

business insurance

update:
Bill extending benefits following layoffs is killed

SACRAMENTO, Calif.—A bill that would have forced companies to continue health benefits to laid-off workers is dead.

A.B. 2839, which was killed in a legislative committee, also would have regulated when employees must be notified of a lay-off, how much severance pay they must receive and what moving expenses must be

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Reporting weekly for corporate risk, employee benefit and financial executives/\$1 a copy; \$40 a year

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Continental Illinois cover for suits tops \$200 million

By BILL DENSMORE

CHICAGO—Continental Illinois Corp. has more than \$200 million of insurance, including a new professional liability insurance policy, to fight current and potential suits over problem loans and a \$61 million second-quarter loss.

The insurance, which includes \$100 million of directors and officers liability insurance, a \$100 million bankers blanket bond and an undetermined amount of errors and omissions insurance, makes the bank holding company one of the best-protected against allegations of mismanagement or fraud.

Two pending shareholder suits, which do not specify damages, stem partly from Continental National Bank & Trust Co. of Chicago's disclosures that it purchased up to \$1 billion in energy-related loans from Penn Square Bank of Oklahoma City, which failed July 5.

Penn Square is believed to have \$5 million in directors and officers liability insurance. MGIC Indemnity Corp., the nation's largest underwriter of D&O insurance for small and

medium-sized banks, would neither confirm nor deny that it underwrites the insurance.

Also, Insurance Co. of North America confirms that it writes a \$4.5 million bankers blanket bond for Penn Square.

Details of the extensive insurance purchased by Continental Illinois, which the bank declines to confirm or deny, emerged from more than a dozen interviews with lawyers, brokers, insurers and others.

Experts agree that the insurance program covering the nation's sixth-largest U.S. bank holding company, which has \$46.5 billion in assets, is among the most extensive of any in the nation.

This spring, Continental was one of the first banks in the United States to purchase bankers professional liability insurance, says Claire C. Steffen, vp-marketing for Rollins Wrightson Co., the New York-based insurance consultant that arranged the coverage.

The errors and omissions coverage, which covers the bank for claims made by clients or customers, was underwritten by the Chicago-

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Insurers hike health rates up to 60% for small firms

By JERRY GEISEL

WASHINGTON—Health insurers are socking small employers with huge rate increases and tougher underwriting rules to try to cut their losses.

Many small businesses—which insurers define as those with fewer than 50 employees—are reacting to whopping rate hikes of as much as 60% by raising deductibles and dropping some coverages.

Prudential Insurance Co.—which has lost more than \$100 million in the small-employer health insurance market over the last two years—has come back with rate hikes of 50% and 60% this year. That's about double the increases Prudential has passed along to

larger employers.

Pacific Mutual Insurance Co. of Newport Beach, Calif., which also has increased rates 50% to 60% for small businesses insured in its Multi-Protection Trust plan, no longer will insure companies with fewer than three employees.

In addition, Pacific Mutual is auditing small employers more frequently to make sure the companies are not breaking contract rules. For example, Pacific Mutual is requesting small firms to submit payroll records to determine if non-employees, like an employee's parents, are fraudulently insured.

If an employer is caught cheating, "he'll be canceled," warns Paul Doerr, assistant vp at

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Punt?

Stadium owners delay buying strike insurance

By RHONDA L. RUNDLE

Several big cities with stadiums that host National Football League teams are pressing their insurance brokers for defense against revenue losses if the players strike.

If there's a walkout, cities that host 26 NFL teams stand to collectively lose nearly \$30 million in 1982 revenues including their share of gate receipts, concession sales and parking.

Contingent strike insurance, if they bought it, could cover a portion of these losses.

The other two teams, the Cleveland Browns and the New England Patriots, own their stadiums.

So far none of the cities scouting contingent strike insurance have signed up for it, say retail and surplus lines brokers who are tackling the assignment. But the coverage was widely available until about July 15 when the labor agreement between the owners and players expired.

Several stadiums turned thumbs down on chances to buy the coverage as recently as two weeks ago. They were discouraged by a two-game regular season deductible out of an eight-game home schedule, no coverage for exhibition games and a pricey premium of about \$90,000 or more.

A handful of stadium managers including those in Tampa, Fla., Cincinnati, Anaheim, Calif., San Diego and Seattle say they are still interested, if they can get the right price.

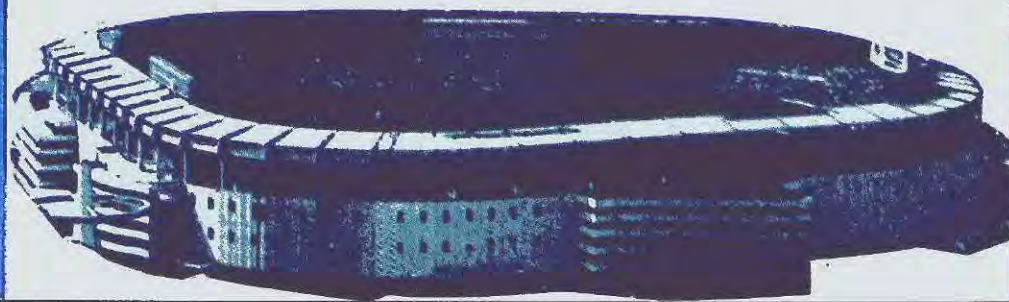
But the price is rising and capacity is evaporating as underwriters read the newspapers and figure that the odds of an NFL strike are climbing daily.

The first exhibition games were expected to be played last weekend with the regular season scheduled to kick off Sept. 12.

Providing loss-of-revenue insurance to cities that own stadiums is much different than insuring the team owners or players, industry experts point out. The league cities are not parties to the labor contract negotiations between the NFL and the players' union and do not control events that could lead to a strike.

Strike insurance bought by baseball team owners last year ignited public controversy over the ethics of insuring parties to labor negotiations. Some critics believe that without the financial protection afforded them by their coverage, the baseball

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Layoff legislation dies

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paid if they are relocated within the company due to a plant closure. The measure was strongly opposed by state business groups and closely watched by employers across the country. Labor groups say they intend to recruit support for a new bill next year (BI, July 26).

Pensions subject to withholding

WASHINGTON—Employers will have to send notices to their retirees to inform them that withholding taxes will be taken out of their pensions next year unless the retirees specifically instruct them not to do so, House and Senate conferees agreed last week.

The conferees, who are working on a massive revenue bill, H.R. 4961, also said retirees can make a one-time decision on whether they want the taxes withheld. However, employers will still have to notify retirees of the withholding option every year (BI, Aug. 9).

Air Florida accuses Boeing

WASHINGTON—Air Florida Inc. and Boeing Corp. appear poised for a potential legal clash over their respective liability in the Jan. 13 crash of a B-737 owned by Air Florida that killed 78 people.

In documents filed last month with the National Transportation Safety Board, Air Florida accuses Boeing of having given 737 operators "inadequate, misleading and ineffective" information about an alleged tendency of the jetliner to uncontrollably pitch up and roll its wings in takeoff during snow or in icy conditions.

However, Air Florida has not made any similar claims in U.S. District Court in Washington where suits naming both companies in the crash are pending, says Robert P. Silverberg, general counsel and corporate secretary for Air Florida.

The NTSB termed the pilots' failure to make sure the jetliner's wings were clear and their failure to turn on an engine anti-icing system as the "probable cause" of the crash in Washington.

But the NTSB, in a unanimous vote Aug. 10, also listed "the known inherent pitch-up characteristics of the B-737 aircraft when a leading edge is contaminated with even small amounts of snow or ice" as "contributing to the accident." The NTSB has urged the Federal Aviation Administration to order that Boeing correct the pitch-up problem. Boeing says it is working on a solution.

Mr. Silverberg says Air Florida disputes the NTSB's placing principal blame on the flight crew.

Exec quits while he's ahead

DENVER—Congress's drive to slash maximum pension benefits already has led one corporate executive to call it quits.

Fred L. Pundsack, the 57-year-old president and chief operating officer of Manville Corp., is resigning next month because he fears Congress will approve a proposal that will reduce to \$90,000 from \$136,425 the maximum benefit executives can receive from corporate pension plans.

"The growing disposition to put limits on private pension retirement benefits created personal factors that led to this decision," a Manville spokesman said. He declined to reveal what Mr. Pundsack's pension is, although he said it will be more than \$90,000.

ABA to reconsider tort reform

SAN FRANCISCO—The American Bar Assn. at its annual meeting last week agreed to appoint a study committee to determine whether it should drop its current opposition to federal product liability legislation. The committee will make its recommendation by February 1983.

Insurers fight comp rate cut

ATLANTA—Workers compensation insurers in Georgia are fighting an Insurance Department order to reduce rates 15.4%.

Aetna Casualty & Surety Co., The Travelers Insurance Co. and the National Council on Compensation Insurance filed separate injunctions to block the Aug. 1 rate reduction.

The NCCI, the rating organization that files rate requests on behalf of work comp insurers in the state, argued that Insurance Commissioner Johnnie L. Caldwell lacks the authority to initiate a rate-making proceeding, and can only approve or disapprove rate filings.

The NCCI also claims the data provided by the Georgia Workers Compensation Board used by the department to prepare the rate reduction was inaccurate and incomplete.

The order to reduce rates 15.4% came after Mr. Caldwell proposed the insurers reduce rates by 20.1%. The NCCI contends that its data shows a 10.8% rate increase is needed.

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Elixir forms Vermont captive to write unrelated business

By JERRY GEISEL

MONTPELIER, Vt.—Elixir Industries, which joined the captive movement in 1978 when it set up its own insurance company in Colorado, now is the first company to operate captives in both the Rocky Mountain State and Vermont.

It is the second company to form a captive under Vermont's year-old captive insurance company law, and more captive charters are in the wings, according to state officials.

The manufacturer of components used by mobile home and recreational vehicle manufacturers chose Vermont as the home for its new captive as part of its plan to develop a fully licensed insurance company subsidiary.

"The main advantage of Vermont which drew us there was the ability to write outside, third-party business," said Gwen Wamsley, risk manager at the Gar-

dena, Calif.-based company. "We can expand our operations more quickly in Vermont than in Colorado," she added.

During the next several months, Elixir will shift a majority of its casualty business now written by its Colorado captive to the new Vermont subsidiary, GarDen Insurance Co. of Vermont.

However, Elixir plans to continue operating its Colorado captive, the original GarDen Insurance Co., with some miscellaneous property risks.

"The ultimate goal of Elixir is to develop a multiline, fully admitted insurance company in all states," Ms. Wamsley said. "We felt that it was to our advantage to maintain our operation in Colorado to aid in the process of being fully admitted sometime in the future," she explained.

Elixir's immediate concern is to develop its Vermont captive, which received its license to operate from the

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Safe delivery protects uninsured profits

By STACY SHAPIRO

LONDON—Sometimes you're not really sure what's worth insuring.

Take Prince William Pottery in Liverpool, for example. The royal baby souvenir business is booming beyond all the company's expectations, and the company is especially relieved.

The royal memorabilia manufacturer, located in Liverpool, was not insured if there had been problems with the delivery of the son of Prince Charles and Princess Diana and the demand for souvenirs had been diminished.

"We did not use insurance this time, actually, but we normally do," said David Sanders, a director of the company. "We just did not realize the business would be as big as it is. Our speculation was small."

The investment in the original stock wasn't enough to pay for a non-appearance insurance on Prince William, he said. And now that the future king is alive and healthy and the mugs are selling, there is no need for insurance.

But, so far, Prince William Pottery, which takes its name from a London street, has sold more than 36,000 mugs and plates commemorating the June 21 birth of the prince.

Queen Elizabeth II's silver jubilee in 1977 was a different matter, though, Mr. Sanders pointed out. "We took out 20,000 pounds on the queen's life with Sun Alliance Insurance Group because at that stage we knew it was going to be such a big event that we set aside mugs for the occasion."

Had something happened to the queen, the non-appearance policy would have paid for the production costs.

Orders are continuing to flow in for the \$1.85 mug that

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Photo: Wide World

Prince William Pottery is relieved that another Prince William is doing well.

Small municipal utilities generate buying power through risk pool

By JAMES C. LAWSON

NORTH ATTLEBORO, Mass.—Twenty-two small municipal utilities in the Northeast are generating insurance purchasing power as well as electricity.

By pooling their risks through the Northeast Public Power Assn., the utilities are cutting their insurance costs while buying broader coverage at higher limits.

The 6-year-old insurance pool operated by NEPPA is solving insurance problems often encountered by small municipal utilities: high rates, few interested insurers and limited coverage (see related story, page 20).

The North Attleboro Electric Department and the Taunton, Mass., Municipal Lighting Plant are among the 22 small municipal utilities that participate in the pool. It is operated by NEPPA, an industry association representing 81 different municipal utilities in New England, with Ebasco Risk Management Consultants of New York as consultant and Alexander & Alexander Services Inc. as broker.

NEPPA General Manager Chap-

man Stockford says pooling has allowed the 22 utilities currently participating to cut their premiums an average of 40% from what they would pay if they tried to buy the same coverage themselves.

Utilities face powerful risks, notes Michael Fitzgerald, a vp with the Boston office of Alexander & Alexander. Most utilities face exposures, in addition to traditional property risks, including: failure to provide power due to brownouts and blackouts; PCB contamination; business interruption; and extra

expenses to provide replacement power should the generator go out of service.

Since the 9,000-customer North Attleboro Electric Department joined the pool last month, Controller Barry Port has managed to save at least 14% of what he formerly paid for insurance. He has also doubled the utility's excess liability limits, added directors and officers coverage and significantly increased the limits on most of its other coverages.

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errors & omissions

• The value of aircraft owned by Middle Eastern Airlines and destroyed by the fighting in Beirut was \$10 million, not \$170 million (BI, July 19). The total value of the airline's fleet, not all of which was parked at the Beirut airport, was \$170 million.

• A story in the Aug. 9 issue profiling Alexander Howden Insurance Services Inc. of Atlanta incorrectly reported Howden's market for environmental impairment insurance. The coverage is written by International Insurance Co. of Chicago and is available through ERAS International in London.

In California. . .

Bill hiking comp benefits moves swiftly ahead

By EILEEN NORRIS

SACRAMENTO, Calif.—The governor is expected to sign a bill that would increase the cost of workers compensation benefits 21%, but reaffirm the system as the exclusive remedy open to the injured worker.

Late last week, an amended version of A.B. 684 was before a conference committee and was expected to move on to both the Senate and the Assembly.

Gov. Edmund G. Brown Jr. has indicated he will sign the bill once it reaches his desk.

Under the Democrat-sponsored bill, employers would pay \$510 million in increased benefits for injured workers beginning Jan. 1, 1983, and an additional \$163 million in 1984.

The California Chamber of Commerce, which is "violently opposed" to the measure, contends the true cost of the package to employers will climb to \$933 million dollars, once expense loading factors are added on for insured and self-insured employers.

"There's no way the employers of California can afford a nearly billion-dollar increase in benefits, no matter what reform comes with it," says Susan Cavazos, the chamber's manager of employee benefits.

Employers are unhappy with the portion of the bill that would remove the \$10,000 limitation on compensation payments for those employers whose "serious and willful misconduct" results in an em-

ployee's injury.

But, besides a substantial increase in benefit levels, the "trade-off reform package" calls for:

- A tightening of the exclusive remedy provision to lessen the chances of employees successfully suing employers outside the workers compensation system in "dual-capacity" cases.

- The state's Workers Compensation Appeals Board to rule on disputed cases on the basis of a "preponderance of evidence," rather than "liberally interpreting" the facts in favor of the injured worker.

- Injured workers to request a rehabilitation program within one year from the date of the last diagnosis of the injury.

But while employers wanted more concessions in this workers compensation reform package, some are satisfied with the "partial reform" the bill would provide, they say.

California has had more than its share of dual-capacity cases, in which an employer is subject to both the payment of workers compensation benefits and lawsuits for job-related injuries (BI, June 21).

The relatively low benefits available under the California system have served to encourage the courts to find ways to compensate injured workers outside the workers compensation system.

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Self-insurers fear they could be hurt by new health care competition law

By CAROL G. BLITZER

SACRAMENTO, Calif.—New legislation in California designed to promote competition among health care providers could cut insurance companies' costs while raising the costs for employers that self-insure health plans.

The legislation, A.B. 3480, which al-

lows insurers for the first time to negotiate rates of payment with health care providers, could result in reduced costs for companies that insure their health plans, if insurers pass along their savings.

Self-insurers, however, fear that they may have to pay part of the insurers' discounts. Although self-insurers have the same price-negotiating privileges, they're afraid they don't have the clout to negotiate the same price reductions as larger insurance companies and may even have to pay more if hospitals pass along the cost of insurer discounts to other payers.

The new law, which takes effect Jan. 1, allows insurance companies to contract directly with health care providers—hospitals, doctors and pharmacies, for example—for "alternative rates of payment"

and to pass these lower rates on as lower costs to consumers.

Although there is some confusion now as to what alternative rates of payment means, most agree that it will allow insurers to negotiate discounts based on various factors, such as speed of payment and number of patients.

A companion bill, A.B. 799, also signed last month by Gov. Edmund G. Brown Jr., allows the state's medical welfare program, Medi-Cal, to negotiate similar arrangements for its patients.

A.B. 3480 also allows health insurers to offer policies limiting employees' choices of providers to facilities or practitioners with whom the insurer has a contract (see related story, page 22).

The law could be a boon for California employers that use the commercial market to insure employees' health coverage if the insurers share their savings with them.

"I have hopes the law will lower costs," says George Gamble, president of the California Council of Employer Health Care Coalitions, which represents many state employers.

But self-insurers are taking a different view. They believe that if health care providers can negotiate reduced rates with large health care payers like insurers and Medi-Cal, the providers will shift excess costs to self-insurers, which do not have the clout to negotiate such contracts.

"Hospitals pass costs around. If they are coerced into signing a contract that

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Lilly could face huge loss from recall of Oraflex

By BETSY SHARKEY

WASHINGTON—Eli Lilly & Co. could face losses well beyond the \$50 million to \$70 million typically pumped into new drug development if the Food and Drug Administration bans the company's controversial arthritis drug, Oraflex.

Lilly voluntarily removed Oraflex from the U.S. market two weeks ago after British authorities announced Aug. 4 that they were banning the drug for 90 days, a decision triggered by reports of 61 deaths among that country's Oraflex users.

The Indianapolis-based pharmaceutical company firmly "stands by the efficacy and safety of this drug," according to a company spokesman, but he would not speculate on when Oraflex might be returned to the U.S. retail market.

Lilly does not have insurance coverage for losses caused by the Oraflex recall, the spokesman said, adding that typical development costs of a product like Oraflex run from \$50 million to \$70 million.

He estimated that the recall would cost Lilly about 15 cents per share in earnings for the quarter, or about \$11 million based on 76 million outstanding shares. However, Lilly's losses could be much more substantial.

For example, following the recall of its superabsorbent Rely tampon, Procter & Gamble set aside a \$75 million cash reserve to pay potential liability claims and expenses associated with taking the product off the market (BI, Oct. 20, 1980).

P&G is now fighting more than 400 lawsuits filed around the country charging that Rely caused toxic shock syndrome in women who used the product.

So far, a \$300,000 award has been assessed against P&G in a Rely suit. However, that case and another, in which P&G was found negligent but was not assessed damages, are unresolved.

Lilly officials said they are not aware of any Oraflex-related suits against the company either in the United States or in Great Britain.

Even though there are no lawsuits, the company is still incurring heavy costs to fund the voluntary recall of the drug in the United States

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Crump's expansion drive pays off in first half of '82

By LEN STRAZEWSKI

Sometimes it pays to be behind the times.

That's what E.H. Crump Cos. Inc., a newcomer to the nation's Top 10 brokerage firms, discovered in the first half of this year. While most larger brokerages are growing only slightly, if at all, the Memphis, Tenn.-based company has had steadily increasing both revenues and income this year—topping all of its competitors in the first half of 1982 and turning the heads of the industry.

Virtually ignored by the major stock analysts and not generally seen as a top competitor for large corporate insurance programs, Crump began building a new image by expanding westward and centralizing management last year. A terrible fourth quarter in 1981, however, made the program look misbegotten.

"It looks like we chose a bad quarter to close out our acquisitions last year," explains James Power, Crump's

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A&A delays its report

Alexander & Alexander Services Inc. has delayed reporting its quarterly financial results until this week, pending the outcome of its fair-value audit of its new subsidiary, Alexander Howden Group, according to Chief Financial Officer William Farley.

A&A announced earlier this month that it was conducting a routine audit of Howden to "dispel rumors" about the British firm's handling of underwriting operations, among other reasons (BI, Aug. 2).

The company's quarterly report will be included in the company's 10-Q filing, due today at the Securities and Exchange Commission.

Pennsylvania comp bill's chances look dim

By EILEEN NORRIS

HARRISBURG, Pa.—Pennsylvania employers say a bill to create a state-fund monopoly on workers compensation insurance won't pass when legislators reconvene next month.

The chances are not very likely that the legislative package of Rep. Roland Greenfield, D-Philadelphia, will gain support in the upcoming mid-September session, according to the state Chamber of Commerce.

The bill doesn't address the abuses in the workers compensation system, the chamber says.

Pennsylvania Manufacturers Assn. Vp Bill Danneberg agrees that the proposal won't move, even with the state's labor movement behind it.

The measure would have a chance only if the Republican-controlled legislature in Pennsylvania is upset by the Democrats in the November elections, Mr. Danneberg said.

House Bill 2573-76 would change the competitive, or "three-way system," that now allows an employer to buy insurance from private insurers or the State Workers Compensation Insurance Fund or to self-insure.

Employers would be forced to buy insurance from a

new state fund or they could self-insure, subject to annual approval of the state fund.

The sponsor claims the workers compensation market in the Commonwealth is too concentrated, with insufficient competition.

He also charged that The Pennsylvania Manufacturers Insurance Co., an affiliate of the Pennsylvania Manufacturers Assn., and Liberty Mutual Insurance Co. control 60% of the private market.

But the American Insurance Assn., which opposes the legislation, says that figure is "highly inaccurate."

"The Pennsylvania market for workers compensation insurance is highly competitive," says Grover E. Czech, an AIA regional vp. "Pennsylvania employers use all three methods to obtain the protection they need," he added.

A.M. Best & Co., which lists the leading writers of workers compensation by insurer and by state, shows that some 50 insurers write 96.8% of the insured workers compensation coverage in Pennsylvania.

Best's shows that the Pennsylvania Manufacturers Insurance Co. had 14.7% of the market share in 1981 while Liberty Mutual had 7.1%.

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Johnson & Johnson offering 401(k) plan

Johnson & Johnson, the health-care products maker based in New Brunswick, N.J., is offering a 401(k) salary reduction plan to 27,000 salaried and non-union hourly workers.

The new retirement savings benefit, which went into effect last month, offers employees the opportunity to defer up to 16% of their annual salaries. The company will match up to the first 6% deferred.

