

# business insurance

update

## Appellate court upholds Hyatt coverage decision

KANSAS CITY, Mo.—A state appeals court has upheld most of a lower-court decision apportioning coverage among excess insurers for Hyatt Corp. and Hallmark Cards Inc. for claims stemming from the 1981 skywalk collapse at the Kansas City Hyatt Regency Hotel.

The three-judge panel affirmed the portion of a 1985 decision by  
*Continued on next page*

Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$60 a year

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## Analysts bullish on insurer stocks

By JUDY GREENWALD

With massive insurance rate increases propelling insurer profits to record highs, is now the time to invest in property/casualty insurer stocks?

Stock analysts say yes: Property/casualty stocks should outperform the overall market over the next year or two.

But there are a number of "firsts among equals" that are expected to do particularly well, security analysts say.

The analysts' top picks: Chubb Corp., American International Group Inc. and General Reinsurance Corp.

Other companies attracting analysts' attention include Fireman's Fund Corp., CNA Financial Corp., American General Corp., USF&G Corp. and Ohio Casualty Corp.

*Business Insurance* interviewed a half-dozen stock analysts specializing in the insurance industry about their stock recommendations and the reasons behind them.

To test these recommendations, *Business Insurance* has created the BI Model Portfolio of some of the property/casualty stocks touted by the analysts. In addition, BI has created a second portfolio by literally pulling the names of property/casualty insurers out of a hat (see story, page 39).

Insurance analysts say in general that investors can't go too far wrong by selecting commercial property/casualty insurer stocks.

"At these price levels, we're pretty much recommending them across the board," says David Seifer, vp at First Boston Corp. in New York.

Property/casualty stocks will outperform the overall market over the next two years, "mainly driven by higher earnings," says James B. Stradtner, general partner at Alex. Brown & Sons in Baltimore.

"I suspect this group will outperform the market over the next year," agrees Gloria Vogel, vp at Legg Mason Wood Walker Inc. in New York.

The property/casualty insurance stock that was most frequently singled out by the analysts was Chubb. Excluding losses on medical malpractice, which are now behind it, Chubb "has had an outstanding underwriting record for decades," says Samuel J. Weinhoff, first vp at Shearson Lehman Bros. in New York.

Early this year Chubb bought a \$285 million excess-of-loss rein-

*Continued on page 39*

## Guaranty fund seeks cap on asbestos claims

By STEPHEN TARNOFF

HARTFORD, Conn.—The first state guaranty fund facing an onslaught of asbestos-related claims is asking a state court to cap its liability at a fraction of what the policyholder is demanding.

The Connecticut Insurance Guaranty Assn. is asking a state court to limit its liability for claim payments to asbestos producer Raymark Corp. of Trumbull, Conn., which was insured by the insolvent Transit Casualty Co.

Transit, now in liquidation in Missouri, wrote \$32 million in limits for Raymark under six excess liability insurance policies, all of which probably will be exhausted by payments to asbestos claimants.

The Connecticut Insurance Guaranty Assn., known as CIGA, seeks to cap its potential liability for the policies at \$1.8 million, less six \$100 deductibles. It argues it should pay only \$300,000, less the deductible, for each of the six policies, not up to \$300,000 for each asbestos claim paid by Raymark.

This is the first time a state guaranty fund has been faced with responding to multiple claims totaling millions of dollars from a policyholder of an insolvent insurer.

Other states have begun to receive and pay asbestos-related claims on behalf of insolvent insurers, but not in the magnitude of the Raymark claims that will be filed in Connecticut (see story, page 33).

Whoever loses the suit faces financial difficulties, if not ruin.

"In the event the \$32 million is not fully available to the Company as needed, either the Company's orderly funding of asbestos costs may be interrupted, or the amount of available insurance may be insufficient to meet pending claims," Raymark said in a recent filing with the Securities and Exchange Commission.

"The company in either such case may have no alternative but to seek relief under Chapter 11 of the federal bankruptcy laws."

CIGA says that based on its ability to assess insurers 2% of premiums written in the previous year, the maximum amount the association may assess in 1986 for the non-workers compensation/non-automobile insurance account is estimated to be \$18 million.

CIGA asks in its suit that if the association's obligations arising from Raymark's Transit policies, along with claims filed by other Transit policyholders, exceed the amount that CIGA can assess its members along with other assets in the account, then claimants who do not reside in Connecticut be ordered to seek recovery from the insurance guaranty associations in the states in which they reside.

