risk Manager
American Trading
& Production Corp.
Baltimore

Public entity risks are managed well

To the editor: I was disturbed to read Charles McAlear's less-than-complimentary comments concerning public entity risk management in his article, "No Conspiracy" (*BI*, July 11). To state that "public entities were unique in providing every agent and broker within miles with copies of insurance specifications every year. . ." and that public entities "refused to purchase liability insurance from reputable insurers offering reasonable prices. . ." is to ignore the professionalism that now exists in the majority of governmental risk management programs. Annual, unstructured bidding is the exception rather than the rule; and any reasonably priced liability insurance that was available in the recent hard market was eagerly purchased by public entities.

I would suggest that Mr. McAlear attend the Public Risk & Insurance Management Assn.'s national conference to observe the high level of competence exhibited by today's public entity risk managers.

Michael J. Natale
Manager, Client Services
Stone & Webster Management
Consultants Inc.
New York

Fax machine aids insurers' mistakes

To the editor: The surprisingly rapid ascent of prices in the recent hard market for commercial lines now seems equally matched by the descent in prices in the current soft market. On the downside of the underwriting mountain, this drop in pricing is not at all like rolling down a gentle hill but more akin to running off a cliff.

Several theories for this sudden return to the insane state of the commercial lines marketplace have been voiced. Reinsurers visiting my offices have commented about the fat in property rates, so a "diet" was in order. Everyone is witnessing the reincarnation of the market-share theory, thought dead and buried in 1985. The practical application of this theory is 1988's home office memo directing branch offices not to lose any renewals, which is sort of like the general telling his command to take no prisoners. All the while, CEOs are publicly proclaiming their intent to sit out the soft market.

One unique theory emerges from the recent reinsurance shortage: The big stock insurers are beginning to like the multimillion-dollar retentions forced on them. This huge, in-house capacity filters down to the local branch office. The absence of reinsurer-imposed discipline now permits a young underwriter in a Dallas branch to lay down a $10 million umbrella for the same price as a $1 million one two years ago.

Another theory is the great "ISO Simplification Program for General Liability." This wonderful program has managed to decrease manual rates for some classes—like supermarkets—by as much as 80%. That same Dallas underwriter thinks he has a terrific deal when a shrewd broker only asks for a 10% credit off manual on these classes.

Some also blame the soft market on the RRGs and RPGs, which by now we all know stand for Reinsurer Reduction Group (to form one, you need a reinsurer that is willing to reduce its surplus) and Reduced Pricing Group (all it takes is a 25% cheaper rate to sell one).

I, too, have a theory about why commercial prices are collapsing. From the porch of their future rest homes, today's underwriters will remember this cycle as the "Fax Market." What a wonderful piece of high technology is the facsimile machine! Is it not remarkable that a broker can obtain a quote from an Atlanta underwriter, then fax an entire submission (hard copy loss runs, etc.) to 20 markets—including the Dallas underwriter—one the day before expiration?

With a few judiciously placed phone calls, he can stir up lots of interest, answering underwriters' inquiries with instant hard copy instead of the old-time soft talk. Increasingly sophisticated use of the fax machine has helped brokers beat the price down by 50% in just 24 hours. Of course, the poor Dallas and Atlanta underwriters don't believe they are being whipsawed and they are too frightened of the attorneys general to talk to each other.

While that other culprit of the high-tech insurance communication explosion—overnight mail—has sped the bidding process, nothing is as urgent, quick and easy (handwritten notes are acceptable) as the fabulous facsimile machine. The best way to stabilize this wild commercial market would be for the chief executives of the major companies to dismantle their fax machines. An "ax-the-fax" memo would be much more effective than their memo to "keep your renewals at any cost."

Unhappily, it seems more likely that the industry is heading once again for negative returns on equity, terror in the executive suites and a thoroughly discredited public image.

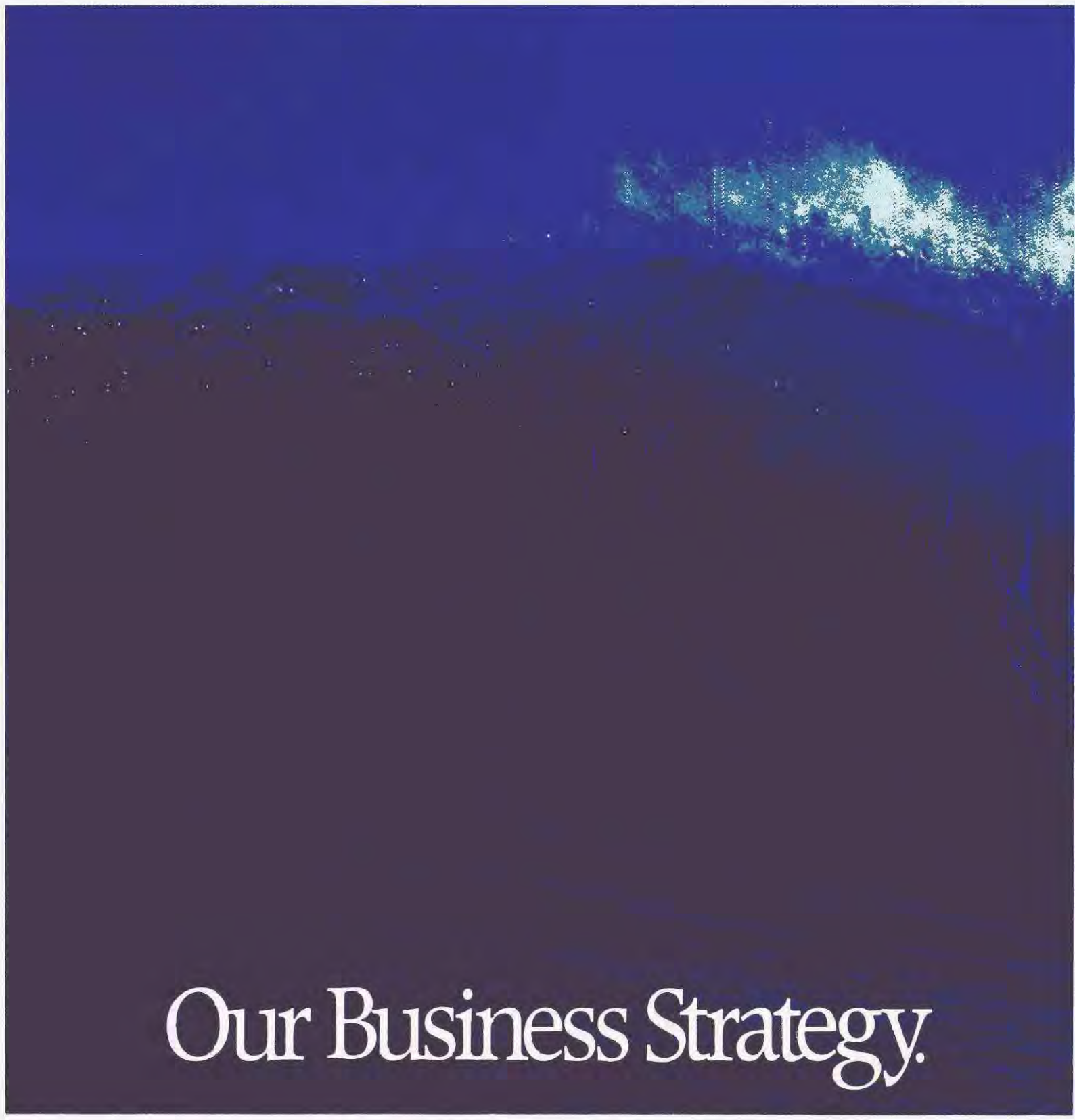
Raymond L. Thomas
President
Shel-Ray Underwriters Inc.
Houston

P.S If you would like some documented evidence of what I speak, I'd be glad to fax it.

Two firms clean L.A. skyscraper

To the editor: In your comprehensive story on the First Interstate Bank fire in Los Angeles (*BI*, July 25), you stated that "the building owners have hired Blackmon Mooring Steamatic. . .to restore the building." BMS was hired to clean the portion of the building that was occupied by First Interstate, and M.F. Bank Restoration Co. was hired by the owners to clean the remainder of the building occupied by other tenants. M.F. Bank also was hired by the insurers of the bank's contents to prepare an inventory and account for the salvable items.

H.F. Lively
President
M.F. Bank Restoration Co.
Norcross, Ga.



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Circle K plan

Continued from page 2

He also noted that some states have anti-discrimination laws to protect people with AIDS.

Thus far, AIDS discrimination cases have been settled out of court primarily because the plaintiffs usually are ill and cannot afford a lengthy court case, Mr. Gisonny said.

But in this instance, civil rights groups said they would take up the cause and file lawsuits based on employment discrimination claims.

Gay rights groups labeled the exclusions an obvious attempt to shut off benefits and even deny employment to homosexuals.

The National Gay Rights Advocates, a gay rights law firm in San Francisco, said last week it was looking for clients who may have discrimination claims against Circle K, said Ben Schatz, an attorney for the group.

"It's an outrageous policy. We're looking for a client to sue" Circle K, Mr. Schatz said last week.

The exclusions seem to be "moralizing" about AIDS and the homosexual community, he said.

In a survey the group conducted last year, all but one of 164 employers that responded said their group health plans cover AIDS-related medical expenses. One employer explained that its medical plans vary at its many locations (*BI*, Sept. 7, 1987).

Businesses have every right to protect themselves against excessive expenses but do not have the right to exclude entire groups of people from benefits or employment, said Brent Nance, insurance case manager for AIDS Project Los Angeles.

"I greatly disagree with their logic and reasoning," Mr. Nance said. "It's blatantly discriminatory."

He pointed to Circle K's announced intention to pay claims for AIDS cases caused by blood transfusions but reject claims by homosexuals and drug users.

Circle K's health care bills for about nine employees with AIDS have been about $90,000 each.

"It's almost as if Circle K says there are innocent victims and guilty victims, and they will cover only innocent victims," Mr. Nance said.

If other self-insured companies rush to follow Circle K's example, they may be inviting further regulation at the state and federal levels, said Lawrence B. Leisure, a principal and the national practice leader for TPF&C.

"I think it's a little spooky. Employers should be very cautious" about taking similar approaches, he said.

One employer cutting off health benefits to even one employee based on "lifestyle decisions" may be ammunition for those who would seek congressional amendment of ERISA to prohibit self-funded insurance plans from restricting coverage for certain health care claims, said Leon Warshaw, director of the New York Business Group on Health Inc., a coalition of nearly 300 employers.

In part, Circle K defended its policy by saying it is permissible in a self-funded plan under ERISA, which exempts most self-insured health plans from state regulatory jurisdiction.

Circle K has been paying health care bills for about nine employees with AIDS at a cost of about $90,000 each and will continue to pay those bills, Mr. Cox said.

Mr. Cox also said the exclusion was not intended to single out homosexual employees but, rather, to identify cases where employees were at fault for their illness.

For example, Circle K was seeking to exclude coverage for health care for injuries suffered in automobile accidents when the injured employee was driving while intoxicated, he said.

However, coverage for drug and alcohol rehabilitation was not excluded under the policy, he noted.

Under Circle K's self-funded health care plan, employees contribute about 25% of the cost of their health care coverage, Mr. Cox said.

There is a deductible of $200 per employee and up to three $200 deductibles per family. The plan pays 80% of the next $5,000 of health care costs and 100% of costs from $5,000 to $1 million.

Circle K employs 26,000 people at more than 4,000 stores in 28 states, but only 8,000 employees are eligible for health care coverage. Most of the others are either part-time employees, working fewer than 30 hours a week, or those who have not completed the six-month waiting period, Mr. Cox said.

Mr. Cox noted that other employers have excluded health care coverage when employees participate in high-risk activities such as glider flying or other sports.

"When you really get down to it, it is no different than any plan that excludes pre-existing conditions," Mr. Cox said.

"I think there are ample precedents for exclusions," Mr. Cox said.

"We're a very compassionate corporation. We're going to do the right thing," said Circle K Chairman and Chief Executive Officer Karl Eller last Wednesday on a segment of NBC-TV's "Today" show.

"We're trying to encourage our employees to make positive choices," Mr. Eller explained.

In addition, Circle K expected that the policy would save on health care costs because prospective employees who likely would file health care claims resulting from their lifestyles would choose not to work for the company, Mr. Cox said.

As of mid-week, telephone calls to the corporate offices in Phoenix were running 3-to-1 in favor of the company's position, Mr. Cox said.

While it may be understandable to try to control health care costs, it was "singularly ill-advised" for any company to create blanket exclusions based on "personal lifestyle" decisions, Mr. Warshaw of the NYBGH said in an interview with *Business Insurance*. On the same "Today" show on which Mr. Eller appeared, Mr. Warshaw said that AIDS cases account for only 2%-3% increases in health care costs at most companies.

Mr. Warshaw and other benefit consultants *BI* interviewed said that the cost of treating AIDS cases can be reduced to $40,000 or less with managed care.

Mr. Warshaw advocated appropriate care for all AIDS cases. "This drives AIDS underground," he said, referring to Circle K's policy.

"More enlightened" companies would supply benefits for sick employees and would deal with cost inflation through other means, said Mr. Leisure of TPF&C.

While noting that employers have been "rather aggressive" in their efforts to cut health care costs, Mr. Leisure said, "Circle K was more aggressive than they should have been."

Clients legally can exclude AIDS treatment from health care plans, but they are advised not to, said Gerard Dewolf, senior consultant with William M. Mercer-Meidinger-Hansen Inc. in Los Angeles.

The costs of most AIDS and substance abuse cases are not excessive if properly monitored and treated, he said.

Continued on next page

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Circle K policy

Continued from previous page

Educating employees also can help keep the lid on the cost of treating AIDS cases (*BI*, Sept. 7, 1987)

Employee benefit managers at other companies say they would not adopt the same policy as Circle K, although one defended the employer's right to do so.

"Every company should be free to establish any plan they want," said Robert Penzkover, director of employee benefits for The Quaker Oats Co. in Chicago. "I support (Circle K) wholeheartedly."

However, Mr. Penzkover said he would not implement a similar benefit plan at Quaker Oats but instead address the problem of lifestyle-related illnesses through employee education programs and wellness programs.

Another employee benefit manager, who asked not to be named, criticized the Circle K plan and said he would not consider implementing a similar plan.

The benefit manager said plans like the one at Circle K could lead to "ridiculous results" if taken one step further. For example, employers could begin excluding medical coverage for smokers and those who are even slightly overweight on the medical charts. "Where to draw the line on lifestyle-related illnesses is very difficult," he said.

A personnel official with Morton Thiokol Inc. in Chicago said: "Our feeling is that employees afflicted with AIDS, as with any other disease, are eligible for coverage. We don't make a judgment on lifestyle, morals or ethics—we simply look at a disease."

A spokesman for Dallas-based Southland Corp., the parent company of 7-Eleven stores, said: "We typically don't comment on the actions of our competitors. However, our AIDS coverage would not differ from coverage for any other disease." ■

Judicial survey

Continued from page 3

than making cost-benefit analyses of what's useful and what's not."

Seventy-three percent of federal judges and 64% of state judges said a major cause of excessive costs was "lawyers and litigants who use discovery as an adversarial tool to intimidate or raise the stakes for their opponents."

And, 47% of federal judges and 45% of state judges said a major cause was "lawyers who use discovery and motion practice simply to drive up the bill."

But judges are not hesitating to punish lawyers they believe are taking advantage of the system, according to the survey.

Within the last three years, 84% of the federal judges said they have imposed sanctions under Rule 11 of the Federal Rules of Civil Procedure, and 52% of state judges have imposed sanctions under state rules. While Rule 11 sanctions usually take the form of a fine, they can include sending a lawyer to continuing education courses or public admonition.

Mr. Shager said the fact that 84% of the federal judges surveyed issued Rule 11 sanctions in the last three years "merely indicates the system is working." All in all, he said, the judicial system "does a very good job of policing itself."

But Mr. Anderson said Rule 11 sanctions are being used by judges "to stop cases they don't like or if they get angry at lawyers."

While the judges polled believe high legal costs and delays pervade all areas of the law, they say high-stakes cases—like product liability, medical malpractice or complex business litigation—are the most costly and time consuming.

Approximately 75% of the federal judges polled said costs of litigating high-stakes civil cases in their jurisdictions were excessive, while just 22% said costs were reasonable and 4% said they were not sure.

Among state judges, a smaller majority—54%—said the costs of litigating high-stakes cases were excessive, while 40% said the costs were reasonable and 5% said they were not sure.

A 62% majority of the federal judges also said that costs associated with typical personal injury cases in their jurisdictions were excessive, while 32% found them reasonable and 6% said they were not sure.

But a majority of state judges—52%—said the costs associated with personal injury cases in their jurisdictions were reasonable, while 44% said they were excessive and 4% said they were not sure.

Likewise, federal judges were more likely than state judges to say that costs associated with contract disputes in their jurisdictions were excessive. While 53% of the federal judges said that these costs were excessive, only 28% of state judges called them out of line.

In fact, 67% of state judges said contract dispute costs were reasonable, compared with 44% of federal judges. Four percent of both federal and state judges said they were not sure.

But despite the problems they see with the current litigation system, "The great majority of the judges are strongly committed to the jury system and tend to oppose almost all of the suggestions for changes in the jury system," the survey authors note.

"Even in complex cases involving scientific or highly technical issues, there is a marked reluctance to abandon the jury system."

However, 63% of the federal judges and 68% of the state judges said that a serious study should be made of alternatives to trial by jury in certain types of cases, especially in minor civil cases involving small sums of money.

Only a minority of the judges were receptive to the suggestion that, after a jury determines liability in a civil case, the judge should set the damages. Only 5% of the federal judges and 7% of the state judges said this should be done in all civil cases, and 41% of the federal judges and 32% of the state judges said it would be appropriate in some civil cases.

But 53% of the federal judges and 60% of the state judges said this suggested procedure should not be followed in any civil cases.

However, 73% of federal judges and 45% of state judges said they had at least once reduced damages set by juries.

Regarding the use of expert witnesses during trial, "Large majorities of judges favor the use of court-appointed expert witnesses. . .who are independent of the parties to the trial," according to the survey.

Although judges were critical of attorneys' actions in the discovery process, "There is no consensus as to what is the most important change that should be made in the discovery process," the survey authors say.

The largest number—41% of the federal judges and 33% of the state judges—said that changing the informal, unwritten practices of the discovery process would be most beneficial.

Only 18% of the federal judges and 33% of the state judges suggested changing the rules governing discovery.

And, 33% of the federal judges and 22% of the state judges said the most-effective action would be greater exercise of judicial discretion, including imposing tougher sanctions on attorneys.

●

Free copies of the survey, "Judges' Opinions on Procedural Issues," are available from Aetna Life & Casualty Co., Corporate Communications, D112, 151 Farmington Ave., Hartford, Conn. 06156; 203-273-6500.

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Salary survey

Continued from page 3

"Bonuses help keep the employee on his toes and tie the pay package in to the profitability of the company," he said. "It's a situation in which the bonus is there if all goes well."

However, risk managers at the largest corporations—those with more than $7 billion in revenues—reported that their employers reduced bonuses by 11% last year to an average of $14,106 from $15,934 in 1986.

Overall, average risk managers' compensation at these companies dropped by 7% to $99,946 from $106,926, with average salary dropping 6% to $85,840 last year from $90,992 in 1986.

While the survey authors point out that the decline could be caused by statistical discrepancies because of the small number of companies in this size category—63 risk managers in the category responded out of the 101 U.S. companies that have more than $7 billion in revenues—they add that last October's stock market crash could have led to a reduction in year-end bonuses for risk managers at huge companies.

"There was some apprehension after Black Monday," Mr. Perry observed.

Mr. Meyers agreed. "The crash could have had an immediate effect on cash flow. I'm sure that money due to be paid out may have been held back."

He pointed out that many bonuses are not paid out until January or February, when they could have been subject to the aftershocks of the crash. "I would expect the bonuses for '88 to go up again," Mr. Meyers said.

However, lower 1987 salaries were not restricted to companies with sales exceeding $7 billion.

Risk managers for companies with $4 billion to $7 billion in sales averaged a 1% salary decline to $76,857 in 1987 and their counterparts in companies with $2 billion to $4 billion in sales reported an average 2% drop in salary to $68,758 in 1987.

But in both of those categories, bonuses made up the deficit. In the $4 billion to $7 billion category, average bonuses were up 15% to $10,525, yielding an average compensation total of $87,382, which is nearly identical to the average of $86,939 reported in 1986. In the $2 billion to $4 billion category, the average bonus increased 20% to $7,398.

'I would expect the bonuses for '88 to go up again,' says Richard Meyers of Logic Associates.

That boosted total compensation to $76,156, or just $3 less than the $76,159 reported in 1986.

Again, the survey authors point out that although salaries may appear stagnant in the largest companies, they expect bonuses in those sales categories to go up in 1988.

The smallest sales volume category—less than $200 million—reported the largest increase in bonuses: a 63% rise to $4,227 from $2,599 reported for 1986.

In the three other sales categories, bonus percentage increases fell as company size grew. In the $201 million to $500 million group, bonuses increased 43% to $4,847 from $3,385. In the $501 million to $1 billion group, bonuses increased 26% to $5,365 from $4,243. And in the $1 billion to $2 billion group, bonuses increased 11% to $7,070 from $6,357.

Risk managers at companies with less than $200 million in sales also reported the largest increase in average salary: 18% to $52,826 from $44,851. These risk managers' average total compensation rose 20% to $57,054 from $47,450.

In other categories:

- At companies with sales of $201 million to $500 million, the average salary rose 8% to $53,803 from $49,608, and average total compensation rose 11% to $58,650 from $52,993.
- At companies with sales of $501 million to $1 billion, the average salary rose 6% to $58,375 from $55,000, and average total compensation rose 8% to $63,740 from $59,243.

The type of industry a risk manager worked in also influenced compensation packages (see chart, page 3).

For instance, among companies with $2 billion to $4 billion in sales, service industry risk managers received the highest compensation with an average salary of $80,967, an average bonus of $7,753 and average total compensation of $88,720.

That was a 12% increase from service industry risk managers' average total compensation of $79,383 in 1986.

For the second year in a row, the highest-paid risk manager responding to the survey was employed by a consumer products company with more than $7 billion in sales.

That risk manager reported compensation of $305,000, which included a bonus of $61,000.

Mr. Perry commented that the most profitable industries are most able to pay the highest risk management salaries.

When the oil business was at its peak, oil company risk managers were the most highly compensated, he said.