Employees can choose to invest their 401(k) accumulations in three different investment vehicles: a fixed rate return fund that currently pays 15.8%; a fund that invests in Johnson & Johnson stock; and a mixed equity fund that pays market interest rates.

The guaranteed income fund is managed by The Travelers Insurance Co., according to Melvin Ben-

benefit beat

jamin, Johnson & Johnson's director of compensation. The diversified equity fund is managed by Capital Guardian Trust, an investment and asset management firm. The Johnson & Johnson stock fund is managed by Bankers Trust Co.

Employees choosing the fixed-return fund can receive the current interest rate on their 1982 401(k) accumulations until 1986, when a new fixed interest rate will be set.

Currently, about 22,000 employees with at least two years of service with the company are eligible. Plan participation, Mr. Benjamin says, has been about 85%.

The 401(k) salary reduction plan allows employees to defer a portion

of their incomes for retirement savings. Withdrawals are restricted to emergencies, retirement, death or termination of service. Withdrawals can be made without paying a penalty.

At Johnson & Johnson, employer contributions are suspended for six months whenever an employee makes a non-hardship withdrawal. However, hardship withdrawals (for college tuition payment or payment of large medical expenses) are not penalized.

Employees must have money in the plan for at least a year before they can make any type of withdrawal. Employees can withdraw on a non-hardship basis once a

year. Hardship withdrawals can be made at any time.

Pension increase

Members of the United Telegraph Workers union are now receiving a 30% increase in pension benefits as part of a three-year contract with Western Union Telegraph Co.

The new pact also calls for a new vision care plan and upgraded dental, life and health benefits.

The pension increase now gives retirees a monthly benefit of 1.3% of the average of their five highest annual salaries. They had previously received 1% of that amount. Now, employees who worked 40 years for Western Union with a five highest-paid years average of \$20,000 would receive a \$260

monthly pension compared to the previous \$200 a month.

Effective Sept. 1, the maximum charges allowed for some surgical procedures covered by the health plan will be increased. The company will pay 80% of these maximums, with the employee paying the rest. Some of the new maximums include:

- Mastectomy—\$1,200, up from \$600.

- Hysterectomy—\$1,400, up from \$400.

- Prostate removal—\$1,100, up from \$550.

The basic health plan also covers 100% of the cost of a semiprivate room for an annual maximum of 120 days. Employees pay no deductible and make no contributions toward the hospitalization plan.

Employees must pay a \$100 annual major-medical deductible. The major lifetime maximum has been increased to \$150,000 from \$100,000. The maximum will increase to \$250,000 on Sept. 1, 1983.

Effective July 28, 1983, the dental plan for union workers will also boast higher payment schedules. The plan will pay:

- \$12 for an examination, up from \$4.

- \$29 for X-rays, up from \$13.

- \$10 for one-surface fillings, up from \$6.

- \$16 for a one-tooth extraction, up from \$8.

- \$218 for prosthetic services, up from \$155.

Hourly employees do not have to pay a deductible or make any contributions for dental coverage.

Under the new contract, which was ratified earlier this month, hourly employees will be provided for the first time with a vision-care program that includes a free examination and a free pair of frames and lenses once every 24 months. Contact lenses will be supplied without charge once every 24 months for employees and dependents who medically require them.

Vision-care services will be provided free to those who employ the services of a panel of providers approved by the plan's underwriter, Vision Service Plan, a prepaid vision-care firm. No deductible will be required under the plan, which will begin July 28, 1983, according to Jerry Grim, international secretary/treasurer for the United Telegraph Workers.

An upgraded life insurance program will begin the same day. Hourly employees can receive a maximum of \$20,000 of coverage based on their earnings, double the previous maximum.

Employees must contribute 60 cents per month per \$1,000 of life insurance coverage, up to a maximum of \$5,000. Western Union pays the balance of the life insurance cost.

Metropolitan Life Insurance Co. underwrites all of Western Union's group insurance coverage except the vision plan.

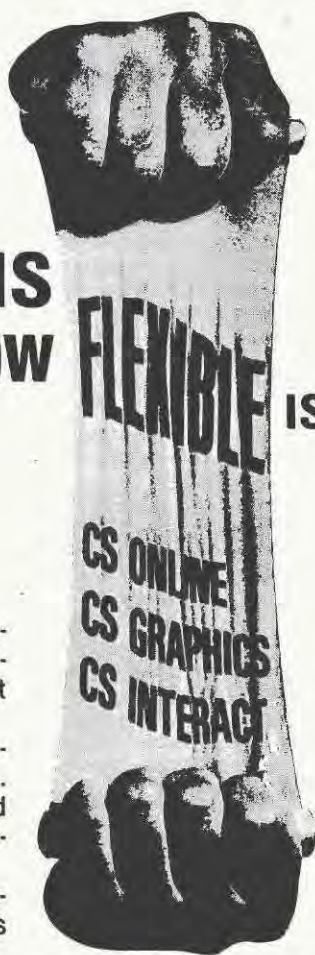
Federal retirees

The Senate, in a move to trim the size of the federal deficit, agreed earlier this month to limit federal retirees' pension benefit increases to 4% a year through 1985.

The Senate's action conflicts with the House, which earlier voted to retain the current formula in which pension benefits for 3 million retired federal workers are increased each year to match rises in the Consumer Price Index. The House and Senate now will have to iron out their differences in a conference committee.

Made any benefit changes? Write James Lawson, Associate Editor, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0143.

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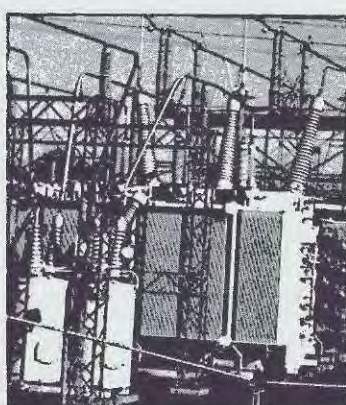
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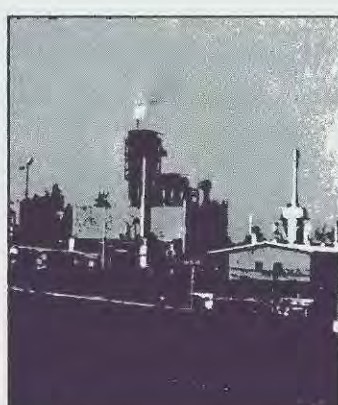
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editorial opinions

Playing fair

CHICAGO-BASED UNR Industries Inc. has been accused by one of its insurers of getting greedy in its demands to underwriters for coverage for asbestos claims.

We would suggest, however, that the insurers became stingy.

UNR, as we reported last week, had been sharing with its insurers the cost of defending and paying asbestos claims under an agreement. But, when Keene Corp. won a court ruling that it provided broad coverage for asbestos claims under its insurance policies, UNR also sought the same broad coverage from its insurers. It is asking that all its insurers from the time claimants were exposed to its asbestos products through the time the diseases appeared to pay toward those claims.

UNR had every right to seek the same broad coverage that Keene Corp. won in its landmark case in the U.S. Circuit Court of Appeals in Washington. It is up to the courts to determine whether UNR is entitled to the coverage.

We question, however, whether UNR's insurers had

every right to stop all payments of claims and defense costs in response to UNR's demands, as at least two insurers have done.

Why didn't all the insurers continue to contribute to defense and claims costs under the prior agreement, while reserving their rights to recover any payments under a court's final determination on coverage? If they thought that was fair at one time, why wasn't it fair after UNR looked for more coverage? Did they stop all claims payments just because UNR sought more coverage? Was this retaliatory? Could it have been a message to other policyholders not to push for coverage?

UNR bought insurance policies under which it deserves some payments toward claims and defense costs. How much is up to the courts. During the time between UNR's decision to sue for broader coverage and the petition for reorganization—which has stayed all the suits—we think all the insurers should have continued to pay something toward the claims and defense costs of UNR.

It was their obligation.

letters

Risk managers learn the truth?

To the editor: After reading the Perspective article, "Risk management: Can insurers really afford the idea?" by Peter Mehlhorn (BI, Aug. 2), I feel compelled to comment.

It is exciting to note that all of the complex ills that affect the underwriting community are the fault of risk management.

It is intellectually stimulating to learn that the definition of risk management is not the one defined in traditional texts on the subject by eminent academicians, but instead is a "cost-saving device for the insurance industry." What a fantastic revelation!

How refreshing are the concepts that risk management is a "gimmick," that risk managers belong in a "low-keyed specialty department" and that "pseudoscientific scholars, computer-minded quantifiers" are part of a "trendy and expensive crowd of researchers, theoreticians and intellectuals" that should be replaced by "seasoned, commercially oriented insurers who have learned their trade from scratch."

Imagine my surprise when I learned that obtaining services on a cost-plus basis with guaranteed profits for the insurer is behavior suited only to a charitable non-profit organization.

Alas, with this new-found perception, I will confess my past sins and remorselessly attempt to terminate our captives; replace what few insurance policies we have with 200 separate policies and all their quaint exclusions and restrictive conditions; put my staff in the growing ranks of the unemployed; and increase our bottom-line expense by \$3 million to \$4 million.

Clearly, these steps will put me in underwriting heaven along with the author, who has failed to mention that (according to Best's Insurance Reports) his U.S. reinsurance firm is 51% owned by approximately 60 German industrial firms (surely, that is not an industry-owned captive, is it?) and that good old-fashioned scratch underwriting was responsible for four years of underwriting loss out of the last five.

Your magazine should be commended for providing us with these simple but revealing solutions to our risk management problems.

Spencer J. Traver
Assistant treasurer
The BFGoodrich Co.
Akron, Ohio

A cost-saving device?

To the editor: Peter Mehlhorn's article "Risk management: Can insurers really afford the idea?" (BI, Aug. 2) is right. In the past, "the (insurance) industry was allowed to be less cost-conscious (less efficient) than it is today."

It's a crying shame that risk managers are now skimming off the cream they have enjoyed for so long and forcing the industry to be "conventional insurers only for the giant or bad risks corporations don't want to retain."

Mr. Mehlhorn said it: "Risk management is basically a cost-saving device." It's time the industry realizes that it is just one of the tools for managing residual risk that can't be eliminated.

The name of the game is to reduce and control risk—not just shunt it into the hands of some insurance company and continue with business as usual. I like the Factory Mutual System's philosophy: "We don't sell insurance—we sell fire protection and guarantee our work."

No, Mr. Mehlhorn, the risk management concept cannot "be contained or limited." The honeymoon is over. Companies that want to participate in large commercial risks had better get on the wagon. Those that can't stand the heat should get out of the kitchen.

Lawrence J. Bell
Assistant vp-risk management
Revco D.S. Inc.
Twinsburg, Ohio

The coming crunch

To the editor: Peter Mehlhorn's Perspective article, "Risk management: Can insurers really afford the idea?" (BI, Aug. 2), is saying to the insurance industry: "You must go back 20 years to when an insurance company was judged on the basis of having a combined loss ratio of less than 100%." I am afraid those days are gone forever. Profit or non-profit to the insurance industry hinges on total income, not part of the income.

The contention that insurers recommended risk managers shift from conventional insurance to alternative insurance is wishful thinking. I believe risk managers, thinking beyond conventional insurance, forced the issue—not the other way around. He is correct; the crunch will get us sooner or later. It is up to the risk manager to know when to trim sail, hopefully before the industry gets too smart.

Louis F. Siegel
Assistant director
Corporate Risk Management Department
Borden Inc.
Columbus, Ohio

Proposed CGL form

To the editor: Having reviewed the Insurance Services Office's proposed comprehensive general liability form and having sent my comments to the Risk & Insurance Management Society, I would like to summarize my feelings as a buyer of insurance.

In any contract negotiated between two parties, the contract should be mutually advantageous. The more sophisticated organizations that practice good risk and insurance management probably will have little occasion to use this form. However, smaller organizations, especially small businesses, will have little alternative, and as I read the form, the options for the insureds are becoming diminished, especially at renewal. The contract can hardly work to the advantage of both parties.

Since the insurance industry primarily is a financing business, it should use its expertise and experience in this area, rather than look for ways to force the insured to assume a disproportionate share of that financing, without the necessary time or experience to do it properly.

Kenneth Bush
Risk and insurance manager
County of Kent
Grand Rapids, Mich.

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. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

action line

Action Line: Can you please tell me how I can obtain a copy of the paper presented to the Sixth Annual National Symposium on Workers' Compensation held in Orono, Maine, by Philip R. O'Connor, former Illinois insurance commissioner, and Georgianne M. Riley?

Bill Herron
Russ Gailor & Associates Inc.
Louisville, Ky.

Mr. Herron: Copies of the paper, discussed in the Aug. 2 issue of *Business Insurance*, can be obtained free by contacting Georgianne Riley, Illinois Industrial Commission, 160 N. LaSalle, 12th Floor, Chicago, Ill. 60601; 312-793-6558.

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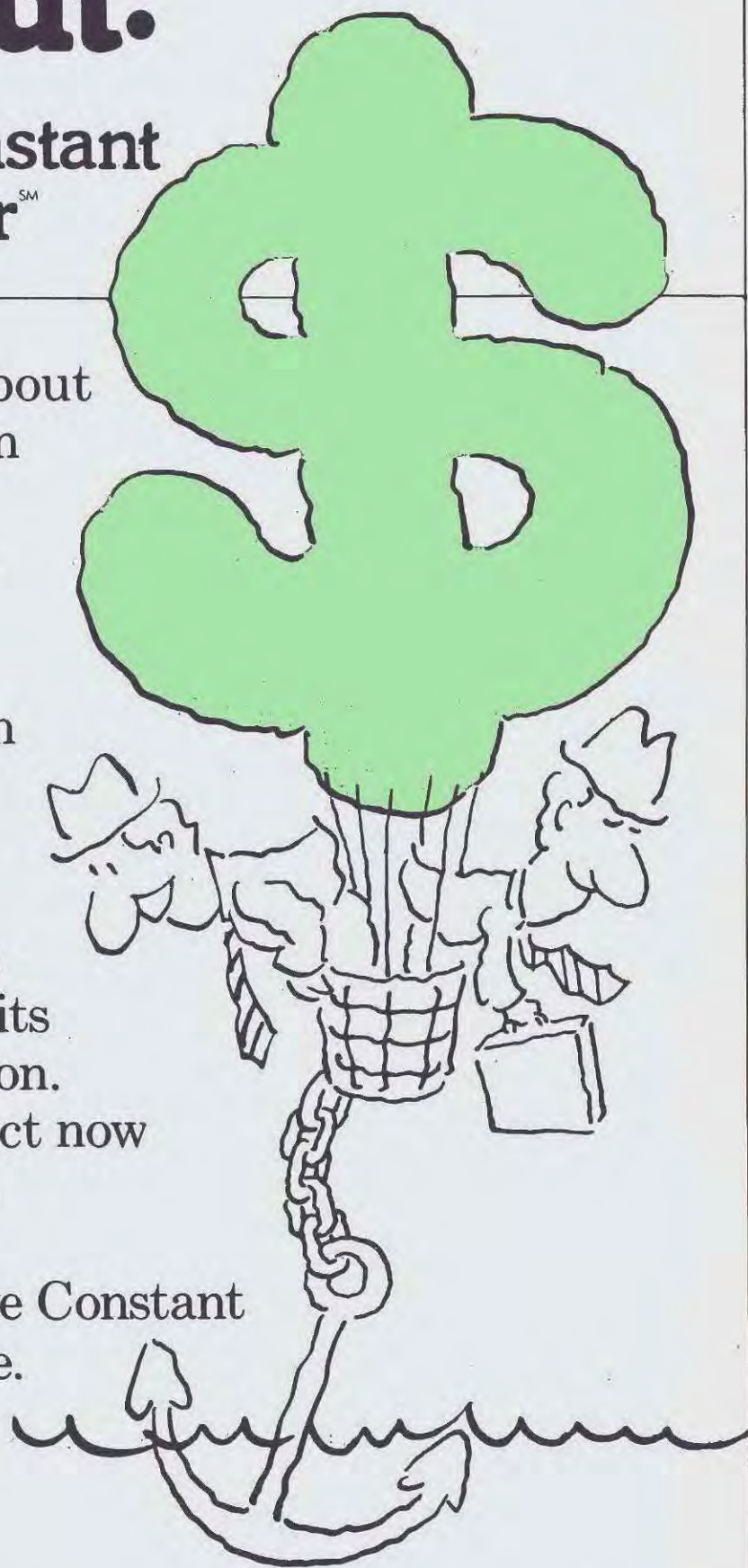
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Hyatt design check recommended in 1979

By BILL DENSMORE

KANSAS CITY, Mo.—Two years before the skywalks collapsed at the Hyatt Regency Hotel in Kansas City, an insurer had suggested that the structural steel system design in the hotel's lobby be checked, previously sealed court-filed documents reveal.

The risk manager for Hallmark Cards Inc., whose subsidiary built the hotel, received that recommendation in an engineering report from the highly protected risk department of Kemper Group's American Protection Insurance Co.

The Kemper subsidiary underwrote builders' risk insurance for Hallmark during the construction of the hotel building owned by Hallmark subsidiary Crown Center Redevelopment Corp.

The Kemper report is the first indication that Hallmark was alerted early about design and installation problems in construction of the ill-fated hotel building.

The insurer's report was written following the Oct. 14, 1979, collapse of a 20-by-100-foot section of the roof of the partially finished hotel's atrium lobby. The concrete-and-steel section plunged to the floor of the atrium at 5:50 a.m., causing no injuries. Damage was estimated at \$200,000 by Hallmark officials.

Kemper, in the engineering report, concluded that design, installation and weather-related problems contributed to the roof collapse. It then recommended:

"The structural steel system design for the atrium area should be completely reviewed with special attention given to the need for expansion joints and for adequate steel/concrete attachment methods."

Nearly two years later, on July 17, 1981, two concrete-and-steel walkways suspended by steel rods over the atrium lobby collapsed. The accident killed 114 people, injured at least 200 others and has



created court battles in four courts over three major issues (see related story).

The federally funded National Bureau of Standards concluded that a design change in the method of attaching the steel rods to the skywalks made the walkways barely capable of supporting their own weight, in violation of local building codes.

The 1979 Kemper report was attached to a letter from Crown Center's insurance broker to Richard C. Heydinger, director of risk management for Hallmark. The letter, dated Nov. 20, 1979, was among exhibits to a transcript of a deposition taken from Mr. Heydinger. The deposition, previously withheld from public scrutiny, was unsealed on Aug. 4 by order of U.S. District Judge Scott O. Wright in response to requests from plaintiffs' attorneys representing victims of the skywalk disaster.

Judge Wright also ordered numerous other depositions and up to 500,000 pages of documents unsealed, but he has not yet put this order into effect.

The insurance agent for the builders risk coverage was Metropolitan Agency Inc., a Kansas City-based partnership of two brokers, Marsh & McLennan and the former R.B. Jones Corp. The insurance coordinators were W.C. Raabe at Marsh & McLennan Inc.'s Kansas City office and Stanley S. Cox of R.B. Jones, also in Kansas City. The Nov. 20 letter on Metropolitan stationery was signed by Mr. Cox.

"The report contains one recommendation for a review of the steel and concrete attachment methods," Mr. Cox says of the Kemper report in his letter. "We had previously advised underwriters of your engagement of your own engineers to accomplish this review, Seiden & Page Inc. and HR Testing Engi-

neers, which will comply with this recommendation."

Mr. Cox apparently was referring to H.R. Inspection Service of Shawnee Mission, Kan.

Just what the two engineering consultants did after the roof collapse is still unclear. Documents that would shed light on the question remain under court-ordered seal and Hallmark attorneys said discussing them would violate canons of legal ethics.

Crown Center did say in papers filed Nov. 2, 1981, in response to questions from plaintiffs' attorneys that after receiving consultants' reports it had directed "that all changes recommended be made in accordance with the strictest and safest standards."

Crown Center also said that it had ordered regular inspections of the areas identified as critical by the architects and engineers.

A dispute exists among the consultants and Hallmark about what the consultants were supposed to do, says an insurer-hired attorney for Hyatt Corp., the hotel operator. "The nature of their involvement and the extent of their involvement is in dispute at this point," says Stephen S. Brown, an attorney with the Kansas City firm of Niewald, Risjord & Waldeck.

The attorney for H.R. Inspection Service said his client was instructed to inspect steel I-beam end

connections supporting the atrium roof and the north and south ends of the suspended walkways. H.R. Inspection Service was not told to inspect the steel rods supporting the walkways or the connection between the walkways and the steel rods, said Joseph H. Moore of the Kansas City law firm of Moore & Willy.

H.R. Inspection Service also only reported what it found on its inspections and did not make recommendations on alterations, Mr. Moore said.

In its report on the roof collapse, Kemper said original structural drawings for the atrium area overlooked provisions for attaching steel roof I-beams to concrete walls of the hotel building. The structural engineer for the project therefore specified the use of a total of nine, ¾-inch bolts imbedded 7 inches into the concrete, Kemper said. Only five bolts were actually installed at the failure point, and the bolts penetrated only 5 inches into the concrete wall, the report said.

Cold weather on the morning of the roof collapse probably caused the I-beam to contract by ¾-inch, Kemper speculated. The design at the failed joint did not provide for expansion and contraction and, as a result, the bolts pulled out of the wall and sheared, the report concluded.

Skywalk litigation grows week to week

KANSAS CITY, Mo.—The litigation arising out of the Hyatt Kansas City skywalks collapse is growing in multiple courts each week.

The status of a federal class-action suit, public access to legal papers and insurance coverage for claims are before four different courts around the country: the U.S. Supreme Court, the 8th U.S. Circuit Court of Appeals in St. Louis,

the U.S. District Court in Kansas City and the Jackson County Circuit Court in Kansas City.

The ultimate rulings on these issues will affect liability and determine insurance coverage for claims filed by the victims of the Hyatt skywalks collapse.

Late last week, lawyers and judges were hammering away on all three issues:

- Plaintiffs' attorneys at Williams & Connolly in Washington, D.C., were trying to preserve a federal class-action suit in the disaster.

Supreme Court Justice Harry M. Blackmun on Aug. 9 denied an emergency request by the firm to temporarily overturn the 8th U.S. Circuit Court of Appeals ruling that dissolved the class action.

Still pending before the Supreme Court is a second request from the firm asking the high court to review the Court of Appeals decision decertifying the class that had been established by Judge Scott O. Wright in U.S. District Court in Kansas City.

If the Supreme Court agreed to review the appeals court decision, it would set the stage for a precedent-setting ruling on class actions in disaster cases.

It also probably would slow down settlement and discovery efforts in Kansas City while lawyers awaited the high court's decision. The wait could last months.

Meanwhile, Judge Wright on Aug. 11 signaled to lawyers in the federal liability cases that he intended to certify a new class of plaintiffs in 10 days unless strong objections are raised by defendants or plaintiffs.

The new class could satisfy the concerns of the 8th Circuit, which had found that the original class certified by Judge Wright violated federal law barring federal courts from interfering with state court actions.