Raymark's \$32 million in potential claims with CIGA also occur at a time when state guaranty funds already are approaching their financial limitations.

In the wake of a record-breaking number of insurer insolvencies during the past two years—21 in 1985 and 20 in 1984, compared with only four in 1983—state guaranty funds are paying out more money to claimants than ever before.

*Continued on page 33*

## Oklahoma court repeals workers comp rate hike

By CAROL CAIN

OKLAHOMA CITY—Commercial workers compensation insurance rates for Oklahoma employers will be reduced immediately and some employers will receive premium refunds in the wake of a landmark state Supreme Court ruling.

In a 7-1 decision handed down July 25, the high court threw out an average 25.9% workers compensation rate increase approved last year by the Oklahoma State Board for Property and Casualty Rates. Those rates took effect Nov. 1.

The court ruled insurers failed to deliver sufficient information to justify the rate increase. According to the court, the insurers had to prove that current rates were unreasonably low and that those rates would endanger insurer solvency or restrict competition.

The court's ruling means that insurers "have to practically prove they are on the verge of insolvency" before they can receive permission to increase rates, said Donald DeCarlo, vp and general counsel of the National Council on Compensation Insurance, the New York-based ratemaking organization that filed the rate

request on behalf of insurers in Oklahoma.

Hank Emiston, an NCCI regional vp, said he interpreted the ruling to mean that "before an insurer could receive a rate increase, it would need clear evidence to show that, without it, it could cause the insolvency of the company."

The decision also could be interpreted to apply to all rate increase requests by all property/casualty insurers in Oklahoma, not just workers compensation rates, some attorneys say.

And some contend the decision could influence other state regulators to use the same standards when considering rate increase requests.

"It will be used to persuade ratemakers and regulators in other jurisdictions," said Larry Derryberry, an Oklahoma City attorney who represented the NCCI in the case. But, he said, it is not a precedent in other states.

Besides overturning the rate increase, the court ordered amounts paid by policyholders in excess of the prior rates to be refunded, though the total amount of the refund has not yet been calculated.

The Oklahoma attorney general's office, which  
*Continued on page 38*

**The ruling 'will be used to persuade ratemakers and regulators in other jurisdictions,' says Mr. Derryberry.**

## update

## Hyatt coverage ruling upheld

Continued from previous page

Jackson County Circuit Court Judge Timothy D. O'Leary that held excess liability insurers for Hyatt, operator of the hotel, should pay two-thirds of all the losses incurred by Hyatt, Hallmark and Hallmark subsidiary Crown Center Redevelopment Corp., which owned the hotel. The ruling also required Hallmark's excess liability insurers to pay the remaining one-third of all judgments, settlements and defense costs (BI, March 11, 1985).

However, the appellate court also reversed portions of Judge O'Leary's opinion, ruling that Hallmark excess insurer American Insurance Co. was only obligated to pay defense costs it had consented to pay under policy terms.

The appellate court also ruled that Hyatt excess insurer Highlands Insurance Co. did not have to cover defense costs in a lower excess layer where defense costs were excluded. These costs should be borne by the policyholders, the court said.

At the time of the collapse, which killed 114 persons and injured more than 200 others, Hyatt had \$200 million in excess liability coverage and Hallmark had \$100 million in excess liability limits.

So far, judgments and settlements from litigation brought by those injured in the collapse have totaled about \$122 million.

## Bears end insurance dispute

CHICAGO—The Chicago Bears say they will play their home games at Soldier Field even though the Chicago Park District has so far secured inadequate liability insurance.

The park district last week was still scrounging the market to find the full \$100 million in general liability insurance required by the Bears' lease, which runs until the year 2000.

The Super Bowl-champion team—which is a named insured on the district's policy—had threatened to play elsewhere because the district had only \$75 million in insurance (BI, July 28).

Since the Bears announced their decision to stay at Soldier Field, the park district lined up an additional \$10 million in coverage and is optimistic that the full \$100 million, or close to it, can be found, said park district attorney Alexander Polikoff.

If the park district meets the insurance requirement, the Bears will forego another lease provision that requires the stadium's beer concessionaire to have \$100 million in liquor liability insurance, said Bears' attorney Don H. Reuben. Beer concession bidders have only been able to obtain at most limits of \$50 million, according to a park district spokesman.

However, even if the park district does not obtain the full \$100 million in general liability insurance, beer could still be sold outside the stadium without violating the lease or the agreement with the Bears, Mr. Polikoff said.