Consumer products manufacturers are now riding the crest, he added.

Logic received 1,144 responses to its seventh annual survey. Logic had mailed 3,240 questionnaires, for a 35% response rate.

•

Copies of the survey are available for $60 each from Logic Associates Inc., 170 Broadway, Suite 1708, New York, N.Y. 10038; 212-227-8000.

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Toledo, OH
September 7
Toledo Marriott Portside (formerly Hotel Sofitel)
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White Plains, NY
September 14
Howard Johnson's Plaza (formerly White Plains Hotel)
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Location: Check hotel reader board for room location.

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Florida comp system falls short: Study

WASHINGTON—Florida's 9-year-old wage-loss workers compensation system has produced some disappointing results that raise serious questions about the system's future, according to a study by the American Insurance Assn.

"A number of key expectations regarding the performance of the Florida wage-loss system have not been realized," said David L. Corum, a senior research analyst with the AIA.

Florida enacted numerous changes in its workers compensation law in 1979, including a fundamentally different approach to compensating workers with permanent partial disabilities. After 1979, such workers were compensated for actual wage loss on a periodic basis rather than the more traditional approach of paying lump-sum benefits that often bear little relationship to actual wage loss.

Other changes included: raising the basic total disability benefit rate, strengthening the role of the Florida Division of Workers' Compensation, restricting the use of lump-sum settlements and establishing a three-person medical panel to set maximum reimbursement.

Since then, restrictions on lump-sum payments were relaxed, maximum death benefits were increased and the definition of wages was broadened.

Among other conclusions the study drew about the system:

- Underwriting results for Florida workers compensation insurers began to deteriorate rapidly two years after wage-loss was first enacted. Unpredictable loss development and administrative complexity create substantial uncertainty and financial risk for insurers, the AIA said.

Florida's system "has been a very difficult system to administer," Mr. Corum said. Contributing to that is the fact that "Florida does not have an effective means for distinguishing between wage loss due to permanent partial impairment and wage loss due to other factors, such as economic conditions," he said in a statement.

- Although workers compensation premiums are not much higher than they were at the time the wage-loss system was enacted, claim costs have risen dramatically in recent years with no indication that the trend will abate.
- Attorneys' and deputy commissioners' involvement in claims disputes is increasing. Disposition hearings increased 93.7% between 1982 and 1987, and the related cost of claimants' attorney involvement is now about $44 million annually.
- Lump-sum payments are becoming commonplace, in spite of the wage-loss system.
- Mandatory vocational rehabilitation has developed into a costly and inefficient feature of the system. The average cost of vocational rehabilitation for claimants whose rehabilitation cases were closed in 1985 was more than $5,000. However, about 40% of rehab programs are never completed.

—By Meg Fletcher

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Cal/OSHA

Continued from page 3

funding. And, Gov. Deukmejian would not have the authority to veto funds for Cal/OSHA approved in an initiative.

The California Labor Federation, the primary sponsor of Proposition 97 (*BI,* Dec. 21, 1987), is building a coalition of labor, environmental, citizen and possibly business groups to back the issue, said Richard Holober, assistant director of the labor federation's education committee.

"I think it's significant that so far the governor has failed to attract business support in opposition to Cal/OSHA," Mr. Holober said.

However, the California Chamber of Commerce has not taken a position on the November ballot issue, a spokesman said.

Though the Chamber of Commerce is still officially neutral on the issue, its officers are considering the "very, very difficult" issue of state or federal regulation, commented James Dufour, special counsel and lobbyist for the chamber.

"Most businesses didn't advocate this and haven't enjoyed it," Mr. Dufour said, referring to the switch to federal from state workplace safety regulation.

The issue has become a sensitive one that forces employers who may support renewed state regulation to oppose Gov. Deukmejian, a popular conservative politician.

Gov. Deukmejian's spokesman said the governor has not taken a position on Proposition 97, although his position on Cal/OSHA is "well-known."

The Senate bill to revive Cal/OSHA funding could be voted on by the Legislature this session, said Rocky Saunders, an aide to Sen. Cecil Green, D-Cypress, the bill's sponsor.

The bill, which would restore $6.8 million for the state's share of the program, passed the Senate fiscal and appropriations committees early this year but has remained "inactive" since then (*BI,* Feb. 29).

The legislation, which is backed by labor, may move to the Senate floor for a final vote by the time the Legislature adjourns in late August, Mr. Saunders said.

"We think we have an issue that needs to be presented," he said.

This legislation, of course, would be subject to Gov. Deukmejian's veto.

Mr. Saunders noted that Sen. Green endorses Proposition 97.

The state Supreme Court has not set a date to hear arguments about the governor's veto of Cal/OSHA funds.

The state 3rd District Court of Appeals in Sacramento last October ruled in a suit brought by California Rural Legal Assistance, a public interest firm in San Francisco, that Gov. Deukmejian's veto of funding for Cal/OSHA violated state law (*BI,* Nov. 2, 1987). Gov. Deukmejian appealed the decision to the state's highest court; the case is still pending.

Mr. Holober of the CLF contends that "a growing case" for state regulation is emerging from information about federal OSHA's performance in the past year.

Inspections declined 65% for the first nine months under the federal jurisdiction and staffing was 40% below that for the state agency, he said.

Since the demise of Cal/OSHA more than a year ago, federal authorities have scrambled to put together a workplace safety regulation program from scratch in the country's most populous state.

Frank Strasheim, regional director of the federal OSHA program, admits the end of the state's regulation "caught us a bit by surprise."

The federal agency had to step into the role in California with little notice and with no established local offices, he said. Federal OSHA still is not yet ready to regulate all private sector workplaces nor is fully staffed, he pointed out.

"It's really kind of awkward," Mr. Strasheim said. "We don't have 200 people waiting in the wings if a state decides to give up its programs."

Most of the approximately 200 state employees Cal/OSHA let go had found other employment before federal OSHA was ready to begin hiring, an OSHA spokesman explained.

It has taken most of the past year to hire nearly 200 people, only a few of whom came from the state program, to run the California enforcement program, the spokesman said. OSHA will open its eighth field office soon to help meet its mandate.

If voters, the Legislature or the courts re-establish Cal/OSHA, Mr. Strasheim faces the opposite problem—how to manage the transition back to state regulation and dismantle the operation he has labored more than a year to build.

"Frankly, we feel a great deal of consternation on one hand and pride on the other" of how federal OSHA has taken over Cal/OSHA's responsibilities, Mr. Strasheim said.

In most states, federal OSHA is seen by many as "the folks wearing the white hats," he said.

That has not been the case in California, where critics were quick to point out the differences between the federal workplace safety program and the former state system, which had been described as one of the toughest and most effective programs in the country.

An analyst for the state Senate Industrial Relations Committee said it is still too early to draw conclusions about the effectiveness of the federal program, but its approach opens questions about whether work sites are less safe now.

A major difference is the type of hazardous situations the two agencies would respond to, said Andy Shaefer, consultant to the Senate committee and the Office of Research.

Previously, Cal/OSHA would send an inspector to any site where injuries occurred or hazards were alleged.

However, federal OSHA routinely investigates only "serious" cases, which are defined as accidents that involve five or more hospitalizations or a fatality.

"That's a huge difference," Mr. Shaefer observed.

Also, federal OSHA responds to a situation "if there's going to be a lot of attention" from the news media, he said.

However, Mr. Strasheim of OSHA said the federal authorities have responded responsibly to workplace problems and indeed can make inspections without a formal complaint if the situation obviously warrants attention.

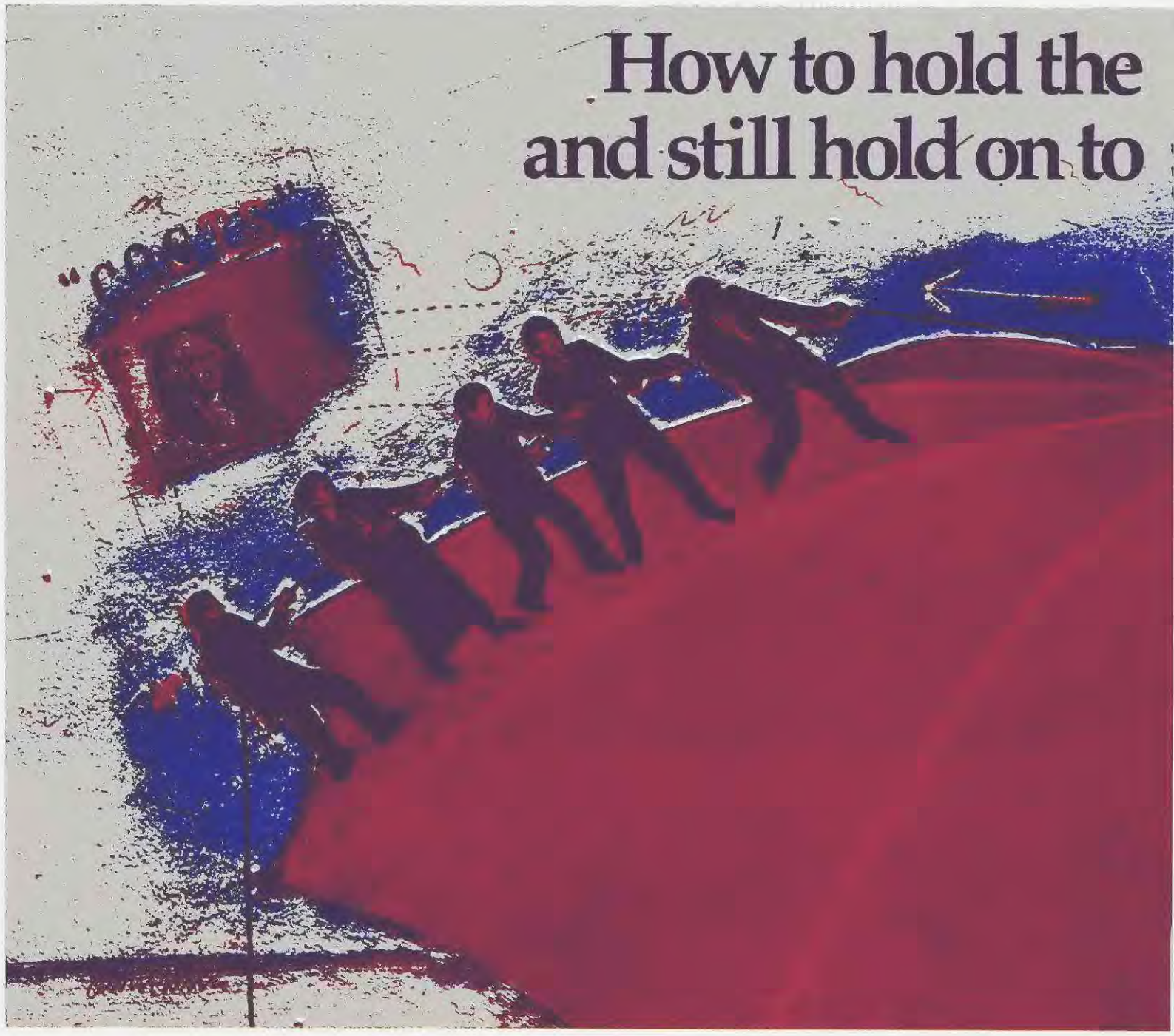
"If we have a serious complaint we do go out on it. To do otherwise would be foolish," he said.

By the end of the current fiscal year in October, federal OSHA will have conducted about 6,000 inspections in California, Mr. Strasheim said.

Cal/OSHA typically conducted about 18,000 inspections annually. But many of those may have been brief checks compared with detailed inspections conducted by federal officials, Mr. Strasheim said.

Federal OSHA conducts "wall-to-wall" inspections that are targeted to industries such as construction and heavy manufacturing, where hazardous conditions are most likely to exist, he said.

The net effect of the targeted inspections by federal OSHA is the same as the state's previous policy of more frequent but less comprehensive inspections, Mr. Strasheim said. ■



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Californians allege toxic warnings missing

Around the states

SACRAMENTO, Calif.—Supermarket chains and tobacco companies have failed to warn consumers of health hazards presented by various tobacco products as required by the state's Proposition 65 anti-toxins law, environmentalists allege.

The complaint was filed Aug. 2 with the state attorney general's office and at local prosecutors' offices throughout the state, said David Roe, attorney for the Environmental Defense Fund in Sacramento. Other plaintiffs include the Sierra Club, the Natural Resources Defense Council and Campaign California.

Proposition 65, approved by state voters in 1986, requires all businesses in the state employing 10 or more people to issue "clear and reasonable" warnings if they expose their employees or the public to one or more of 63 hazardous chemicals (*BI*, Aug. 1; April 4).

The complaint, the first enforcement action attempted under Prop 65, alleges that manufacturers and retailers of certain tobacco products have not properly warned consumers about risks associated with the products, he said. The only notice presented in stores has been posting of signs that direct consumers to a toll-free telephone service, supported by a coalition of manufacturers, that may or may not have information about a particular product, Mr. Roe said.

"The 800-number is no substitute for genuine warnings to consumers and relying on it gives no protection under Proposition 65," according the environmental groups' complaint.

"Until the courts say otherwise, it (toll-free phone service) is a perfectly acceptable way to provide warnings," countered Leslie Howe, vp of governmental affairs for the California Retailers Assn. in Sacramento. The association represents all of the retail chains named in the environmentalists' complaint.

The action was filed at numerous places in the state because Proposition 65 allows local prosecutors, including the state attorney general, to intervene in any legal challenges under the law and, thus, take over prosecution of the case.

State Attorney General John Van de Kamp is considering the complaint, according to a statement.

If state or local prosecutors fail to take up the action, the environmental groups will pursue the case on their own, Mr. Roe said.

The law makes businesses liable for fines of up $2,500 per day for violations. The total penalties in this case could run as high as $1.3 billion, Mr. Roe said.

Retailers named in the lawsuit are Safeway Stores, Vons Inc., Ralph's Stores, Lucky Stores and Thrift Drug Stores. Manufacturers of 225 tobacco products such as cigars, pipe tobacco and chewing tobacco also are named, Mr. Roe said. Cigarettes are not included in the action because they already carry health warnings required by federal law.

—By Glenn Huntley

VDT law under fire

HAUPPAUGE, N.Y.—Four Long Island, N.Y. businesses are challenging the Suffolk County law regulating the use of video display terminals in the workplace as unconstitutional.

The law, which took effect July 18, requires employers in the Long Island county with 20 or more VDTs to implement safeguards designed to protect workers who operate terminals for 26 or more hours per week (*BI*, June 13).

But, according to the complaint filed in New York State Supreme Court in Suffolk County late last month by ILC Data Device Corp. of Bohemia, Lumex Inc. of Bay Shore, Micra Corp. of Hauppauge and Applied Digital Data Systems of Hauppauge, the law is unconstitutional and invalid because:

- Suffolk County lacks the authority to enact it and the law is pre-empted and superseded by state or federal legislation.
- The law unconstitutionally authorizes warrantless inspections of employers' premises.
- It arbitrarily and capriciously denies employers equal protection.

"It's expensive enough to do business in Suffolk County," said Jeffrey Morosoff, director of special projects for the Suffolk & Nassau Counties' Chamber of Commerce, adding that the county intervened in an issue that essentially involves labor and management.

However, Elisa Riordan, a staff representative for the Communications Workers of America, says the cost of filing the suit is money that would be better spent providing a safer and healthier workplace for VDT operators.

"Reports have shown that problems exist and the law is constitutional and properly written," Ms. Riordan asserted.

Gary Sazer, a partner in the law firm Parker Chapin Flattau & Klimpl in Jericho, N.Y., representing the plaintiffs, claims that the issue has elicited so much emotion because Suffolk County is regarded by many as "the Silicon Valley of the East."

Reports on VDT health hazards are inconclusive, Mr. Sazer said, adding that Suffolk County lacks authority to institute such regulations, which come under the jurisdiction of the Occupational Safety and Health Act of 1970.

The law affects more than 10,000 VDT workers in the county, Mr. Sazer estimated.

—By Collin Nash

HMO liquidated

HARRISBURG, Pa.—Omni Health Plan Inc., a Scranton, Pa.-based health maintenance organization, has been declared insolvent and ordered liquidated by the Commonwealth Court of Pennsylvania.

As of March 31, 1988, Omni's net assets were $365,182 and its liabilities were $1,764,662, making the HMO insolvent by $1,399,480, the court order said.

The action by the Commonwealth Court came in response to a Pennsylvania Insurance Department petition for liquidation filed on July 25.

Existing health care coverage contracts with Omni, which was marketed primarily to northeastern Pennsylvania employers, terminated on July 31, 1988.

Among the replacement coverage options available to the HMO's approximately 3,500 members are

Continued on next page

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Around the states

Continued from previous page

Geisinger Health Plan, HMO of Northeastern Pennsylvania and Blue Cross of Northeastern Pennsylvania.

In addition, Omni's reinsurer, North American Life & Casualty Co., has agreed to write indemnity coverage until Aug. 31 for Omni members, although rates and benefits will differ.

All persons having claims against Omni must file proof of claims forms with the Pennsylvania Insurance Department's Bureau of Liquidations and Rehabilitations by Jan. 23, 1989.

—By Collin Nash

Director resigns

JEFFERSON CITY, Mo.—Lewis Crist has resigned as director of the Missouri Division of Insurance to take a new position as president of The Bar Plan in St. Louis beginning Oct. 1.

Mr. Crist has served as director of the division since January 1986.

The Bar Plan is an insurance company sponsored by the state bar association that provides professional liability coverage to attorneys.

—By Lauren Sinai

New Jersey surcharge

TRENTON, N.J.—A proposed surcharge on medical malpractice insurance premiums paid by doctors and podiatrists in New Jersey has been raised to 5% from 4%.

The New Jersey Department of Insurance had proposed a 4% surcharge earlier this year to finance claims against a now-deactivated special malpractice insurance association (*BI*, Jan. 18).

However, because claims against the New Jersey Medical Malpractice Reinsurance Assn. continued to mount while the department reviewed public comments on its proposal, the size of the surcharge sought had to be increased, according to the Insurance Department.

MMRA had insured 3,300 physicians and 450 podiatrists between 1977 and 1982, and had reinsured commercial medical malpractice insurers. Members of the association were the state's property/casualty insurers.

The association, which the Legislature created in 1976, was deactivated in 1982 when medical malpractice insurance became readily available. The association is estimated to be insolvent by about $64.3 million, said Insurance Commissioner Kenneth D. Merin.

The surcharge, which would remain in effect for seven years, is expected to raise about $9.2 million annually from 1989 through 1991, or a total of $27.6 million, Mr. Merin estimated. The surcharge could be adjusted in 1992 through 1995, depending on the association's remaining deficit.

Auditors estimate that if the surcharge is not imposed, the association's cash will be exhausted by the second quarter of 1989.

The surcharge would range from a low of $277 for general practitioners, who in 1988 paid average premiums of $5,545, to a high of $2,021 for neurosurgeons paying average premiums of $40,414. Podiatrists would pay a $346 surcharge on average premiums of $6,929.

The surcharge would be assessed on all doctors in the state, regardless of whether they were covered by MMRA, because all doctors benefitted by the stability the association brought to the marketplace, according to the Insurance Department.

Chiropractors, however, will not be subject to the surcharge.

It is expected to take several months before the surcharge plan wins final approval.

—By Collin Nash

Day-care MAP

NEW YORK—Licensed day-care providers who work out of their homes will be able to obtain up to $1 million in liability insurance coverage under a newly created Family Day Care Market Assistance Program offered under the auspices of the New York Insurance Department.

The program will be available to both licensed providers of family day care, which is defined as three-to-six children, and licensed providers of group family day care, which is defined as seven-to-12 children.

A total of 15 insurers are participating in the program, including Aetna Casualty & Surety Co., which will act as the MAP's servicing insurer, according to the New York Insurance Department.

Liability limits of $100,000 per occurrence/$300,000 aggregate will cost $79 annually per child. Limits of $300,000 per occurrence/$300,000 aggregate will cost $107.60 per child, while limits of $500,000 per occurrence/$1 million aggregate will cost $139.92 per child.

Also included in the coverage, which will be written on an occurrence basis, is basic $5,000 per-child medical payment coverage.

For further information, agents or brokers should call the Insurance Department's liability hot line at 212-602-0541 or 800-522-4370. Assistance is also available through the Independent Insurance Agents Assn. of New York at 800-962-7950 and the Professional Insurance Agents Assn. of New York at 800-742-6369.

—By Judy Greenwald

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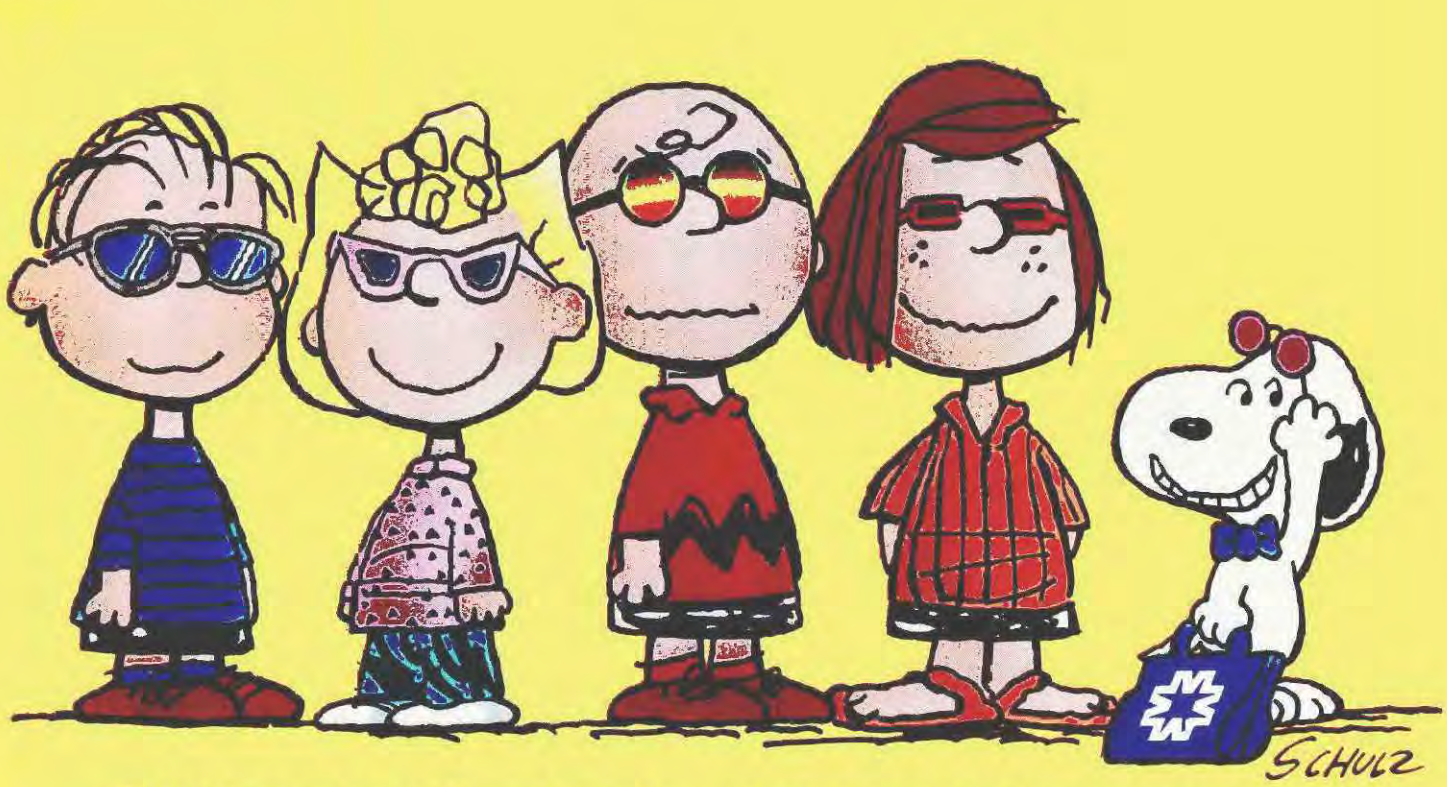

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2 states take action against PRIME

By DOUGLAS McLEOD

TALLAHASSEE, Fla.—Two state insurance departments are taking regulatory action against Professional Risk Insurers Management Exclusive Co. Ltd., an unlicensed offshore medical malpractice insurer.