The new class would allow victims who don't want to participate in the class to pursue their claims individually.

Most attorneys in the skywalks litigation agree that hotel operator Hyatt Corp. and owner Crown Center Redevelopment Corp., a

subsidiary of Hallmark Cards Inc., would face potentially higher liability costs in a class-action suit than in individual trials.

- The 8th U.S. Circuit Court of Appeals said Aug. 11 it will consider an appeal by the main defendants in the liability litigation over an order to disclose legal documents.

Hyatt, Hallmark and others are appealing an order by Judge Wright ordering them to release legal documents to a U.S. magistrate. Judge Wright wants the magistrate to determine if the documents can be admitted as evidence in his court.

The defendants argue that the documents, all prepared after the July 17, 1981, disaster, are privileged from disclosure because they represent communications between lawyers and their clients.

The defendants argue that, under Missouri law, an attorney need never disclose attorney-client communications, even to a judge or magistrate. Judge Wright says he is not bound by Missouri law and federal rules of evidence allow inspection of the documents by a judge.

Defendants fear the documents could prejudice their liability cases pending before Judge Wright.

- The controversy over which insurers are liable for the claims was pending in Jackson County Circuit Court, where Judge Timothy D. O'Leary has two key insurance questions to decide.

The first is the request by North-

brook Excess & Surplus Insurance Co., a Hyatt excess insurer. Northbrook is seeking \$11 million from Hallmark's primary insurer, Commercial Union Insurance Co., to help pay defense and settlement costs Northbrook has incurred in settling claims on behalf of Hyatt and Hallmark.

Almost \$25 million has been paid so far in settlement costs, almost entirely by Northbrook under its \$25 million first excess liability policy underwritten for Hyatt. Also contributing to settlements were Hyatt's primary insurer for \$1 million and the insurer of another defendant.

Judge O'Leary also has been asked by Hallmark to order a Hyatt excess insurer, Columbia Casualty Co., a CNA Financial Corp. subsidiary, to recognize Hallmark as an insured.

Judge O'Leary's rulings would begin to resolve which insurers among Hyatt's \$201 million master insurance program for all its hotels and Hallmark's \$101 million liability insurance program should pay claims in the disaster.

At issue is whether Hyatt's master insurance program for all its hotels was properly endorsed to include Hallmark as an additional insured for the Kansas City location.

Judge O'Leary's rulings could be appealed to the Missouri Court of Appeals, which would increase to five the number of courts in which litigation relating to the Hyatt disaster would be pending.

Foundation sponsors study

BROOKFIELD, Wis.—A doctoral candidate at the University of California at Los Angeles has been awarded a \$2,800 research grant sponsored by the International Foundation of Employee Benefit Plans.

The grant, awarded to Gary S. Whitted, will be used to support a study of the management of American corporation's health care expenditures. The research and resulting report will also investigate the companies' cost-containment strategies, according to Robert D.

Cooper, the foundation's research director.

The results of the research by Mr. Whitted, a candidate for a doctoral degree in public health services, will be published by the foundation.

The IFEFP sponsors grants for research on different aspects of employee benefits by U.S. and Canadian graduate students in business, labor and industrial relations, law, economics and the social sciences. The grants run for 12 months, but they are renewable.



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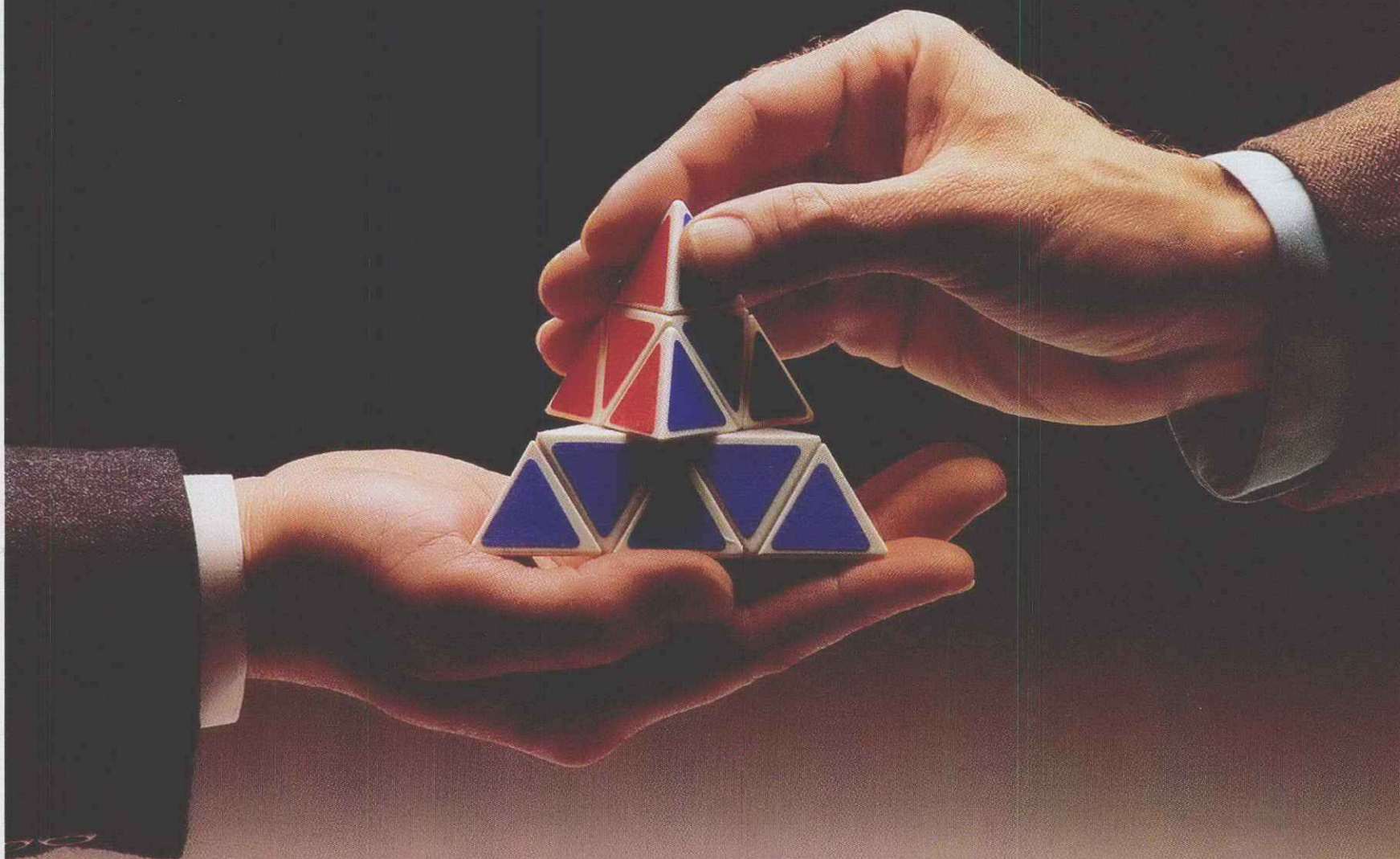


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Bank hopes review plan will cut health bill

By JAMES C. LAWSON

BALTIMORE—Maryland National Bank is hoping that a new hospitalization review program will help it beat the one-two punch of soaring health care costs and high hospital utilization.

To help fight the rising costs, the Baltimore-based employer of 5,000 three years ago began to self-insure a health program that allowed it to improve medical and surgical coverage and add new benefits at no additional cost.

But high costs and high utilization remain a problem. Bank employees rank close to the state average of 700 annual hospitalization days per 1,000 individuals.

"We were looking for a way to save money and not take anything from anybody," says Don S. Hillier, vp and director of the bank's office of corporate benefits.

The bank thinks the answer is a comprehensive admission review program that involves a series of pre-admission, ongoing and post-admission reviews.

The bank, with 180 branches statewide, is one of 13 major self-insured Maryland employers that have joined the program designed to cut utilization and to make providers more accountable.

The program, administered by Willse & Associates Inc., a third-party administrator in Baltimore, requires providers to submit to pre-admission reviews of about 65 elective medical and surgical procedures. Post-admission reviews will be conducted within 48 hours of emergency or urgent admissions and ongoing admission reviews will be done when physicians recommend their patients stay longer than the length of time established for the particular problem.

The program is expected to cost about \$5 per patient admission.

"This program questions the medical procedures. The plan will more than pay for itself, Mr. Hillier says.

No matter what the result of the review, the participating employers will still pay medical claims. The employee, Mr. Hillier explains, will "never be left holding the bag."

If a physician continually refuses to submit to a review, the hospital will be brought in and asked to force the doctor to comply.

And if the charge for a treatment and the opinion of the review panel differ, the employer will pay the charge but then try to negotiate a lower fee with the provider.

Willse & Associates has contracted with five Professional Standards Review Organizations to conduct reviews for employees who are treated by providers in Maryland and neighboring Pennsylvania, Virginia and the District of Columbia.

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Convalescent Hospital: Up to 60 days in full, following hospital confinement.

Hospice Care: Up to 60 days in full.

Employee Claim Assistance

Call Willse & Associates, Inc. (301) 547-0454

Photo: Willse & Associates Inc.

Cards employees carry spell out the review plan to hospitals.

nia, Virginia and the District of Columbia.

The plan, which went into effect July 1, encourages outpatient care instead of lengthy hospitalization through the use of convalescent, home health and hospice care.

"The medical community agrees there are a number of medical procedures that can be done on an outpatient basis, but usually are done on an inpatient basis. A lot of people were going to hospitals and staying for procedures which could have been performed in outpatient facilities," explains Mr. Hillier.

Under the program, which covers more than 36,000 employees at the 13 companies, employees are presented a special plan identification card that instructs providers how to verify coverage and begin the review process.

Coverage varies depending upon the employer's health plan.

However, all 13 employers will pay 100% of convalescent care charges for a maximum of 60 days. They will pay 100% of all home health care charges for a maximum of 40 days and 100% of all drug, nursing service and physicians' charges for terminally ill patients who request hospice care for a maximum of 60 days.

Maryland National Bank currently spends more than \$3 million annually to provide employees with a health plan that pays 100% of all hospitalization charges in a

semiprivate room. The plan pays 80% of all surgical charges and 80% of all charges under the major medical portion of the plan.

Employees pay no deductible under the hospitalization portion of the medical plan, but must pay a \$100 annual deductible for major medical coverage. The major medical lifetime maximum is \$500,000.

Deregulation of some lines expected in New Jersey

TRENTON, N.J.—Rates for most commercial lines of insurance are expected to be deregulated in New Jersey soon.

A bill calling for a use-and-file rate system, passed without opposition by both the Assembly and Senate, is now on Gov. Thomas Kean's desk. It will become law if Gov. Kean signs it by Aug. 27 or if the Assembly reconvenes next month before he signs it.

The bill dictates that most commercial policies, excluding workers compensation and certain other lines, with a minimum annual premium in excess of \$10,000 will be exempt from prior rate and form filings.

"It seems pretty definite" that the bill will become law, says a spokeswoman for Assemblyman

While self-insured, the bank has purchased specific stop-loss insurance to cover any individual medical claims that exceed \$25,000. The stop-loss protection is underwritten by Crown Life Insurance Co. of Canada, which also underwrites the company's group life plan.

"We felt we had exhausted all of the normal means of saving them (client companies) money," says David Willse, president of Willse & Associates, examining the motive behind the program. "Our groups were experiencing exorbitant health cost escalations, from 18% to 20% over the past 1½ to two years."

"We had been used to seeing about 7% to 12% increases in the past. We were anticipating higher rates in the future, so we felt we had to do something like this."

The program, Mr. Willse says, should help employers reduce hospital use to about 400 to 450 annual days per 1,000 employees. Currently, program participants have an average utilization rate of 525 days per 1,000 plan participants.

The other participating companies, all either based in or with operations in Maryland, include:

- The Arundel Corp.
- Equitable Trust Co.
- JLG Industries Inc.
- The Kirk-Satieff Co.
- Landmark Financial Services.
- MSC Corp.
- Preston Trucking Co.
- Printing Industries of Maryland.
- Sheppard & Enoch Pratt Hospital.
- Steel Tin Can Corp.
- Union Trust Co. of Maryland.
- Mercy Hospital of Baltimore. ■

Thomas Cowan, D-Jersey City, co-sponsor of the legislation.

The bill was proposed after an advisory committee on the deregulation of commercial insurance determined in December 1980 that "the present system of prior approval of rates for commercial lines (in New Jersey) was both time-consuming and not particularly productive."

A spokesman for the New Jersey Insurance Department says the bill would "free it (the insurance market) from regulation that wasn't doing much anyway."

The committee found that deregulating the market would stimulate industry competition and "bring the benefits of rate competition to the admitted market."

"The present system often distorts the ratemaking process because of the attempt by insurers to adjust proposed rates to make up either for an anticipated delay in rate approval or a denial of the full requested rate of change," the committee said.

"We are very happy about it," says Charles McCrann, an attorney in Marsh & McLennan Inc.'s New York office. "It seems like a step in the right direction."

"It's a very progressive move by the state of New Jersey, and we'd like to see other states consider it," he says. "Commercial insurance of this nature (premiums in excess of \$10,000) is a different product than smaller line policies that perhaps require greater regulation."

The legislation would apply to all types of insurance except workers compensation, ocean marine, mortgage guaranty, title, medical malpractice, employers liability, personal lines and policies written through the New Jersey Insurance Underwriters Assn. or through medical and hospital service corporations. ■

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THE SAMEX GROUP

Lemesis to head benefits at United Airlines

Gus Lemesis, 39, is the new director of compensation and benefits at United Airlines Inc. in Elk Grove Village, Ill. Prior to joining United, Mr. Lemesis was with Honeywell Inc. in Minneapolis for nine years, most recently as manager of benefit planning. In his new position he will have overall policy and design responsibilities for non-union compensation and benefits programs and for housing and relocation programs. Mr. Lemesis received a bachelor of arts degree from Wesleyan University in Middletown, Conn. He is a member of the U.S. Chamber of Commerce employee benefit committee and is chairman of the Chamber of Commerce ERISA subcommittee. Mr. Lemesis replaces **Irwin Brand**, who has left the company. Mr. Lemesis reports to Personnel Vp Jim Guyette.

Milliken & Co. in Spartanburg, S.C., has promoted **W. Thomas Maynard**, 33, to corporate risk and insurance manager. Mr. Maynard was previously the company's as-

comings & goings: buyers

sistant insurance manager. In his new post he will handle property/casualty programs. Prior to joining Milliken in 1980, Mr. Maynard was a staff attorney with Seibels Bruce & Co. in Columbia, S.C. He received bachelor of science in finance and juris doctor degrees from the University of South Carolina. Mr. Maynard replaces **Paul Wilson**, who is retiring after 31 years as manager of the insurance department. Mr. Maynard will report to Walt Pettiss, vp and assistant treasurer.

Robert J. Thurston, 25, has been appointed flexible benefits coordinator, a new position, at Delta Drilling Co. in Tyler, Texas. Mr. Thurston is in charge of design, implementation and record keeping for the company's new flexible benefit plan. After an internship at International Business Machines Corp. as a benefit planning analyst,

Mr. Thurston worked as an independent consultant, helping plan Delta Drilling Co.'s flexible employee benefit program. He received a bachelor and master of business administration degrees from Brigham Young University in Provo, Utah. He reports to Bob Merryman, employee benefits manager.



Mr. Thurston

David Burr, 26, has been named assistant risk manager at Santa Fe Industries Inc. in Chicago. In the newly created position Mr. Burr will assist in property/casualty insurance management. Before joining the company, he was a large lines casualty underwriter in Crum

& Forster's Chicago office. He received a bachelor's degree in risk and insurance from Michigan State University in East Lansing and holds the Associate in Risk Management designation. Mr. Burr reports to J.A. Cornelius, director of risk management for the transportation company.

Jeff Mingori, 29, has been appointed manager of insurance with Central & Southwest Services Inc. in Dallas. In the new position he will be responsible for property/casualty and workers compensation insurance for the company. Mr. Mingori previously was an account executive with Hartford Insurance Group and an underwriter with Continental Insurance, both of which are located in Dallas. He received his bachelor of arts degree in history and his master of business administration degree from the University of Texas. He will report to Leon Wesner, assistant vp of benefits and insurance.

Joel Brandt, 29, is the new director of risk management for Westchester County, N.Y., replacing **Robert Bieber**, now with Ebasco Risk Management Consultants Inc. Mr. Brandt will handle all insurance purchasing and management, loss control and safety for the county. He is the former risk manager with Jordache Enterprises Inc. in New York, and also was assistant risk manager with Rapid American Corp. in New York. Mr. Brandt received a bachelor of arts degree in political science from Brooklyn College of the City University of New York, and the Chartered Property and Casualty Underwriter designation. He reports to Vincent R. Castaldo, general services administrator.

We'd like to report on staff changes in your risk management or benefits department. Just drop a note to Sallie Drury, Editorial Assistant, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5398.

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Bermuda Fire & Marine buys N.Y.-based Marine Indemnity

markets

Bermuda's largest domestic insurer, The Bermuda Fire & Marine Insurance Co. Ltd., has purchased Marine Indemnity Insurance Co. of America, based in New York.

The acquisition, which will give BF&M a significant presence in the U.S. market, is believed to be the first purchase of a U.S. insurer by a Bermuda-based company.

The deal has already been approved by the New York superintendent of insurance.

Marine Indemnity, a property/casualty company that last year reported direct premium income of \$6.6 million and net earnings of \$2.2 million, will continue to be managed by William H. McGee & Co. Inc.

However, ownership will shift to BF&M's newly-formed subsidiary, Bermuda Fire & Marine International of Delaware.

BF&M has assets worth almost \$32 million and posted earnings in 1981 of \$2.4 million.

Marine Indemnity was formed in 1973 and is licensed in 17 states and two Canadian provinces. It writes commercial multiperil and inland and ocean marine coverages.

Group insurance

Corroon & Black Corp. has established a new division called Association Management Services to develop and market association and group insurance programs.

The new venture will be a member of C&B's Advanced Risk Management Services division and will be headquartered in Coral Gables, Fla. The president of the new subsidiary is Thomas W. Abell, a specialist in association business who joined Corroon & Black earlier this year.

Overseas investment

Marsh & McLennan Cos. Inc. has increased its equity interest in Henrijean & Cie S.A. and Henrijean International S.A. to 62.57%.

Henrijean is the largest insurance brokerage in Belgium and markets employee benefit services under the name of William M. Mercer Henrijean.

HMO facility

INA Healthplan Inc. will open a \$2 million medical center in Hollywood, Fla., on Aug. 16.

The 10,000-square foot facility will house adult, pediatric and specialty care physicians and diagnostic, X-ray and laboratory equipment.

INA Healthplan has 30,000 members in Broward and Dade County, Fla. Nationwide, the HMO provides services to more than 600,000 people.

Additional authority

M.J. Hall & Co., managing general agent for general aviation insurance written by Fremont Indemnity Co. and Comstock Insurance Co., has received authority to do business in 11 additional states.

The Fremont/Comstock program is now available in Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming.

Offices consolidated

Allstate Insurance Co. is consoli-

dating some of its commercial regional office functions.

By November, all claims processing and some underwriting functions will be consolidated at Allstate commercial territorial offices in Atlanta and Chicago.

The Atlanta office will serve the East and the South, while the Chicago facility will serve the Midwest and West, according to Robert A. Leibold, vp of commercial operations.

Allstate will also establish commercial field underwriting offices in Brea, Calif.; Long Island, N.Y.; Atlanta; and Rolling Meadows, Ill. All new business will be underwritten at these four offices, while existing business will be handled from the two territorial offices.

The consolidation will cut Allstate's workforce by about 230 people.

Employee benefits

Fred S. James & Co. of California has added an employee benefits department in its Los Angeles office.

Gregory Perez, a James vp, will manage the new department.

Reinsurance

Signet Reinsurance Co. has begun to write property facultative reinsurance through C/Re Management Corp.

Signet's capital and surplus has also been increased to approximately \$12.5 million.

Both Signet and C/Re are subsidiaries of W.R. Berkley Corp., an insurance holding company in Cos Cob, Conn.

Acquisition

Rollins Burdick Hunter Co. has reached an agreement to acquire **Kahn & Nippert Co.**, a San Francisco brokerage.

New office

Rollins Burdick Hunter of Kansas Inc. has opened a new office in the International Flying Farmers Buildings, Mid-Continent Airport, Wichita, Kan. 67201.



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riskWatch

Employers missed a chance to clarify 1978 pregnancy law

By JERRY GEISEL

WASHINGTON—Even a court composed of Solomons would have a hard time deciding just how far Congress intended the Pregnancy Discrimination Act of 1978 to extend.

The law is ambiguous on an important question: Must group health plans cover the pregnancies of wives of male employees to the same extent they cover any other illness of a spouse of either sex? It is no wonder the courts can't agree on how to answer this question.

The 9th U.S. Circuit Court of Appeals in San Francisco last month said the pregnancy act only requires employers to treat the pregnancies of female employees as any other illness suffered by an employee. Group health plans do not have to cover the pregnancy medical expenses incurred by male employees' spouses as they would any other illness of a spouse of either sex, the court said (BI, Aug. 2).

As a result, in a case involving Lockheed Missiles & Space Co., the appellate court ruled that the Sunnyvale, Calif., aerospace giant did not violate federal law by refusing to provide pregnancy benefits to male employees' wives in its self-funded medical care plan.

Interestingly, under a new labor contract, Lockheed since December 1980 has provided male employees' wives with the same coverage it provides female employees.

The recent 9th Circuit ruling, however, contradicts a decision in January by the 4th Circuit Court of Appeals. In that case, involving Newport News Shipbuilding, the court said the law protects pregnancy benefits of wives of male employees as well those of female employees (BI, Feb. 1).

That decision upheld 1979 guidelines issued by the Equal Employment Opportunity Commission. It says the law does mandate equal pregnancy benefits for spouses. Newport News Shipbuilding—which pays all reasonable and customary expenses for spouses of female employees, but places a \$500 cap on pregnancy hospitalization benefits for spouses of male employees—had challenged those guidelines.

The courts' confusion is understandable. Nowhere in the brief 1½-page law does Congress state clearly whether it intended the law to cover pregnancy benefits for male employees' wives.

Eventually, the Supreme Court may try to mend the split between the appellate courts. But even a Supreme Court decision may not resolve the issue. Congress could always reverse the high court's ruling if it doesn't agree with the decision. After all, the Pregnancy Discrimination Act itself was passed by a Congress that disagreed with a Supreme Court decision that said General Electric did not have to treat pregnancy as an illness under its disability plan.

But, by the time the issue of how much employers must pay toward the pregnancy medical expenses of male employees' wives is resolved—and there is no indication that will be anytime soon—employers will have spent hundreds of thousands of dollars in legal fees fighting the EEOC's pregnancy benefit guidelines.

Those costs could have been avoided. A one-sentence amendment inserted into the pregnancy act when the bill was under consideration—explaining whether the measure also applied to employees' spouses—could have avoided lengthy and costly legal battles.