## Grace guilty; Beatrice out

WOBURN, Mass.—In the first phase of potentially landmark toxic chemical litigation, a federal court jury says that W.R. Grace & Co. contributed to the contamination of two municipal drinking wells, but that Beatrice Foods Co. did not.

The July 28 verdict came after a four-month trial in which 33 plaintiffs allege that chemicals in the drinking water caused various illnesses including leukemia. The next phase of the litigation will decide whether the chemicals caused the illnesses.

As a result of the decision, Beatrice is out of the lawsuit. The Chicago-based company currently is litigating with American Mutual Liability Insurance Co. over coverage for defense costs in the Woburn litigation (BI, July 28).

## Dyna Span suing regulator

BOCA RATON, Fla.—Dyna Span Corp.—which claims to offer commercial insurance buyers liability coverage under the provisions of the federal Risk Retention Act—is suing the Florida Insurance Department and Insurance Commissioner Bill Gunter for defamation and illegally ordering it to stop writing business.

In the complaint filed last month in Palm Beach County Circuit Court, Dyna Span charges that a June 4 letter from the Florida department saying that the company was not operating legally under the federal act constituted an illegal cease-and-desist order.

Dyna Span charges that the letter, sent before a scheduled hearing on Dyna Span's status under the federal act, violated both its constitutional rights of due process and Florida statutes.

A hearing had been scheduled for last Friday on an administrative complaint filed against Dyna Span by the Florida department in April. The hearing was to precede the issuing of any cease-and-desist order (BI, March 3; May 26).

However, a state appeals court last Thursday granted Dyna Span a temporary stay of this hearing. Dyna Span's motion for the stay had earlier been denied by a state court judge, who also ruled that the department's June 4 letter was not a cease-and-desist order.

The department contends that it has not issued a cease-and-desist order to Dyna Span, according to a department attorney.

The Dyna Span complaint also charges that department employees released false and defamatory information about Dyna Span—including that Dyna Span had filed bankruptcy proceedings—and that the department tried to disrupt the group's business.

The complaint seeks an injunction to block enforcement of the alleged cease-and-desist order and \$100,000 in damages, the maximum allowable under state law.

The Florida department has not yet answered the complaint.

## Briefly noted

New York Gov. Mario Cuomo signed into law a bill giving victims of five toxic substances, including DES, one year to file suit against manufacturers. Victims previously were barred from suing because statutes of limitations had expired (BI, June 30).

## Joint and several liability to persist under Superfund

By ROBERT A. FINLAYSON

WASHINGTON—Polluters will continue to be held jointly and severally liable under a new version of the Superfund hazardous waste cleanup law.

As a result of this and other liability provisions in the legislation, insurers probably won't resume writing environmental impairment liability insurance, according to one industry lobbyist.

In addition, House and Senate conferees last month adopted new provisions that will force businesses to publicly disclose the releases of toxic substances.

In a key agreement reached July 25, conferees resolved most of the major differences between the Senate- and House-passed bills reauthorizing The Comprehensive Environmental Response, Compensation and Liability Act. The agreement clears the way for final enactment of the Superfund legislation.

The only remaining obstacle to Congressional approval of the Superfund reauthorization is resolution of the highly charged debate over the tax provisions of the Superfund Act. The issue is how to raise the \$8.5 billion Congress is likely to authorize for the toxic waste cleanup program.

Conferees have been trying for months to resolve the wide differences in the House and Senate versions of the Superfund reauthorization measure, particularly the provisions governing liability issues (BI, Dec. 16, 1985; Dec. 9, 1985).

The conference committee adopted the House-passed language on most of the key liability issues, generally considered a setback for risk management and insurance industry interests. Industry lobbyists generally had favored the Senate-passed reauthorization bill.

"We did not come out well," concludes Melvin L.

Stark, a consultant on Superfund issues to the American Insurance Assn. The language adopted by the conferees makes it unlikely that insurers will resume writing environmental impairment liability insurance he added.

"I can't see any of our companies getting into (EIL) insurance. You can't underwrite this sort of thing. You don't know what your ultimate loss is going to be," he says.

In addition to reaffirming strict, joint and several liability and creating a new community right-to-know program that will force businesses to publicly disclose the hazardous substances they use and any release of those substances, the conferees also agreed to:

- Allow plaintiffs in toxic tort cases to reopen those cases if the litigation was dismissed because state statutes of limitations had expired.