The Florida Insurance Department on Aug. 5 filed a cease-and-desist order against PRIME, charging that the insurer—which is domiciled in St. Vincent, British West Indies, and operates through a Chicago post office box—has violated Florida law by soliciting business without being licensed or approved in the state as a surplus lines insurer.

The order cited four cases in which doctors in Miami, Lake Worth and Tampa received unsolicited letters from PRIME offering malpractice coverage.

The "dear doctor" letters include what appears to be a check payable to the doctor in the amount of $7,056.28, though the check is marked "non-negotiable coupon" and is described in the letters as a "non-negotiable inquiry voucher" representing "expected savings when redeemed" by doctors buying insurance from PRIME.

PRIME, according to the letters, is a "10-year-old stock insurance company licensed and domiciled in St. Vincent and the Grenadines, West Indies, and operates pursuant to English common law."

The St. Vincent registrar of companies confirmed PRIME's registration since September 1982.

The letters note that doctors can obtain more coverage information by sending inquiries to the Chicago post office box or by calling a toll-free number shown in the letter.

The number connects to an office in Etobicoke, Ontario, near Toronto.

The cease-and-desist order notes that PRIME has not provided the Florida department with financial or other information, and that the insurer "poses a threat of irreparable financial harm as well as an immediate and serious danger to the public safety and welfare of the people of the state of Florida."

Separately, the Kansas Insurance Department has notified PRIME that it will hold a hearing Sept. 8 to determine whether the insurer has violated Kansas law by engaging in the unauthorized transaction of insurance in the state.

Several Kansas doctors have received letters in recent weeks similar to those mailed to Florida physicians, according to Michael Broemmel, an attorney for the Kansas department.

If the Insurance Department concludes that PRIME has violated state law, a cease-and-desist order will be issued, Mr. Broemmel said.

PRIME Manager Peter Brock has told the Kansas department that a PRIME representative will be at the hearing, Mr. Broemmel said.

However, PRIME will probably not respond to the Florida cease-and-desist order, according to Dennis J. Simon, a Southfield, Mich., lawyer representing the insurer. Mr. Simon explained that PRIME is subject only to St. Vincent law and not to the laws of Florida or any other state.

He also denied that PRIME is actually transacting business in the United States, saying the letters to doctors are not solicitations and that they include notices stating that they are not solicitations.

"It sounds very mysterious, but it isn't," Mr. Simon said.

Mr. Simon said he could not provide any information about PRIME's finances, including the amount of its capital and surplus.

"Whatever it is, it must be enough," he said, explaining that as long as the insurer pays its claims, the capital and surplus level "really doesn't matter."

Stanley K. John, a St. Vincent lawyer acting as PRIME's local representative, also declined to provide financial information. Mr. John said he maintains records for PRIME but is not involved in underwriting or claims processing.

Although Mr. John said PRIME has its own office in St. Vincent, the insurer does not have a local phone listing. A call to a PRIME phone number Mr. John provided was answered by Mr. John himself.

Mr. John referred questions to Mr. Brock at a Chicago phone number. The Chicago number, however, has been disconnected with calls being referred to the Etobicoke toll-free number. Mr. Brock could not be reached at the toll-free number.

Several other states have already hit PRIME with cease-and-desist orders, including Arizona, Colorado, Illinois, Kentucky, Missouri, Nevada, New York, Oklahoma and Virginia (*BI*, Aug. 1; Aug. 31, 1987; Sept. 22, 1986). ■

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RLI Insurance Company and Mt. Hawley Insurance Company

STATUTORY SURPLUS (000 Omitted)
1983 – $12,238
1984 – $16,739
1985 – $37,037
1986 – $53,063
1987 – $57,243

COMBINED RATIO
1983 – 94.9
1984 – 97.0
1985 – 99.7
1986 – 84.1
1987 – 84.2

5 YEAR COMBINED RATIO: 89.8 (1983-1987)

ASSETS (000 Omitted)
1983 – $ 35,156
1984 – $ 48,719
1985 – $105,993
1986 – $159,568
1987 – $168,859

LOSS RESERVES (000 Omitted)
1983 – $ 4,985
1984 – $ 9,150
1985 – $22,784
1986 – $46,243
1987 – $59,712

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The Facts About Rain Insurance

For more than 100 years, Chubb has been regarded as one of this nation's most respected providers of insurance.

That reputation is what we sell. It is a reputation for financial and personal integrity, for service, for keeping our word. It is a reputation we earned the hard way, maintaining traditional values, managing our business prudently and dealing with our clients fairly and responsibly.

Recently, because of issues related to the "rain insurance" controversy, our reputation has been under public attack for the first time in our history. Chubb chose to manage this situation in our traditional way–working directly with customers, meeting with regulatory authorities, putting our experts to work in a dedicated way to solve problems.

What Happened?

Good Weather International, a Chubb agent, marketed a "rain insurance" policy to farmers in the Midwest that would provide payments if there were a shortfall of rain during June, July and August.

For 1988, Chubb authorized Good Weather to make available no more than $30 million of coverage. We set an application deadline of June 15th. We said that applications were not binding on Chubb until accepted, and that premiums must be submitted with applications because of the short-term nature of the policy. All of this is typical in the agricultural weather insurance business.

On June 14th and 15th, the independent brokers dealing with Good Weather's field office, each working with his or her own customers, took applications from more than 6,000 farmers for over $330 million in coverage. Most brokers sent, by regular mail, the applications and checks they received on those two days to Good Weather's field office. They were then sent on to Good Weather's head office in Jericho, New York. Most of those applications did not arrive in Jericho until June 27th –12 days after the deadline. Applications were still arriving last week.

What Did We Do?

We made the following immediate decisions:

- –We directed Good Weather to send all premiums back to the brokers for return to farmers so we could cope with the unexpected oversubscription.
- –We established a 125 person Special Task Force to process all of the applications and talk with the farmers directly.
- –We met with the Insurance Commissioners in each state to explain what was happening and to discuss the steps we were taking.
- –We increased the available coverage from $30 to $40 million.
- –We offered all the farmers who met the application deadline a payment equal to their returned premium.
- –We also offered the farmers who qualified for policies, but no longer wanted them, the option to take the payment instead.

Thousands of farmers could be eligible for these payments, representing a potential out of pocket cash outlay by Chubb of $20 million. We have already talked with a majority of the farmers on our special 800 number hotline. They seem to understand the situation and appreciate how we are coping with it.

Setting the Record Straight

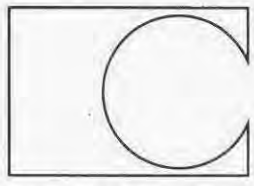
Unfortunately, much of what you may have read or seen about Chubb and "rain insurance" in recent weeks is misleading and a lot is simply wrong. Because that misinformation goes directly to our reputation for keeping our word, which is fundamental to the product we sell, we must set the record straight.

Three specific charges have been reported in the media. Here is our response:

1. Chubb did *not* "watch the weather" while deciding what to do. Our decision to have all premiums returned was made as soon as we knew how oversubscribed Good Weather's program was. Our public announcement of that decision was made on July 15th, only after we met with each state's Insurance Commissioner to discuss it.
2. Chubb did *not* "renege" on a single policy. No broker in the field had binding authority from Chubb on this policy. The premium checks were part of the application process for this policy, not the basis of an agreement.
3. Chubb did *not* "sit on the money." We did *not* cash any checks or earn any interest on the farmers' premiums. The delay in returning premiums was the unavoidable result of the late arrival of applications and the sheer volume itself.

Going Forward

We intend to continue to deal fairly and responsibly with the farmers involved. We intend to cooperate with the Insurance Commissioners and to respond to all proper requests for information. We will always protect our reputation whenever and wherever we are unfairly attacked. Our responsibility to our policyholders, shareholders, and employees demands nothing less.



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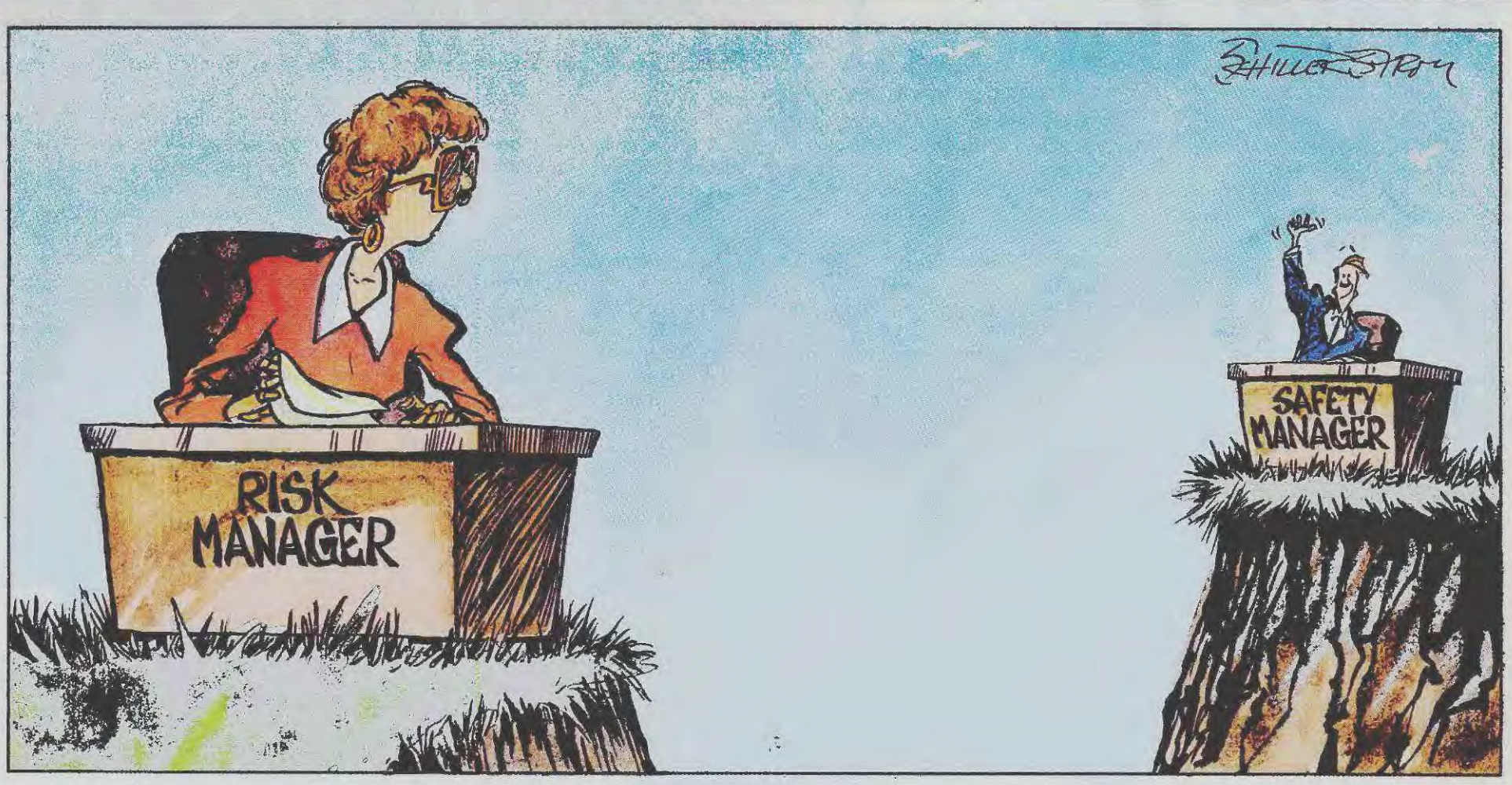


ASK A RISK MANAGER

Should safety manager report to risk manager?

Q **Do you think the safety function should report to the risk management department?**

A This is an interesting and somewhat controversial question that understandably does not have a simple "yes" or "no" response. Rather, we should evaluate the corporate structure that houses both functions to determine if one reporting approach has a benefit over the other.

In this instance, we will assume the risk manager is actively involved with loss prevention, having evolved beyond the outdated notion that buying insurance is the preferred method of controlling risk.

Establishing safety objectives, maintaining open communications and providing mutual support are three critical elements in the successful blending of the risk management and safety responsibilities. Let's focus on each to better understand how they interface:

- Establishing safety objectives.

Regardless of whether the safety manager reports to the risk management department or to another unit of the company, the primary responsibility facing the risk manager is to clearly specify what is required of the safety manager for the betterment of the overall risk control program.

By definition, the risk management process is concerned with the identification, evaluation, control and transfer of risks that can ultimately result in loss. The safety function should assist with the execution of these objectives and reinforce basic loss prevention guidelines established by the risk manager.

- Maintaining open communications.

Poor communication and a general lack of understanding between these individuals can be disastrous to the successful execution of the risk management and safety programs.

Some companies operate under a "territorial" management style and foster the philosophy of protecting one's turf. If a risk manager is incapable of freely moving throughout an organization, *not* having the safety manager report to the risk management department brings an added disadvantage. A concentrated effort would be required to keep communication channels open.

It's worth emphasizing that good communication flows two ways: from within and from outside the corporate structure.

Another important communication issue concerns the distribution of claims data. The two positions inherently view this information differently. A risk manager sees claims in financial terms, keeping a perspective toward the loss development factor as it relates to the total dollars incurred, whereas a safety manager sees claims in terms of frequency, severity and recordable causes under Occupational Safety and Health Administration rules.

It is critical, therefore, for the risk manager to provide the "big loss picture" to the safety manager. Problems arise if the risk manager is forced to increase the claims expense allocation based on trended and developed loss experience that has not been communicated to the safety manager. The increase will appear unreasonable because the claims data shown on the loss run is not indicative of the final cost of loss. As a result, the safety manager may believe the loss prevention program is meeting its goals when actually the reverse is true.

- Provide mutual support.

As I stated previously, the risk management process involves identification, evaluation, control and transfer of risk. It is important to have the risk management and safety functions continually interact in this process. They ideally should complement each other.

When the risk manager and safety manager operate as a team to address these objectives, both parties and their entire organization will benefit. For example, if losses are adequately controlled (safety), the organization realizes a reduction in insurance costs (risk management).

The risk manager's and the safety manager's philosophies should be consistent insofar as loss prevention is the ultimate goal.

As I see it, the paramount issue becomes how effectively these three elements operate if the safety manager reports to an area other than risk management. If corporate politics dictates the reporting sequence, the two functions can find themselves constantly at odds attempting to serve two masters.

These issues now considered, it is my opinion that risk manager and safety manager should exist within the same department. However, since successful programs have been developed under both approaches, I welcome comments from our readers on this subject.

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

Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Duva's and Ms. Werner's columns usually appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in October.

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.

RMIS depend on accurate data

THE DEGREE to which the risk manager and risk management information system respond to major external shocks will determine how useful the system really is.

The first major system exposure is probably the most insidious: A lack of data integrity. Without good data, even the best-designed system will produce incorrect output.

Too many people retain a certain naivete about computers, assuming that "if it comes from a computer, it must be right." Nothing could be a more dangerous assumption. Despite a RMIS' ability to calculate complex equations in split seconds, maintain vast data bases and produce specific reports quickly and efficiently, the system depends on sound data to produce useful results.

Imagine a Fortune 500 company risk manager presenting a financial projection on losses for the upcoming year based on erroneous information. For example, senior management relies on the risk manager's RMIS-based reserve projections for workers compensation and plans its budget accordingly. However, if the data entered into the computer is off by 20%, a severe undercutting of projected reserve adequacy will occur, generating a significant deficit that must be made up at year's end.

Too many mistakes like that will either result in a new career path for the risk manager or, at best, a greatly undermined credibility with superiors.

The purpose of an RMIS is to assist the analytical/evaluation process, not to undermine effectiveness. What follows is a discussion of some of the quality control checks a risk manager must utilize to minimize exposure to faulty data:

- Claims organizations.

If data is erroneously gathered and/or reported by the claims organization—be it an insurance company, claims administrator or internal claims department—then it will not matter how effective the system's internal audits and validation procedures are. A breakdown of data accuracy at this point negates the RMIS' effectiveness.

Although some systems are designed to catch obvious mistakes—such as a "Feb. 32, 1988"-type entry or abnormally high reserves entered without verification and re-entry into the system—even the best system cannot detect whether or not a claimant suffered a fracture of the left elbow when, in reality, he suffered a broken leg.

Nor can the computer detect subtleties in reserving practices. Whereas the system might identify and question a staggering reserve increase as would occur from a minor back injury to a ruptured disc, it may not pick up $10,000 to $15,000 in additional reserves on several claims that are unjustified, thus prompting a risk manager to question the increases.

Therefore, establishing the accuracy of the data—which is the result of sound claims investigation and reporting—must precede its introduction to an efficient RMIS. The claims organization personnel have a key responsibility in preparing the information for eventual use by the RMIS and risk manager.

- Data conversion provider.

The next step comes in the transformation of field information into a computer-acceptable format. If you already utilize a full-service vendor—one that provides claims service and RMIS—the transfer of data takes place immediately. However, the most common procedure is the loading of the data onto a floppy disk or magnetic tape by the claims organization. The data is then supplied to either the risk manager or an RMIS vendor for another transfer of that information to a format acceptable by the particular RIMS.

The key stage during this process occurs at the claims organization: The transference of the raw information—claimant's name, date of injury, description of injury, initial reserves, etc.—into a computer format. It is important that the claims organization be as accurate as possible in entering written data into its own system.

In that regard, the claims adjuster and/or supervisor on that particular account should have regular access and even a quality control methodology to ensure that the information gathered in the file is the same that is entered into their own system. That information will be used by the RMIS vendor and the risk manager to make important predictions and evaluations; therefore, it must be accurate.

Although much maligned and accused as the weak link in the data integrity chain, data entry clerks are statistically very accurate, according to most RMIS vendors. The most common errors arise in the location coding area. Nevertheless, having the adjuster and supervisor of the claims organization oversee and monitor the quality of the data that is entered into their own system for eventual transfer to the risk manager's system is quite important.

I recommend that the risk manager perform regular audits on the efficiency and accuracy of his claims organization. Proper claims management is not only necessary for generating good data for use in the RMIS, but is essential to the client/policyholder as well. A future column will address how RMIS can help in the evaluation of a claims management program.

- Risk manager.

It is absolutely essential that the risk manager have accurate location listings on file with the RMIS vendor and claims organization so that the claims values can be allocated to the proper area. Most providers or claims administration/RMIS services point out that it is here that most data errors occur.

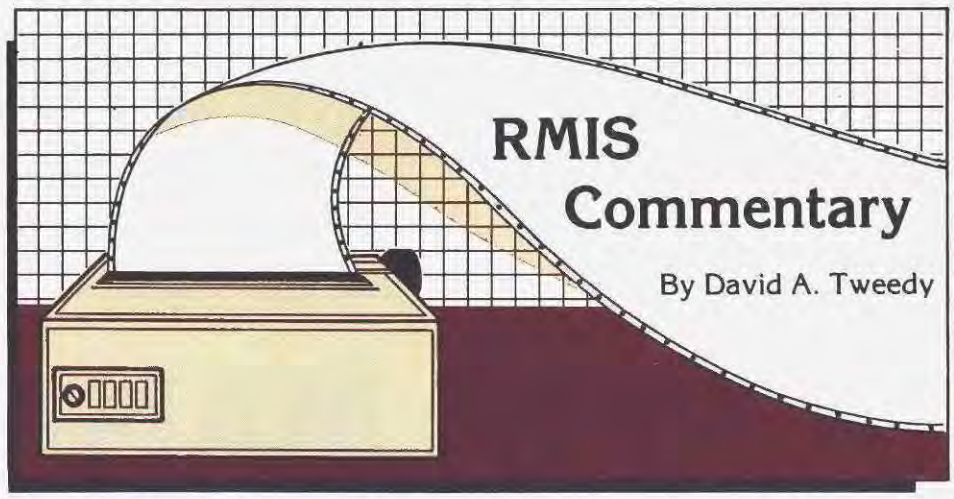
It becomes even more difficult when a corporation has many subsidiaries in many locations. Omitting locations that have incurred claims can disrupt the continuity and accuracy of cost allocation and produce erroneous results. A sophisticated RMIS with good edits and validation checks can't tell whether a claim should be assigned to Des Moines when it really happened in Chicago. The risk manager, therefore, is responsible for making sure that both his claims organization and RMIS vendor (or internal RMIS manager) are fully aware of all locations and their proper codes.

The risk manager's responsibility increases substantially for data integrity maintenance if he has a stand-alone RMIS. If outside expertise is not monitoring and guaranteeing the accuracy of the data, the risk manager must assume this responsibility. If there are a small number of claims occurring per year, which are simply fed into a microcomputer, that task is not quite as onerous. However, as the claims volume increases, there is greater chance for errors in data entry.