But business groups didn't press hard for such an amendment, which probably would have been accepted. Instead, employer groups initially fought to kill the bill and later sought minor changes, like giving companies more time to comply with the law.

Most individual companies didn't do any lobbying. Many clearly opposed the idea of being told by Congress that they had to treat pregnancy as any other illness. They didn't want to be told to stop capping the benefit for pregnancy medical costs and denying disability benefits to pregnant workers. But, they thought the bill would pass regardless of their lobbying efforts, which was probably right.

What many companies and trade groups didn't realize—and still don't—is that lobbying is far more than fighting to pass an eagerly sought bill or battling to kill a very bad one. With a record number of lobbyists in Washington all competing for influence, a single company or trade group rarely has the power to kill or pass a bill.

But employers and their associations can be enormously effective in shaping the course of legislation. Committee staff members want to know if there are holes in their bills. If a bill is ambiguous on an issue, staffers want to know how to remove the ambiguity.

For example, if a benefit manager or consultant in 1977 or 1978 had asked backers of act whether the legislation was intended to cover the pregnancies of male employees' wives, it could have been quickly amended to provide a clear answer.

This reporter, who covered the debate on the pregnancy act, doesn't remember any experts raising this as an important issue.

Raising that kind of issue, however, means employers and those lobbying for them will have to immerse themselves much more into the nitty-gritty of pending legislation.

It is often attractive to work to kill an entire bill to get rid of the entire problem, but not so productive. Remember the cliché about half a loaf is better than none. Well, a well-written bill that mandates an undesired action is certainly better than a poorly written bill that mandates an undesired action—and then some. Asking one good question or clarifying just one sentence in a bill often can save enormous legal bills later on.

As one benefit expert notes, it is 10 times easier to amend a pending bill than to try to undo the damage after a bill is a law.



Mr. Geisel

NCCI publishes full names of insolvent underwriters

BROOKFIELD, Wis.—The president of the National Assn. of Insurance Commissioners is notifying members that an NAIC task force reproduced a report that listed the incomplete names of insolvent insurance companies.

The blunder created quite a stir, especially for a financially healthy insurance company with a name similar to an insolvent one that was listed (BI, July 12).

The report of the NAIC Liquidators Task Force, which met June 6 in Philadelphia, "contains certain information which might be misleading," NAIC President Lyndon L. Olson Jr. wrote in a letter addressed to all registrants at the NAIC's summer meeting.

"I regret any inconvenience which may have been caused to companies having similar names to those listed incompletely in the original task force report," he said.

The problem started with identifying a company in insolvency sim-

ply as "American Centennial."

That bit of information was repeated by the New York-based law firm of LeBoeuf, Lamb, Leiby & MacRae in a report to its clients that said the company was among those "insolvent or threatened with insolvency."

The precise name of the insolvent company is American Centennial Life Insurance Co., which is in receivership in Maryland. American Centennial Insurance Co., of Peapack, N.J., which underwrites property/casualty reinsurance and credit insurance, sent telexes and letters to all its clients to quell the misleading information.

LeBoeuf, Lamb has also written its clients to straighten out the confusion.

The NAIC has changed its report to the list as it appears below:

- Reserve Insurance Co. (Illinois; receivership).
- Security Casualty Co. (Illinois; receivership).

- Kenilworth Insurance Co. (Illinois; receivership).
- Proprietors' Insurance Co. (Ohio; receivership).
- American Reserve Insurance Co. (Rhode Island; receivership).
- Cosmopolitan Mutual Insurance Co. (New York; receivership).
- Consolidated Mutual Insurance Co. (New York; receivership).
- Long Island Mutual Insurance Co. (New York; receivership).
- Safeguard Mutual Insurance Co. (Pennsylvania; receivership).
- Northeastern Fire Insurance Co. of Pennsylvania (Pennsylvania; suspension).
- American Centennial Life Insurance Co. (Maryland; receivership).
- Stuyvesant Mutual Plate Glass Insurance Co. (Pennsylvania; receivership).
- Pilgrim Life Insurance Co. (Indiana; receivership).
- Mobile Insurance Co. (Texas; receivership).

Vermont studies model rating laws

around the states

MONTPELIER, Vt.—A 10-member task force will look into the possibility of introducing competitive rating for workers compensation and all other property/casualty insurance.

Appointed by state Insurance Commissioner George Chaffee, the task force will look at two model laws on the subject: one from the National Assn. of Insurance Commissioners and the other from the American Insurance Institute.

The task force is made up of four members from industry, four from Independent Insurance Agents of Vermont and two from Professional Insurance Agents.

The task force's report is expected by late fall and legislation could be introduced in 1983.

major rule changes in five years for workers compensation have been sent by a state agency to the Legislature for final approval.

If approved by an Assembly and a Senate Labor committee, the rules could be effective in October.

The proposed changes are expected to improve reporting requirements, streamline administration and further protect workers injured on the job in Wisconsin.

The proposed changes, written following hearings by the workers compensation division of the Department of Industry, Labor and

Human Relations, would:

- Help ensure more complete and accurate reporting of data from employers and insurers. New information would be required and data requested would be clarified.
- Require more detailed state review of all compromise agreements made between insurers or large employers and claimants, in order that all claimants are treated fairly.
- Encourage the exchange of medical or technical information before actual hearings begin on contested disability claims.

Product liability

NEW ORLEANS—Product liability losses were twice the amount of premium collected in Louisiana in 1980, according to the state Insurance Department.

Incurred losses totaled \$44.6 million on earned premiums of \$22.5 million. That was a 300% increase in incurred losses compared with a 46% increase in earned premiums for product liability increased 46% from 1979 to 1980.

The greatest disparity between premiums and losses was among manufacturers. Although premiums for that group dropped 15.6% to \$4.1 million from \$4.9 million, losses climbed 783.6% to \$26.9 million from \$3 million.

Wholesalers and distributors enjoyed an 11.1% decrease in premiums but suffered a 212.4% increase in losses. Retailers' premiums fell 8.1%, but their losses increased 87.6%.

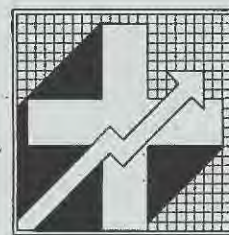
Businesses in all other categories saw their premiums rise 31.8% and their losses grow 104.2%.

From 1978 to 1981, paid losses for all lines of property/casualty insurance in Louisiana climbed 67% while written premiums for the same period rose 35.9%, less than the 39.4% increase in the Consumer Price Index, said John Coon, president of the Insurance Information Institute's Louisiana committee.

Competition among insurers and higher-than-normal returns on investments are two reasons why some businesses are paying less for their insurance, Mr. Coon explained.

Work comp changes

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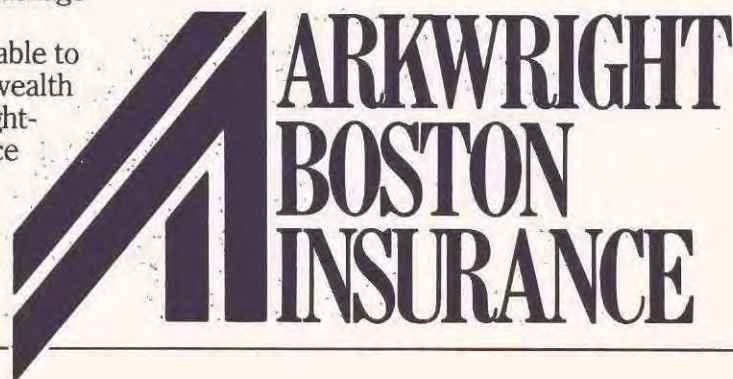
For one thing, our new policy includes boiler and machinery. Unavailable in many package arrangements.

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REDUCING HEALTH COSTS

Cutting fees must start with providers and users

By Alton E. Lutz

COMPETITION IN health care is a phrase the administration is using to describe or identify current schemes to control the rising cost of medical expenses.

They propose that within each company employees have a choice of medical expense reimbursement plans, service plans or HMOs based on cost. Any reduced cost usually means reduced benefits.

At this point, any cost saving is merely cost transference to the employee due to the reduced benefits payable or available. The cost control implied under these schemes is that those faced with higher cost sharing who have opted for lower-cost plans will be able to effect lower prices for services, or lower utilization through abstinence.

To make this proposition attractive, those who opt for the lower-cost plans would be offered rebates of the cost differential. While the rebates would help the employee pay an increased share of medical expenses, they would also eliminate any cost saving under the plan for the employer.

Yet several forces underlying the group insurance mechanism seem to have been overlooked. Also ignored is the experience in the federal employees' group insurance plan that has offered high options and low options for the employees to pick and choose. The subjective aspects of illness and insurance will prevail where such choices exist. We call these choices "adverse selection."

In this instance, adverse selection means that predominantly healthy people will opt for the cheaper plan. Those who do not use the plan cannot possibly save the plan any money through lower utilization. They will have no effect on prices for medical services. Those in poorer health, or those planning a family or an addition to their family, will opt for the greater-benefits, higher-cost plan. With greater benefits, they are less likely to complain about the prices.

With less support in the rating structure from healthy people, the resulting rates for those in the greater-benefit plans will escalate, in more or less direct proportion. Even without rebates, any savings under such a scheme are certainly ephemeral.

The stated objectives of the three bills in Congress—S. 139, S. 433 and H.B. 850—are:

- Increase competition in the health care field.
- Slow the rise of health care costs.
- Provide increased consumer choice of health care plans.

Analysis of the three bills discloses that all of them rely solely upon plan design and premium taxation in some fashion to achieve the desired goals. None of them addresses either the users or the providers directly. The entire emphasis is on the funding mechanism rather than the expenses incurred for medical treatment and services. The consequence of the enactment of any one of these would be regulation and complexity within the

Financing personal health care (billions of dollars)

Source of funds	1950	1955	1960	1965	1970	1975	1980	1981 est.
Direct consumer payments	7.1	9.1	13.0	18.5	26.0	39.0	70.6	76.0
Private insurance	1.0	2.5	5.0	8.8	15.6	30.1	58.1	66.8
Government (federal, state and local)	2.4	3.6	5.2	7.7	22.5	46.1	86.4	100.8
Other	.3	.4	.5	.8	1.0	1.6	2.9	3.1
Total	10.8	15.6	23.7	35.8	65.1	116.8	218.0	246.7

Source: "Curbing Health-Care Costs," The Morgan Guaranty Survey, January 1982, a publication of Morgan Guaranty Trust.

scope of pensions.

Another consequence is the estimate by David Stockman, director of the Office of Management and Budget, of \$17 billion of additional tax revenue for the government. The certainty of additional taxes deserves consideration. They must be considered part of the cost, and added to the expenses. The amount of taxes and rebates combined will greatly exceed any possible savings through reduction of the escalation of medical care costs under any one of these plans, or any similar plan.

If taxes must be used to focus attention on the problem, they should be assessed on the users and the providers. No other purpose than income to the government can be served by taxing the non-users. They are not part of the problem. Would it be unconscionable to tax the patient's hospital or doctor bill? That is where and when the expenses are incurred. If complaints about the prices are to be made and heard, this is the time and place.

If taxes are to affect prices charged by providers, would it be an effective remedy to place excess profits taxes on all manufacturers, wholesalers and retailers of medical supplies, equipment and services? Excise taxes would merely add to the cost being passed along. In view of the national concern about escalating medical costs, a different approach to taxes in medical economics might be appropriate.

The Hospital Cost Containment Board of Florida, in its third annual report, released in March, stated that operating return on investment of investor-owned (private) hospitals in Florida for the fiscal year March 1979 to April 1980 was 32.1%. A net after taxes of 15.5% was reported. If such private hospitals were permitted a return of 16% on investment without taxes, and paid excess profits taxes of 100% on all investment returns exceeding 16%, they could reduce actual charges by 12% and lose nothing. This form of cost shifting, from taxes paid to government to reduced health-care bills for the public, is certainly worth investigating.

A more likely result of the enactment of the health legislation is that employers generally will pay all of the cost of the cheapest plan, thereby eliminating, where

possible, the specter of rebates. Such a posture would exacerbate the element of adverse selection for the more costly plans. While the predictable lower level of participation in the higher-cost plans would mean more employees would have lesser benefits, meeting one of the administration goals through mere cost transference, this can be achieved through much simpler legislation.

To avoid total chaos, the requirement in S. 433 that three different plans be provided by three different insurers must be dropped. Most insurers require a minimum participation of 75% of eligible employees in any employer plan to provide the spread of risk and economies of scale that allow group insurance to be written at predictable rates. Some states also have minimum participation rules in their insurance regulations, recognizing the fundamentals of group insurance mechanisms.

The proposed legislation also ignores the sources of funds used to pay for health care. Private insurance accounts for only one quarter of the funds effecting medical economics. Direct consumer payments still account for a greater portion of the total than insured plan benefits and government payments are the largest segment of all (see chart).

The charge that private insurance plans are now paying too much of the sick person's bill may be valid for some, such as the federal employees' high-option plans, but not all plans are that generous. Many working people are not fully covered and many do not earn \$20,000 or more per year. (The median income for a family of four in 1979 was \$19,700.) They can save little money, and large medical bills (their deductible and coinsurance) would still be a problem, even if both spouses work.

Government statisticians tell us that in more than 50% of families, both spouses are working. The result of double employment is often double coverage for group insurance—two fund sources for the same claims.

While coordination of benefits provisions found in most group policies limits total benefits to 100% of the bills, it is important to realize that in all such cases

of double coverage, the combination will continue to pay 100% of the bills for working couples even if the coinsurance were reduced to 50/50. When the source of funds is two group policies, nothing in the proposed bills addresses the problem.

In reality, the hoped-for effects of the proposed legislation won't measure up to expectations. There are many other obvious problems and solutions that would be much simpler to implement with suitable legislation.

For example, only a few states have eliminated double coverage of medical expenses through group and auto insurance by making one primary and one secondary. In all other states, double payment is the result. Where allowed, little subrogation is done because it is time-consuming and expensive.

Most states specify that group insurance cannot coordinate against individual policies. This invites speculation and overinsuring. Those people who might have legitimately bought individual policies to supplement group insurance a few years ago, when the group plans were not as complete, may not find it profitable to be sick. While it may not be said that they were guilty of "stacking," why should they profit from illness or injury?

In auto insurance, it is not illegal to buy more than one policy, but collecting on more than one policy is considered fraud. The same is true in residential fire insurance. Compare these circumstances with the health insurance legislation that makes it legal to collect more in insurance than the amount of medical expenses.

Obviously, legislative remedies are more readily available through states rather than the federal legislature for some of these problems. Health care financing problems exist in all states. Perhaps Congress can devise the means to help eliminate the double coverage of medical expenses in all states.

Since no figures have been compiled on the extent of double coverage or situations where more than 100% was paid, this part of the problem is impossible to measure.

Shouldn't double coverage be addressed, particularly in conjunction with any widespread intrusion by the federal government into private health care funding mechanisms?

Insurance companies writing group health insurance are themselves victims of competition for the health care premium dollar. The added expense of poorly conceived and greatly detailed federal regulations will only add to premium cost. Since other possibilities, as suggested, exist to reduce health care cost, more effort should be made along these lines.

Why think that any plans before Congress affecting only 25% of the medical economy will change the course of future costs for all?

Alton E. Lutz is group underwriter at Independent Life & Accident Insurance Co. in Jacksonville, Fla.

perspective

Consumer awareness of fees is first step to lower health costs

speaking out

DEAR SECRETARY Schweiker:

During the past year there has been considerable discussion and debate on the pro-competition proposals to control medical care costs. Recently, Dr. Robert J. Rubin of your department expressed the administration's goals to hold down health care costs at the annual meeting of the Health Insurance Assn. of America.

While I believe competitive forces are a crucial element to controlling medical care costs, my professional experience as a former group insurance underwriter, employee benefits consultant and in my current position as an employee benefits administrator, leads me to the conclusion that the emphasis of the current pro-competition proposals is misdirected.

Tremendous competition between insurers already exists. Offering multiple benefit levels would create excessively burdensome administration problems and add to current administration costs. In addition, complicated employee communication programs would be necessary. Since the vast majority of employees are not adequately familiar with benefits under a single benefit program, it is unrealistic to expect them to become knowledgeable of the benefits under a multiple option plan.

Again, I do believe in competitive forces to control medical care costs. The

competition, however, must be between the providers of medical care. In order to create a competitive atmosphere among providers, two elements are necessary:

- Consumer cost awareness.
- Immediate economic involvement by the consumer.

I wish to offer a proposal that will create the necessary competitive environment. This proposal would require very limited government involvement, would be relatively easy to communicate to employees and would involve minimal administrative concerns to employers.

The proposal is:

1. Require all doctors to complete a price list for a predetermined number of common duties or procedures. For example, the list could include the cost of:

- Office visits.
- Home visits.
- Hospital visits.
- Immunizations.
- Common surgical procedures.
- Cost to complete insurance forms.

2. Require hospitals to complete a similar listing showing the cost of such items as:

- Private room.
- Semiprivate room.

- Drugs.
- Operating facilities.
- Therapeutic facilities.
- Emergency room.
- Professional fees.

3. A "Hospital/Physician Price Book" would be printed on a regional basis, for either cities or whole counties.

4. The "Hospital/Physician Price Book" would be updated and distributed annually to all families in the region.

(The first four steps outlined above would accomplish the first objective, creating a competitive atmosphere by providing for consumer cost awareness.)

5. Limit the payment under employer-sponsored group medical reimbursement plans to the average charge of the region for each particular procedure. This concept would replace the traditional reasonable and customary definition of eligible charge. Medical charges in excess of the average regional charge would be a patient responsibility.

(Step 5 accomplishes the second objective in creating a competitive atmosphere by requiring the consumer to be involved in an immediate economic

decision.)

Steps 1 through 5 provide a basis for the consumer to compare prices and make an economic decision that directly and immediately affects them. Providers of medical care will also become more aware and concerned about their competitive posture in the delivery of health care services.

There is one additional step that would be helpful in controlling inflationary trends:

6. Each year, doctors and hospitals could update their charges without limit. The average regional charge, however, would not be increased more than a percentage figure determined by a prespecified cost of living index.

I firmly believe that this proposal would provide guidelines to promote competition where it is truly needed—between providers of medical services.

Thank you for considering my proposal. I would appreciate your comments.

Joseph C. Dressler

This letter was sent by Joseph C. Dressler, benefit specialist at Central Maine Power Co. in Augusta, Maine, to United States Department of Health and Human Services Secretary Richard S. Schweiker.

Insurer allowed refund only for overpayment

A LUMP-SUM retroactive Social Security payment could not be used to reduce monthly disability payments due under a group disability insurance policy, according to a federal appellate court.

Georgianna Bush was covered under the group policy issued to her employer by Metropolitan Life Insurance Co. The policy provided that if any benefits paid "should not have been paid," the insurer was entitled to a refund. The policy also had a clause reducing benefits by Social Security disability benefits.

Ms. Bush became totally disabled but was denied Social Security benefits. Metropolitan Life then commenced benefits under its policy.

Later, Ms. Bush's Social Security appeal resulted in an award to her of benefits retroactively, with payment of a lump sum. Metropolitan Life then started to reduce her monthly benefits by the amount of the regular Social Security monthly benefits. But, in addition, Metropolitan Life reduced her monthly payments further to recoup the amount of the retroactive Social Security awarded to Bush.

As a consequence, from July 1976 through July 1978, Ms. Bush received no benefits from Metropolitan Life. Bush challenged Metropolitan Life's "carve out" of the amount equal to the Social Security lump-sum payment and won in the trial court.

On appeal, Metropolitan Life argued that the policy language should allow it to be entitled to a refund in situations in

legal briefs

which later developments render the earlier payments incorrect. But, the court said that at the time of Metropolitan Life's payments, the Social Security benefits were not benefits that "should not have been paid."

According to the court, another interpretation of the policy language was that recoupment was permitted only when the insurance company erroneously overpays according to the conditions manifest at the time of payment. Because of the ambiguity of the policy language, the court chose to rule in favor of the insured. *Bush vs. Metropolitan Life Insurance*, U.S. Court of Appeals for the Sixth Circuit, Aug. 12, 1981 (BI/02/M.-\$5).

Beneficiary change

What is the effect of an insured's failure to, cause or direction to deliver a change of beneficiary form on a group life insurance policy? A federal appellate court held that, where the insured takes positive action that shows his desire for a change of beneficiary, the courts will adopt such construction as needed to assist in carrying out such intention.

Julius Balsley was covered under a group life insurance policy issued to his employer by Connecticut General Life Insurance Co. Initially, he named his wife and mother as beneficiaries. On March 11, 1979, in the presence of a witness, Mr. Balsley executed a change of beneficiary

form designating his daughter as the new beneficiary. He left the form with his daughter saying he would return to get it and deliver it to his employer.

The policy showed that in order for a change of beneficiary to be effective, the insured would file a change form with the employer. Mr. Balsley, however, did not return the form to his employer.

Mr. Balsley died unexpectedly on March 18. Two days later his daughter mailed the form to his employer. In this action, Connecticut General sought guidance from the court as to which should be the beneficiary. The trial court ruled against the daughter.

The appellate court reversed. The court noted that there was no hint of fraud or duress in the execution of the form or evidence that Mr. Balsley had changed his mind. Given these circumstances, his failure to deliver the form to his employer the week after it was executed was, according to the court, not a strong argument against giving effect to the document. *Connecticut General Insurance Co. vs. Balsley*, U.S. Court of Appeals for the 7th Circuit, Jan. 11, 1982 (BI/01/S.-\$5).

No action clause

The fact that an insurer acquiesced to a settlement negotiation process without objection was not in any way inconsistent with its position that it could only be bound by the final product of such

negotiations if it consents in writing, according to a Texas appellate court.

This controversy arose out of a contract between Munster Steel Co. and a customer it agreed to provide with structural steel for a building project. The customer found the steel unsatisfactory and withheld payment. Munster sued on the account and the customer countersued for costs incurred in bringing the steel within specifications and for construction delay expenses.

The Travelers Indemnity Co. insured Munster. The policy required that before action could be brought against The Travelers, the amount of the obligation to be paid had to be determined either by a judgment against the insured or by a written agreement. Munster settled with the customer with full notice of the proposed settlement agreement given to The Travelers. However, no written agreement was obtained from The Travelers. Munster lost its suit against The Travelers in the trial court.

The appellate court rejected Munster's argument that the fact that it kept The Travelers informed of the settlement negotiations and their failure to object constituted a waiver of the requirement that Travelers consent in writing to the settlement agreement. *Munster Steel Co. vs. Travelers Indemnity Co.*, Court of Civil Appeals of Texas, July 15, 1981 (BI/03/M.-\$5).

A copy of the entire decision may be obtained by sending \$5 to Cases Unlimited, in care of Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the case number.