The language approved by the conferees pre-empted statutes of limitations—now in effect in about a dozen states—that are triggered by exposure to a hazardous substance.

This provision—which is retroactive to December 1980, when the Superfund law was first passed—says that statutes of limitations in cases involving personal injury or property damage caused by exposure to a hazardous substance commence on the date the plaintiff "knew (or reasonably should have known)" of the injury, regardless of when he or she was exposed to the injurious substance.

- Allow citizens to sue businesses and the U.S. Environmental Protection Agency for violating any standard, regulation or order issued pursuant to the Superfund Act.

The conferees dropped a requirement contained in

Continued on page 3

## Court allows LTV to resume retiree plans

By DAVE LENCKUS

DALLAS—LTV Corp. retirees will retain their group life and health insurance benefits for another six months under a New York bankruptcy court ruling.

The court last week granted LTV's request to continue providing the benefits to 78,000 retirees, retroactive to July 17.

The Dallas-based steel maker had canceled the benefits when it filed for reorganization under Chapter 11 of the Federal Bankruptcy Act on July 17 (BI, July 28).

Workers at LTV's Indiana Harbor plant in East Chicago, Ind., had been on strike since July 25 in protest of the cancellation of the retirees' benefits, and workers at other LTV plants threatened to strike on July 31 unless the company reinstated the benefits.

The workers at the Indiana plant were expected to return to work late last week.

LTV has not decided what it will do at the end of the six-month period, a spokesman said. How

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## New Jersey considers tighter non-renewal rules

By MEG FLETCHER

TRENTON, N.J.—The latest proposed changes in New Jersey's regulations governing insurance policy cancellations and non-renewals restore some of the punch that was lost when the regulations were weakened early last month.

Regulations implemented July 7, after 10 months of negotiations between the state Insurance Department and insurers, removed the more onerous provision restricting non-renewals in the state's pioneering effort to limit insurers' rights to cancel and not renew policies (BI, Oct. 7, 1985).

In exchange for less strict regulation, commercial insurers agreed to make strong commitments to a market assistance program for several hard-to-place risks.

But, just a few weeks after implementing the softer July 7 regulations, the department issued new amendments governing non-renewals and other issues.

Insurers agree the new amendments are not as strict as the original September regulations, but nonetheless complain the latest changes were not part of the deal.

"We do intend to have discussion with the department" about the proposed amendments, said Robert J. Sullivan, vp of government affairs for Crum & Forster Corp. in Morristown, N.J., and a spokesman for a group of about six insurers involved in the negotiations.

The department will accept comments on the amendments until Aug. 20; effective dates will follow.

The regulations and proposed amendments apply to all admitted insurers writing commercial property/casualty lines, excluding surplus lines; ocean marine and aviation; out-of-state risks covered by policies issued in New Jersey; workers compensation and

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## inside

➤ One of the developers of three proposed insurers that would write excess liability coverages for Canadian companies says the plan has generated strong buyer interest. PAGE 32



➤ A bill that would significantly alter California's workers compensation system is under scrutiny by the Workers' Compensation Insurance Rating Bureau, while a New York commission urges an overhaul of that state's system. PAGE 28

➤ In the Perspective section, Thomas S. Bloom, president of Grand Rapids, Mich.-based McAlear Associates Inc., disputes the benefits of the "brave new world" created by the introduction of claims-made general liability forms for blanket use. PAGE 23

➤ A British Department of Trade and Industry report alleges that three men acted dishonestly in connec-

tion with the placement of reinsurance for Lloyd's of London syndicates managed by PCW Underwriting Agencies Ltd. PAGE 31

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# Employee Benefits Communications Awards

## The 1986 EBC winners

Fourteen companies and six employee benefit consulting firms are winners in the 1986 Employee Benefits Communications Awards competition.

The 14th annual competition, sponsored by *Business Insurance* to recognize outstanding accomplishments in employee benefits communications, attracted a record 174 entries this year.

Sixteen awards are being made this year: first-, second- and third-place awards in five categories, as well as a special award in the audio-visual category.

A new category was added to this year's compe-

tion: interactive computer communication programs.

The new category, which attracted nine entries, recognizes the growth of this new method of communicating benefit programs to employees.

The biggest growth in entries occurred in the categories of booklets and total communication programs—involving several media to communicate a company's total benefits program.

A panel of 11 judges evaluated the 174 entries from more than 145 employers to select the winning entries. Twenty-two consultants were

involved in 149 of the entries.