Therefore, it would be wise for the risk manager to implement a series of quality control checks to measure the accuracy of data entry into the RMIS and coding verification. He may desire to hire an outside expert or have his corporate data processing department be involved in this process.

In conclusion, an RMIS is a great asset to the risk manager in gauging exposure to risk and in mapping potential solutions. But, its usefulness depends on the accuracy of gathered claims information that eventually is transferred to the RMIS.

Next month, I will address another major impact on an RMIS: mergers/acquisitions and divestitures.



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Cosmetic surgery not covered by group health policy

Legal briefs

An Alabama court ruled that a policyholder's congenital ear malformation did not constitute a "disease" within the coverage of a group medical insurance policy.

James D. Hays had a lifelong problem of protruding ears. At age 29, Mr. Hays consulted a doctor concerning his condition and indicated that he wished to improve his "corporate image."

The doctor diagnosed his condition as a congenital malformation and advised that it only could be corrected by reconstructive surgery. Mr. Hays had no hearing deficiency. The surgery was performed.

Mr. Hays was covered under a group medical insurance policy issued by Aetna Life Insurance Co. Inc.

He submitted a claim seeking recovery of nearly $3,000 in medical expenses for his surgery. The insurer, however, denied the coverage. Mr. Hays sued and won in the trial court.

The appellate court reversed, stating that the claimant's condition did not amount to a "disease," which it defined as a serious illness that has impaired the constitution or left in its wake some organic or chronic effect undermining general health.

The court concluded that the surgical procedure performed on Mr. Hays was simply to improve his appearance and, therefore, was not covered by the policy.

Aetna Life Insurance Co. Inc. vs. Hays, Court of Civil Appeals of Alabama, June 24, 1987 (*BI*/05/April-$10).

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

Competition may reduce FTZ's growth

By JUDY GREENWALD

NEW YORK—The New York Free Trade Zone's growth is likely to be stunted by the softening property/casualty insurance market this year, insurers predict.

In addition, business in the FTZ could be further curtailed if the definitions of some of the types of business that can be written in the zone are tightened.

The Free Trade Zone permits specially licensed, admitted insurers in New York to write jumbo and certain unique and exotic risks without rate or form approval—including exemption from New York's flex-rating system. And brokers are free to present business to FTZ-licensed insurers on the same basis they place it with other admitted insurers. They do not have to satisfy the potentially onerous process required by the New York Insurance Department's Regulation 41, which stipulates brokers must receive three rejections from admitted insurers before they can place business with non-admitted companies.

And, because FTZ-licensed insurers are admitted insurers, policyholders whose coverage is written through the Free Trade Zone are still protected by New York's property/casualty guaranty fund in the event of insurer insolvency.

While the FTZ's premium volume increased 16.4% last year, insurers that write business in the zone say they are feeling the pinch of competition from standard markets (*BI*, Aug. 8).

"I think the Free Trade Zone sort of suffers the same fate as the surplus lines market," said Thomas J. Bonaros, general counsel for Utica Mutual Insurance Co., based in New Hartford, N.Y., which wrote $1.2 million in net written premiums in the FTZ last year. "I don't know if you could realistically expect an increase (in 1988) given the state of the market."

"The standard lines companies are back into the marketplace with an appetite," said Joseph M. Walsh, president of Cincinnati-based American Empire Insurance Co. "They just take the business back."

Because of the softening market, Mr. Walsh anticipates the amount of gross premiums written in the zone in 1988 by American Empire will be slashed in half to $5 million.

"The market has become a lot freer and a lot more competitive," said Thurson J. Millett, executive vp of New York-based Associated Insurance Management Corp., which underwrites business in the zone on behalf of the U.S. Branch of Colonia Insurance Co. Because of the softening market, Colonia also expects to write less than the $4.7 million in net premiums it posted in 1987, Mr. Millett said.

"I think we will probably see a 25% to 30% drop in written premiums," said Mike Bonner, vp of underwriting for New York-based Generali Underwriters, a wholly owned subsidiary of the U.S. branch of General Insurance Co. of Trieste & Venice. The insurer wrote $4.7 million in business in the zone last year.

"In '87, we began to feel the softening of the market," said Charles Venezia, director of surplus lines for Royal Group. Royal Indemnity Co., which is part of the Royal Group, wrote $15 million in business in the FTZ in 1987, down from $18.8 million in 1986. Royal still ranked as the second-largest FTZ underwriter last year.

In 1988, "I see a further erosion. I don't think that's any surprise to anyone," Mr. Venezia said.

"We feel committed to the Free Trade Zone," he added. "We try to use the Free Trade Zone as our primary vehicle for writing surplus lines business in the state of New York. We continue to operate on that basis, but we are in a soft market. It is soft and is getting softer."

The largest FTZ insurer, New York-based American International Group Inc., concedes that the market for tough risks is slowing.

"I would say there's a drop off in hard-to-place markets everywhere right now," said Patrick Foley, vp and assistant general counsel at AIG, who added that he did not know how market competition will affect AIG's business in the FTZ.

AIG units wrote $89.4 million in net premiums in the FTZ last year, a 63.1% increase from the $54.8 million in 1986.

One specialty insurer, Albany, N.Y.-based Hospital Underwriters Mutual Insurance Co., expects that its 1988 FTZ volume probably will be about even with the $3.2 million in net premiums it wrote last year, said Robert Nugent, vp. However, that's because it is the only insurer to aggressively pursue hospital liability insurance business in the state, he said.

"We seem to be the only game in town," said Mr. Nugent. "Overall, I don't see any competition in the next year."

Charles Rapacciuolo, who supervises the special risk section of the New York Insurance Department's Property Companies Bureau, disagrees with those who predict the FTZ's volume will decrease this year. "I think you'll still see some steady growth."

Mr. Rapacciuolo believes the softening market, as well as the closing of the New York Insurance Exchange, could benefit the FTZ.

Because of the competitive market, he said, insurers active in the FTZ may be more willing to take on business they would otherwise have rejected.

And Mr. Rapacciuolo said that business that FTZ insurers formerly rejected so that it could be written by affiliated NYIE syndicates now may be written in the zone. Under now-moot rules, brokers had to obtain three rejections from FTZ insurers before placing direct business on the NYIE.

While the softening market may ultimately reduce the amount of business written in the FTZ this year, FTZ activity set a record in 1987.

Net premiums written in the FTZ rose 16.4% to $204.6 million last year, compared with $175.7 million in 1986. Underwriting losses, however, increased a whopping 126.7% to $11.2 million from $4.9 million.

Fifty-seven of the 120 insurers that paid $1,000 for an FTZ license last year wrote some business in the zone.

As in previous years, AIG dominated the zone, accounting for about 43.7% of its net written premium volume.

The AIG companies reported $26 million in underwriting losses on FTZ business, a 36.8% increase from the $19 million in losses reported in 1986.

Investment income on FTZ-written business is not reported.

Referring to the increase in overall FTZ underwriting losses, Mr. Rapacciuolo commented: "We don't like it. Obviously, we don't like to see it, but it's right in line with what's happening in the rest of the industry. The Free Trade Zone has not been exempted from the overall experience of the business."

In the first quarter of 1988, net premiums written in the FTZ increased 144.7% to $129.7 million from $53 million in the comparable quarter of 1987. Underwriting results were not released.

Mr. Rapacciuolo noted, however, that the first-quarter figures are not necessarily indicative of overall trends because some business may have been booked in the first quarter that ordinarily would have been booked later in the year.

Business written in the FTZ is divided into two classes. Class I business includes coverages that produce a minimum annual premium of $100,000 for one line of insurance or $200,000 for a package policy involving more than one line.

Last year, Class I business produced $112.3 million in premiums.

Continued on next page

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Free Trade Zone

Continued from previous page

a 22.1% boost from $92 million in 1986.

Class II business includes 321 designated risks that have an unusual nature, a high loss potential, or are difficult to place. Examples of these risks range from landscape architects' errors and officials to stud fee coverage, reducing salons professional liability and catfish farms "crop" insurance.

Class II risks accounted for $923 million in net premiums written last year, up 10.2% from $83.6 million in 1986.

However, some regulatory changes could limit the amount of Class II business in the FTZ, while other changes could increase the types of coverage eligible to be written as Class II risks.

Mr. Rapacciuolo plans in the coming year to issue definitions for all Class II risks.

Some insurers take advantage of Class II categories of business for which specific definitions have not been drafted to "circumvent the law" and place business in the zone that really should be written in the standard market, he explained.

Classes that have been incorrectly interpreted include corporate trustees errors and omissions coverage, he noted, which is intended to cover bank and other officials who act as trustees of other businesses. "It would seem to me that it's pretty clear what the coverage is," yet what has actually been written in that category in some cases has turned out to be "quite different than expected," he said, but would not elaborate further.

However, Mr. Rapacciuolo's plans worry Royal's Mr. Venezia.

"If the regulation is changed to make it impossible or much more difficult to place business in the Free Trade Zone, then it's just going to drive business to the non-admitted market." And, if that occurs, more policyholders will lose guaranty fund protection.

But, Mr. Venezia conceded, some insurers have encountered troubles because of the ambiguity of certain types of business eligible to be written in the zone.

If Class II categories are redefined so that American Empire can no longer write them, brokers who place business with American Empire will simply obtain the affidavits necessary to have it placed on a surplus lines basis, said Mr. Walsh, who also is president of American Empire Surplus Lines Insurance Co. "Brokers don't like to go through that drill."

Besides drafting definitions, the New York department may approve an additional 50 types of business that can be written as Class II FTZ business, said Mr. Rapacciuolo. The department has considered adding the new classes for the past two years, but approval has been delayed until the department studies the impact of New York's flex-rating system (*BI,* Aug. 11, 1986).

Among the 50 categories under consideration are asbestos removal and amusement park liability.

Walter A. Rhulen, chairman and president of Frontier Insurance Co. of Monticello, N.Y, the fourth-largest FTZ insurer with $11.2 million in business in the zone last year, of which $10.8 was Class II business, said he would welcome the additional 50 categories.

Other insurers that are active in the FTZ include:

- United States Fidelity & Guaranty Co. of Baltimore, which ranked third with $12.5 million in net premiums and a $1.7 million underwriting profit. The business represents a reinsurance treaty written by USF&G for another insurer that writes commercial automobile insurance, said Jim Stannard, senior vp at F&G Re, a USF&G reinsurance underwriting management subsidiary.
- New York-based William H. McGee & Co., a New York-based underwriting manager that ranked fifth by writing a total of $10.3 million in net premiums on the zone that generated a $5.8 million underwriting profit.

McGee writes on behalf of six companies whose parents are foreign-based: London Guarantee & Accident Co. of New York; Marine Indemnity Insurance Co. of America; Royal Exchange Assurance of America Inc.; The Baloise Insurance Co. of America; Sun Insurance Co. of New York; and Phoenix Assurance Co. of New York.

- Greater New York Mutual Insurance Co., which wrote $7.8 million in net premiums and posted a $2 million underwriting profit.
- Hartford Accident & Indemnity Insurance Co. and Twin City Fire Insurance Co., both units of Hartford Insurance Group, with a combined $6.9 million in net premium volume and a $2.4 million underwriting profit. ■

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Tort reforms

Continued from page 3
to the tort system.

"Today, American manufacturers and their insurers are trying to take away many of the common law rights we presently enjoy. What they mean to do is not reform the tort system, but deform it. Indeed, they would like to dismantle it."

Trial attorneys steadfastly believe the drive to change the nation's tort system by limiting damage awards and eliminating joint and several liability is based on the incorrect assumption that these tort reforms will make insurance more affordable, Mr. Brodeur said.

Trial attorneys also believe that insurers created a false liability insurance crisis in a scheme to muster support for destroying the tort system, he added.

"If the American people give up these precious common law rights in exchange for the privilege of not being blackmailed by the nation's insurance industry, they will, in effect, give the manufacturers of toxic chemicals a license to inflict disease," said Mr. Brodeur.

Another method that manufacturers and their insurers are using to destroy America's jurisprudence system is "gross misuse" of the federal bankruptcy laws, according to Mr. Brodeur.

He staunchly denounced companies like Manville Corp. and A.H. Robins Co. that use bankruptcy laws "to escape from their liability" to the victims of occupational disease.

Both Manville, which faces tens of thousands of asbestos bodily injury claims, and Robins, which faces 195,000 claims from women who were injured using the Dalkon Shield intrauterine device, have filed for bankruptcy. Under each company's plan for reorganization, victims will be compensated through a trust fund. Victims are prohibited from suing either company directly or from seeking punitive damages against either company (see related story).

"Manville, perhaps the most culpable corporation in the history of world jurisprudence, has been allowed to take refuge in Chapter 11 of the U.S. bankruptcy code for six years, and during that whole period of time has not been required to pay a single dime to compensate or ease the suffering of any of the 52,000 disabled and dying asbestos disease victims who have filed claims against it," Mr. Brodeur said.

However, during the six years Manville has been in bankruptcy more than $100 million has been paid in legal and professional fees, according to Mr. Brodeur.

A spokesman for Manville later said the company has only spent $75 million in legal and professional fees since it filed for bankruptcy.

And, Mr. Brodeur noted that Manville's former chief executive officer, John McKinney, who retired in 1986, saw his salary balloon from $408,000 in 1982—the year Manville filed for bankruptcy—to $638,000 in 1985, a 56% increase.

"Talk about thriving in bankruptcy," Mr. Brodeur quipped.

The Manville spokesman said Mr. McKinney's salary was $443,750 in 1982 and $638,005 in 1985, a 30% increase.

"These gross misuses of Chapter 11 by tort-feasors trying to escape their responsibility to their victims establishes a dreadful precedent," Mr. Brodeur asserted.

"It teaches industry that if you kill, injure, disease, disable or otherwise maim enough unsuspecting victims, all you have to do is spin off a few assets, file for Chapter 11, put yourself on the market and, in fact, walk away," he argued.

Mr. Brodeur urged ATLA to lobby members of Congress to change the bankruptcy laws to prevent other manufacturers that face mass tort litigation from escaping their liabilities.

Furthermore, Mr. Brodeur sharply criticized both the Manville and A.H. Robins reorganization plans for "reducing tragedy to dollars and cents and depriving victims of corporate misconduct of dignity."

Because bankruptcy bars claimants from having their day in court, it is "dehumanizing," said Mr. Brodeur. "It is, in essence, a no-fault scheme that protects the guilty."

Insurers also are guilty of misconduct under the Manville bankruptcy plan, according to Mr. Brodeur, because although they are not insolvent, they have bought themselves Chapter 11 protection from claimants by contributing to the trust fund.

Claimants cannot directly sue Manville's insurers, which have reached more than $650 million in settlements with Manville.

"By agreeing to contribute to the trust fund, Manville's 29 insurers are totally off the hook, completely insulated from future claims even though they are not and cannot be under the protection of Chapter 11," said Mr. Brodeur.

"This was a backroom deal, this insurance settlement," said Mr. Brodeur, who said the insurance settlements could underestimate Manville's true insurance coverage by more than half.

Finally, Mr. Brodeur said the $2.5 billion Manville trust fund is "grossly inadequate" to pay all the asbestos bodily injury claimants that eventually could sue the company.

"Manville would have the nation believe that out of 3 million cases of potential disease, there are going to be at most only 50,000 more claimants," said Mr. Brodeur. "What a colossal hoax." ■

Manville, Robins trusts differ, trustee explains

KANSAS CITY, Mo.—While both Manville Corp. and A.H. Robins Co. are using Chapter 11 of the Federal Bankruptcy Act to cope with massive tort litigation, their claimant trust funds are substantially different, according to one of the five trustees recently appointed to administer Robins' trust fund.

The reorganization plans of both Manville—which faces tens of thousands of asbestos bodily injury claims—and Robins—which faces 195,000 claims from women who used the Dalkon Shield intrauterine device—propose compensating victims through a trust fund.

However, how those funds will operate is essentially different, according to Gene Locks, a Philadelphia trial attorney with his own practice, who spoke at the recent Assn. of Trial Lawyers of America convention.

In comparing the two trust funds, Mr. Locks pointed out the following differences:

- The Robins trust fund—which was approved by the claimants, shareholders and bankruptcy court in late July (*BI*, Aug. 1)—is expected to be operational within two weeks to pay some types of claims and to pay for in vitro fertilization desired by claimants who are nearing the end of their childbearing years.

The Manville trust fund won't be able to pay claims until Manville's reorganization plan, which currently is being appealed to the U.S. Supreme Court (*BI*, June 27), is approved. The plan has been stymied for six years as the result of appeals by claimants, he said.

- Each company has set aside about $2.5 billion to pay claimants; however, the Robins fund is composed entirely of cash, while the Manville fund is made up of cash, stock and a percentage of future company profits, said Mr. Locks.

In addition, the amount of money in the Robins fund is firm, whereas the amount of money in the Manville plan is fluid because it is tied to company profits.

- The number of claimants expected to tap the Robins trust fund is known, but the number of outstanding Manville claimants is unknown.
- The bankruptcy court overseeing Robins' reorganization has exerted much more control over the trust fund than the court overseeing Manville's reorganization.

However, Mr. Locks noted that the Manville plan specifies how much money individual claimants will receive based on their injuries while the Robins trustees currently are determining how much to pay individual claimants.

—By Stacy Adler

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Some legal issues on AIDS uncertain

KANSAS CITY, Mo.—A typical AIDS case is worth $80,000 to trial lawyers, who boil every human affliction down to a specific amount of money.

The $80,000 figure represents the cost of medical care for the average acquired immune deficiency syndrome patient, according to doctors and attorneys speaking at a program entitled "AIDS: The Developing Law" held earlier this month at the Assn. of Trial Lawyers of America convention in Kansas City, Mo.

However, others estimate that an AIDS case can be treated for as low as $40,000 using proper case management.

While the trial lawyers were certain about the amount of damages to seek, they said whom to sue is not always clear.

Among unresolved AIDS-related legal issues are the liability of doctors who fail to diagnose AIDS or to warn an AIDS victim's sexual partners, and the liability of blood banks and hospitals that inadvertently transmit the deadly disease via blood transfusions.

"We can answer fewer questions about AIDS from a legal point of view than doctors can from the medical end," explained Robert G. Sullivan, an attorney with Lipsig, Sullivan & Liapakis in New York.

'We can answer fewer questions about AIDS from a legal point of view than doctors can from the medical end,' says Robert G. Sullivan, an attorney with Lipsig, Sullivan & Liapakis in New York.

In some instances, Mr. Sullivan said, the doctor who fails to diagnose AIDS in the husband of a pregnant woman could face successful litigation from the wife, even though there is no formal relationship between the doctor and the wife.

Similarly, "The man who has AIDS and doesn't tell his sexual partner and continues to have sex" also exposes himself and his doctor to liability, said Mr. Sullivan.

David Baum, an attorney with his own practice in San Francisco, said he is getting ready to try the first AIDS-related lawsuit testing the liability of doctors who fail to warn the sexual partners of AIDS victims.

And, Mr. Sullivan said, the sexual partner or spouse of an AIDS victim also can seek damages for AIDS phobia: the fear of contracting the disease.

However, it would be very difficult to bring a successful lawsuit against a blood bank that inadvertently uses AIDS-contaminated blood because the blood banks perform very stringent tests on all the blood they use, Mr. Sullivan said. But, he did suggest that attorneys look into the possibility of suing the hospital for unnecessary blood transfusions if the patient should contract AIDS from such a blood transfusion.

"The problem with all these cases," Mr. Sullivan noted, "is that by the time they go to court, the patient is dead."

—By Stacy Adler

Every 78 seconds, an American teenager ATTEMPTS suicide.

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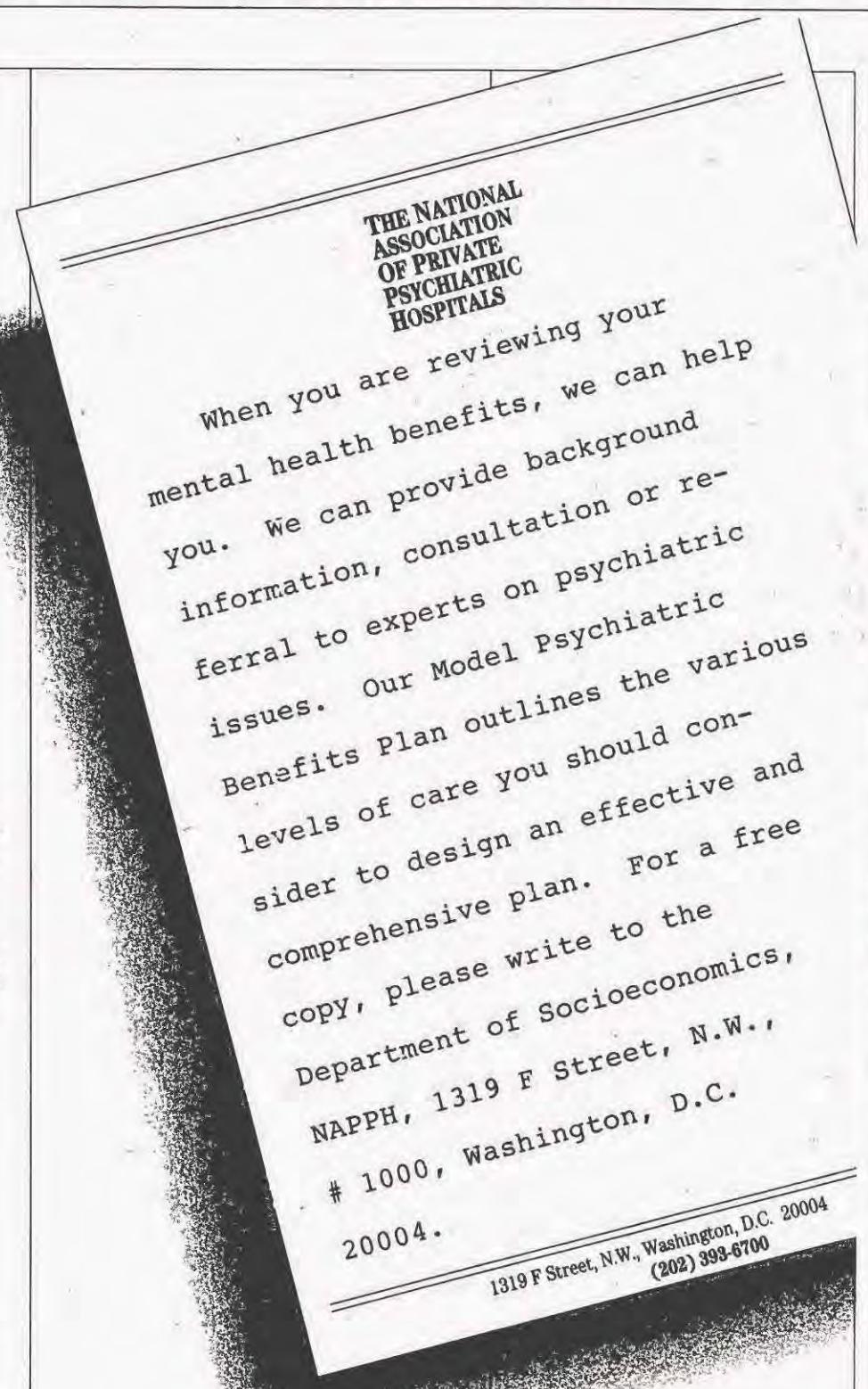

THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS

* (Source: National Center for Health Statistics)
** (Source: American Psychiatric Association, 1986)

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Trial lawyers aim at insurers, manufacturers

By STACY ADLER

KANSAS CITY, Mo.—They call themselves hunters and killers. Their prey are insurers, chemical manufacturers and doctors. They are America's trial lawyers.