Now is the right time to consider competitive bidding

By Edgar W. Armstrong

THIS IS ABSOLUTELY the best, most receptive market for financial institutions' insurance I have ever seen. This comes as no surprise to most insurance professionals. But do they even know just how good it is? More specifically, does the average banker know what can logically be expected from competitive bidding of his insurance program today?

I have a lot of opportunities to be involved in competitive bidding situations and the results have been little short of incredible this past year. Within reason, a banker can get virtually anything he or she may ask for.

I have asked for the "moon" in scope of coverage and have almost always gotten it, more than I had any right to expect in the previous market situations, and at unbelievably low rates.

One interesting aspect of this unique market is the way it varies. Quotations come in from nearly all over the map.

You can't be sure what an insurance company's quote is going to be until you actually see it. I really haven't been able to find a pattern for any one insurance company or any one insurable risk. For example, the quotations for bankers blanket bond coverage for a commercial bank in the billion-dollar asset range in April were:

- \$186,000 annually.
- \$150,000 annually.
- \$107,000 annually.
- \$85,000 annually.
- \$50,000 annually.

The range, from \$50,000 to \$186,000, was so wide it was almost unbelievable—and from insurers that you would expect to be using approximately the same rate basis. It is another outgrowth of the extremely competitive pressures we see in today's insurance market.

But those were for the bankers blanket bond alone. Let me give you the package quotations for the same bank. Now remember, this bank has assets in excess of \$1 billion. The owned property value exceeds \$25 million and the quotations include coverage for fine art, extra expense, demolition and increased cost of

construction, loss of rents, valuable papers and broad-form general liability endorsement. We obtained the following quotations:

- \$30,000 annually.
- \$29,000 annually.
- \$26,000 annually.
- \$23,000 annually.
- \$17,000 annually.

The bank had been paying \$45,000 for much less coverage. It's another indication of what is available to the banker in this market today.

Why is the insurance market so competitive? Why are such attractive quotations available to the banker knowledgeable enough to take advantage of them?

The answer is fairly simple. Interest income in today's financial markets has enabled underwriters to absorb substantial underwriting losses. This has created intense competition among insurance underwriters. The beneficiary, at least for the present time, is the insurance buyer.

Bidding, however, is not for everyone. I know most bankers realize the adverse consequences to bidding insurance too often. That is, you will lose long-term brokerage relationships, brokers might become discouraged and not be interested in the bank's insurance business and finally, brokers realizing that the program will be bid at every renewal date will add start-up costs to their quotations to protect their own financial interests.

Generally speaking, programs should not be bid any more often than every six to nine years unless for some reason you are unhappy with your brokerage services or you run into a market as receptive as that available today. If a banker hasn't bid this program recently, he should make sure he has a good reason for not doing so. I don't know when there will be a better chance to optimize an insurance program.

The potential benefits of bidding an insurance program are to:

- Increase the scope and quality of insurance coverage.
- Lower premium cost.
- Improve present and future bargaining positions with brokers and insurers.
- Find out, by comparing proposals, just who the best agent in town really is.
- Consolidate the risk management program more thoroughly.

What concessions should a banker be able to reasonably expect from bidding this program in today's receptive market? Let me list a few that I know bankers can expect because we have been able to get them on a

fairly regular basis:

- A broad named insured on all policies.
- Ninety-day cancellation notices.
- Free physical appraisals by professional engineers.
- A loss-control manual with the services of and prepared by a professional engineer.
- Computer financial reports, including: five-year risk experience, total cost of risk reports, target loss status reports and a cost allocation system.

We have also found that umbrella insurance can be obtained with no self-insured retention or deductible layer.

Although I won't go through all the mechanics of a bidding situation, there are several specific points you should be aware of in any bidding process:

- Limit the number of brokers so participants will feel they have a good chance at your business and give it their best shot.
- Assign each broker specific markets. Insurers are always suspicious when approached for the same bank's business by more than one brokerage representative.
- Don't try to assign reinsurance markets.
- Allow brokers to improve on specifications you prepare. Brokers can be very inventive, particularly in competitive situations. It is not to your advantage to hamper their ability to improve on the policy's specifications.
- Make sure you know what the broker's income will be from the insurance program so that the broker and you will be aware of what you are paying for his or her service.
- Be specific about services you require like: cost allocation, appraisals, safety engineering and claims reviews.
- Make it clear to the bidders that you don't intend to put the program out to bid every year or two. You are looking for a long-term relationship with the best brokerage partner you can find. If the brokers know this and you handle your bidding process professionally and fairly, you should be able to expect to obtain the best advantages in today's extremely receptive insurance marketplace.

To briefly summarize, you won't find a more receptive insurance market than the one that exists today. If you work it correctly, you should be able to obtain virtually every reasonable request you make in today's market.

Hence, you have a unique chance to consolidate insurance coverages and make sure you have the best in scope of coverage, premium cost and brokerage/underwriting services.



Edgar W. Armstrong is a consultant with The Wyatt Co. in Washington, D.C.

Proper management makes good security better

By Belden Menkus

"Corporate and Industrial Security"
By A. Lewis Russell
Butterworths, 10 Tower Office Park,
Woburn, Mass. 01801
288 pages, \$19.95

A GOOD SECURITY program seeks to protect the company in all its parts and in all its activities—in an operational sense, then, security transcends all departments within a company. The program should protect personnel, plants, offices, equipment, material, operations, methods, procedures... even the company's reputation and good name."

books & ideas

That's the philosophy propounded in this book. The author, now retired, was the architect of what may be the most comprehensive and efficient corporate security in the world—that of Exxon Corp. Mr. Russell spent 35 years there; he has drawn heavily on that experience in this book. Its contents reflect the perspective of international operations in unfriendly nations. Fire protection examples are drawn, naturally, from the author's petroleum industry background.

This also leads Mr. Russell to an extensive discussion of a long-standing problem in that industry—business

espionage and the protection of sensitive, proprietary corporate information. (Sadly, there is almost no mention of the role insurance plays in a corporate security effort. Perhaps this omission reflects Exxon's apportionment of corporate duties while the author was there.)

Mr. Russell quite properly presents the corporate security program as one of the basic management tasks. He places strong emphasis in this context on the planning and evaluation aspects of the conventional managerial role. Thus, the book opens with a discussion of how threats to an organization's security may be identified

and evaluated. This is followed by an explanation of how to organize a staff charged with resolving those threats. Here, a model organization chart and charter are presented. In this vein, the book contains a number of helpful evaluation and planning checklists and policy statement samples.

The book, written by an unquestioned expert on corporate security, presents the subject in a clear, straightforward manner. It will be valuable to the risk manager who has just become responsible for corporate security activities or who must establish such a function.

Belden Menkus is a security consultant in Middleville, N.J.

Utility pool cuts costs, broadens coverage

Continued from page 2

North Attleboro currently pays an annual premium of \$19,562 for its property, fire, general liability, excess liability, fidelity bond, valuable papers, data processing, directors and officers and boiler and machinery coverages.

The coverage includes a package policy combining \$2 million of property insurance, \$500,000 of fire insurance and \$100,000 of general liability insurance. The package with a \$1,000 aggregate self-insured retention costs \$7,422 annually.

The utility also buys a \$1 million boiler and machinery policy for \$1,850 annually.

A \$10 million excess liability policy that North Attleboro buys through the pool costs \$9,790. The \$5 million directors and officers policy, with a \$20,000 retention, was included in the excess liability package at no additional cost, according to Mr. Port.

Before joining the pool, the utility purchased a boiler and machinery policy at half the new policy limit—\$500,000—and at a higher price of \$2,120 annually.

The utility's former excess liability insurance also went only half as high and was written in two layers with no directors and officers coverage. It cost an annual premium of \$7,045.

Smaller savings were realized on the additional insurance policies purchased by North Attleboro. A \$50,000 data processing policy that provides replacement costs coverage for any physical damage to its computer or related accessories, a \$10,000 valuable papers policy protecting the loss of any important documents and a \$25,000 fidelity bond were purchased for \$500 annually, \$200 less than North Attleboro previously paid.

All of the coverages offered by the pool, except excess and directors and officers liability, are underwritten by Continental Insurance Co. The excess liability and D&O coverages are underwritten by Evanston Insurance Co. in Evanston, Ill.

Besides cutting costs, the pool offers some utilities hard-to-get liability coverage.

Taunton Municipal Lighting Plant, a utility serving 22,000 customers, went without insurance for a very brief period when no insurer wanted to provide a policy.

"In 1976," recalls William O'Connor, the utility's assistant general manager, "there was an apparent reluctance on behalf of insurers to offer general liability to small utilities. Suddenly, our insurer told us it no longer would cover us. We weren't able to get any general liability coverage because of our size.

We couldn't get coverage and there had never been a claim."

The coverage cancellation came at an inopportune time, recalls Mr. O'Connor. "We were making a \$24 million expansion and we knew we needed to have liability coverage."

Fearing the exposure, the Taunton utility began establishing reserves to self-insure against potential claims. However, those reserves—approximately \$200,000—had to come from operating revenues, not from a rate increase.

"The NEPPA program came around at the right time," explains Mr. O'Connor, whose utility joined the pool 1976.

Taunton currently spends \$500,000 annually for an insurance package that includes property, fire, general liability, directors and officers and excess liability coverage.

The utility also purchases its insurance in a three-year package on which it prepaies its premiums, locking in lower rates and becoming eligible for additional discounts.

"We save \$30,000 a year just on general liability alone," explains Mr. O'Connor.

Taunton, Mr. O'Connor explains, carries a \$100,000 self-insured retention on a \$10 million general liability policy. It carries a \$10,000 retention on a \$5 million directors and officers policy, a coverage it was not able to buy until it joined the pool.

Taunton also has a \$10 million excess liability policy and a \$50 million property and fire package.

Mr. O'Connor counts among the advantages for Taunton to purchase insurance through the pool:

- Being able to obtain types of coverage it never was able to buy before.
- Much lower premiums.
- Fixed rates.
- Lower deductibles or self-insured retentions.

Although the NEPPA has helped the utilities buy additional coverages, the pool does not offer workers compensation, life, health and short-term disability insurance. By Massachusetts law, such policies must be purchased by the local municipality, explains Mr. Stockford, NEPPA's general manager.

But, in hope of getting better control of their entire insurance programs, some small municipal utilities have started to lobby for legislation that would allow them to purchase life, health and workers compensation insurance themselves.

North Attleboro already has begun entertaining quotes for its own dental coverage.

Pooling is the answer: Consultant

NEW YORK—Despite the soft insurance marketplace, it's often difficult for small electric utilities to obtain the proper insurance coverage they need.

Their lack of adequate safety personnel and cash flow—along with exposures like electrocution, explosions, blackouts and brownouts—make most insurers shy away from the small utility market, says Frederick Abdo, a vp with Ebasco Risk Management Consultants Inc. in New York.

Even in today's market in which insurers usually will undertake most any risk to generate more premium volume, small utilities still tend to be underinsured. And if they manage to find coverage, they're hit with high premiums, Mr. Abdo says.

With that prospect, it's increasingly important for small utilities, public or private, to pool their resources.

"By going out on their own, they're (small utilities) going to run into the problem of high minimum premiums, which they often can't afford," explains Mr. Abdo. "It's important for the small utility to become part of a group or a larger association. Together, they'll do better in price."

But low rates should not be their only objective

when pooling, warns Mr. Abdo.

"Price is one thing, but proper coverage is another thing."

Small utilities, because of their size and potential exposures, usually have trouble obtaining excess liability insurance to protect against catastrophes, he says. They also can find it difficult to purchase boiler and machinery insurance to protect their turbine generators and related machinery and directors and officers coverage to protect trustees, board members and other officials from lawsuits.

And in some cases, buying primary liability coverage is a hard bargain.

The Taunton Municipal Lighting Plant, a small Taunton, Mass., power company with 22,000 customers, was forced to self-insure against potential liability claims several years ago because its former liability insurer cancelled its coverage despite the utility's good loss experience. The utility has since joined a pool (see related story).

Another small utility firm, Mr. Abdo says, couldn't purchase liability coverage because "they couldn't get enough money in their budget to purchase it."

datebook

AUG. 25-27. Safety for the Oil Field Industry seminar in Houston, sponsored by the International Safety Academy; \$375. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77024.

AUG. 29-SEPT. 1. Corporate Benefit Management conference in Hershey, Pa., sponsored by the International Foundation of Employee Benefit Plans; members, \$470; non-members, \$545. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

SEPT. 3. The Ergonomics in Accident Prevention and the Prevention of Back Injuries conference in Anchorage, Alaska, sponsored by Alaska National Insurance Co.; \$95. Ken Burns, 7001 Jewel Lake Road, Anchorage, Alaska 99502; 907-248-2642.

SEPT. 9-10. Fundamentals of Insurance course in Chicago, sponsored by the Risk & Insurance Management Society Inc.; members, \$345 (\$195 for each additional registrant from the same company); non-members, \$445. Claudia Shneider, RIMS School Administrator, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 10-11. Occupational Disease Litigation program in New York, sponsored by the Practising Law Institute; \$325. Also Oct. 15-16 in San Francisco. Practising Law Institute, Department ZKC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5703.

SEPT. 12-15. International Benefits seminar in St. George's, Bermuda, sponsored by the International Foundation of Employee Benefit Plans; members, \$470; non-members, \$545. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

SEPT. 13-14. A Total Systems Approach to the Occupational Back Injury and Cost Control Problem seminar in San Francisco, sponsored by Back Dynamics Institute; \$745. Back Dynamics Institute, Box 8104, Foster City, Calif. 94404; 415-574-1087.

SEPT. 13-15. Techniques of Risk Management course in Washington, sponsored by Risk & Insurance

Management Society; members, \$345 (\$195 for each additional registrant from the same company); non-members, \$445. Claudia Shneider, RIMS School Administrator, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 13-17. Fundamentals of Money Management workshops in Philadelphia, sponsored by the Wharton School of the University of Pennsylvania and the International Foundation of Employee Benefit Plans; members, \$650; non-members, \$775. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

SEPT. 13-17. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; \$535. Also Oct. 4-8. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77024; 713-932-9400.

SEPT. 13-24. Insurance Management course in Long Grove, Ill., sponsored by Kemper Group; \$900. Chris Miller, Education, F-6, Kemper Group, Long Grove, Ill. 60049; 312-540-2884.

SEPT. 13-16. Crossroads for Security program in Atlanta, sponsored by the American Society for Industrial Security; members, \$220; non-members, \$295. Patricia Rivers, ASIS, 2000 K St. N.W., Suite 651, Washington, D.C. 20006.

SEPT. 14-15. General Liability Insurance conference in Philadelphia, Pa., sponsored by the International Risk Management Institute; \$295. IRMI, 10300 N. Central Expressway, Building III, Suite 208, Dallas, Texas 75231.

SEPT. 16. Targeting Results in Risk Management Communications workshop in Culver City, Calif., sponsored by Barbara Y. Akk & Associates; \$95; \$75 for additional persons from the same company. Barbara Y. Akk & Associates, 33 Sequoyah View, Oakland, Calif. 94605.

SEPT. 16-17. Occupational Noise and Hearing Conservation: Compliance with the New Laws course in Los Angeles, sponsored by the University of Southern California; \$200. University of Southern California, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90007; 213-743-6523/24.

SEPT. 16-17. Human Factors Engineering for Controlling Hazards course in Washington, sponsored by the International Institute of Safety & Health; \$295; \$250 for three or more are registered from the same company. IISH, 5010A Nicholson Lane, Rockville, Md. 20852; 301-984-8969.

SEPT. 16-17. Ergonomics course in Occupational Safety and Health in Los Angeles, sponsored by the University of Southern California; \$225. USC, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523.

SEPT. 16-17. Fifth Annual Aviation Law-Insurance symposium in Orlando, Fla., sponsored by Embry-Riddle Aeronautical University; \$250. Professional Programs, E-RAU, Star Route Box 540, Bunnell, Fla. 32010; 904-672-3439.

SEPT. 20-21. Financial Considerations of Managing Offshore International Insurance Companies seminar in Bermuda, sponsored by Tillinghast, Nelson & Warren Inc.; \$500. Frederick O. Kist, 3340 Peachtree Road, Suite 2000, Atlanta, Ga. 30026; 404-261-5420.

SEPT. 20-21. Outlook for Independents: Strategies for the '80s conference in Houston, sponsored by The Energy Bureau Inc.; \$695. Robin St. George, The Energy Bureau, 41 E. 42nd St., New York, N.Y. 10017; 212-687-3178.

SEPT. 20-22. Risk and Insurance Management conference in Chicago, sponsored by the American Management Assns.; members, \$405; non-

members, \$465. Registrar, AMA, 135 W. 50th St., New York, N.Y. 10020; 212-586-8100.

SEPT. 20-22. Employee Benefits Management conference in Chicago, sponsored by the American Management Assns.; members, \$405; non-members, \$465. Registrar, AMA, 135 W. 50th St., New York, N.Y. 10020; 212-586-8100.

SEPT. 20-24. Total Loss Control Management seminar in Boston, sponsored by the International Safety Academy; \$570. Also Oct. 11-15 in Boston. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77024; 713-932-9400.

SEPT. 21. Safety/Loss Control: Plan, Design and Evaluation seminar in Seattle, sponsored by the International Safety Academy; \$150. Also Oct. 14 in Seattle. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77024; 713-932-9400.

SEPT. 21-23. Fundamentals of Reinsurance seminar in Dallas, sponsored by the Risk Management Institute; \$445. Professor Bruce Evans, University of Dallas, Risk Management Institute, International Center, University of Dallas Station, Irving, Texas 75061; 214-721-5299.

SEPT. 23-24. Quantitative Techniques for Risk Management seminar in San Francisco, sponsored by The College of Insurance; \$495. Also Dec. 2-3 in Newport Beach, Calif. Margaret Wilder, The College of Insurance, 123 William St., New York, N.Y. 10038; 212-962-4111.

SEPT. 23-24. Black Lung Liability Under the New Legislation conference in Arlington, Va., sponsored by The Energy Bureau Inc.; \$695. Barbara Louis, The Energy Bureau, 41 E. 42nd St., New York, N.Y. 10017; 212-687-3178.

SEPT. 23-24. Radiation Protection of the Public in a Nuclear Accident course in Washington, sponsored by the International Institute of Safety & Health; \$295; \$250 if three or more are registered from the same company. IISH, 5010A Nicholson Lane, Rockville, Md. 20852; 301-984-8969.

SEPT. 23-25. Depositions in Corporate Litigation seminar in San Francisco, sponsored by the Practising Law Institute; \$425. PLLI, Department YWC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

SEPT. 27-29. Loss Control for Risk Management seminar in Houston, sponsored by the International Safety Academy; \$375. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77024; 713-932-9400.

SEPT. 27-30. Captive Insurance Companies: Establishment, Operation and Management conference in Hong Kong, sponsored by Risk Research Group Ltd.; \$25 pounds; \$500 pounds for subsequent participants from the same company. Sue Moore, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD, England; 01-236-2175; telex 8811636.

SEPT. 28. Workers Compensation and Workplace Liability conference in Harrisburg, Pa., sponsored by the Pennsylvania Chamber of Commerce; \$65. Tim Holt, Manager of Compensation and Casualty Insurance, Pennsylvania Chamber of Commerce, 222 N. Third St., Harrisburg, Pa. 17101; 717-255-3271.

NOV. 1-2. Communicating Employee Benefits conference in Chicago, sponsored by Business Insurance; \$475; 10% discount for additional participants from same company. Ann Vazquez, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

NOV. 3-4. Risk Financing seminar in Chicago, sponsored by St. Paul Risk Services Inc.; \$335. Kathleen Moriarty, St. Paul Risk Services Inc., 230 Hamm Building, 408 St. Peter St., St. Paul, Minn. 55102; 612-221-7763.

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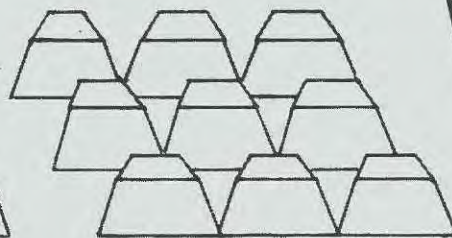
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	ISSUE DATE	AD CLOSING
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	SEP 6	Aug 25
MARINE INSURANCE: IIAA Convention	SEP 13	Aug 31
Risk Management Board Survey	SEP 20	Sep 8
EMPLOYEE BENEFITS: PERSONNEL ADMINISTRATION	SEP 27	Sep 14
	OCT 4	Sep 22
FINANCIAL SERVICES: FOR CAPTIVES & SELF-INSURERS	OCT 11	Sep 28
Employee Benefits Board Survey	OCT 18	Oct 6
REINSURANCE: NAI Conference	OCT 25	Oct 12
	NOV 1	Oct 20
NEW ENGLAND MARKET REPORT	NOV 8	Oct 26
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	DEC 6	Nov 23
EMPLOYEE BENEFITS: IN RETROSPECT	DEC 13	Nov 30
Employee Benefits Board Survey	DEC 20	Dec 8
	DEC 27	Dec 15

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California lets health insurers negotiate rates

Continued from page 3

doesn't cover costs, these will be passed on to others not under contract," says John C. Wilson, manager of employee benefits and safety at DiGiorgio Corp. in San Francisco, a consumer goods and land resources company that self-insures its employee health benefits.

"I think there should be pressure to keep costs down, but not by giving discounts to preferred customers," Mr. Wilson says.

DiGiorgio employs about 2,500 people in California, but their biggest plant has only 200 employees in it. "If we were concentrated, we would be a major factor in that market," he notes.

"We might be able to use our administrative services contract with The Travelers as clout, but that's not fair, either," he adds, while also noting that such a decision could bring pressure to bear against a self-insurer that handles its own claims services.

Charles King, corporate manager of compensation benefits for Foremost-McKesson Inc. in San Francisco, is also concerned about his company's ability to negotiate for cheaper services. "We aren't centralized at all," he says, noting that only 750 out of the company's 17,000 employees are in the Bay Area.

"We don't know how many employees go to each doctor. All this works against finding a focus for negotiations," Mr. King said.

Although some self-insurers have expressed their reservations about the legislation, it has attracted wide support.

Lewis Keller, president of the Assn. of California Life Insurance Cos., which backed the bill along with Blue Cross of California, says that business coalitions, labor, taxpayers' organizations and chambers of commerce were all in favor of the legislation.

"We think it offers a lot of possibilities for health care cost savings. I don't know how much," he adds, pointing out that insurance companies are still prohibited from pooling and must enter into each of the contracts as an individual company.

"There's a great potential for savings by simplifying the process of delivering cash to hospitals. If insurance companies can get the money faster to the hospitals, they'll get a better deal on the price," says Alexander Grieve, vp of the consulting firm Towers, Perrin, Forster & Crosby in San Francisco.

But along with the possibility for real savings by delivering more efficient financing mechanisms, the

legislation poses some tremendous potential liabilities, he warns, including:

- Will a hospital start delivering less adequate care for a reduced rate?

- If a patient feels mistreated, will medical malpractice suits against the provider be the result?