Articles describing the winning entries appear on pages 4-26, while the judges are listed on page 27.

The winners, and their consultants, are being honored this week during *Business Insurance's* conference in New York, "Employee Benefit Communications: A Changing Environment Offers New Choices."

Each winner receives a plaque signifying the award. A report on the conference will appear in the Aug. 18 issue of *Business Insurance*.



### Audio-Visual

**1st**

**PepsiCo Inc.**  
White Plains, N.Y.  
A.S. Hansen Inc.

**2nd**

**Pacific Gas & Electric Co.**  
San Francisco  
Towers, Perrin, Forster & Crosby

**3rd**

**Marine Midland Bank**  
Buffalo, N.Y.  
Hewitt Associates

### SPECIAL AWARD

**Sun Life Assurance Co. of Canada**

Wellesley Hills, Mass.  
Hewitt Associates

### Total Communications Program

**1st**

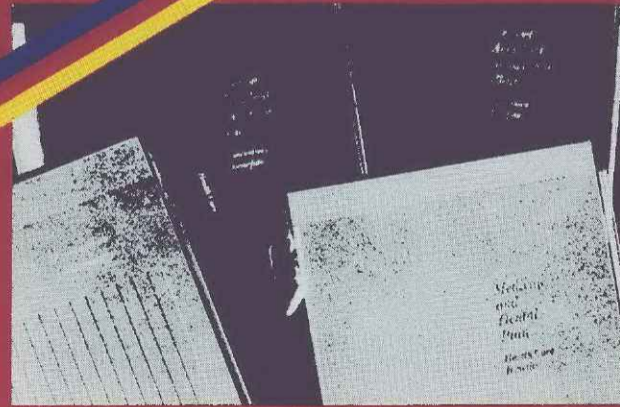
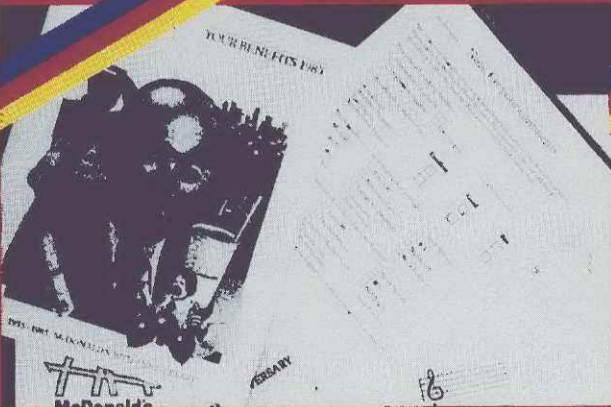
**Pacific Gas & Electric Co.**  
San Francisco  
Towers, Perrin, Forster & Crosby

**2nd**

**The New England**  
Boston  
Produced in-house

**3rd**

**First American Bankshares Inc.**  
Washington, D.C.  
The Wyatt Co.



### Computer Communication

**1st**

**Hanes Group**  
Winston-Salem, N.C.  
William M. Mercer-Meidinger Inc.

**2nd**

**NCR Corp.**  
Dayton, Ohio  
Hewitt Associates

**3rd**

**Santa Fe Southern Pacific Co.** Chicago  
William M. Mercer-Meidinger Inc.

### Personalized Correspondence

**1st**

**McDonald's Corp.**  
Oak Brook, Ill.  
Hewitt Associates

**2nd**

**Barnett Banks of Florida**  
Jacksonville, Fla.  
Hewitt Associates

**3rd**

**Xerox Corp.**  
Stamford, Conn.  
Benefacts Inc.

### Booklets

**1st**

**Sara Lee Corp.**  
Chicago  
William M. Mercer-Meidinger Inc.

**2nd**

**The Marine Corp.**  
Milwaukee, Wis.  
Hewitt Associates

**3rd**

**Los Angeles Unified School District** Los Angeles  
William M. Mercer-Meidinger Inc.

# PepsiCo benefits video pops with satire



By DONNA DiBLASE

PURCHASE, N.Y.—PepsiCo Inc. is using a bit of reverse psychology to persuade employees to take their benefits seriously.

Regenerating employees' enthusiasm for the company's 5-year-old flexible benefits plan requires a special touch, said Suzanne Samuelson, manager of benefits communication for the company.

"When we were going into producing our video, we thought if we treated the subject lightly, employees would think more seriously about the plan," she explained.

The result was "The Edge of Choice," a humorous look at the way some mythical employees make their benefit elections under "Benefits Plus You," PepsiCo's flexible benefits plan.