When these legal eagles met earlier this month to exchange hunting tips at the Assn. of Trial Lawyers of America convention in Kansas City, Mo., they placed insurers and manufacturers at the top of their hit list because insurers and manufacturers are leading the drive for tort reform.

The nation's trial lawyers also set their sights on health care providers, contending that only the threat of medical malpractice lawsuits ensures quality care.

Tort reforms, because they limit damage awards and attorneys' fees, are as opposed by trial lawyers as bag limits are by deer hunters.

Trial lawyers applaud states that have declared some of these tort reforms unconstitutional and are encouraging attorneys elsewhere to continue to look for constitutional flaws.

"We want a domino effect that will leave the tort reform movement as a negative loss for those who have spent millions of dollars to take away victims' rights," said Jerry R. Palmer with the Topeka, Kan., law firm of Palmer, Marquardt & Snyder.

Trial lawyers, who see themselves as valiant upholders of public justice—the sole access to relief for victims injured by industry's wrongful conduct—steadfastly maintain that insurers created the liability insurance crisis of the mid-1980s out of "wanton greed."

Without this mythical shortage of liability insurance, there would be no need for tort reforms, trial lawyers say.

"The insurance crisis was not caused by the tort system," said Jeffrey White, assistant to ATLA's general counsel. "The insurance crisis was caused by greed and malfeasance on the part of insurers."

Now that insurers are in the spotlight as a result of the antitrust lawsuits filed by 19 states' attorneys general (*BI,* June 27; April 4; March 28), some trial lawyers advocate filing their own barrage of lawsuits charging insurers with bad faith, fraud and false advertising (*BI,* Aug. 8).

Trial lawyers also attack the nation's manufacturers as reckless dumpers of cancer-causing toxic chemicals.

And, assessing the nation's health care system as "woefully inadequate," trial attorneys say that the only way to bring about higher

Continued on next page

Litigation threat helps ensure quality medical care: Lawyers

By STACY ADLER

KANSAS CITY, Mo.—Only the constant threat of medical malpractice awards will ensure quality health care in the United States, trial lawyers and consumer advocates contend.

In fact, when an audience of hundreds of plaintiffs' attorneys were told by an officer of a physician-owned medical malpractice insurer that "America has the best health care system in the world," the attorneys jeered.

The remarks and reactions of lawyers attending a health care symposium earlier this month at the annual convention of the Assn. of Trial Lawyers of America underscored the growing rift between health care providers and trial attorneys.

The symposium, titled "Health Care and the Law: Patients, Doctors, Lawyers and Juries," featured an 18-member panel of plaintiffs' and defense attorneys, a state attorney general, judges, health care professionals, consumer advocates, a juror, a reporter and the insurer executive.

The panel discussion quickly turned into a roast of doctors, including charges that many doctors are incompetent, according to consumer advocates and trial lawyers.

"Medicine is one of the least regulated professions," charged Charles Inlander, president of the People's Medical Society, a consumer advocacy organization based in Emmaus, Pa., and co-author of the book "Medicine on Trial."

"Why is it that there is not a doctor in the country who has someone come in and inspect his blood pressure cuff, yet in most states you have to have someone come in and check the calibration of a butcher scale twice a year?" he asked.

'Being sued does not make better doctors; it makes more cautious doctors,' says Dr. Scalettar.

"There is no regulation of the things that ultimately affect consumers," said Mr. Inlander.

However, Dr. Raymond Scalettar, a trustee of the Chicago-based American Medical Assn., said: "Being sued does not make better doctors; it makes more cautious doctors."

The cost of being more careful and performing extra medical tests —what he termed "defensible medicine"—as well as higher medical malpractice insurance costs are ultimately passed on to the medical consumer, Dr. Scalettar noted.

But, Philadelphia plaintiffs' attorney David Shrager countered: "There is no cost more important than letting a person who has an actual claim get into court."

Mr. Shrager, a senior partner

Continued on next page

ATLA meeting

Continued from previous page

quality medical care is to blanket doctors and hospitals with medical malpractice lawsuits.

But, amid all this aggressive "hunting" talk, trial lawyers exchanged soft-spoken questions about ethics during their annual convention, which was attended by about 1,500 lawyers.

ATLA passed a new, stricter code of conduct that prohibits any member from personally contacting an injured person to solicit business and from advertising to victims or initiating media contact within 10 days of an injury-causing event unless the lawyer foregoes compensation.

The new code "will go a long way to ensure that trial lawyers conduct themselves in an ethical and professional manner and that the privacy of victims and their families is respected," said ATLA President Eugene I. Pavalon.

ATLA has been struggling with the issue of attorney solicitation for the past several years, beginning with the 1984 gas leak from a Union Carbide Corp. pesticide manufacturing plant in Bhopal, India, that killed 1,600 people and injured more than 200,000 others (*BI*, Dec. 10, 1984).

Since that time, Mr. Pavalon reported, there have been several other instances of lawyers soliciting clients in the wake of disasters, such as the Dupont Plaza Hotel fire in San Juan, Puerto Rico. That New Year's Eve 1987 fire swept through the hotel's casino and lobby area, killing 97 people and injuring about 200 others (*BI*, Jan. 19, 1987; Jan. 12, 1987; Jan. 5, 1987).

"ATLA is keenly aware of the negative public perception of trial lawyers descending on the scene of a disaster to solicit business," Mr. Pavalon said. ■

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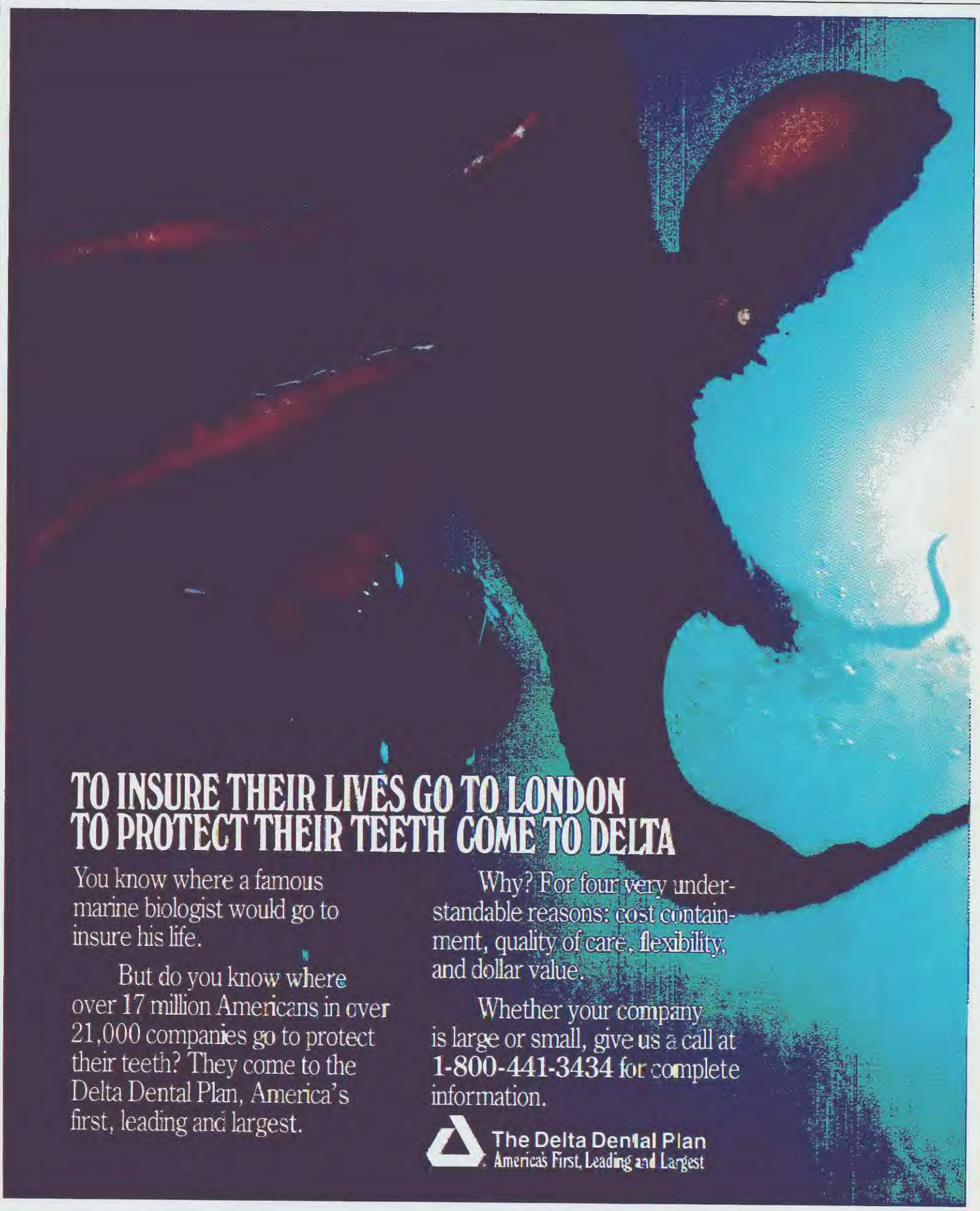

Photo: Carl Murray

Philadelphia plaintiffs' attorney David Shrager, left, and Charles Inlander of the People's Medical Society spoke at the ATLA meeting.

Malpractice

Continued from previous page

with Shrager, McDaid, Loftus & Flum, is president of the Roscoe Pound Foundation, a legal research foundation that hosted the symposium.

Consumer advocate Ralph Nader, who heads the Center for Responsive Law, said that many of the medical malpractice claims filed by attorneys now stem from "thousands of unnecessary operations: unnecessary Caesarean sections, unnecessary hysterectomies, unnecessary coronary bypass surgery, etc."

Dr. Scalettar answered Mr. Nader's attack on physicians by saying: "You decry the number of unnecessary Caesarean sections being done today in the United States, but we all know that you don't get sued for doing a Caesarean section; you get sued for not doing one."

But, Mr. Nader replied: "You are going to get sued for doing a Caesarean section because now the details are out on comparative hospital rates. So get ready for that," he said, explaining that plaintiffs' attorneys now are filing suits against doctors who perform unnecessary procedures.

Many medical malpractice claims filed by attorneys now stem from 'thousands of unnecessary operations: unnecessary Caesarean sections, unnecessary hysterectomies, etc.,' says consumer advocate Ralph Nader.

Panelists also attacked the AMA's proposal that state medical boards, rather than juries, resolve medical malpractice claims.

The plan, which has been endorsed by 32 other medical societies, provides that medical malpractice cases be adjudicated by state agencies consisting of claims reviewers, case examiners and medical boards that would have the authority to dismiss the claims or award damages within certain limits.

Under the plan, the agencies also would be authorized to monitor physicians' performance by gathering information from hospitals, insurance companies and other doctors and levy disciplinary actions against physicians. (*BI,* March 14; Jan. 18).

Dr. Scalettar of the AMA said the proposal "is not an attempt to torpedo the jury system, but rather an attempt to bring order out of chaos."

But ATLA President Eugene I. Pavalon called the proposal "the most Draconian process ever unleashed on the American public."

"It is the first time anyone has had the temerity or the guts to recommend to the public that we use a fault-based system with no right of appeal," Mr. Pavalon said.

Mr. Inlander agreed with Mr. Pavalon, saying the AMA proposal "is about as pro-consumer as the AMA's stand against Medicare, its stand against HMOs, its stand against Medicaid and its stand against every other thing that has been pro-consumer in this country."

Finally, the panelists also said the fear of medical malpractice rate increases keeps doctors from reporting other physicians' errors.

"I fault doctors primarily for one major failing: that they have allowed this system of insurance industry exploitation and peer group pressure to deprive themselves of their critical sensitivity and compassion to blow the whistle on the doctors who are killing and injuring because of crass, gross, generic malpractice and negligence," Mr. Nader said.

He also lambasted insurers for increasing medical malpractice insurance rates while, at the same time, reaping what he described as huge profits.

Other members of the panel included: Robert L. Habush, a plaintiffs' attorney with Habush, Habush & Davis in Milwaukee and a former president of ATLA; John Dvorak, a reporter for the Kansas City Times; Peter Pryor, a senior partner and defense attorney in the Englewood, Colo., firm of Pryor, Carney & Johnson; and Judge Patrick Higginbothan of the 5th U.S. Circuit Court of Appeals.

Also serving on the panel were: Leonard Dale, administrator for the Milwaukee Public School System Department of Human Relations and a former jury foreman; A. John Smither, president of the Pennsylvania Medical Society Liability Insurance Co., a physician-owned insurance company; Charles Brown, the attorney general of West Virginia; Michael Anthony, senior vp-legal affairs for the American Hospital Assn.; and Judge Jim R. Carrigan of the Colorado U.S. District Court.

The panel also included: Dr. Warren H. Pearse, executive director of the American College of Obstetricians and Gynecologists; William Johnson, a senior partner and defense attorney with the Chicago firm of Johnson, Kusack & Bill; Richard Godosky, a defense attorney and partner with the New York firm of Molod, Berkowitz & Godosky; and Jim Jeans, professor of law at the University of Missouri Kansas City Law School.

The panel was moderated by Arthur Miller, a professor at the Harvard Law School. ■

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New 401(k) rules

Continued from page 1

minutia in those rules," said Gary Blank, a consultant in The Wyatt Co.'s San Francisco office and chairman of Wyatt's defined contribution plan practice committee.

For example, while employees can make hardship withdrawals to cover college education expenses, the withdrawal can be used only to pay tuition for the next semester or quarter, not for a full academic year. A separate withdrawal would have to be made for each semester or quarter.

"Employers will have to monitor with precision the hardship withdrawal request to make sure they are not distributing too much," Mr. Blank said.

"The rules are excessively complex with many traps," said John Woyke, a technical consultant with TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

Indeed, the regulations, on top of the complexities previously added to 401(k) plans by the Tax Reform Act of 1986, are changing the very nature of 401(k) plans.

"The 401(k) plan that everyone loved so much because it was so simple will no longer be so simple," said Henry Saveth, a managing consultant with A. Foster Higgins & Co. Inc. in New York.

Inevitably, employers, more than ever, will be forced to rely on consultants for assistance in complying with the rules, which will increase administrative costs.

"These are complex regulations, and there will be a strong need to use outside service providers," said Howard Golden, a partner with Kwasha Lipton in Fort Lee, N.J.

While the new IRS rules are a heavy blow to 401(k) plans, employers can take comfort that at last they know the IRS' positions—detailed in 203 typewritten pages—on a variety of issues.

"The regulations do answer a lot of questions. A lot of the uncertainty has come to an end," said Karen Frost, a consultant with Hewitt Associates in Lincolnshire, Ill.

While the rules most likely will reduce participation in 401(k) plans and boost employers' administrative costs, it is inconceivable that major companies would terminate their plans, experts say.

"I can say with certainty that the rules will not discourage employers from offering 401(k) plans. The rules, though, do call upon employers to treat 401(k) plans as more than simple employee benefit plans," said Wyatt's Mr. Blank.

Indeed, the very basic ingredients that have made 401(k) plans the fastest growing and most popular employee benefit program of the 1980s remain intact:

- A 401(k) plan allows employers to provide pension benefits at a fixed and predictable cost.
- Employees like 401(k) plans, because the plans allow them to use pretax dollars to save for their retirement. Those pretax dollars, often matched by employer contributions, earn tax-free interest until they are withdrawn.

"A 401(k) plan is one of the best games in town. You can make pretax contributions, often get a matching contribution and receive professional management of the funds," said Frederick Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

With those kinds of attractions, it is no surprise that 401(k) plans have become almost universal among major employers.

For example, Hewitt Associates found that 91% of 240 major employers surveyed offered a 401(k) plan in 1987, up from just 2% in 1982 (*BI*, Feb. 15).

And, the plans have proved resilient to prior attacks. For example, while the 1986 tax law stung plan participants by imposing a 10% excise tax on withdrawals, employers note that the penalty has not seriously affected participation.

But the new tough rules governing hardship withdrawals undoubtedly will cause some decline in 401(k) participation, observers say.

Under those rules, which establish a two-prong test, employees will be allowed to make such withdrawals for an immediate financial need. Those needs are defined as:

- Medical expenses incurred by the employee, a spouse or dependents.
- Purchase of a primary residence for the employee.
- Payment of tuition for the next semester or quarter of postsecondary education for the employee, a spouse or dependents.
- The need to prevent the eviction of the employee from his principal residence or foreclosure of the employee's principal residence.

Employers already, by and large, require employees to meet criteria similar to those laid down by the IRS before they will approve a hardship withdrawal.

Instead, it is the second prong of the IRS hardship withdrawal test that will cause problems.

Under this section, a withdrawal would be considered as necessary to satisfy a financial need only if the employer—based on the "representations" of the employee—found that the need could not be first met by:

- A "reasonable" liquidation of the employee's assets.
- Halting all contributions to the plan.
- Other distributions, such as removal of aftertax contributions, from the plan.
- Taking a loan from any employer-sponsored savings plan or borrowing from commercial sources, like a bank, on "reasonable commercial terms." The rules do not define "reasonable commercial terms."

While 401(k) plan loan provisions are popular with employees—as a way of obtaining plan funds without being subject to the general 10% excise tax on pre-retirement distributions—it is rare for an employer to require employees to apply for a plan loan before approving a hardship withdrawal request.

And, it is virtually unheard of for an employer to require employees to first seek a bank loan before acting on a withdrawal request.

"You are telling the employee. 'You must apply for or take a loan at a bank. Only then can you seek a hardship withdrawal.' That is a significant disincentive to participate in a plan," said Jim Geld, a principal with William M. Mercer-Meidinger-Hansen Inc. in New York.

"The IRS is saying to employees that they will have to go into debt before their employer can give a hardship withdrawal. That is another disincentive to participate," Mr. Blank said.

Experts note that loans—as opposed to hardship withdrawals—may be less attractive to some employees because employees:

- Have to pay interest on the loans.
- May have a psychological fear of being swamped by debt.

Employers that do not want to go through the time and expense of verifying whether employees are truly in financial need have another alternative laid down by a safe harbor in the regulations. Under this safe harbor, a withdrawal to satisfy financial needs automatically would be allowed if:

- The employee first obtained all other distributions and loans available from all savings plans maintained by the employer.
- The employer barred the employee from making contributions to its plans for 12 months after he or she took the hardship withdrawal.

Continued on next page

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New 401(k) rules

Continued from previous page

For example, if an employee withdrew $3,000 from a 401(k) plan in July 1989, he or she could not contribute to the plan until July 1990.

- The employer would have to reduce an employee's maximum contribution to a 401(k) plan in the taxable year succeeding a hardship withdrawal by the amount contributed to the plan in the year the withdrawal is taken. For example, assume an employee deferred $3,000 to a 401(k) plan during the first six months of 1989. Then, on July 1, 1989, the employee made a hardship withdrawal of $3,000. Under the IRS rules, the employee could not make deferrals to the plan until July 1, 1990. And, for the remainder of 1990, the employee's maximum deferral to the plan would be the limit set by the IRS—the 1988 limit is $7,313—minus the 1989 deferral of $3,000.

That kind of reduction would be a direct hit on highly compensated employees, noted Ms. Frost of Hewitt Associates. In addition, such offsetting of future deferrals by prior deferrals would require excellent employer record keeping, she said.

The rules also would make it much tougher for 401(k) plans with matching contributions and 401(m) aftertax contribution provisions to pass the already tough non-discrimination tests.

Under the 1986 tax law, the average deferral percentage (ADP)—or the amount of salary deferred to a plan—elected by highly compensated employees cannot exceed the greater of:

- 125% of the ADP of the lower-paid employees.
- The lesser of either 200% of the ADP of the lower-paid employees or the ADP of the lower-paid employees plus two percentage points. For example, under this 200%/two percentage points test, if the ADP of the lower-paid employees was 4%, the higher-paid workers' ADP could not exceed 6%.

Employers generally have gravitated to using this test rather than the 125% test since, in most circumstances, it is easier to pass.

While the 1986 tax law did not make it explicitly clear, employers also have been using the 200%/two percentage points test to examine 401(m) contributions for discrimination.

The IRS, though, is proposing to end multiple use of the 200%/two percentage points test. If an employer, for example, uses this method to test 401(k) deferrals, it would have to use the tougher-to-pass 125% test for 401(m) contributions.

While the IRS is offering some flexibility to this one-time use of the 200%/two percentage points test, that flexibility probably will not help many employers, consultants say.

The IRS says that if an employer did not, for example, use all of the ADP in meeting the 200%/two percentage points test for 401(k) deferrals, it could transfer unused ADP to help it pass the 125% test for 401(m) contributions.

Conversely, if the employer used the 200%/two percentage points test for 401(m) contributions it could transfer unused ADP to help it pass the 125% test.

For example, assume the ADP of the higher-paid is 5.5% and the ADP of the lower-paid is 4%. At the same time, the 401(m) ACP—short for average contribution percentage—for the higher-paid employees is 4.2%, while the ACP for the lower-paid is 3%. The employer could transfer 0.5 percentage points of the unused ADP for 401(k) to the lower-paid's 401(m) ACP to enable the plan to pass the 125% test, experts say.

Thus, under this example, the ACP for the lower-paid employees would be effectively increased to 3.5%.