Others groups also have expressed misgivings about the bill. For example, the California Hospital Assn. "tried to eliminate the private-insurance amendment" to the legislation, according to a spokesman, although it did not take a position on the other bill that also allows Medi-Cal to negotiate provider rates.

"This could mean the end of freedom of choice for private patients. It depends on how far they go," the spokesman says. "Employers welcome it because they want to quit subsidizing Medi-Cal, but we'll probably end up with Medi-Cal and non-Medi-Cal hospitals as a result."

A very real possibility, he says, is that a difference will develop in medical care between the two types of hospitals. "We could develop a no-frill hospital with basics only. We have in recent years made hospitals more and more alike. Most were brought up to a certain level of care, but now we would develop levels of distinction," the spokesman predicts.

"Quality and amount of care, which have not been issues in the recent past, are likely to become issues," he says.

The question of quality of care is of grave concern to Robert Burnett, president-elect of the California Medical Assn. "If a doctor has to answer to a corporation president, the potential for decreasing quality is there," he says.

The California Medical Assn. is actively promoting additional legislation to fill in what are perceived to be legal loopholes in A.B. 3480. "The legislators wanted a quick fix and were very shortsighted," Dr. Burnett says.

One of these shortcomings, according to Bruce Dizenfeld, editor-in-chief of the California Health Law News and a member of the California Society of Health Care Attorneys, is that it is not readily apparent what is meant by "alternative rates."

Mr. Dizenfeld also notes that the California Department of Insurance has had no involvement in the preparation of the legislation and in fact did not know there was a major insurance component in the legislative package until 30 minutes before the bill hit the committee floor.

New law could prompt new policies

SACRAMENTO, Calif.—The new health care competition law in California not only allows insurers to negotiate discounts with health care providers, but also could prompt significant changes in the policies that health insurers in the state now offer.

The law allows insurers to offer policies that limit consumers' choices of health care providers to those that negotiate contracts with the insurer.

Insurance companies say they have not yet prepared new policies according to the law, and California benefit managers can now only guess at the changes that will be made.

However, the California Council of Employer Health Care Coalitions has invited insurers to a meeting next month to offer its members' perspectives on the new law and any policy changes they will make.

"I'm very hopeful that our concerns will be answered positively," says George Gamble, president of the council.

One type of policy that has been suggested would limit consumers' choices of hospitals or doctors in exchange for lower rates.

"This is not a replacement for a full free-choice policy," says Emery (Soap) Dowell, assistant to the president at Blue Cross of California. "This is an alternative product of interest to some customers and some providers."

Mr. Dowell predicted that insurers, under the new California law, could develop two- or three-tiered policies:

- The most costly would allow employees to choose whichever hospitals or doctors they desire, as most present policies do.

- A less-costly policy would provide 100% coverage if an employee received treatment from a health care provider that had a contract with the insurer. If the employee chose a provider that was not under contract, the coverage would be reduced to 80%.

- The least-expensive policy would require an employee to seek treatment from a health care provider that was under contract with the insurer.

"Heretofore we've been unable to sell anything but Cadillacs," Mr. Dowell explains. "Now we'll be able to sell Buicks."

Coalition opposes bill to free doctors from FTC authority

By JERRY GEISEL

washington

WASHINGTON—The Washington Business Group on Health is opposing pending legislation that would strip the Federal Trade Commission of its authority to stop doctors and dentists from price fixing and other anti-competitive practices.

The bill, S. 2499, introduced by Sen. Robert Kasten, R-Wis., and currently pending on the Senate floor, would exempt certain professionals, including doctors and dentists, from FTC regulation (BI, June 28).

While the Washington Business Group on Health, whose employer members provide health insurance coverage to 55 million people, says it wouldn't normally rush to the defense of the FTC, it does admit that Sen. Kasten's bill is a special case.

"The proposed exemption is in total contradiction to our goals of reducing the rate of health care cost escalation and increasing real price and service competition in the health care marketplace," said Willis Goldbeck, the group's executive director.

If Sen. Kasten's proposal—which is attached to the FTC reauthorization bill—is enacted, future FTC initiatives that could control some

health care costs may have to be scrapped.

For example, the FTC is currently studying restrictions that prevent dentists from delegating certain tasks to specially trained auxiliaries.

War on regulation

The Reagan administration says it is winning its war against excessive paperwork and government regulations.

It has reduced the size of the Federal Register—the daily digest of government rules—by one-third and cut down the number of new rules by about half, according to the Office of Management and Budget.

In addition, the administration contends that it has reduced by 200 million hours the paperwork burdens imposed on employers by the government.

Money fund theft

The Securities and Exchange Commission earlier this month censured the manager of Washington's largest money market fund for lax accounting procedures that allowed an employee to allegedly embezzle \$1.55 million last year (BI, Dec. 7, 1981).

The SEC reprimand of Government Securities Management Co., manager of First Variable Rate Fund for Government Inc., means that First Variable will have to

have its accounting procedures scrutinized by independent auditors through 1984.

First Variable, which has assets of \$1.46 billion, was able to recover the embezzled funds when it traced the money to a Swiss bank account of a boyfriend of a former First Variable employee.

First Variable, which had about \$1.5 million of fidelity insurance from Federal Insurance Co. of Short Hills, N.J., at the time of the theft, never filed an insurance claim because the management firm covered the loss until the money was returned.

Crash inquiry

The National Transportation Safety Board will hold a public hearing on Sept. 14 in New Orleans as part of its investigation into the July 9 crash of a Pan American World Airways 727 jetliner in Kenner, La., that killed 154 persons.

Witnesses at the hearing, which will begin at 9 a.m. at the Hilton Airport Inn, are expected to include officials of the Federal Aviation Administration, Pan Am, Boeing Aircraft Co. and the National Weather Service.

The Pan Am jet crashed during a storm shortly after takeoff from New Orleans International Airport. Of the 154 people who died in the crash, 146 were passengers on the jet and eight others were on the ground.

Royal trinkets not covered

Continued from page 2

says, "To commemorate the birth of Prince William of Wales, 21st June, 1982."

Nearly 10,000 pieces are being sent to Canada, said Mr. Sanders, which is the largest overseas market. And he said he recently received an inquiry from a woman from Columbus, Ohio.

"They are having a British week there and they want some of these," he explained.

Royal Doulton, which is also making Prince William memorabilia, doesn't buy non-appearance insurance, said a spokeswoman,

who added that the company really doesn't need to. The basic shapes of the products are always the same for any royal occasion, she said, "so we just fill in the information."

Any mishaps, and Royal Doulton can use the products for another occasion.

A Royal Doulton derby cup embossed with Prince William's name costs 70 pounds (approximately \$119) and is limited to an edition of 500. Doulton is also selling a loving cup at about 20 pounds (\$34), a plate at about 30 pounds (\$51) and crystal goblets at 75 pounds (\$128) in limited editions.

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Small firms hit with big health rate hikes

Continued from page 1
Pacific Mutual.

In addition, some insurers that couldn't increase rates fast enough to keep up with big increases in health care costs are scrapping 12-month policies in favor of plans that only allow small employers to lock in rates for six months.

In May, for example, Mutual Benefit Life Insurance Co. of Newark, N.J., which insures 24,000 employers with three to 50 employees through its Charter Series plans, shifted to six-month policies.

"We don't want to get caught (by health-care inflation) like we did late last year," Senior Vp John Antliff explained.

Other large insurers that dominate the small-employer health insurance market—including Aetna Life & Casualty Co., the Connecticut General division of CIGNA Corp., The Equitable Life Assurance Society, John Hancock Mutual Life Insurance Co. and The Travelers Insurance Cos.—say they have imposed rate hikes averaging 23% to 30% on both small and large firms.

But, these rate increases have caused more pain at smaller firms, which usually have more difficulty absorbing health insurance cost hikes than larger companies.

Those hefty rate hikes are forcing small employers to try new

health insurance options, like higher deductibles, to keep costs down, insurers say.

During the second quarter of 1982, for example, Mutual Benefit Life's Mr. Antliff said that more small employers opted for plans with \$300 deductibles than plans with \$100 deductibles.

Just last year though, more than twice as many small firms selected plans with the traditional \$100 deductible than the \$300 deductible.

Small employers are choosing plans with higher deductibles for good reason. Mutual Benefit Life, for example, can cut rates 22% for employers that opt for a \$300 deductible instead of a \$100 deduct-

ible.

Other employers are cutting benefits, like dental coverage, which they added to their plans when the economy was more robust.

"Small employers are doing whatever they can to stay afloat economically," said George Sutherland, director of marketing at Connecticut General.

And insurers like Prudential and Pacific Mutual, which have lost tens of thousands of small employers to competitors since 1980 when they raised rates above the industry norm, are overhauling their plans in an attempt to regain market share.

This fall, Prudential will unveil new small-employer plans that will include higher deductibles and coinsurance. However, the plans will offer less protection from frequent rate hikes.

Prudential also plans to check more frequently on agents and brokers selling its small health insurance plans to verify that underwriting standards are being met. "We have a lot of holes to plug," Richard Drake, vp and associate actuary, candidly admits.

Prudential's recovery from its huge losses in the small-employer health insurance market isn't going to be easy.

Currently, Prudential is trapped by what Mr. Drake calls "anti-selection." This occurred when Prudential's best risks fled to competitors when the insurer imposed those 50% and 60% rate hikes.

For example, just in the last year, the number of people enrolled in Prudential's Employee Benefit Program, which covers employers with two to nine employees, plunged to 220,000 from 375,000.

Those employers remaining in the program often were the poorest risks that filed the most claims. This caused Prudential's experience to deteriorate further, causing additional rate increases.

Pacific Mutual also blames lax underwriting for major rate hikes. "You could have had one foot in the grave and still be covered," Mr. Doerr said.

But Pacific Mutual now prescreens employers with fewer than six workers to make sure it isn't

about to cover employees' pre-existing medical conditions.

Many insurers, though, say that small employers, like bigger firms, shouldn't expect relief soon from large rate increases.

For example, Equitable, which during the last year raised rates paid by small employers in the Equi-Group program by an average of 23% to 26%, anticipates rate hikes of 28% to 30% in 1983.

"I don't see the cost of claims abating one bit," adds Connecticut General's Mr. Sutherland.

Factors that have forced insurers to continue to boost rates include:

- Cost shifting onto employers from Medicare and Medicaid programs, which do not fully reimburse hospitals for costs incurred by patients covered by the programs. Hospitals try to recover these losses by charging private patients more.

- "Cost shifting may account for 5% to 8% of a rate hike," said Mutual Benefit Life's Mr. Antliff.

- An increase in expensive medical treatments. "Ten years ago, for example, open-heart surgery was rare," said Don Schwartz, head of Equitable's Equi-Group department in New York.

- Continued fears about layoffs, which lead employees to seek medical treatment before they lose their jobs and their health insurance coverage.

However, there is one glimmer of light that continues to illuminate a health insurance picture that's been darkened by big rate hikes and tougher underwriting standards: Health insurers are convinced they can make money writing policies for small employers.

"We have a commitment to providing health insurance to groups of all sizes. We feel we can do it, rather than the federal government," said Sue Parent, director of marketing employee benefits at Aetna Life & Casualty in Hartford, Conn.

"The business is marginally profitable. It will never be a very big profit maker. But it gives insurers' agents the entry they need to sell more profitable products, like pension plans, to small firms," one insurance company executive says. ■

Lilly could face big losses from recall of arthritis drug

Continued from page 3

and to comply with Great Britain's ban.

Insurers are reluctant to sell product recall insurance to cover such losses to large pharmaceutical companies, and if they do, premiums and deductibles are so high that the cost of the coverage is not feasible, several brokers explained.

"Product recall is nothing but extra-expense insurance," said Johnson & Higgins Vp Bob Roberts in New York. "With primary coverage, you are just swapping dollars."

"The number of recalls companies institute themselves make it a constant process," he said. "Most consider it as part of their business expense."

Myra Tobin, managing director of Marsh & McLennan Inc. in New York, said that while recall insurance is available, her experience indicates "it is so expensive that almost nobody is buying it."

"And from an underwriter's perspective, typically pharmaceuticals have been viewed as one of the more hazardous types of exposure."

Because of the high risk of liability suits, major pharmaceuticals carry liability coverage with deductibles or retention levels ranging from \$5 million to \$20 million. The \$20 million level is becoming increasingly common, say brokers.

Coverage limits for the drug-makers range to \$300 million and higher, they say.

The Lilly spokesman would not comment on the company's liability insurance coverage.

Oraflex, which has been marketed in Great Britain for nearly two years, was introduced in the United States three months ago. Since that time there have been 11 deaths among Oraflex users reported to the FDA.

Three public interest groups petitioned the FDA and the Department of Health and Human Services to have the drug permanently banned after the British government reported deaths among Ora-

flex users.

Then on Aug. 2, just two days before Lilly pulled Oraflex off the U.S. market, the groups jointly filed suit in federal court against the FDA, the Department of Health and Human Services and HHS Secretary Richard Schweiker, seeking to force quick action on the Oraflex issue.

Justice Department attorneys for the government in the case are expected to file an answer within 60 days.

Exactly what Lilly's next step will be is unclear, according to a company spokesman. However, drug industry observers speculate that the company's decision will hinge on what Great Britain does at the end of its 90-day review period.

Many major U.S. drug companies, which sell drugs with the same "non-steroidal, anti-inflammatory" classification as Oraflex, are watching the situation closely.

"It is too early to tell what effect the Oraflex situation will have on the long-term anti-arthritis products," said a spokesman for Warner-Lambert Co., headquartered in Morris Plains, N.J. A Warner-Lambert subsidiary markets such a drug.

There are approximately 10 to 12 other non-steroidal anti-inflammatory drugs on the market, according to the FDA.

"They all cause liver toxicity," said an FDA spokesman. "There is not one company that is exempt from this (the risk of fatalities), but all but Lilly's are still on the retail shelf."

The 11 U.S. deaths among Oraflex users still are under investigation by the FDA, but according to the spokesman "those aren't totally and irrevocably tied to Oraflex. Most of those individuals were taking four or five other prescription medications in addition to Oraflex."

"We are monitoring Lilly's recall," he said. "We have essentially two interests, insuring that it's recalled and still trying to find out what happened in Great Britain."

The suit against the FDA, the Department of Health and Human Services and Mr. Schweiker—filed by the Public Citizen's Health Research Group, the American Public Health Assn. and the National Council of Senior Citizens—seeks to have Oraflex declared "an imminent hazard to public health" and barred from the market.

Diane Cohn, an attorney for the groups, said the suit would not be dropped even though Lilly recalled the drug since the company still retains the license to sell Oraflex.

The suit specifically targets Oraflex because of the high incidence of adverse reactions and deaths among its users, Ms. Cohn said.

"It is all a matter of degree," she said. "We compared statistics on all the drugs (in this class)."

The research, compiled by the Public Citizen's Health Research Group, an organization sponsored by consumer advocate Ralph Nader, indicated that the incidence of death among Oraflex users was "approximately equal to the total number of deaths among all the 10 to 12 other drugs combined and within a population size of 10 million for the other drugs compared to about a half-million Oraflex users," Ms. Cohn said.

In addition to the medical controversy surrounding Oraflex, Lilly is also being scrutinized for the way it reported findings on Oraflex and five other drugs to the FDA.

Hearings conducted by the House Intergovernmental Relations subcommittee, which concluded Aug. 3, centered on an FDA investigation into Lilly's research practices, including an internal FDA recommendation that criminal prosecution of the company be considered.

A former Lilly employee alleged to the committee that "Lilly has repeatedly failed to make required reports of important adverse findings" associated both with experimental drugs and products currently on the market.

Any decision on litigation against Lilly would rest with the FDA. "That investigation is still open and we cannot comment on it," an FDA spokesman said.

The committee's primary concern was with FDA procedural issues rather than the agency's scientific assessment of Lilly's products, according to a committee staff member.

"We are not in the business of second-guessing the scientific judgments of the agency," said the staffer. "We are looking at several procedures against the background of an FDA proposal to accelerate the approval process for a drug."

If the FDA should decide to prosecute Lilly, it would make a recommendation to the Justice Department for action. ■

Comp bill's chances slim

Continued from page 3

"This reflects little concentration in the marketplace and a high degree of competition," said Mr. Czech. "The proposal flies in the face of the facts and ignores other states' experience with monopolistic state funds," he added.

Only six other states—Nevada, Ohio, North Dakota, Washington, West Virginia and Wyoming—have monopolistic state funds for their workers compensation coverage.

"Monopolistic state funds are inherently inefficient because they

lack any financial discipline motivated by the profit incentive under a private insurance system," said Mr. Czech.

State funds often become political footballs and serve as a source of jobs for political appointees, not people who are experts in workers compensation administration, he added.

"The fund pays no premium taxes to the state the way private insurers do, and state taxpayers inevitably make up for the missing millions of dollars one way or another," he added. ■

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Stadium owners delay buying coverage

Continued from page 1

owners might have bargained in better faith to prevent a strike.

For this reason, Transport Indemnity Co. in Los Angeles stipulated in its offer of contingent strike insurance to stadiums that the coverage would become null and void if NFL owners or players obtained strike insurance, explained Vp Vince Reardon.

Transport Indemnity teamed up with Atlanta International Insurance Co., a unit of Alexander Howden Group U.S. Inc., to quote coverage for Anaheim, home of the Los Angeles Rams, and Tampa, but neither chose to buy.

Transport Indemnity withdrew from the market after mid-July. Atlanta International could not be reached for comment.

The NFL owners and players do not have strike insurance, confirmed a spokesperson at the NFL Management Council in New York. However, the 28 team owners have pinned down a \$150 million line of credit at Crocker National Bank in San Francisco to fund overhead expenses if there is a walkout (BI, April 19).

Most of the cities with stadiums that house NFL teams seem to have considered purchasing strike insurance, sometimes at the request of a city manager acting independently of the risk or stadium manager. The International Assn. of Auditorium Managers in Chicago passed information to member stadium managers about a program available through broker Frank B. Hall & Co. in Houston, which is very similar to programs quoted by other brokers.

"We're still looking," said Henry Saavedra, director of finance and administration for the Tampa Sports Authority, a local governmental agency. "We've had some presentations, but the premium was too high."

The 11 members of the Tampa Sports Authority's board were still huddling over at least one strike insurance proposal last week from

Frank B. Hall.

One program they rejected was offered by an independent agency in Tampa.

"Tampa came to us about two months ago and asked us what we could come up with," recalls Wayne Pflasterer, vp of Crowder Insurance Inc. It took 50 days to put together a program involving 13 domestic, Canadian, British and Mexican insurance companies.

Tampa Stadium, with a capacity of 72,000, nets revenues of about \$92,000 per game. Terms of the coverage included reimbursement of up to 100% of lost revenues with a two-game regular season deductible. Total premium cost would have been 16% of revenues for six games, or between \$88,000 and \$90,000. Claims payment would be made in six separate checks 30 days after each covered game.

Mr. Pflasterer says he quoted the coverage to about 20 stadiums, but none of them bought it. "They all decided the cost was too high." He believes that capacity is no longer sufficient to insure all the stadiums but that a market exists for a handful of stadiums willing to pay the price.

Crowder Insurance Inc. has placed strike insurance for a parking concessionaire with revenues totaling about \$850,000 from several different stadiums.

Among stadium owners that have rejected programs there remain varying degrees of interest in coverage if it were available at cheaper prices.

"We investigated and elected not to purchase," reports Charles F. Haas, acting risk manager for the city of Cincinnati, home of the Bengals. The city manager checked into it on his own, then the city financial officer and the risk manager got involved.

Two exhibition and two season games were part of the deductible. The third regular season game triggered the insurance, which would reimburse only about \$75,000 per lost game out of average per-game

revenues of \$125,000 to \$150,000.

The premium for the program would have been about \$100,000 for benefits worth a maximum of \$450,000, or \$75,000 times six games. "It wasn't worth it," summed up Mr. Haas.

The cities of Anaheim, San Diego and Seattle reached the same conclusion.

Marsh & McLennan made a presentation to Anaheim in March. "The city manager wanted it, but the City Council voted it down on a close decision," said Gary Hanson, vp in charge of the broker's Newport Beach, Calif., office.

At that time, coverage was available for eight, nine or 10 of the city's total of 11 regular season and exhibition Ram games. Anaheim could have opted for a one-, two- or

three-game deductible. Transport Indemnity and Atlanta International quoted the risk.

City risk managers in Seattle and San Diego said they had looked into the coverage and are interested in principle, but said the cost is too high.

"I would be interested, too, if the price were realistic," notes Jack Mathews, treasurer of the Chicago Park District, which owns Soldier Field, where the Bears play. The nearly \$2 million brought in by football is important to the park district, he stressed.

"But just to throw out \$200,000 or \$300,000 in premium—it's not worth it. It's like shooting craps—will they play or won't they play?"

"They all turned out to be too cheap to buy it," quipped a frus-

trated surplus lines broker who spent long hours piecing together a program geared to respond against the peril of strike.

"This was a piece of real E/S business," he added. "But I would be laughed at today by the same underwriters who quoted on it two weeks ago." As of last week, he said, the coverage through his markets is no longer available.

Despite the apparent riskiness of such coverage, the surplus lines broker said that it had appeal for underwriters because exposure would end with the 1982 playing season. Unlike some hard-to-place risks, there would be no long-tail losses.

"Within a three-month period you know if you win or lose—it's like shooting dice," he said.

OPIC to offer civil strife coverage

By JERRY GEISEL

WASHINGTON—Insurance coverage for property that is damaged or destroyed during civil strife overseas will be available by the end of the year as an endorsement to political risk insurance offered by the Overseas Private Investment Corp.

OPIC, the thriving federal corporation that insures U.S. companies against damage, destruction and expropriation of their overseas properties during a war, insurrection or revolution, has been authorized by Congress to develop the special endorsement.

The endorsement, which OPIC would like to introduce by the end of the year, will fill a "gray area" in the political risk market, an OPIC spokesman said.

Some insurance buyers fear that OPIC's war risk policy leaves their investments unprotected in certain non-war situations. For example, a U.S. company's overseas property might be damaged during a student protest against a government's pol-

icy.

Rates for a civil strife endorsement to the political risk insurance are not available yet.

While perhaps concerned about the breadth of coverage, insurance buyers have been flocking to OPIC. During the first nine months of fiscal 1982, OPIC issued record amounts of insurance and produced record revenues and income.

It issued policies with totaled insured values of \$2.1 billion in various political risk coverages, an increase of more than 350% over the same period of fiscal 1981.

"Our volume of insurance business for the first nine months of the current fiscal year exceeds the record \$1.5 billion written during all of fiscal 1981," said OPIC President Craig Nalen.

"This surge in insurance activity reflects not only a growing interest by American investors in the use of political risk insurance, but also indicates a higher level of investment by U.S. businesses in the growing markets of the Third World," Mr. Nalen added.

OPIC also reported that gross income for the nine-month period ending June 30 jumped to \$71.7 million, up 18% from \$60.9 million during the corresponding period in 1981.