While experts say such an example is possible, the likelihood of successful ADP or ACP transfers is small.

For example, it is not uncommon for employers to match 401(k) deferrals dollar for dollar, up to the first 6% of salary deferred. Under such a plan design, the ADPs, which cover employees' own salary deferrals, will be the same as the ACP, which covers the employer's matching contributions.

For example, if the higher-paid employees' ADP is 6%, their ACP also will be 6%. And, if the lower-paid's ADP is 4%, their ACP also will be 4%.

As a result, in plans where deferrals are automatically matched by employers, there may be no unused ADP to transfer.

"There may be nothing left to transfer because one part of the plan may have already fully used the 200% test," said Mr. Saveth of Foster Higgins. ■

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Court rescinds mortgage cover citing false info

By JUDY GREENWALD

ALEXANDRIA, Va.—Two mortgage insurers do not have to pay claims in connection with defunct real estate syndicator Equity Programs Investment Corp. because their decision to insure mortgages issued to EPIC was based on incorrect and misleading information, says the U.S. District Court in Alexandria, Va.

The case involved a suit brought by United Guaranty Residential Insurance Co., a unit of American International Group Inc., and Foremost Guaranty Corp. against Dominion Federal Savings & Loan Assn. and First National Bank of Maryland.

Dominion had purchased loans from EPIC, and First National Bank is trustee for holders of EPIC securities. The plaintiffs had insured the lenders issuing mortgages to EPIC.

About $8 million in claims, plus interest, was at stake in the litigation, said United Guaranty attorney Richard L. Gray.

Foremost had insured about $102,000 of EPIC's loans, according to court papers.

Judge Claude Milton's decision pointed out that United Guaranty and Foremost are entitled to rescind the insurance "because EPIC Mortgage failed to provide them with complete, accurate and truthful information."

The decision will have no impact on two other EPIC mortgage insurers that have had to pay on EPIC-related claims: Milwaukee-based MGIC Investment Corp. and Republic Mortgage Insurance Co., a unit of Old Republic International Corp. of Chicago, according to company officials.

Bill Lacy, president of MGIC, said his firm has paid out $45 million so far under a workout plan. Mr. Lacy said his firm pulled out of EPIC business two years before United Guaranty and Foremost became involved, and that there was no evidence of fraud uncovered at that time.

Old Republic settled in June for an undisclosed amount (*BI*, June 6). "We were in a different set of circumstances than those companies," said President A.C. Zucaro.

An official of the California Insurance Department, which is overseeing the liquidation of Los Angeles-based TMIC Insurance Co., would not comment on the ruling.

EPIC's collapse in April 1985 is blamed for TMIC's demise (*BI*, Feb. 29; Sept. 2, 1985). ■

Resignations at Lloyd's expected to climb

By STACY SHAPIRO and CAROLYN ALDRED

London

LONDON—A record 1,700 Lloyd's of London members are expected to resign effective Jan. 1, 1989, compared with just 280 members who resigned in 1987 for the 1988 underwriting year, Lloyd's Chief Executive Alan Lord estimated earlier this month.

So far, 1,064, or more than 3%, of Lloyd's 33,540 members have resigned from writing any new business beginning Jan. 1, 1989.

Of those resigning, 233 are members who work in the market and 831 are non-working members, Mr. Lord said.

Each resigning member writes an average of 231,000 pounds ($392,700) of premium income, while those remaining write an average of 329,000 pounds ($559,300) in premiums, he said.

New members, however, may take the place of those who are resigning, according to Mr. Lord.

A June 30 deadline had been set for members to tender their resignations, but Lloyd's is continuing to receive notices, Mr. Lord said, adding that "between 1,500 and 1,700 members will resign by the year-end."

Lloyd's members planning to resign have indicated that investing at the market is no longer profitable because premium volume is down, the British government has reduced tax incentives and syndicate overheads have grown. They have also said they are resigning because they fear that the risk of unlimited liability for losses outweighs the rewards (*BI*, June 27; June 6).

However, Mr. Lord said that resigning members indicated to Lloyd's only "personal reasons" for resigning.

Meanwhile, as the announcement of Lloyd's 1985 results—which closed at the end of 1987 under Lloyd's three-year accounting system—approaches, about 166 members have failed Lloyd's solvency test, said Mr. Lord. As a result, just more than 12 million pounds ($20.4 million) of Lloyd's Central Fund, which totals nearly 300 million pounds ($510 million), will be earmarked to pay claims.

Matthey suits

At least four more lawsuits have been filed in the growing dispute surrounding tens of millions of dollars of insurance claims filed by British conglomerate Johnson Matthey P.L.C.

The Argent Insurance Co. Ltd., Johnson Matthey's Bermuda-based captive insurer, last month filed four separate lawsuits against various units of New York-based American International Group Inc. and brokers Fielding Juggins Money & Stewart Ltd., Fielding & Partners (Marine) Ltd.—both now part of C.E. Heath P.L.C.—and Hinton Hill Group Ltd., formerly known as Johnson Matthey & Hinton Hill Ltd.

Earlier lawsuits charged that two AIG units are refusing to pay at least 20 million pounds ($34 million) in claims filed by Johnson Matthey and its former banking subsidiary, Johnson Matthey Bankers Ltd.

The AIG units say they will not pay the claims because Johnson Matthey did not disclose details of fraud at Johnson Matthey Bankers when the policies were written. The bank currently is being investigated by the London police fraud squad (*BI*, May 16).

The insurers also are questioning 22 million pounds ($37.4 million) of claims that Johnson Matthey's former banking subsidiary has filed, but about which it refuses to give more details.

Meanwhile, about 180 retrocessionaires of Argent—which retroceded a portion of the Johnson Matthey risks that the AIG companies ceded to it—are refusing to indemnify the captive, alleging non-disclosure.

The retrocessionaires also are involved in litigation with the AIG units, which claim they are named as cedants on the retrocession contract.

In one of the latest lawsuits, filed in London's Commercial Court on July 7, Argent is seeking a declaration from the London office of the New Hampshire Insurance Co. that Argent is "entitled to avoid a contract of reinsurance" written between itself and New Hampshire on Feb. 20, 1981. Argent also seeks unspecified damages for negligence and misstatement.

In two separate lawsuits against American International Underwriters (Overseas) Ltd. and American International Underwriters (U.K.) Ltd., Argent seeks damages for breach of contract and negligence in relation to the establishment and operation of Argent's insurance arrangements between 1981 and 1985.

In another lawsuit, Argent is seeking damages for breach of contract and negligence from brokers Fielding Juggins, Fielding & Partners (Marine) and Hinton Hill in relation to various reinsurance contracts.

Winchester Bowring

Three London market excess-of-loss reinsurance brokers are leaving Lloyd's of London broker Winchester Bowring Ltd. to form their own firm under an "umbrella" agreement with Lloyd's broker Norex Insurance Brokers Ltd.

Continued on page 35

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NOTICES

REQUEST FOR PROPOSAL

JOINT PURCHASE INSURANCE GROUP FOR THE PENNSYLVANIA ASSOCIATION OF MUNICIPAL TRANSIT AUTHORITIES

The KETRON Project Team, (KETRON, Inc.; The David L. Ellis Agency, Inc.; and Fred S. James of PA, Inc.) is providing consultant services to the Pennsylvania Association of Municipal Transit Authorities (PAMTA) for the placement and implementation of a Joint Purchase Insurance Group (JPIG) to be effective January 1, 1989.

The PAMTA JPIG will provide commercial auto and C.G.L. coverages for 29 Public Transit Authorities throughout the Commonwealth of PA., including approximately 800 revenue vehicles developing 1987 premium of approximately $3.2 million.

The anticipated release date of the Request for Proposal (RFP) is August 26, 1988, with responses due by 2 PM Eastern Standard Time on November 23, 1988.

To obtain a copy of the RFP, numbered KI-RFP-RMS-001, please send a letter of interest in an envelope marked PAMTA JPIG, to: **THE KETRON PROJECT TEAM, MR. JOHN N. BALOG, VICE PRESIDENT, TRANSPORTATION, PLANNING AND OPERATIONS, C/O THE DAVID L. ELLIS AGENCY, INC., 100 CHESTNUT STREET, SUITE 207, HARRISBURG, PA 17101.**

London

Continued from page 33

Under the umbrella arrangement, Norex will act as a guaranteeing broker for the new company being formed by nonmarine LMX brokers Chris Harman, Matthew Swayne and Ian Wicks, formerly directors of Winchester Bowring.

After about three years, the brokers will be able to seek Lloyd's authority to act as an independent Lloyd's broker.

Chatset dispute with Outhwaite

A dispute between Lloyd's of London underwriting agency R.H.M. Outhwaite (Underwriting Agencies) Ltd. and syndicate analysts Chatset Ltd. has been settled out of court.

Outhwaite began litigation against Chatset in the High Court July 1 claiming that Chatset's "Lloyd's League Tables" of syndicates issued false statements about Outhwaite's syndicate 317 for the underwriting years 1984 and intended to do so in the 1985 tables to be published in September.

The lawsuit was withdrawn in early July, however, after Chatset agreed to split the open years of a syndicate's accounts from the closed years.

Outhwaite had sought an injunction to restrain Chatset from publishing "any false statement to the effect that the Lloyd's syndicates 317 under the plaintiff's management made an underwriting loss in the underwriting years 1984 and 1985 or any other injurious falsehood to similar effect."

Chatset had included the massive losses of the syndicate in 1982, which was left open into the 1984 and 1985 underwriting years, and as a result showed a loss for those years when, in fact, they were profitable, court papers show.

Syndicate 317 generated a 14.2 million-pound ($21 million) profit in 1984 and 14.6 million-pound profit in 1985 ($27.4 million), the year just closing under Lloyd's three-year account system, court papers show.

So far, Outhwaite's member agency has received approximately 50 inquiries about Chatset's figures, which have "damaged the reputation of the plaintiff," court papers say.

Lloyd's agencies merging

Lloyd's of London underwriting agencies John Hayter Holdings Ltd. and Alston Brockbank Agencies Ltd. plan to merge in September.

The new company, which will be renamed Hayter Brockbank P.L.C., will be headed by John Hayter as chairman.

The combined group's members agencies will represent Lloyd's members with an aggregate premium capacity of 130.9 million pounds ($222.5 million) in 1988. Its managing agencies will manage six Lloyd's syndicates and a minority interest in two stop-loss syndicates resulting in a combined capacity of 83.3 million pounds ($141.6 million).

John Hayter will issue additional shares, giving Brockbank shareholders 50% of the total shares of John Hayter.

Controlling purchase

General Accident Fire & Life Assurance Corp. P.L.C. secured a controlling share of Auckland, New Zealand-based insurance group NZI Corp. Ltd. on July 26.

Authorities in New Zealand, specifically the New Zealand Overseas Investment Commission and the Commerce Commission, have approved the sale.

Perth, Scotland-based General Accident last month agreed to acquire a 38% shareholding in NZI currently held by Brierley Investments Ltd. for 264 million pounds ($449 million). The purchase will be financed by 116 million pounds ($197.2 million) in cash and 148 million pounds ($251.6 million) generated by selling 17.5 million new General Accident shares.

General Accident also is selling its existing businesses in the Pacific Basin to NZI in exchange for NZI shares. ■

Political conventions

Continued from page 1

Each broker lined up about $100 million in general liability insurance and numerous other types of coverage (see story, page 1).

But just as both political parties have their own platforms, each had their own approach to engaging insurance brokers.

Sinclair Kouns, chairman of Kouns & Green, landed the Republican convention business because of a previous association with Patrick Taylor, chairman of the Greater New Orleans Convention Fund, which was responsible for bringing the convention to New Orleans.

Mr. Taylor, who heads oil producer Taylor Energy Inc., "was an insured of mine," said Mr. Kouns, a former head of Alexander & Alexander Inc. of Louisiana who has placed insurance for big risks in the past.

Mr. Taylor asked Mr. Kouns if he was interested in working on the convention coverage; Mr. Kouns said he was.

Mr. Kouns' brokerage, which places about $25 million in premiums annually for about $2.3 million to $2.5 million in commissions, worked alone in setting up the coverage.

"We went all the way on this thing," he said. Much of the coverage is written by units of New York-based American International Group Inc.

Rosenbush Claims Service in New Orleans and the city of New Orleans' in-house legal counsel will administer claims.

Mr. Kouns said the broker came in "way under" the $1.2 million budget it was given to put together the Republicans' insurance program. However, he would not reveal the program's total cost.

Bids were solicited from AIG; Transamerica Corp.; Kansas City, Mo.-based Gulf Insurance Co., a unit of Control Data Corp.; and Boston-based First State Insurance Co., a unit of Hartford Insurance Group.

"We're very proud of" of the program put together, Mr. Kouns said.

Mr. Kouns noted that while he has placed insurance for large conventions before, the Republican convention was his first national political convention. "It was a terrific opportunity for us to do it, and we hope we did the type of job that was necessary to save them money and get the right coverage," he said.

Mr. Kouns said last week he would not be nervous during the convention. "We feel like we provided the coverage they required and everything will be fine," he said.

"Of course, you never know," he added.

Mr. Kouns will be at the Republican convention this week—but not as a broker. "I'm just going on down as a guest," he said.

If last month's Democratic gathering in Atlanta is any indication, claims will be few.

"We don't have a complete number (of claims), but we are amazed at the few incidents that we were apprised of," said M&M Vp John A. Ferguson.

While Mr. Kouns did not have to campaign to capture the Republicans' business, Marsh & McLennan had to go through an elaborate "beauty contest" before it was selected as broker for the Atlanta '88 Committee, which managed the Democratic convention.

"We competed with other major alphabet houses and local agencies and presented a hard-copy conceptual," explained Mr. Ferguson.

That original outline was followed by several presentations. Brokers continued to be cut from a list of several candidates until M&M was chosen, according to Mr. Ferguson.

"As they say on television, 'We earned it,' " he added.

M&M worked with Jenkins, Owens in accordance with the Democrats' desire to follow a city ordinance that requires municipal-related projects let for bids to involve minority-owned businesses.

Transamerica was the primary insurer on the program.

While M&M says few incidents marred the Democratic convention, the brokerage's employees did have some bad moments before the convention. "Each of us here at M&M had a lot of frustration and a lot of anxiety putting it together because it touched on so many different types of activity," Mr. Ferguson said of the insurance for the convention.

For example, the broker had to find coverage for the more than 250 automobiles driven by volunteers and more than 200 buses used to transport delegates and officials.

M&M also had to arrange liability coverage for about 200 parties and other types of functions "using all types of facilities, from the largest ballroom in town in Atlanta down to the private home in the neighborhood."

"We had demonstrations that were beautifully managed by the police," Mr. Ferguson said, noting that demonstrations were staged for "every and all causes that we might imagine."

One of M&M's challenges was the logistics involved in gathering the necessary information to obtain adequate coverage, explained Walter Gilstrap, an M&M assistant vp. "It was a kind of moving target, if you will."

"Everything was dependent on the thing just in front of it," Mr. Ferguson said. For instance, before a party could be held, a hall had to be rented and the landlord satisfied about insurance. "The puzzle had to fall in place, and as it fell in place, it was fun," Mr. Ferguson said.

M&M employees also kept busy during the convention, he noted. "We set up an office and phone contact. We had a presence at the convention itself. We had claims people on site able and ready to do the necessary, and we were just happy that our phone didn't ring too often."

M&M is preparing a report for the Democratic Party on the broker's experience to make it easier for whomever places the coverage for the 1992 convention, Mr. Ferguson said.

If M&M had it to do all over again, "We wouldn't be as concerned as we were because we know what to expect," Mr. Ferguson said.

The broker would not necessarily do anything different, though, Mr. Gilstrap said. "Just a little bit better." ■

GOP's liability coverage totals $100 million in limits

By JUDY GREENWALD

NEW ORLEANS—The Republican Party will be covered by $100 million of liability insurance during its national convention this week, while the Democratic Party lined up at least $82 million for its convention last month.

American International Group Inc. of New York is the lead insurer for the Republican convention, and Transamerica Corp. of Los Angeles was the lead insurer for the Democratic convention, according to the brokers who placed the coverage.

Sinclair Kouns, chairman of Kouns & Green Inc. in Shreveport, La., the broker who placed the coverage for the Republican convention, said the $100 million comprehensive general liability coverage for the convention was written excess of a $300,000 self-insured retention. Insurers on the policy are:

- AIG, providing the first $35 million of coverage.
- International Insurance Co. of Chicago, a Crum & Forster unit, providing $5 million excess of $35 million.

The London Agency Inc., an Atlanta-based C&F unit, was the underwriting manager for this layer, according to Archie Estopinal, a London Agency vp.

- Aetna Casualty & Surety Co. of Hartford, Conn., providing $10 million excess of $40 million.

Five insurers are writing the $50 million excess of $50 million layer on a quota-share basis. They are:

- Chubb Custom Insurance Co., a unit of Warren, N.J.-based Chubb Corp., for $25 million.
- Planet Insurance Co. of Philadelphia, a member of Reliance Group Inc., for $10 million.
- First State Insurance Co., a Boston-based unit of Hartford Insurance Group, for $5 million.
- Lloyd's of London underwriters for $5 million.
- Zurich American Insurance Cos. of Schaumburg, Ill., for $5 million.

Mr. Kouns expects that any claims would be covered by the first $50 million of coverage.

AIG also wrote $5 million in automobile coverage, including physical damage, excess of a $300,000 self-insured retention. The policy will cover automobiles as well as buses used during the convention.

Workers compensation coverage for the 1,500-2,000 workers at the convention is written by New Orleans-based Anglo American Insurance Co.

The insurer is a unit of Dallas-based Anglo American Insurance Group, and is not related to the London-based Anglo-American Insurance Co. Ltd.

In addition, the state-owned Superdome's liability insurance overlays the Republicans' coverage.

"It would have to be a totally catastrophic situation before our coverage comes to bear," noted Robert Rummel, Superdome vp of finance and administration.

The Superdome has a $101 million CGL policy, with the first $1 million self-insured by the state, said J. Douglas Higley, director of the Louisiana office of risk management in Baton Rouge.

Insurers on the Superdome coverage are:

- National Union Fire Insurance Co. of Pittsburgh, Pa., an AIG unit, $15 million excess of $1 million.
- International Insurance, $5 million excess of $16 million.
- First State, $5 million excess of $21 million.
- American Excess Insurance Co. of Hartford, Conn., $75 million excess of $26 million.

The first $1 million coverage for garage keepers legal liability is self-insured by the state, with the next $250,000 in coverage written by Lloyd's underwriters.

The Superdome also has $339 million in property damage insurance that covers the building and its contents for fire and other catastrophes. The first $1 million is self-insured by the state, with excess coverage issued soley by Hartford, Conn.-based Standard Fire Insurance Co., an Aetna Casualty & Surety Co. unit.

The Superdome's workers compensation coverage is underwritten by Travelers Corp.

The Superdome also has $15 million in boiler machinery physical damage and liability coverage with American Manufacturers Mutual Insurance Co., a Kemper Group unit.

A $25 million airport liability policy, which covers the heliport landing pad on top of the Superdome, is written by the United States Fire Insurance Co., a Crum & Forster unit.

The first $25,000 of bond and crime coverage is self-insured by the state, with $275,000 in excess coverage written by a unit of Hartford Insurance Group, according to Mr. Higley.

John Ferguson, vp at M&M of Atlanta, refused to say precisely how much coverage it placed for the Democratic national convention, but he said it was in the same "ballpark" as the Republicans' $100 million CGL coverage.

In addition to the primary CGL policy, Transamerica wrote automobile liability insurance for the Democratic convention.

Eight insurers issued excess liability insurance policies totaling at least $82 million. They were: Planet Insurance Co.; National Union; International Insurance; Los Angeles-based Harbor Insurance Co., a Continental Corp. unit; Hartford, Conn.-based Constitution State Insurance Co., a unit of Travelers Corp.; Novato, Calif.-based Fireman's Fund Insurance Cos.; Chubb; and First State.

A Reliance spokeswoman said Planet provided $10 million excess of $1 million in coverage.

Steve Sutton, assistant vp in charge of underwriting for Constitution State, said the insurer wrote $5 million in coverage as part of a $25 million layer excess of $25 million.

And Lawrence S. Doyle, chief executive officer of First State, said the insurer wrote $5 million of a $32 million layer that was in excess of $50 million.

Transamerica also provided workers compensation coverage for more than 7,000 workers and volunteers at the convention, builders risk coverage and coverage for "real and personal property," including electronic data processing equipment and valuable papers.

National Union wrote directors and officers liability and fidelity coverages for the Democratic convention, Mr. Ferguson said.

The premium for the Democratic convention coverage totaled $1.25 million.

Delaware ruling supports directors

By MARK A. HOFMANN

DOVER, Del.—Directors of companies spinning off subsidiaries could gain some protection from liability from a recent Delaware Supreme Court ruling, provided that those directors make full disclosure of agreements accompanying the divestitures.

The June 23 decision in *Anadarko vs. Panhandle* upheld a lower court ruling that a parent company and the directors of a wholly owned subsidiary in the process of being spun off do not have a fiduciary responsibility to the prospective shareholders of a new company before the date of the new company's stock distribution.

"The case suggests that where there are gray areas as to whether a fiduciary duty exists, full disclosure may be a defense," said Dan A. Bailey, an attorney with the Columbus, Ohio, firm of Arter & Hadden and co-author of the recently published fourth edition of "Liability of Corporate Officers and Directors."

In addition, the ruling could have a significant impact, Mr. Bailey said, because Delaware is the most popular state of incorporation for U.S. companies.

While both corporations involved in the suit—Anadarko Petroleum Corp. and Panhandle Eastern Corp.—are based in Houston, they are incorporated in Delaware.

However, John W. Morrison, an attorney with the Chicago firm of Altheimer & Gray and co-author of a London Institute of Insurance study of D&O liability, disagreed that the decision could have a big impact on future litigation.

Because the decision is very "fact-specific," he said, it may not have a sweeping effect on D&O liability cases elsewhere.

However, Mr. Morrison added that the decision "is important to the extent it tells directors and officers that if you make full disclosure, the courts will give you the protection to which you're entitled."

In August 1986, Panhandle's directors voted to spin off Anadarko by distributing a share of Anadarko common stock for each share of Panhandle stock held of record on Sept. 12, 1986.

After the dividend was declared, but before it was distributed on Oct. 1, 1986, Panhandle and the Anadarko board—a majority of whom also were directors of Panhandle or its subsidiaries—entered into agreements that benefitted Panhandle. Among the agreements was a requirement that Anadarko reduce the price of natural gas sold to another Panhandle unit.

Before Anadarko was spun off, Panhandle issued an information statement regarding the agreements.

On Oct. 1, 1986, a new Anadarko board formed, which later sued Panhandle and three Panhandle directors who had served on the previous Anadarko board to void the agreements on the grounds that Panhandle and the directors owed a fiduciary responsibility to future Anadarko shareholders. The suit did not seek monetary damages.

But the Delaware Chancery Court held that Panhandle had clearly spelled out that Anadarko would continue to be a wholly owned subsidiary until the date of distribution, despite the trading of Anadarko stock. Therefore, no trust relationship existed between Panhandle and its directors and future Anadarko stockholders, the court ruled.

On appeal, the state Supreme Court affirmed the lower court's ruling.

Anadarko has filed a motion for a rehearing of the case, but no decision is expected until the fall, said an Anadarko spokesman. He also said that the Delaware Supreme Court does not routinely rehear cases.

Attorneys for Anadarko and Panhandle were unavailable for comment.

Mr. Morrison said the *Anadarko vs. Panhandle* ruling underscores the importance of adequate disclosure of corporate directors' activities, citing a case involving similar questions.

The U.S. Supreme Court ruled earlier this year in *Basic Industries vs. Levinson* that corporate officials cannot make false or misleading statements about merger talks, even during the delicate preliminary negotiations, without exposing themselves to liability (*BI,* May 16).

The Delaware Supreme Court's decision 'is important to the extent it tells directors and officers that if you make full disclosure, the courts will give you the protection to which you're entitled,' says John W. Morrison, an attorney with the Chicago firm of Altheimer & Gray.

Mr. Morrison noted that the Delaware court specifically pointed out that: "Through the information statement, Anadarko's prospective stockholders were thus on notice that Panhandle continued to exercise both legal and equitable ownership of Anadarko and that this ownership would be used to effect contractual arrangements between the two companies."

Mr. Bailey said that the court's decision also could affect third parties in D&O cases, noting this is a "hot area of D&O litigation." Courts around the country have issued conflicting opinions as to the fiduciary duties that directors owe to non-shareholders, like bondholders and option holders, he said.

"The fundamental question is, who are the constituents of the directors?" Mr. Bailey said. The Delaware court took the position that the duty was owed to the existing Panhandle shareholders, he said.

The decision is "good news from a directors and officers standpoint," Mr. Bailey said. "It suggests that courts won't be as liberal as some of us had feared in the area of third-party liability."

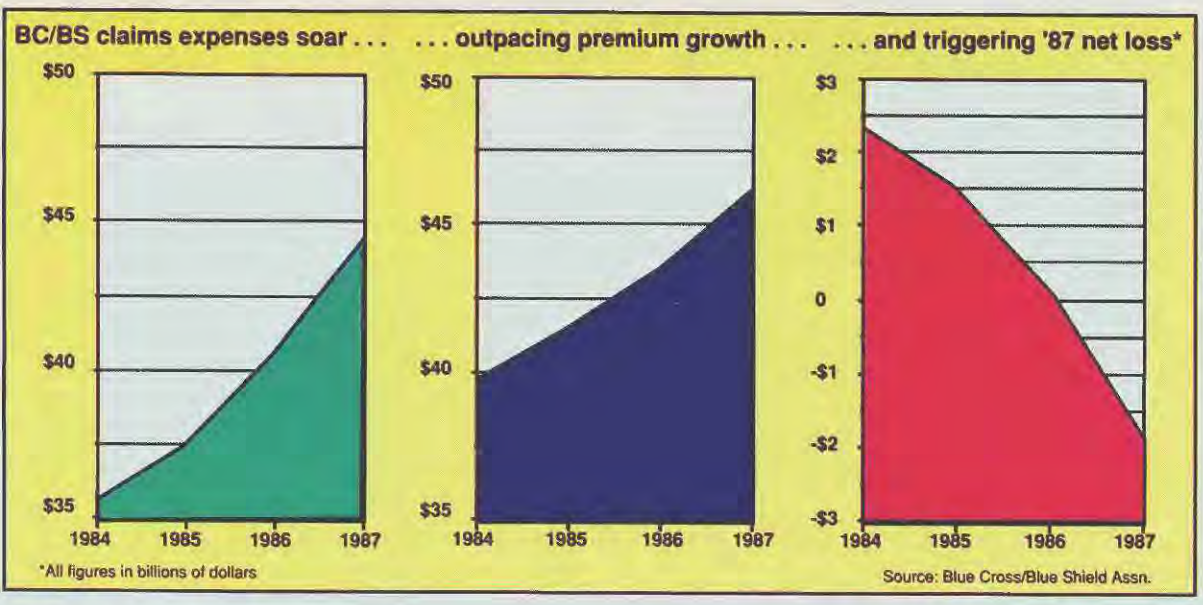
Jack Rowan, an account executive for Chicago brokerage Near North Agency, who advises risk managers on D&O exposures, said that while the decision in itself did not seem to be a landmark ruling, it could gain importance in the future.

For example, if the economy heats up, fueling leveraged buyouts, acquisitions and divestitures, the number of spinoff-related suits is sure to increase, Mr. Rowan said. And, as the number of such suits increases, the cost of defending them is going to grow as well, he added.

The Wyatt Co.'s 1984 and 1987 surveys of the D&O liability insurance market bears out the contention that spinoff-related suits are becoming more common.

"Claims against directors and officers involving spin-offs of subsidiaries or divisions ranked eighth in frequency in the 1987 Wyatt survey and represented 4.3% of all claims reported, an increase of over 50% from the 1984 Wyatt survey," said Kenneth Wollner, a consultant with Wyatt in Chicago.

"The statistics thus indicate that corporate executives are increasingly susceptible to claims arising out of spin-off activities, but, as compared to other corporate reorganization changes, plaintiffs have a smaller chance of success and the corresponding magnitude of the loss exposure to the directors and officers is lower," Mr. Wollner explained. ■



BC/BS strategies

Continued from page 1

increases charged by its members, but Blue Shield of California provides a guide: The average range of increase this year was between 20% and 30%, compared with 15% in 1987. And small-employer group premiums were increased between 30% and 40%.

Meanwhile, BC/BS Assn., which coordinates marketing, product development and public relations for its otherwise autonomous members, is actively touting its national managed care programs and a new national claims administration service in an effort to attract more large, national employers to its members.

"The emphasis on managed care products will do more than improve our market share," emphasized Mr. Tresnowski. "In addition, the broader the basis on which we phase these products into our book of business, the better the effect will be on financial results," since these programs will control health care costs and utilization, Mr. Tresnowski pointed out.

Already, nearly a third of BC/BS Assn. business is produced by managed care plans, compared with only 9% five years ago.

BC/BS plans now sponsor 96 HMOs with 4.5 million members, and 56 PPOs that are available to some 8 million people.

The national managed care plans—created from individual BC/BS HMOs and PPOs—are designed to provide employers with consistent, single-source administration of multistate HMO and PPO programs.

So far, HMO USA, the nationwide HMO, has 300,000 enrollees, while Preferred Care USA, the nationwide PPO product, is available wherever a participating local plan operates a PPO (see story, page 39).

The new national claims administration service, a joint venture among five BC/BS plans, offers an integrated claims administration and data service to national employers buying indemnity coverage, HMO plans and PPO plans from BC/BS Assn. members. So far, five major employers and 15 smaller employers have contracted with the company, National Account Services Co. (see story, page 38).

In addition, BC/BS plans have formed or purchased some 30 third-party claims administrators around the country.

"All of that spells a very broad-based effort to help identify whatever methods are fruitful at helping employers control health care costs," said Leonard E. Wood III, senior vp in the BC/BS National Marketing Division in Chicago.

But, some employee benefit managers and consultants suggest that BC/BS plans must make some important changes in its relationships with employers to grow and prosper in the future.

"The first thing the Blues need to do is to treat the employer as the buyer. The Blues still talk about the individuals they insure as members" without recognizing the employer as the purchaser of health care, said Lawrence B. Leisure, national practice leader for group benefits at TPF&C in New York, a division of Towers, Perrin, Forster & Crosby Inc.

"The Blues need to get over their institutional or bureaucratic organization," he added. "Sometimes, it's like dealing with the post office."

Questions also remain whether BC/BS can provide consistent and competitive managed health care services and claims administration to national employers.

The highly decentralized nature of the BC/BS Assn., in which each member plan administers its own claims by type of coverage, has created inconsistencies in benefits administration, consultants and employers say, asking how the same structure can overcome these problems now.

"They have not done a very good job of serving national employers," said Mr. Leisure.

"One problem is that they don't seem to be able to collect good data, massage it and report it back to employers," he said. "Another problem that could stand in the way of serving national employers is that there is very little cooperation among plans in developing consistent services."

"The fact that there are 77 autonomous plans could cause BC/BS to have a real difficult time dealing with the problems of multistate employers," agreed Herbert V. Kaighan, a principal in the Los Angeles office of William M. Mercer-Meidinger-Hansen Inc.

"Dealing with the BC/BS organization can't be likened to 'a rose is a rose is a rose.' Instead, it's more like a Blues plan is not a Blues plan is not a Blues plan," said David P. Rahill, a vp in the Princeton, N.J., office of A. Foster Higgins Inc.

"There is no national organization like there is with a Metropolitan or a CIGNA that can tell a Blue Cross plan of New Jersey or Ohio or Texas that they've got to get in line with other Blues players and be a team player," Mr. Rahill said, referring to Metropolitan Life Insurance Co. and CIGNA Corp.

For a multistate employer whose group health care plans are administered by several BC/BS plans in different states, "it gets to be a problem when all the plans are separately administered," said Robert Varecha, manager of benefits for American Telephone & Telegraph Co. in Morristown, N.J.

Although multistate employers like AT&T primarily deal with one BC/BS plan that acts as a control plan or coordinating plan, claims are administered separately by each of the BC/BS plans serving the employer's branches.

AT&T, which self-funds the indemnity plan it offers to its 300,000 employees in almost every state, earlier this year began contracting with NASCO.

"We had no control before, but NASCO makes it a little easier on our part to start identifying costs and negotiating rates with the different plans," Mr. Varecha explained, referring to rates for administrative services only.

The BC/BS Assn. is an umbrella organization headquartered in Chicago for the 77 autonomous Blue Cross and Blue Shield plans that operate in 50 states and Puerto Rico. The plans provide health insurance to some 79 million people—or 53% of the estimated 149.14 million Americans with health insurance.

About 87% of the individuals covered by BC/BS plans are covered through employer-sponsored plans, including self-funded plans administered by BC/BS members.

Yet despite their size, the plans are losing money. BC/BS Assn. last year reported its largest aggregate loss ever: $1.9 billion.

The association blames the loss on the rising cost of health care, created by the same problems plaguing all health plans: increasing health care utilization, the high cost of medical technology and the aging of the population.

While its annual aggregate premium income—including administrative-services-only fees—has steadily increased, claims expenses have soared. BC/BS earned almost $3 billion more in premium income in 1987 than in 1986, but it paid out almost $4 billion more in claims.

Premium income in 1987 totaled $46.3 billion, up from $43.5 billion in 1986, $41.5 billion in 1985 and $39.9 billion in 1984.

Claims expenses increased to $44.5 billion in 1987, up from $40.6 billion in 1986, $37.5 billion in 1985 and $35.7 billion in 1984.

Administrative expenses totaled $4.5 billion in 1987, $4.2 billion in 1986, $3.7 billion in 1985 and $3.2 billion in 1984.

Total reserves to pay future claims of BC/BS Assn. member plans declined 25.2% to $6.2 billion in 1987 from $8.2 billion in 1986.

While blaming rising health care costs for the huge 1987 loss, BC/BS Assn. officials also point out that BC/BS historically follows a three-year underwriting cycle: three years of falling income followed by three years of advances.

"So, the plans spend three years trying to get ahead of the curve and then have three years of gains," explained Douglas Peters, senior vp of representation and public affairs for the BC/BS Assn.

The three-year cycle has three phases, Mr. Tresnowski said.

In the first year of the cycle, the "recognition" year, plans begin to notice developing trends in health care costs and utilization. "You know that you should take action, but you can't until the competitors notice the trend and take action," he said.

Continued on next page

Update

AIA sues over N.Y. assessment

ALBANY, N.Y.—An assessment levied on New York insurers to bolster the state's guaranty fund was not necessary because the fund had almost $2 million more than the $150 million minimum requirement as of Dec. 31, charges a suit filed last week.

The suit, filed by the American Insurance Assn. and 24 insurers, is the third sparked by the more than $14 million assessment levied earlier this year. The state's general revenue fund siphoned more than $124 million from the Property/Casualty Insurance Security Fund between 1979 and 1982. Six insurance associations and more than 60 New York insurers as well as three State Farm Group units also filed suits in June (*BI*, June 6).

The AIA suit seeks the return of all the funds taken plus interest.

The suit says the New York State Department of Taxation and Finances' investment portfolio summary shows the fund had a total value of $151.7 million on Dec. 31, 1987, even though Insurance Superintendent James P. Corcoran has said the assessment was necessary because the fund had "dipped below" $150 million on that date. And, even if the fund were below $150 million, the state's withdrawal of money from the fund was unconstitutional, the suit says.

Farmers Group appeals ruling

LOS ANGELES—Farmers Group Inc. is appealing a state court decision voiding California Insurance Commissioner Roxani Gillespie's move to block a hostile takeover of the insurer.

The appeal, filed Aug. 8 in the 2nd District Appellate Court in Los Angeles, keeps Ms. Gillespie's ruling in effect while the matter is further reviewed by the courts.

The commissioner had concluded that Louisville, Ky.-based Batus Inc.'s acquisition of Los-Angeles-based Farmers would violate state regulations because more than 10% of its parent company, London-based B.A.T. Industries P.L.C., is owned by government entities (*BI*, June 27).

However, California Superior Court Judge Kurt Lewin ruled on Aug. 5 that Ms. Gillespie could not apply the government ownership prohibition to Batus.

Farmers also plans to appeal Ohio's approval of Batus' takeover bid and already is appealing Arizona's approval.

Insurance regulators in three other states—Oregon, Idaho and Washington—have rejected the Batus takeover plan.

AGC to divest three units

HOUSTON—American General Corp. plans to divest its property/liability and group life and health insurance business, the only two of its six insurance segments that rely on independent agents and brokers.

"This move is consistent with the direction of the company for the past six years. Primarily as a result of a series of acquisitions beginning in 1982, more than 80% of American General's operating earnings are now generated through company-managed distribution systems marketing directly to the consumer, as contrasted to marketing indirectly through independent agents," said Harold S. Hook, American General chairman and chief executive officer.

The property/liability and group life and health insurance sectors accounted for 33% of the company's revenues and 12% of business segment earnings for the first six months of 1988. Through June 30, these segments also accounted for 12% of AGC's assets.

Briefly noted

The London Marine Insurance Market Cargo War Risks Rating Committee cut **cargo insurance rates** 30% and hull rates by 25% for most of the Persian Gulf last week. Rates remained unchanged in high-risk areas in the gulf and in areas where underwriters consider rates adequate. . . .**Alexander & Alexander Services Inc.**'s board of directors last week authorized the repurchase of up to 2 million shares of its common stock. The broker has repurchased 3 million shares of its common stock since November 1987. . . .A federal judge in Cincinnati has certified as a class action a lawsuit brought against **Chubb Corp.** by an Ohio farmer who paid for—but did not receive—the insurer's drought coverage. This means that all 8,715 farmers who paid for but did not receive the drought coverage—and who meet the definition of the class—are automatically included in the suit (*BI*, Aug. 8; July 25; July 18). . . .The U.S. District Court for the Eastern District of Louisiana rejected a motion by **Mentor Insurance Ltd.** liquidators to reconsider its April 15 decision dismissing the liquidators' suit against Ocean Drilling & Exploration Co. and 10 other defendants on the grounds of forum non conveniens. The decision, which held that Bermuda is the proper forum for the suit, can be appealed to the 5th Circuit after discovery is completed in October. . . .A Cook County, Ill., Circuit Court judge last Thursday rejected a proposed settlement of a class-action suit against **Audi of America Inc.** over alleged sudden, unintended acceleration of its 1978-1986 model 5000 autos. The judge said Audi's offer to rebate up to $2,000 each to nearly 400,000 owners was unacceptable because the owners would have to apply the rebate to the purchase of new Audis (*BI*, June 13). . . .Standard & Poor's has placed **Travelers Indemnity Co. Intercompany Pool**'s AAA claims-paying ability rating on CreditWatch following an announcement that Travelers Corp. took a $415 million charge against its second-quarter earnings to increase commercial loan loss reserves at its life insurance unit. . . .In response to a suit filed in June by California Insurance Commissioner Roxani Gillespie (*BI*, July 11), Borg-Warner Corp. says it cannot be held liable for the debts of its insolvent reinsurance captive, **Centaur Insurance Co.**, because it did not dominate and control Centaur. . . .The Labor Department will delay enforcing a provision in a final regulation that suggested that employers with **flexible benefit plans** would have to put salary deferrals into special trusts (*BI*, May 23). The department is re-examining the issue.

BC/BS strategies

Continued from previous page

In the second year, or the "response" year, "everyone begins to take action, but by then you've already lost a lot of money," he said.

By the third year, or the "recovery" year, losses are limited as a result of the corrective action.

"The only thing that would suggest that our cycle would not continue as it has would be if we had made an error in predicting what would happen with costs and utilization. And, we don't see anything happening that indicates we made an error in these estimates, so the cycle will hold," he explained.

"This cycle goes back for 30 years," noted Mr. Wood. "We are now in the third year of loss in the current underwriting cycle. So, if history repeats itself, next year should be a year of modest profits."

BC/BS Assn. reported net income of $144 million in 1986, $1.6 billion in 1985 and $2.4 billion in 1984.

Although BC/BS plans are chartered as non-profit health plans, they attempt to make enough money each year to maintain adequate reserves to pay future claims, as well as to cover growth and other operating expenses.

The BC/BS underwriting cycle, just like the cycle of the overall health insurance industry, is driven partly by health care cost inflation but primarily by competitive pricing practices within the health insurance industry, Mr. Wood said.

And, the pricing environment differs by region of the country. "Within the 77 Blue Cross and Blue Shield plans, we will have various plans at various points in the underwriting cycle. Consequently, 13 plans made money last year while the others lost money," he said.

"The performance of the individual plans is affected by local economic conditions," like local health care costs, said Mr. Peters.

In addition to raising premiums, some BC/BS plans have implemented premium surcharges and internal cost-cutting measures after experiencing staggering drains on their claims reserves.

For example, BC/BS of Michigan recently implemented a 1% surcharge on all premiums paid by individual policyholders and employers and on fees paid by employers with ASO contracts.

The surcharge was approved by the state when the insurer's claims reserves dropped to a negative $7 million balance in June, said a plan spokesman.

BC/BS of Michigan reported a net loss of $303 million in 1987 on premium income of $4.3 billion, compared with a net loss of $19.4 million in 1986 on premium income of $4.1 billion.

The BC/BS underwriting cycle is driven partly by health care cost inflation but primarily by competitive pricing practices within the health insurance industry, Mr. Wood says.

Reserves dropped to $95 million in 1987, down from $398 million in 1986. The Michigan plan also offered early retirement programs to 600 employees to control costs (*BI*, Aug. 8).

BC/BS of Rhode Island staved off underwriting losses in 1987 in part by assessing, on a prospective basis, a premium surcharge on employers that offered employees HMOs in addition to BC/BS indemnity coverage (*BI*, Feb. 23, 1987).

The surcharge was intended to help protect the insurer from the costs of adverse selection. Adverse selection against an indemnity plan occurs when a group's younger, healthier risks opt for HMO coverage, thus leaving higher utilizers of health care in the indemnity plan.

BC/BS of Rhode Island phased out the prospective surcharge during the year "because we found a leveling off of the adverse selection effect and because it caused a lot of consternation" among employers whose group health plans were written by BC/BS, said Senior Vp Ron Battista.

The surcharge, along with improved cost-containment programs and better-than-expected claims payment results, "contributed to a very good financial year for us in 1987," he added.

On premiums of $442.1 million in 1987, the plan reported net income of $9.1 million. It boosted reserves to $29.1 million from $18.7 million in 1986.

In 1986, with premiums of $408.6 million, BC/BS of Rhode Island reported net income of $8.7 million.

Despite the success of some local plans, it remains to be seen whether BC/BS Assn.'s broad-based effort to regain profitability will succeed.

"We looked at HMO USA when we were putting our program together but decided against the network because of the Blues' inability at that time to provide a network that offered out-of-network coverage as well as HMO coverage," said Joseph W. Duva, corporate director of employee benefits for Allied-Signal Inc. in Morristown, N.J.

Allied-Signal earlier this year began phasing in a national open-ended HMO network with CIGNA that eventually will replace its myriad of self-insured indemnity plans and HMOs (*BI*, Feb. 22).

"It's hard to generalize about the Blues as a whole because the plans vary so much. But, trying to put together a national managed care plan will be very difficult for them. I just don't think the Blues could give you consistent services on a national basis," Mr. Duva said.

"I think the Blues are going to have less of an opportunity to rest on their laurels," said TPF&C's Mr. Leisure, noting that the plans often think they will retain employer contracts merely because of long-term relationships with the benefit managers.

"This is true because of the change in who is making the benefits decisions in corporations today," he said, explaining that top financial officers now are more involved in benefits decisions. Often, these executives do not have long-term relationships with any particular health insurer and are mainly interested in purchasing the most cost-efficient services, regardless of the insurer.

While the typical BC/BS employer client remains local government entities and large manufacturing corporations with large numbers of unionized employees, BC/BS plans serve many other groups, Mr. Wood of BC/BS said.

BC/BS plans in California, the Great Plains states, Texas, Alabama and Mississippi serve many small and medium-sized employers from various industries as well, he said.

Responding to the major criticism of the structure of BC/BS Assn., Mr. Tresnowski said: "It's the classic dilemma of centralization vs. decentralization."

But since BC/BS plans provide services to both employers that desire decentralization as well as centralization of services, the plans now provide both, he said.

"Our offering of services to the employer desiring decentralized services, plus our development of more centralized services for employers, provides our buyers with the best of both worlds," he said.

"If they get their act together, they can be an awesome force in providing managed care, because of their already strong relations with health care providers, their potential national networks and the sheer volume of people they already cover," Mr. Kaighan of Mercer said.