OPIC's net income, however, grew only 12% to \$59.5 million from \$52.9 million in the nine months in 1981.

Higher operating expenses and more claims payment limited net income growth.

For example, during the first nine months of fiscal 1982, OPIC paid more than \$12.7 million to settle insurance claims involving inconvertibility of local currency and expropriation of property, an increase of more than 50%.

However, OPIC has already obtained \$10.1 million through recoveries from host governments and reimbursements from reinsurers. Additional recoveries are pending, including claims totalling \$40 million against Iran.

As of June 30, OPIC's reserves and retained earnings topped \$735 million.

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Financial Management:	
chief financial officers,	
vps of finance, secretaries,	
treasurers, etc.	9,385
Insurance Management:	
vps, directors, managers of	
insurance, risk, benefits,	
compensation, safety,	
security, etc.	5,791
Government, Associations,	
Unions, Educational	
Institutions	1,001
Commercial Consumers	
Sub-total	23,000
Insurance Agents	
& Brokers	9,741
Insurance Cos	4,735
Financial Institutions	303
Actuaries, Attorneys,	
Adjusters, Appraisers	
& Consultants	2,208
Others allied to the field	776
TOTAL	40,763

*Source: Business Occupational breakdown of qualified circulation Nov. 2, 1981 issue, as submitted to BPA for December 1981, BPA Publisher's Statement

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Continental's coverage

Continued from page 1
based International Surplus Lines Insurance Co., a Crum & Forster subsidiary, Ms. Steffen confirmed. The limits were not disclosed, but one knowledgeable source said Continental's coverage probably is about \$20 million.

As few as four other U.S. banks are believed to have purchased the insurance, which previously was available only for trust department operations.

The broad E&O policy purchased by Continental has been available for fewer than six months, notes Edgar W. Armstrong, manager of the Washington risk management office of The Wyatt Co.

Three dozen of the top 125 banks in the United States are examining bankers' E&O insurance, but "Continental is on the cutting edge of it," said Ms. Steffen.

The policy, which is "thought of as a catastrophe cover," according to Ms. Steffen, picks up "about everything except D&O," said Mr. Armstrong of Wyatt.

As of January, the bank also had a \$100 million directors and officers

liability policy with a \$10,000 deductible applied to claims made against individuals and a \$100,000 deductible applied to claims made against the corporation.

D&O insurance indemnifies a company against shareholder suits such as the two naming Continental and its top officers.

The Harbor Insurance Co. of Los Angeles, an affiliate of Continental Corp., a large New York-based insurer not affiliated with Continental Illinois Corp., confirms it is "involved" in the \$25 million primary layer.

The identity of insurers underwriting the next \$75 million could not be confirmed.

Directors and officers insurance is commonly purchased by the nation's largest corporations to protect against shareholder suits. A 1980 Wyatt survey found that of 1,770 corporations responding, \$10 million was their most frequent limit and \$100 million was the highest reported at that time.

That remains the highest reported by any bank, according to Warren G. Brockmeier, a vp in

Wyatt's Chicago office who works on the survey. With 1982 results still being tabulated, he says, one utility reported a \$200 million D&O coverage limit. Major New York banks, as well as The First National Bank of Chicago, are believed to have current limits of \$50 million.

Wyatt found the principal insurers in the U.S. bank D&O market in 1980 were MGIC Indemnity Corp., International Surplus Lines of Chicago, National Union Fire Insurance Co. of Pittsburgh, Pa., (an American International Group Inc. affiliate) and Stewart Smith East Inc. of New York, underwriting managers for CNA Insurance Cos.

Industry sources, however, say the principal writers of D&O insurance for the nation's largest banks are Harbor, National Union and the Evanston Insurance Co., an affiliate of Shand, Morahan & Co. Inc. of Evanston, Ill. Shand is owned by Alexander & Alexander Services Inc., the New York-based broker.

"Basically, you're insuring the management operations of the bank," says James C. Willis, assistant vp-financial institutions at Shand, Morahan. The typical D&O policy is written on a claims-made basis and includes legal defense

costs as part of the policy limits, excluding coverage of any liability due to criminal activities.

Directors and officers liability insurance pays claims made by bank officials or the bank itself for losses caused by any act, error, omission, misstatement, misleading statement or neglect or breach of an insured acting in his bank capacity, the source adds.

Both the D&O and E&O coverages are brokered by Rollins Burdick Hunter of Illinois, confirmed Brendan T. Bolger, a senior vp and account executive in Chicago. However, he declined to confirm other details of the two packages.

Continental Illinois also carries a standard \$100 million bankers blanket bond with a \$1 million deductible, brokered by Marsh & McLennan Inc., which indemnifies the bank against any cash or securities losses due to fraud or theft.

The bank and broker decline to name the insurers backing this coverage or comment on other insurance details.

"I'm sorry, we don't discuss it," says James A. Crawford, director of risk management for Continental Illinois.

Typically, the bankers blanket bond covers losses due to dishonesty, fraudulent or criminal acts of officers and/or employees as well as cash or securities losses on bank premises due to burglary, robbery, larceny, false pretenses, holdups, misplacement and mysterious or unexplainable disappearances.

The latest suit naming Continental claims, among other things, that the bank made a misleading statement in its first-quarter 1982 report to shareholders. The suit was filed Aug. 4 by Chicago attorney Lawrence Walner on behalf of Fred L. Steinlauf, a Chicago resident who purchased 1,200 shares of Continental Illinois.

Continental subsequently disclosed a \$61 million second-quarter operating loss resulting from purchase of \$1 billion in energy-related loans from Penn Square, which was closed by federal regulators on July 5. Continental's second-quarter report also disclosed a surge in so-called non-performing loans, to \$1.3 billion and the end of June from \$519 million a year earlier.

Continental's stock, purchased for \$23.87 a share by Mr. Steinlauf on June 22, closed at \$15.75 on Aug. 9 in composite New York Stock Exchange trading, creating a \$9,744 paper loss for Mr. Steinlauf.

"In its report for the first quarter of 1982, Continental cited its 'great strength in commercial lending' and stated that 'credit quality held up well against the increasing pressures of recession,'" says Mr. Steinlauf's suit filed in U.S. District Court.

"In a July 21, 1982, second-quarter report reflecting a loss of \$63

(sic) million, defendant (Continental Chairman Roger E.) Anderson stated that Continental's 'total loan portfolio (was) expected to reflect a higher percentage of non-performing credits than other major money center banks.'

"That expectation was not previously communicated and a contrary image was projected," the suit says in alleging violations of securities laws by Continental and its management.

Mr. Steinlauf's suit also alleges that James D. Harper Jr., a Continental executive vp for real estate services, sold his entire personal portfolio of Continental Illinois stock of 68,938 shares between April 22 and April 29, "at least in part with inside information about some or all of the Continental problems and deteriorating financial condition."

The suit seeks a judgment against Mr. Harper for profits realized due to "inside information" as well as general and punitive damages from the bank and officers and certification of a class action of the bank's 17,000 shareholders.

Bernard I. Mirochnick, another Continental shareholder, sued on July 29, also in U.S. District Court, also alleging securities violations and seeking a class action to determine whether the bank, its parent company and officers "entered into a conspiracy, combination or course of conduct" aimed at fraudulently promoting purchase of Continental Illinois shares at inflated prices.

Mr. Mirochnick purchased 1,000 shares prior to the Penn Square disclosures.

Mr. Mirochnick is represented by two law firms—Much, Shelist, Freed, Dennenber, Ament & Eiger in Chicago, and Greenfield & Chimicles of Bala-Cynwyd, Pa., a Philadelphia suburb. Richard D. Greenfield and Nicholas E. Chimicles describe themselves as experienced at representing shareholders in bank-fraud cases.

Both suits also name Continental Illinois' accountants, the Cleveland partnership of Ernst & Whinney, as defendants.

In a news conference, Mr. Anderson of Continental said a task force of bank officers, "outside" accountants and lawyers would look into the bank's people, policies and procedures in light of what he called "the Penn Square situation."

Continental Illinois maintains a close relationship with a Chicago law firm, Mayer Brown & Platt. The firm's senior partner, Edmund A. Stephan, confirmed that it is helping the bank review its people, policies and procedures in light of the Penn Square-related losses.

The bank's task force of officers and lawyers also includes auditors from Ernst & Whinney, he said.

Mayer Brown & Platt will defend the bank in the two shareholder suits.

Comp bill moving swiftly ahead

Continued from page 3

The courts have held that in cases when the employer occupies a dual capacity—such as an owner of premises, lessee of premises, provider and maintainer of equipment or as vendor of goods and services—the injured worker could file suit and collect from the employer in that other role.

The bill reiterates the intent of workers compensation as the sole and exclusive remedy for injured workers, effectively overturning the "dual-capacity" doctrine.

There are some exceptions to the sole remedy rule under the bill, however:

- Workers would still be able to sue employers—and possibly collect twice—if the injury was aggravated by the employer's "fraudulent concealment of the existence of such injury and its connection with the employment."

- Employees could sue outside the work comp system if the "injury was caused by a defective product manufactured by the employer and sold, leased or transferred to a third party who provides it for use by the employee."

- A lawsuit could still be brought if the employer removed or failed to install a safety guard on a punch press, or in cases where the employer physically attacked the worker and the incident resulted in injury or death.

The bill would further aid employers by mandating that, in disputed cases, the California Workers Compensation Appeals Board weigh any evidence and decide a case on the basis of a "preponderance of the evidence."

The current law says the facts shall be liberally construed to extend benefits for the protection of injured workers.

A.B. 684 also requires a disabled worker, who is entitled to receive rehabilitation benefits in California, to request those benefits within one year from the date of the last diagnosis of the injury.

The only exception would be in cases where the worker's injury had further deteriorated, creating the need for additional benefits.

Currently, there is no time limitation in which the employee requests a rehabilitation program. Injured employees allegedly have been requesting rehabilitation years after injuries occur and sometimes long after rehabilitation could have been beneficial.

What employers especially don't like in the bill is a change in the penalties for employers whose "se-

rious and willful misconduct results in an employee's injury."

Currently, employers found to be in that category are subject to a 50% increase in workers compensation benefits, with a cap of \$10,000 on that added penalty. The bill removes the \$10,000 limitation.

A.B. 684 is receiving laurels from most, but not all, workers compensation insurers who stand to financially gain from the increase in premium volume, which will help their cash flow and boost the amount of money they can invest.

The Assn. of California Insurance Cos., representing 20 workers compensation insurers in the state, supported the amendments to A.B. 684, which were added by Assemblyman Bruce Young, D-Cerritos.

The insurance trade group worked on the workers compensation reform with the California Labor Federation, the AFL-CIO, the Teamsters, the California Trial Lawyers Assn. and the California Applicants Attorneys Assn.

"Among the 50 states, California ranks about 37th in terms of benefit levels," said Edward Levy, general manager of the ACIC. "Yet it ranks in the top five in terms of cost to employers."

"Although workers compensation is supposed to provide an injured worker with tax-free benefits equal to two-thirds of his average weekly wage during temporary disability, this payment is currently subject to a maximum of \$175 per week," said Mr. Levy.

"In addition, the maximum permanent partial disability benefit hasn't been raised in the past 10 years and is now far below the two-thirds requirement even for those at the minimum wage level. The need for increased benefits should be apparent to everyone," he added.

But the bill received mostly darts from employers' groups like the California Chamber of Commerce, the California Self-Insurers Assn. and the California Manufacturers' Assn., which testified against the bill.

Under the bill, which will apply only to those injured on or after Jan. 1, the maximum weekly benefits to workers temporarily disabled or permanently and totally disabled will rise from the present \$175 to \$196 in 1983 and to \$224 in 1984.

The maximum weekly benefits for permanently partially disabled workers will increase from the current \$70 to \$130 in 1983 and to \$140 in 1984.

Death benefits for one dependent will increase from the current \$50,000 to \$60,000 in 1983 and to \$70,000 in 1984. The maximum death benefit for multiple dependents will increase from the present \$75,000 to \$85,000 in 1983 and to \$95,000 in 1984.

"Many will agree that the benefit levels should be increased, but what about the amount employers feel they can pay? That wasn't considered," said Joseph E. Markey, legislative advocate for the California Self-Insurers Assn.

Indeed, the amended bill was criticized as being snuck by, preventing employers and the insurance industry from either contributing to the drafting process or testifying on the proposal's effects, complained Myron Du Bain, president of Fireman's Fund Insurance Cos.

"They apparently agreed to bypass the normal legislative process by amending already-passed legislation to include the new proposal," he added.

While Fireman's Fund is one of the few insurers opposed to the proposal, Mr. Du Bain did say the company supports increased benefits for injured workers.

"But there has to be a trade-off and we have to cut out some of the legal expenses," he said.

"There are serious problems in our workers compensation system and this proposal does not solve them," he added.



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Managers outnumber captives in Vermont

There are more companies ready to manage captives in Vermont than there are captives to be managed—by a ratio of 4-to-1.

The Hanna Mining Co. in Cleveland and broker Smith Bell & Thompson Inc. of Burlington, Vt., have just formed a new management company, Altamid Management Co. (Vermont) Ltd., to manage insurance companies under the Vermont captive insurance company law.

That brings to eight the number of companies approved to manage captives in Vermont compared with the two captives there.

The only two captive management companies in Vermont with clients are: M&M Insurance Management Services in Burlington, a subsidiary of Marsh & McLennan Cos. Inc., which is managing the BFGoodrich Co. captive, First Charter Insurance Co.; and RBMS-Risk & Benefit Management Systems Inc. from Aurora, Colo., which is managing the new captive formed by Elixir Industries, GarDen Insurance Co. of Vermont (see related story).

Other companies licensed to manage captives in Vermont are: Waite Hill Services, a subsidiary of Figgie International; Green Mountain Captive Management Inc., formed by a local broker and local law firm; Sommerset Underwriting Management Ltd. from Bermuda; Risk Management Services from West Lake, Calif.; and Vermont Insurance Management Inc., formed by Link Miller and Harry Bonyum of Waterbury, Vt.

Hanna Mining already owns a captive management company in Bermuda, Altamid Management Co. Ltd., which manages Bermuda-based captives.

Duane E. Allen, assistant treasurer at Hanna Mining in Cleveland and chairman of its management companies, said Hanna Mining is expanding its Bermuda captive management operations to Vermont because, "It's a natural extension. A couple of our Bermuda clients have contemplated having an operation in Vermont. It

ties in with our services to our CIRCL (Corporate Insurance & Reinsurance Co. Ltd.) clients," said Mr. Allen.

Among Altamid's 10 Bermuda clients are the group-owned reinsurance company CIRCL and corporate-owned captives who are members of CIRCL.

"We were going to do it on our own (in Vermont)," Mr. Allen noted. "Then Smith Bell got in touch with us. It seemed like a good step to establish with someone already there."

Altamid (Vermont) will offer financial and management accounting, supervision of insurance and reinsurance processes, investment supervision, reinsurance supervision and placement and counseling on the feasibility of a captive.

Smith Bell & Thompson, which has a staff of 20 people, will handle accounting and policy supervision. Warren L. Thompson, president of Smith Bell & Thompson, is president and chief operating officer of the new management company.

The Vermont management company also will be able to call on the experience and expertise of Altamid Management Co. in Bermuda and of Hanna Mining's risk management department, which has operated a captive since 1970, Mr. Allen noted.

Neither Mr. Thompson nor Mr. Allen appear concerned about the oversupply of management companies in Vermont now.

Mr. Thompson says there has been a great deal of interest expressed in organizing new captives under the state's captive law.

Mr. Allen predicts that Vermont ultimately will be more popular than Colorado, which was the first state to adopt a law encouraging companies to start their subsidiary insurance companies in the United States. Colorado hosts about two dozen captives.

"I think Vermont will surpass Colorado fairly quickly because of the more favorable regulation on financial reporting, freedom to set form and rates, and more freedom on pure and industrial captives,"

said Mr. Allen.

He predicted that Vermont will attract captives now located in Bermuda and other states, which include Colorado and Tennessee, and that new captives will be formed.

Altamid already is talking to a couple of potential clients, Mr. Allen noted.

"We can service our clients on a cost-efficient manner," he said. Altamid will charge for only the time and expense spent on a client, plus

a fee, said Mr. Allen. Hourly charges will range from \$25 for clerical work to \$70 for executive time, and the fixed fee will average about 30% of time and expense charges.

The officers of Altamid (Vermont) in addition to Mr. Allen as chairman of the board and chief executive officer and Mr. Thompson as president and chief operating officer, are: Vp Roger D. Teese (vp of Smith Bell & Thompson); Vp Gene H. Heskett (risk manager at

Hanna Mining); Treasurer Kenneth F. Graboski (of Smith Bell & Thompson); Secretary John S. Pyke Jr. (vp and secretary of Hanna Mining), and Assistant Secretary Jonathan H. Stevens (attorney of the Winooski, Vt., law firm of Stevens & Clark).

Altamid's Vermont offices are located at 102 S. Winooski Ave., Burlington, Vt. 05402; 802-658-4600. Mr. Allen also will answer inquiries from his Cleveland office, telephone 216-589-4311.

Elixir charts Vermont captive

Continued from page 2

Vermont Department of Banking and Insurance on July 29.

GarDen Vermont, capitalized at \$550,000 through a letter of credit issued by the Merchants Bank in Burlington, Vt., began to do business just two days later.

It is issuing to Elixir a \$1 million combined single limit product liability insurance policy.

It also is reinsuring portions of workers compensation, general liability and auto liability policies underwritten by Northwestern National Insurance Co. of Milwaukee. GarDen reinsures the first \$300,000 of workers compensation risk on a per-occurrence basis and the first \$250,000 per occurrence of auto liability and general liability risks.

Elixir purchases excess insurance above the \$1 million product liability policy and the Northwestern National policies.

During its first full year of operations, GarDen's premium volume should exceed \$1.5 million, Ms.

Wamsley said. Elixir's Colorado captive had a premium flow of \$1.4 million in fiscal 1981, according to a report filed with the Securities and Exchange Commission.

Risk & Benefit Management Systems, which manages Elixir's Colorado captive, also will manage GarDen Insurance Co. of Vermont. General Adjustment Bureau will adjust claims.

Before GarDen was chartered in Vermont, BFGoodrich Co., the huge tire manufacturer, set up First Charter Insurance Co. in September 1981. Goodrich was attracted by Vermont's captive law that gives captives freedom from rate and form regulation and imposes no investment restrictions on pure (single-parent) captives (BI, Sept. 14, 1981).

Goodrich's and Elixir's captives may soon have lots of company, asserts George A. Chaffee, Vermont's insurance commissioner.

"I wish you could see me jumping up and down," Mr. Chaffee said.

"This is the beginning of a new wave," he predicted.

Currently, four captive applications are pending, and three new captives may receive approval to operate within the next six weeks, Mr. Chaffee said.

"Our law is finally beginning to bear fruit. For captives starting out fresh, we have the best statute in the country," Mr. Chaffee boasted.

Although officials in Colorado and Tennessee would beg to differ, the Vermont captive law was drafted in consultation with the Risk & Insurance Management Society.

RIMS represented corporate risk managers' interests in the development of a state captive law that would be less restrictive than other state captive laws and so could compete with the regulatory advantages of captive laws in Bermuda and the Cayman Islands.

Already, Tennessee has liberalized portions of its captive law to be more competitive with Vermont (BI, March 29 and April 19).

Fred S. James & Co. elects Weatherford vice chairman

comings & goings: industry

William E. Weatherford has been elected vice chairman of Fred S. James & Co. Inc. in New York. He will share vice chairman responsibilities with William E. Burch, a former president of the company.

Mr. Weatherford had been executive vp of Fred S. James and continues to serve as chairman of Fred S. James of Texas and Southwest regional director.

Other agent/broker changes:

Jerry Underwood elected vp of Olliver/Pilcher Insurance Inc. in Phoenix, Ariz. He manages the bond department and is in charge of surety bonds for the company. Mr. Underwood was previously with Aetna Life & Casualty Co.

Rudolph F. Toffenetti appointed vp at Jardine Ter Bush & Powell Inc. in Schenectady, N.Y. He is responsible for management of the large risk department. Mr. Toffenetti had been manager of the commercial property department.

Insurers

Robert F. Froehlke elected vice chairman of The Equitable Life Assurance Society in New York. Mr. Froehlke will assume his new position in November and will succeed Chairman and Chief Executive Officer **Coy G. Eklund** when he retires in April 1983. Mr. Froehlke was most recently president of the American Council of Life Insurance.

Jerry D. Paugh appointed resident vp of the Arizona branch of Western Employers Insurance in Phoenix, Ariz. Mr. Paugh was previously branch manager of the Phoenix office.

Jurgen W. Englert appointed vp, controller and treasurer of Ma-

rine Office of America Corp. in New York. Mr. Englert was previously an assistant vp at MOAC. Also, **Francis J. Murphy** joined MOAC as vp and manager of the company's Western region, based in Chicago. MOAC is a subsidiary of The Continental Corp.

Dr. Erik D. Olsen elected president of Delta Dental Plans Assn., based in Chicago. Dr. Olsen had been a Delta Dental vp.

Norman G. Parsons elected president of Group Health Inc., a non-profit health insurer based in New York. Mr. Parsons had been acting president since May and had formerly been executive vp of GHI, which provides medical and dental coverage for more than 1.75 million people.

James B. Pope appointed vp of the Southwest region for Wausau Insurance Cos., located in Dallas, Texas. He had been regional casualty underwriter manager for the company in Dallas. Mr. Pope replaced **Robert O. Helberg** who retired.

Michael J. O'Hara named president and general manager of Iowa Kemper Insurance Co., an affiliate of the Kemper Group in Mason City, Iowa. He had been branch manager of Kemper's Syracuse, N.Y., office.

Reinsurers

Frederick W. Meyer named vp in the San Francisco office of North American Reinsurance Corp. He will be responsible for treaty marketing in the Western United States. Mr. Meyer was pre-

viously assistant vp. Also **William H. Stempson** named vp-treaty marketing at North American Re in New York. He was previously an assistant vp at the company.

John J. Norton elected president of Stewart Smith Reinsurance Intermediaries Inc. in Chicago. He was previously executive vp at Stewart Smith Re. He has been with the firm since 1976.

Monica Dobbie appointed vp of Heddington Brokers Ltd., a Bermuda-based reinsurance brokerage jointly owned by Willis Faber (Bermuda) Ltd. and Heddington Insurance Ltd., a subsidiary of Texaco Inc. She was most recently employed with Walton Insurance Ltd. in Bermuda.

Other suppliers

William H. Kooser has joined The Wyatt Co. in Chicago. Mr. Kooser will be involved with employee benefit plan design, administration and funding.

Larry Mornhinweg has been named vp-claims at Adminco, a self-insurance administration firm based in Walnut Creek, Calif. He will be responsible for California claims operations. Also, **Ralph Rogers** named vp-safety and loss control in the Walnut Creek office, and **James R. Grove** named vp-safety and loss control in the Los Angeles office.