"I am a believer that the Blues are important to the community at large, because in many instances, they are the insurer of last resort," said Jack Shelton, manager of employee insurance for Ford Motor Co. in Dearborn, Mich., referring to the large number of individuals BC/BS plans insure.

"But, they also have to be competitive, both from a delivery standpoint and from a cost point of view, if they are to survive," said Mr. Shelton.

Ford has been a client of BC/BS for 40 years. ■

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BC/BS offers multistate firms centralized claims handling

A new joint venture among five Blue Cross and Blue Shield plans offers multistate employers with BC/BS-insured or administered group health plans a single source for claims administration and health plan data.

National Account Services Co., which began operations in January, was "prompted by an interest in providing our large national accounts with a more centralized and consistent approach to benefit administration," said William C. Van Faasen, chairman of the executive committee of NASCO and senior vp of operations at BC/BS of Michigan.

NASCO gives BC/BS national employer accounts "the best of both worlds—the advantage of single-site claims processing, while maintaining the advantage of having local relationships and discounts with health care providers," said James Bruce Cardwell, chief executive officer of the Atlanta-based company.

In addition, NASCO will help BC/BS plans to "compete with large commercial insurers, which are very good at single-site claims processing. With NASCO, we want to marry this with the local delivery of health and local provider discounts" for which BC/BS is known, Mr. Cardwell added.

NASCO will help BC/BS plans to 'compete with large commercial insurers,' says James Cardwell.

NASCO also will administer benefits under all of an employer's BC/BS plans, including indemnity, health maintenance organizations, preferred provider organizations and dental plans.

This capability is new to BC/BS. Generally, each type of plan is administered separately.

"The Blues have traditionally had problems in administering claims under managed care and health care cost containment-types of programs," like indemnity plans that include utilization review features, said Daniel O'Malley, a principal in the Pittsburgh office of TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc.

"They typically have three types of claims administration systems: one for hospital claims, one for physician claims and one for major medical claims." This makes it difficult to effectively implement utilization review, he said.

In addition, "This makes it difficult for employers to get data on particular cases," Mr. O'Malley said.

Now, NASCO offers "an integrated, single data base," said Mr. Van Faasen.

There will, however, continue to be separate billing by type of plan, such as one billing for the HMO, one for the indemnity plan and one for the preferred provider plan.

NASCO was created in April 1987 by five plans, all of which are general partners in the company: BC/BS of Michigan; BC/BS of Connecticut; BC/BS of New Jersey; Empire BC/BS of New York; and Blue Shield of California.

NASCO contracts with EDS Corp., a Dallas-based computer programming and processing firm, to program and process the claims.

EDS is a wholly owned subsidiary of General Motors Corp. in Detroit, which was the first national employer to move its administration of BC/BS plans to NASCO, beginning in January 1988.

Other NASCO clients so far are Armonk, N.Y.-based International Business Machines Corp., New York-based American Telephone & Telegraph Co. and 15 smaller accounts.

Detroit-based Chrysler Corp. will become a NASCO client on Oct. 1 and K mart Corp. of Troy, Mich., will become a client on Jan. 1, said Mr. Van Faasen.

Multistate employers that do not contract with NASCO continue with the traditional method of claims handling. Each BC/BS plan handles claims locally. One plan, usually the one covering the largest number of the employer's group, known as the control plan, coordinates administration.

For example, Ford Motor Co. offers BC/BS plans to its more that 150,000 employees in 20 or so locations nationwide. BC/BS of Michigan is the control plan for all of the company's BC/BS health plans, explained Jack Shelton, Ford's manager of employee insurance.

Any BC/BS plan has access to NASCO's services for their multistate employer accounts, Mr. Cardwell said. "We currently have 30 plans participating in NASCO and our goal is to have 60 plans participating," although all 77 could participate.

NASCO also eventually will be able to provide employer clients with data and analysis of health care claims, Mr. Cardwell said.

NASCO hopes that its information someday will be accessible to employers by computer.

Having benefits administration transferred from a control plan to NASCO will not increase, or decrease, a multistate employer's administrative costs under its BC/BS health plans, Mr. Van Faasen said.

—By Donna DiBlase

BC/BS promotes managed care

By DONNA DiBLASE

Blue Cross & Blue Shield Assn. is marketing its national managed health care plans not only as cost-savers but as time-savers.

Last month, 1,600 benefit managers received a package in the mail containing three darts and promotional materials touting the advantages for a multistate employer that contracts with HMO USA, the association's national HMO network.

The theme of the package: Benefit managers will have a few minutes a day for a game of darts once they hand their HMO administration tasks over to HMO USA.

The HMO USA dart board also was sent to 200 brokers and employee benefit consultants and 100 labor union leaders.

The materials highlight centralized administration of all of an employer's BC/BS HMOs in HMO USA, a network spanning over 200 cities.

BC/BS Assn. also is marketing a similar national network of preferred provider organizations in an effort to appeal to employers with multiple locations.

Both networks are made up of HMOs and PPOs sponsored by the independent local health plans that belong to the BC/BS Assn.

The insurer began developing HMO USA in 1983, and the network now includes 75 of the 96 BC/BS HMOs sponsored by the 77 BC/BS plans nationwide. HMO USA operates in 40 states serving 300,000 enrollees—far fewer than the 4.5 million people in all BC/BS HMOs, which together rank as the second largest HMO.

So far, about 70 employers have contracted with HMO USA.

"Our HMOs serve a lot more national employers, but we just haven't networked the employers into HMO USA," said Judy Wilson, director of HMO USA marketing in Chicago.

So far, "the typical employer that contracts with HMO USA is a large corporation with locations in more than one state—particularly employers that have gone through a merger themselves and now need to look at consolidating what often is 100 or more HMOs," she said.

HMO USA also appeals to some smaller employers with 1,000 to 1,500 employees in more than one state, she added.

Among the features of HMO USA are:

- A single contract covering all of the BC/BS HMOs the employer offers.
- One monthly premium payment for all of an employer's BC/BS HMOs. The consolidated premium is based on the premiums individually developed by each HMO.

The one billing statement can include a detailed breakdown of costs, such as by region or corporate division.

- One account executive who manages all of the employer's needs within HMO USA, such as contracting, implementing coverage for each employer location and monitoring HMO USA operations under the employer's contract.
- "Away from home care," which provides the employer's enrollees with the opportunity to receive covered health care from network HMOs if the employee needs health care when away from home. HMO USA provides a toll-free hot line that coordinates referrals in these cases.

The jury is still out on HMO USA.

"The chain that the Blues are trying build on a national basis is only as good as its weakest link. There are some very strong pieces of the chain, but the biggest issue still is whether they can build a unified system and make the weak links in the chain better," said David P. Rahill, a vp in the Princeton, N.J., A. Foster Higgins Inc. office.

Robin Weiner, a consultant in the Los Angeles Foster Higgins office, said: "I have some concern about the consistency of services throughout the HMO USA network. We are getting some help from the account managers at HMO USA when an employer needs to deal with an HMO within the system."

However, "HMO USA has the problem of it's a committee trying to rule a committee. They don't pay the salaries of or own the individual HMOs, so there's no control over the individual HMOs," she said.

Along with HMO USA, the BC/BS Assn. in 1985 began developing Preferred Care USA, a national network of PPOs.

So far, the network includes 16 PPOs sponsored by local BC/BS plans and expects to include another 16 PPOs by the end of the year, according to Del Nagy, manager of Preferred Care USA.

A total of 56 of the local BC/BS plans sponsor PPOs. These plans are available to about 8 million individuals covered by these plans, though only individuals covered by a Preferred Care PPO can obtain coverage through a PPO sponsored by a different BC/BS plan.

Preferred Care USA offers multistate employers the same features of HMO USA and currently has contracts with 20 national employers. The network includes utilization review features like pre-admission review, mandatory ambulatory surgery for certain procedures, mandatory second surgical opinion and case management.

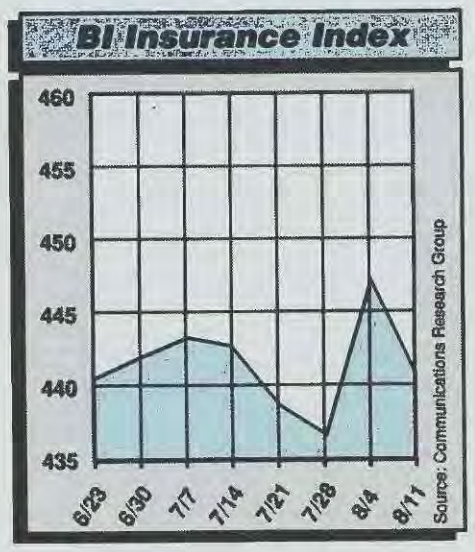
Providers that participate in Preferred Care USA are at risk to deliver cost-effective care in that they are financially responsible for the cost of any care that is not certified through the utilization review features.

Preferred Care USA also includes an optional program, "National Health Management," which provides health risk assessments and health education for PPO participants.

BC/BS Assn. also is working on the development of a "point-of-service HMO," or an HMO that also would permit enrollees to receive limited coverage for health care received outside the HMO provider network, said Rich Maturi, executive director of managed care programs for BC/BS.

He could not estimate when the new product would be introduced.

The association probably first will work with individual BC/BS plans to help them introduce the product on a local basis before offering the product nationally. ■



Insurance industry stocks took a dive in the market last week, as the *Business Insurance Index* dropped 6.2 points to 441.2 on Aug. 11, from 447.4 on Aug. 4. Advancing issues were led by Farmers Group Inc., up 16.2%; Belvedere Corp., up 15.0%; American General Corp., up 6.5%; Business Mens Assurance Co., up 2.8%; American Indemnity Financial Corp., up 2.3%; and Provident Life & Accident Insurance Co., also up 2.3%. Declining issues were led by Frank B. Hall & Co., down 13.6%; Statesman Group Inc., down 12.7%; Home Group Inc., down 7.7%; United States Fidelity & Guaranty Corp., down 5.9%; SCOR U.S. Corp., also down 5.9%; and Kemper Corp., down 5.3%. Issues showing the most activity during the period were: Farmers Group Inc., 7.2 million shares traded; American General Corp., 4.1 million shares traded; and Sears, Roebuck & Co. (Allstate), 1.8 million shares traded. The *Business Insurance Index* lost 1.4% for the period, faring better than the leading market indicators: The Dow Jones 30 Industrials dropped 4.1%; the Standard & Poor's 500 fell 3.4%; and the New York Stock Exchange Composite lost 3.2%.

British Issues

Aug. 11 Companies	Price pence	P/E	Div. pence	Yield %	1 Week 8/4—8/11 pence	pence
Comml Union	365	14.5	21.9	5.8	365—	370
Gen'l Accident	915	10.6	47.9	5.2	915—	883
Gdn Royal Exch	887	13.0	55.2	6.0	887—	874
Royal	400	10.6	26.4	6.4	400—	400
Sun Alliance	988	14.9	43.1	4.2	988—	913
Brokers						
Bradstock	227	12.4	6.8	3.0	227—	222
CE Health	428	11.9	34.5	8.0	428—	409
Hogg Robinson	168	10.9	9.6	5.6	168—	148
Lloyd Thompson	190	20.7	6.8	3.1	190—	155
PWS Holdings	145	8.3	14.4	9.7	145—	188
Sedgwick Grp	230	15.6	16.4	7.0	230—	225
Steel Brrl Jones	197	14.0	13.7	6.8	197—	194
Willis Faber	254	13.0	15.4	6.0	254—	251

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BC/BS started with AHA in 1939

The Blue Cross Assn. dates back to 1939, when the American Hospital Assn. developed membership standards for local nonprofit organizations that offered people insurance for hospital care.

In 1960, the Blue Cross Commission—as the organization of local hospital care insurers was known—became the Blue Cross Assn. By 1972, the new organization operated independently of the AHA and was supported through dues paid by Blue Cross plans.

Blue Shield plans, which traditionally have offered insurance covering physician care, have existed since the turn of the century, originally as networks of physicians that contracted with mining and lumberjack employers in the Pacific Northwest to provide health care for their employees. The plans were then known as Medical Service Bureaus. The first Blue Shield plan was created in 1917 in Tacoma, Wash., and still exists today as the Pierce County BC/BS plan.

In 1947, nine Blue Shield plans formed the Assn. of Medical Care Plans, which was renamed the Blue Shield Assn. in 1976.

The Blue Cross & Blue Shield Assn. was officially created in 1982, when the separate entities of the Blue Cross Assn. and the Blue Shield Assn. merged.

BI Industry Stock Report

AUGUST 11, 1988 — 8/5/88 THRU 8/11/88

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	22.25	-3.3	25.4	24.88	17.75	201	1.00	4.5	15.9	3.71	6.00
Baldwin & Lyons Inc.	OTC	16.00	0.0	33.3	16.50	12.00	0	0.20	1.3	6.3	18.31	0.87
Corroon & Black Corp.	NYSE	29.13	-2.1	3.1	34.75	28.00	33	1.08	3.7	4.4	5.43	5.36
Gallagher Arthur J. & Co.	NYSE	17.75	-1.4	10.9	18.88	13.88	8	0.48	2.7	12.8	5.16	3.44
Hall Frank B. & Co.	NYSE	4.00	-13.6	38.9	5.50	2.88	65	0.00	0.0	12.8	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.00	0.0	12.8	12.75	9.75	19	0.00	0.0	12.8	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	53.63	-1.1	8.3	58.50	45.25	337	2.40	4.5	13.1	6.74	7.96
Poe & Assoc Inc.	OTC	8.50	0.0	21.4	9.25	6.75	0	0.40	4.7	2.0	0.57	14.91
BROKERS	AVERAGE		-2.7	19.3					2.7	9.0		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	26.75	-4.9	11.5	29.00	23.50	153	0.36	1.3	6.0	17.63	1.52
Berkshire Hathaway Inc.	OTC	4200.00	-1.2	42.4	4525.00	2755.00	120	0.00	0.0	20.5	69.38	11.37
ITT (Hartford Group)	NYSE	48.00	-3.8	6.7	53.38	43.25	1415	1.25	2.6	6.6	52.23	0.92
Sears, Roebuck & Co. (Allstate)	NYSE	36.00	-0.4	7.0	39.88	32.25	1756	2.00	5.6	9.0	34.74	1.04
CONGLOMERATES	AVERAGE		-2.6	16.9					2.4	10.5		
INSURERS & REINSURERS												
Aetna Life & Cas Co.	NYSE	47.00	-2.6	3.9	49.88	39.50	851	2.76	5.9	7.3	53.56	0.88
American General Corp.	NYSE	32.75	6.5	3.1	36.38	27.50	4123	1.40	4.3	8.8	28.04	1.17
Amer Heritage Life Invt	NYSE	25.25	0.0	4.1	26.00	24.00	2	1.08	4.3	11.0	20.98	1.20
Amer Indty Fin'l Corp.	OTC	11.25	2.3	25.0	11.75	8.25	6	0.56	5.0	43.3	15.26	0.74
American Int'l Group	NYSE	60.63	-2.6	1.1	65.38	49.00	1157	0.40	0.7	9.4	33.56	1.81
Aneco Reins Ltd.	OTC	2.63	0.0	-22.2	4.00	2.63	0	0.00	0.0	4.5	2.58	1.02
Aon Corp.	NYSE	26.75	-1.4	16.9	27.75	21.88	248	1.28	4.8	9.1	15.13	1.77
Argonaut Group	OTC	43.00	-1.7	44.5	49.00	29.50	586	0.00	0.0	7.0	29.19	1.47
AVEMCO Corp.	NYSE	24.25	1.0	23.5	28.75	17.88	15	0.34	1.4	11.8	7.74	3.13
Belvedere Corp.	AMEX	4.75	15.0	8.4	6.00	4.00	5	0.04	0.8	6.6	7.87	0.60
Business Mens Assurn Co.	OTC	32.00	2.8	19.6	36.75	25.50	126	1.20	3.8	58.2	24.45	1.31
Chubb Corp.	NYSE	53.75	-4.0	-3.8	63.38	51.25	361	2.16	4.0	6.2	46.13	1.17
CIGNA Corp.	NYSE	47.75	-1.5	8.8	51.88	42.75	555	2.96	6.2	7.7	49.19	0.97
CNA Fin'l Corp.	NYSE	53.38	-0.7	-4.0	64.25	51.00	237	0.00	0.0	7.9	46.40	1.15
Continental Corp.	NYSE	40.38	-1.5	4.2	41.63	34.75	570	2.60	6.4	8.3	42.10	0.96
Durham Corp.	OTC	32.75	-0.8	52.3	36.25	21.50	50	0.92	2.8	30.9	26.00	1.26
Farmers Group Inc.	OTC	62.75	16.2	55.9	65.75	40.50	7241	1.44	2.3	14.9	22.02	2.85
Fireman's Fund Corp.	NYSE	31.00	-2.0	19.2	33.50	25.75	266	0.50	1.6	10.9	26.17	1.18
Fremont Gen Corp.	OTC	10.50	0.0	9.0	13.50	8.75	165	0.60	5.7	10.9	16.24	0.65
General Re Corp.	NYSE	53.13	-4.5	-4.9	57.38	45.50	890	1.20	2.3	11.4	26.21	2.03
Home Group Inc.	NYSE	12.00	-7.7	1.0	14.38	11.50	160	0.20	1.7	2.9	17.75	0.68
Hanover Ins Co.	OTC	27.00	0.0	16.1	27.75	20.50	156	0.36	1.3	5.6	25.10	1.08
Harleysville Group Inc.	OTC	15.38	-1.6	17.2	16.38	13.38	25	0.40	2.6	6.5	16.65	0.92
Hartford Steam Boiler	OTC	30.75	0.0	33.7	32.75	22.50	251	1.20	3.9	11.1	10.65	2.89
Kansas City Life	OTC	31.25	0.0	19.0	31.25	25.25	0	0.00	0.0	11.1	0.00	N/A
Kemper Corp.	OTC	25.25	-5.6	23.2	27.50	20.75	231	0.72	2.9	7.9	26.50	0.95
Lawrence Ins. Group	AMEX	10.88	-1.1	141.8	11.63	4.50	5	0.21	1.9	17.0	2.90	3.75
Liberty Corp. S.C.	NYSE	38.25	-1.9	7.7	47.25	34.50	6	0.80	2.1	13.6	17.40	2.20
Lincoln Nat'l Corp.	NYSE	50.13	1.5	24.9	50.38	40.25	313	2.36	4.7	9.7	36.62	1.37
NAC Re Corp.	OTC	26.00	-2.4	46.5	27.50	18.50	61	0.00	0.0	13.3	19.92	1.31
Nobel Ins Ltd.	OTC	6.25	0.0	-28.6	9.50	4.50	27	0.44	7.0	29.8	9.37	0.67
Northwestern Nat'l Life	OTC	29.88	-0.8	30.6	30.38	22.63	99	1.12	3.7	7.7	35.05	0.85
Ohio Cas Corp.	OTC	35.50	0.0	-2.1	38.25	32.25	54	1.88	5.3	7.1	27.86	1.27
Old Rep Int'l Corp.	OTC	24.38	-3.9	21.9	25.88	19.13	108	0.74	3.0	5.6	27.82	0.88
Orion Cap Corp.	NYSE	15.38	-3.1	13.9	17.63	13.13	13	0.76	4.9	5.3	9.34	1.65
Phoenix Re Corp.	OTC	8.88	-2.7	36.6	9.50	6.75	35	0.00	0.0	5.2	11.08	0.80
Protective Life Corp.	OTC	13.75	0.0	12.2	15.13	12.25	24	0.70	5.1	14.9	17.25	0.80
Re Capital Corp.	AMEX	9.38	-5.1	-10.7	11.75	9.13	9	0.00	0.0	29.3	11.49	0.82
Provident Life & Acc Ins Co.	OTC	22.50	2.3	44.0	23.00	15.63	279	0.84	3.7	48.9	27.45	0.82
St. Paul Cos. Inc.	OTC	42.00	-4.0	-8.7	51.00	38.25	568	2.00	4.8	6.0	35.83	1.17
SAFECO Corp.	OTC	24.50	-3.5	-11.7	30.00	22.75	458	1.08	4.4	7.6	21.39	1.15
SCOR US Corp.	NYSE	8.00	-5.9	-13.5	9.50	6.63	27	0.10	1.3	5.6	9.39	0.85
Seibels Bruce Group Inc.	OTC	13.00	-2.8	15.6	14.25	11.00	47	0.80	6.2	8.7	12.51	1.04
Selective Ins Group Inc.	OTC	25.50	-1.9	34.2	26.25	19.25	86	1.24	4.9	5.7	19.52	1.31
Statesman Group Inc.	OTC	3.44	-12.7	-26.7	5.56	3.44	71	0.05	1.5	5.7	3.48	0.99
Tokio Marine & Fire Ins	OTC	73.50	-3.3	11.6	85.88	63.25	53	0.22	0.3	65.6	0.00	N/A
Torchmark Corp.	NYSE	31.63	-0.4	29.1	33.50	24.50	172	1.20	3.8	10.0	12.24	2.58
Transamerica Corp.	NYSE	33.25	-2.6	11.8	36.75	29.75	488	1.84	5.5	6.9	24.94	1.33
Travelers Corp.	NYSE	35.00	-2.8	-0.4	40.00	33.00	530	2.40	6.9	12.0	45.28	0.77
Trenwick Group Inc.	OTC	13.25	0.9	29.3	13.50	9.75	31	0.16	1.2	10.3	15.41	0.86
United Fire & Cas Co.	OTC	26.00	-1.0	0.0	27.00	24.00	2	1.08	4.2	4.9	22.56	1.15
United States Fid & Gty	NYSE	30.00	-5.9	5.3	34.38	28.88	1637	2.64	8.8	7.5	19.53	1.54
UNUM Corp.	NYSE	24.38	-1.5	31.8	25.00	17.88	460	0.48	2.0	11.1	28.53	0.85
USLIFE Corp.	NYSE	37.50	-1.3	31.6	40.13	28.00	147	1.28	3.4	9.7	46.77	0.80
Washington Nat'l Corp.	NYSE	27.38	-3.5	14.7	28.75	24.00	342	1.08	3.9	12.7	32.33	0.85
Zenith Nat'l Ins Corp.	NYSE	19.25	-5.5	28.3	23.88	15.00	72	0.80	4.2	9.2	12.53	1.54
INSURERS & REINSURERS	AVERAGE		-1.2	16.0					3.3	13.3		
ALL COMPANIES	AVERAGE		-1.5	16.4					3.2	12.8		

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