William R. Gorton elected to the newly created position of executive vp of Insurance Management Services Inc. in Cleveland. He had been vp of finance at Insurance Management.

insurance services guide

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Crump's first-half results shine

Continued from page 3

vice chairman and chief financial officer. "We had a charge against earnings that didn't make us look too good. But now it's all beginning to pay off."

Fueled by last year's purchases including Kindler & Lauczi Insurance Brokers Inc. in San Francisco and LaBow, Haynes Co. Inc. of Bellevue, Wash., Crump gross revenues for the first half of 1982 jumped 69% to \$25.1 million from about \$14.9 million for the same period last year. Net income in the first half, including a profit from the company's underwriting division, Southern American Insurance Co., grew about 39.2% to \$1.7 million from about \$1.2 million last year. Earnings per share increased a penny to 48 cents for the first six months of 1982.

Results for the second quarter alone indicate an even more dramatic improvement. In the second three months of 1982, Crump's gross revenues grew about 76.4% to \$12.6 million from \$7.1 million for the same period last year. Net income nearly doubled, reaching \$763,000 in the second quarter of this year, compared to \$384,000 last year. Earnings per share for the quarter grew to 22 cents from 15 cents in 1981.

"We are also seeing some solid improvements in interest income due to better internal management," Mr. Power adds. "Frankly, we have lagged behind the other brokers in managing our float. Now our income from this source is going up while the other brokers are seeing theirs go down as interest rates drop again."

Although Crump is divesting one agency, Fisher-Brown Inc. in Pensacola, Fla., it continues to acquire others. The brokerage recently completed an agreement with Ligon, Gump & Ligon Inc., a Dallas agency, and is prospecting further in the Southwest. Although the retail brokerage is virtually unrepresented in the Northeast with only a single office in Camden, N.J., officials do not expect to purchase brokerages in that area soon.

Poe & Associates of Tampa, Fla., which like Crump is coming off a recent acquisition program, also had a good first half. Gross revenues for the first six months of 1982 grew about 38.1% to \$12.8 million from about \$9.3 million for the same period last year and net income increased 6.7% to a little more than \$1 million from \$960,000 in 1981. Earnings per share increased a penny to 54 cents.

Poe's second quarter gross revenues jumped 35.8% to \$6.5 million from about \$4.7 million while net income grew only 2% to \$399,000 from \$391,000. Earnings per share

BI ticker

First-half broker results (in millions)

	Gross revenues	% change	Net income	% change
Corroon & Black	\$ 86.3	10.3	\$ 8.2	34.3
E.H. Crump	25.1	69.0	1.7	39.2
Frank B. Hall	189.6	8.0	17.1	- 4.7
Fred S. James	123.6	1.0	8.9	- 8.6
Marsh & McLennan	483.6	11.4	66.4	1.9
Poe & Associates	12.8	38.1	1.0	6.7
Rollins Burdick Hunter	40.2	- 1.1	3.5	-22.2

dropped 1 cent to 22 cents.

Also on the rebound among the public brokers is Corroon & Black Corp., which is emerging from a disappointing 1981 with a solid first half in 1982. In the first six months, gross revenues were up 10.3% to \$86.3 million from about \$78.2 million for the same period last year. Net income is bouncing back strongly, up 34.3% to \$8.2 million from \$6.1 million in the second half of 1981. Earnings per share for the first six months grew to \$1.03 from 77 cents.

In just the second quarter of this year, gross revenues topped \$42 million, up nearly 7.9% from about \$40 million in the same period last year. Net income grew about 36.1% to about \$3.4 million from \$2.5 million last year. Earnings per share in the second quarter jumped 11 cents to 42 cents in the second three months of 1982.

Meanwhile, the remainder of the publicly held brokers shared what stock analysts termed "an unsurprising and not particularly good" first half.

Analysts blamed falling interest income and shrinking contingent income for the lackluster results.

Marsh & McLennan Cos. Inc. led the giant brokerage firms with an 11.4% gross revenue gain in the first half of 1982 to \$483.6 million from \$434.2 million for the same period last year. Net income, however, grew only 1.9% to \$66.4 million from \$65.2 million. Earnings per share increased to \$1.81 from \$1.78.

In the second quarter of 1982, M&M revenues grew 7.9% to \$232.5 million from \$215.4 million last year, while net income increased a little more than 1% to \$31.6 million from about \$31.2 million. Earnings per share in the second quarter grew 2 cents to 87 cents.

Frank B. Hall & Co. Inc. also floundered a bit in the first half of this year. Although the brokerage's revenues grew 8% over last year, net income fell 4.7%. Revenues grew to \$189.6 million from \$175.6 million over the same period last year while net income fell to \$17.1 million from \$17.9 million. Earnings per share dropped to \$1.49 from \$1.56.

In the second quarter, revenues grew 7.2% to \$95.7 million from \$89.3 million while net income dropped 10% to \$67.8 million from about \$8.7 million last year. Earnings per share fell to 68 cents in the second quarter from 76 cents last year.

One good sign, however, was the first profit in four years for Jartran Inc., Hall's truck and trailer renting subsidiary. Jartran, which filed for a Chapter 11 reorganization shortly after being purchased by Hall, earned \$200,000 in June, an improvement over a \$2 million loss in the same period last year.

At Fred S. James & Co. Inc., first-half gross revenues grew only 1% while net income declined 8.6%. Revenues for the first six months of 1982 reached \$123.6 million from \$122.6 million for the same period last year, while net income dropped to \$8.9 million from nearly \$9.8 million in 1981. Earnings per share fell to 99 cents from \$1.08 last year.

During the second quarter only, James revenues grew less than 1% to about \$62 million from \$61.8 million for the same period last year while net income dropped about 10% to \$4.3 million from \$4.8 million. Earnings per share in the second quarter.

Rollins Burdick Hunter also had an off first half as gross revenues dropped 1.1% and net income fell 22.2%. Revenues for the first six months of 1982 fell to \$40.2 million from \$40.6 million last year, while net income dropped to \$3.5 million from \$4.4 million for the same period last year. Earnings per share in the first half fell to 80 cents from \$1.00.

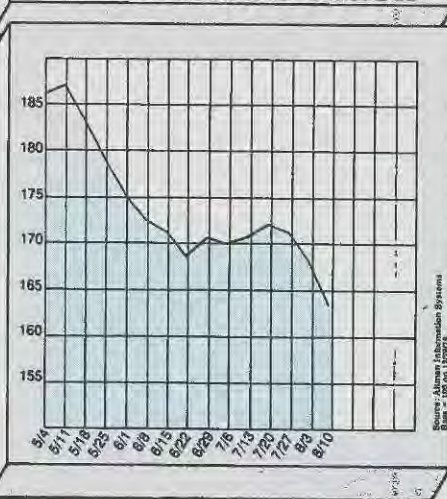
Although RBH commissions and fees from brokerage operations grew 2.3% in the first half, the sales gains were offset by a 22% decline in contingent income and a 13% drop in investment income, the brokerage said.

In the 1982 second quarter, RBH revenues dropped 1.6% to \$19.7 million from a little more than \$20 million, while net income fell 28.4% to \$1.4 million from about \$2 million. Earnings per share dropped to 33 cents from 45 cents in the second quarter of 1981.

Although Ryan Insurance Group, a combination of brokerage and underwriting interests, reported revenue and income gains for the first half, brokerage revenues excluding investment income at the company were up 13.8% for the half but down 13% for the second quarter. Ryan's agency commissions and fees for the first six months reached nearly \$17 million, up from about \$15 million last year. For the second quarter, commissions and fees dropped to \$8.4 million from about \$9.7 million.

Overall, the Ryan Group net income grew nearly 15.7% to about \$4.8 million in the first half from about \$4.3 million for the same period last year. Second-quarter net income grew 16.4% to \$2.7 million from \$2.2 million. Earnings per share for the first half and second quarter were \$1.16 and 66 cents, respectively.

BI Insurance Index



Insurance industry stocks tumbled again, setting another new low for the year in the period ending Aug. 10, as the *Business Insurance* stock index dropped 4.8 points to 163.5 from 168.2. Forty-four stocks reported losses, nine gained and 15 were unchanged. The largest declines were posted by Mission Insurance Group Inc., 15.3%; The Travelers Corp., 10.6%; Alexander & Alexander Services Inc., 9.4%; PennCorp Financial Inc., 9.2%; and Aneco Reinsurance Co. Ltd., 8.3%. The largest gains were reported by Crum & Forster, 5.7%; Old Republic International Corp., 3.7%; and The Hartford Steam Boiler & Inspection Co., 2.3%. The 2.8% drop in the BI index was less than the declines in the other major stock market averages.

British Issues

August 10	Price	P/E	Div.	Yield	1 Week	High-Low
Companies	pence		pence	%	pence	pence
Commi Union	134	14.1	16.86	12.6	138-134	
Eagle Star	328	11.7	21.43	6.5	329-322	
Geni Accident	296	7.7	23.21	7.8	310-296	
Gdn Royal Exch	288	7.3	25.00	8.7	302-288	
Phoenix	254	10.2	24.00	9.4	260-254	
Royal	356	9.2	36.07	10.1	367-356	
Sun Alliance	780	9.8	61.43	7.9	786-774	

Brokers	Price	P/E	Div.	Yield	1 Week	High-Low
	pence		pence	%	pence	pence
CE Heath	361	9.9	18.71	5.2	362-350	
Hogg Robinson	99	7.6	8.57	8.6	100-97	
JH Minet	142	12.9	5.43	3.8	144-142	
Sedg Grp	172	11.1	8.57	5.0	173-170	
Stenhouse Hldg	112	8.7	7.28	6.5	112-111	
Stew Wrightson	266	9.5	18.57	7.0	267-265	
Willis Faber	490	12.2	21.43	4.4	492-487	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitecat & Aitken Stockbrokers, London

BI Industry Stock Report

Aug. 10, 1982 8/4/82 THRU 8/10/82

Insurance Cos.	Price	% Chg.	P/E	\$ Div	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE 33.63	-2.9	5.4	2.52	7.5	34.38	33.63	668.8
American Bankers Ins Group	NYSE 7.30	-3.2	5.9	0.48	6.4	7.50	7.38	68.1
American Gen Ins Co	NYSE 31.88	-1.2	4.4	2.20	6.9	32.38	31.63	100.4
American Intl Finl Corp	NYSE 13.13	1.0	9.8	1.12	8.5	13.13	13.00	2.1
American Indt Corp Inc	NYSE 57.25	-3.8	8.7	0.48	0.8	59.50	57.25	290.1
American Natl Ins Co	NYSE 12.75	-8.1	5.6	0.76	6.0	12.75	12.63	53.9
American Sts Life Ins Co	NYSE 18.00	0.0	5.8	0.80	4.4	18.00	18.00	1.0
Aneco Reins Ltd	NYSE 2.75	-8.3	0.0	0.00	0.0	2.88	2.75	11.8
Aveco Corp	AMEX 10.63	-7.6	6.7	0.54	5.1	11.50	10.63	10.2
Banks Iowa Inc	NYSE 36.00	0.0	6.8	1.48	4.1	36.00	36.00	0.5
Bitco Corp	NYSE 27.50	-1.8	4.2	1.92	7.0	28.00	27.50	4.3
Carolina Cas Ins Co	NYSE 6.50	-3.7	6.4	0.32	4.9	6.75	6.50	5.6
Chubb Corp	NYSE 30.00	-6.2	4.8	2.92	9.7	31.75	30.00	119.7
Continental Corp	NYSE 19.38	-3.7	5.2	1.80	9.3	19.88	19.38	664.8
Crawford & Co	NYSE 22.00	-4.9	6.6	2.60	11.8	23.00	21.88	164.2
Crown Life Ins Co	NYSE 13.25	0.0	9.7	0.56	4.2	13.25	13.25	2.2
Crum & Forster	NYSE 69.50	0.0	5.2	3.10	4.5	69.50	69.50	0.0
Employers Cas Co	NYSE 23.25	-5.7	4.5	1.76	7.6	23.25	21.38	938.5
Equifax Inc	NYSE 25.25	-1.9	5.3	1.20	4.8	25.50	25.25	2.5
Excelsior Ins Co	NYSE 32.88	1.2	9.3	2.60	7.9	33.00	32.38	36.0
Farmers Group Inc	NYSE 12.50	0.0	32.6	0.74	5.6	12.50	12.50	0.5
First Colony Life Ins Co	NYSE 29.88	-2.4	8.4	1.24	4.2	30.50	29.88	194.7
Foremost Corp Amer	NYSE 66.25	0.0	18.8	1.02	1.5	67.00	NO TRADE	0.0
Great West Life Assur Co	NYSE 25.25	0.0	7.5	1.12	4.4	25.25	25.00	27.9
Hanover Ins Co	NYSE 180.00	0.0	6.9	10.00	5.6	180.00	180.00	0.0
Hartford Steam Boiler Insptn	NYSE 37.75	0.0	3.8	0.88	3.2	38.25	37.75	16.9
Jefferson Natl Life Ins Co	NYSE 33.25	2.3	6.6	2.80	8.4	34.25	33.00	17.9
Kemper Corp	NYSE 38.00	-2.6	10.6	0.76	2.0	39.00	38.00	1.1
Lincoln Natl Corp Ind	NYSE 24.13	-6.3	4.3	1.80	7.5	25.38	24.13	34.1
Mission Ins Group Inc	NYSE 35.00	-6.4	6.1	3.00	8.6	37.38	35.00	290.2
Nationwide Corp Ohio	NYSE 18.00	-15.3	4.6	0.80	4.4	20.75	18.00	63.9
Northwestern Natl Life Ins	NYSE 26.25	-0.9	7.5	0.70	2.7	26.50	26.25	5.4
Ohio Cas Corp	NYSE 19.38	-5.5	4.0	1.50	7.7	20.50	19.38	13.0
Old Rep Intl Corp	NYSE 31.13	-3.1	5.7	2.36	7.6	31.50	31.00	53.2
Preferred Risk Life Ins Co	NYSE 17.75	3.6	4.1	0.92	5.2	17.75	17.00	61.8
Provident Life & Acc Ins Co	NYSE 18.25	-4.1	4.9	0.92	5.3	18.25	17.50	1.1
Ryan Ins Group Inc	NYSE 36.50	-7.6	5.2	2.44	6.7	39.50	36.50	8.8
St Paul Cos Inc	NYSE 32.75	-1.6	13.5	0.16	0.5	32.75	32.25	1.2
Safeco Corp	NYSE 38.75	-1.0	5.1	2.60	6.7	39.13	38.50	704.6
Sri Corp	NYSE 30.25	-5.8	5.6	2.20	7.3	31.63	30.25	160.9
Seibels Bruce Group Inc	NYSE 8.50	-6.2	4.3	1.12	5.9	20.25	19.00	29.3
Statesman Group Inc	NYSE 20.25	-0.6	11.9	0.80	4.0	20.25	20.25	10.1
Tokio Marine & Fire Ins Co	NYSE 4.88	-4.9	4.2	0.15	3.1	5.13	4.88	12.1
Travelers Corp	NYSE 78.38	-4.1	6.2	1.00	1.3	81.00	78.38	16.8
	NYSE 16.88	-10.6	4.4	1.64	9.7	18.88	16.88	563.6

Aug. 10, 1982 8/4/82 THRU 8/10/82

Insurance Cos.	Price	% Chg.	P/E	\$ Div	% Yld.	High	Low	Vol. (000)
United Fire & Cas Co	NYSE 28.50	0.0	7.4	0.88	3.1	28.50	28.50	1.9
United States Fid & Gty Co	NYSE 32.25	-3.7	6.8	3.60	11.2	33.63	31.88	487.0
United Svcs Life Ins Co	NYSE 12.38	-7.5	4.5	1.00	8.1	13.38	12.38	30.5
UsLife Corp	NYSE 16.00	0.8	3.4	0.84	5.3	16.13	15.88	73.2
Washington Natl Corp	NYSE 16.75	-4.3	7.0	1.08	6.4	18.00	16.75	57.3
Zenith Natl Ins Corp	NYSE 12.25	-5.8	5.7	0.76	6.2	13.25	12.25	22.8
INSURANCE COMPANIES	AVERAGE		6.2		5.4			
Agents/Brokers								
Alexander & Alexander Svcs	NYSE 20.38	-9.4	7.0	1.94	9.5	22.50	20.38	1,048.0
Baldwin & Lyons Inc	NYSE 34.50	0.0	6.0	0.80	2.3	34.50	34.50	0.5
Corroon & Black Corp	NYSE 20.25	-1.2	9.9	1.76	8.7	20.50	20.25	159.7
Crump E H Cos Inc	NYSE 8.63	0.0	16.0	0.40	4.6	8.63	8.63	17.8
Emmet & Chandler Cos Inc	NYSE 8.50	-2.9	12.7	0.00	0.0	8.75	8.50	23.0
Hall Frank B & Co Inc	NYSE 27.00	-2.3	10.5	1.70	6.3	29.13	27.00	258.0
Integrated Res Inc	AMEX 14.50	-4.9	5.5	0.00	0.0	15.00	14.50	16.3
James Fred S & Co Inc	NYSE 22.00	-1.1	10.7	1.40	7.3	22.00	22.00	72.0
Marsh & McLennan Cos Inc	NYSE 31.00	-5.7	9.4	2.20	7.1	32.88	31.00	561.7
PennCorp Fincl Inc	NYSE 7.38	-9.2	5.2	0.16	2.2	8.00	7.38	149.5
Poe & Assoc Inc	NYSE 9.00	0.0	10.2	0.80	8.9	9.00	9.00	0.0
Reed Stenhouse Cos Ltd	NYSE 11.00	0.0	9.5	0.60	5.5	11.00	11.00	3.8
Rollins Burdick Hunter Co	NYSE 15.25	-1.6	10.9	1.32	8.7	15.50	15.25	15.9
AGENTS/BROKERS	AVERAGE		8.4		5.8			
Conglomerates/Holding Cos.								
American Express(Fireman's Fd)	NYSE 35.75	-7.4	6.3	2.20	6.2	37.38	35.75	1,042.6
Anderson Clayton(Ranger/PanAm)	NYSE 23.38	-5.6	4.6	1.32	5.6	23.63	22.88	86.2
Aramco Inc	NYSE 15.75	1.6	6.2	1.20	7.6	15.75	15.50	260.8
City Investing Co. (Home Ins.)	NYSE 16.63	-6.3	5.1	1.70	10.2	18.25	16.63	384.3
CNA Finl Corp (CNA)	NYSE 13.25	1.9	5.5	0.00	0.0	13.25	12.88	21.4
Control Data (Comm. Credit)	NYSE 21.25	-13.7	5.1	0.55	2.6	23.75	21.25	926.9
General Re Corp	NYSE 37.38	-5.7	8.5	1.08	2.9	39.63	37.38	343.6
Gulf Utd Corp	NYSE 19.25	-2.5	6.8	1.32	6.9	19.88	19.25	99.9
Cigna Corp	NYSE 32.63	-3.7	4.2	2.30	7.0	34.25	32.63	659.8
ITT (Hartford Group)	NYSE 23.13	-3.6	5.1	2.68	11.6	24.13	23.00	1,230.2

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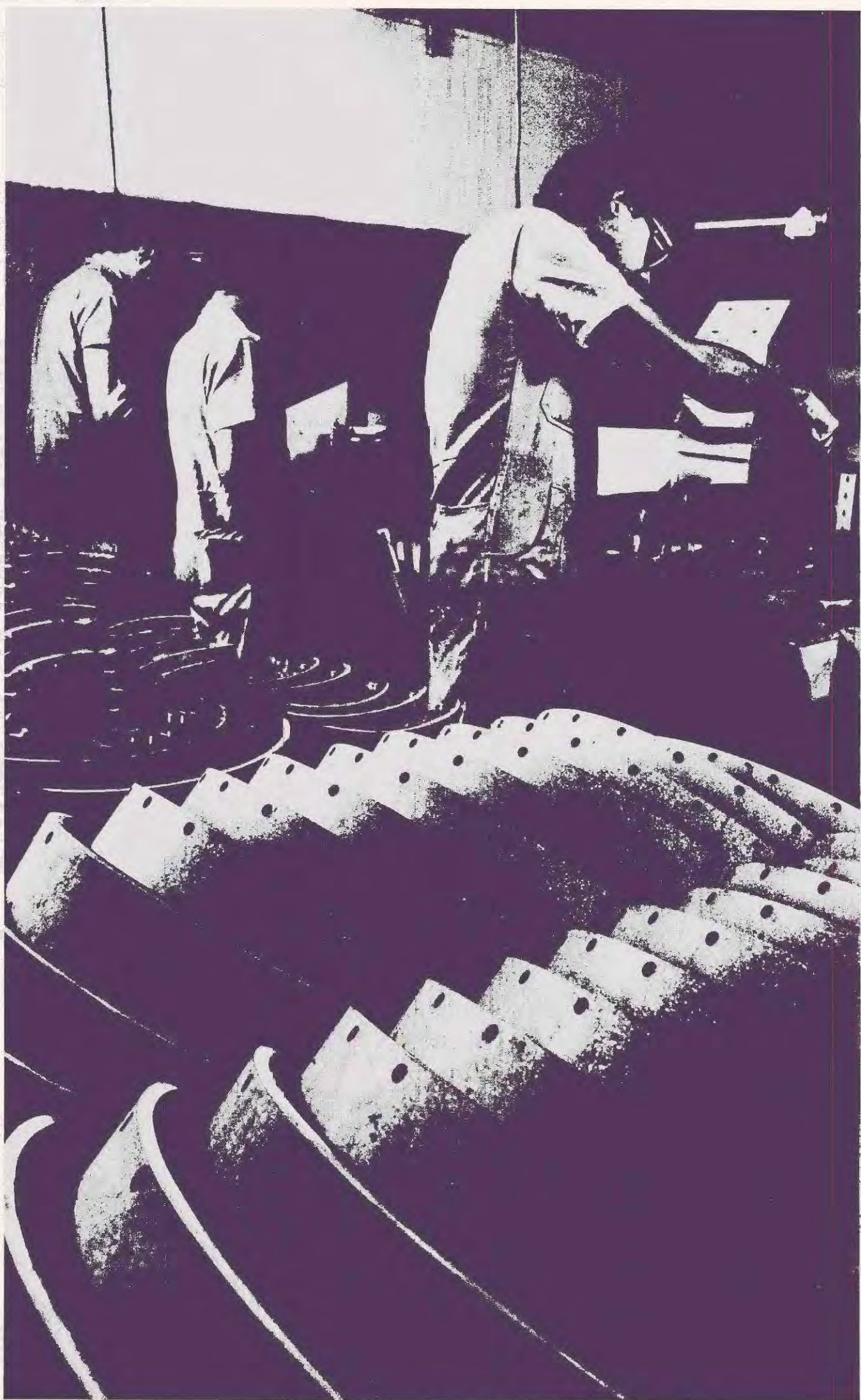
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