The video, shown to about 10,000 employees at four divisions of the company, won first place in the audio-visual presentation category of the *Business Insurance* Employee Benefits Communications Awards.

"We wanted to convey to employees that they need to re-evaluate their choices. We wanted to hammer home choice—not details," said Ms. Samuelson.

PepsiCo conducted a survey a year ago to find out how employees felt about the flexible benefits plan, she said.

"We found out that employees really did appreciate the plan, but we wanted to regenerate enthusiasm," she explained.

"PepsiCo spends a lot of money on enrollment every year," said Steven Sundheimer, a senior con-

sultant in the White Plains, N.Y. office of consultant A.S. Hansen Inc. "But, they wanted to make sure employees didn't feel like 'hohum, oh, it's this again,' at enrollment time" he added.

The company began by changing the name of the plan from "Benefits Plus" to "Benefits Plus You" to personalize the program, said Ms. Samuelson.

"We also streamlined the enrollment workbook, making the materials easier to use," she said.

Then, to stimulate attendance at the voluntary enrollment meetings, PepsiCo introduced "The Edge of Choice."

The 12-minute video, which cost \$60,000 to produce, was shown at the beginning of the meetings to entertain employees as well as to inform them of any changes in the plan.

As the melodrama begins, viewers visit the living room of George and Marsha, a middle-aged couple faced with the dilemma of making decisions about the flexible benefits plan offered by Marsha's employer.

George swears that he can't cope with making another decision. He says he has recurring nightmares of a giant man-eating question mark with bulging red eyes chasing him through a dark alley. George has figured out that he makes 173 decisions a day.

Marsha decides that George is a victim of "option burnout," but reminds him that as long as she has a choice, "we've got an edge."

However, a few blocks away, their friend Scott has his own system for making his choices under the plan. Seated on his sofa, he aims darts at a dartboard marked with the options under the plan.

Suddenly, Scott hears a knock at the door. At first, he says he thinks it's opportunity knocking. But, he discovers instead that it's his friend Brian.

Brian says he is shocked at the way Scott is making benefit elections. Brian reminds his friend that the enrollment materials are simpler this year, so there is no excuse for his behavior.

Scott reconsiders after Brian reminds him of the tax advantages of the plan because, after all, "benefits are money," he says.

But, next door, the Robinsons are having their own problems.

Doris Robinson is a wife and mother who has set up an office at home to make the most of her time. She is a woman obsessed with time management and her policy is, "if it takes more than 15 minutes, it's probably not a worthwhile project."

This has left her husband, Hal, and their teen-age daughter, Charlene, to cook and assume other household responsibilities. To get into her office to see her, they have to knock and sign in—if she has the time available.

Since Hal already has used up his allotted time with Doris, it is Charlene who has to inform her mother of the changes under Hal's flexible benefits plan.

Charlene reminds her mother that this is important. She tells her mother that last year they did not elect dental coverage and now that she has braces, "this family has become a dentist's dream." Charlene mentions to her mother that improvements in the dental coverage have been made.

As the show closes, the narrator asks if George and Marsha and their friends will make their benefits choices wisely.

Then, he asks the viewers, "What about you? Will you take time to make informed choices, or will you find yourself teetering on the edge of choice?"

Continued on page 6

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## PepsiCo video

Continued from page 4

Mr. Sundheimer of Hansen said the video "tries to prove its point through exaggeration. We wanted to get employees' attention."

"I hope that employees don't make their benefit elections by throwing darts, but that all comes back to the title of the video—that every employee is teetering on the edge of choice," said Ms. Samuelson.

Also, "the 'option burnout' scene was meant to poke fun at the fact that this program has been around for five years. And, we felt that some employees might be feeling that, 'it's October and I have to do this again.' We wanted them to think about their choices," she explained.

Although PepsiCo produced four versions of the video for four divisions of the company, making the video was still cost-effective, Ms. Samuelson explained.

"The interesting thing about this is that we were able to shoot one video and then splice in inserts relating the details in the four plans," she said.

Ms. Samuelson admitted it has been difficult to judge employees' reactions to the video.

"We found that if you do something light and funny like this, as long as you have it properly positioned, it will work. If you have a good meeting leader who can provide a lot of the details after the video, then it will work," she explained. However, she added, "This is not something that could stand on its own."

"It's not your typical benefits show," Mr. Sundheimer said, but he added it serves the purpose of getting employees' attention.

One EBC judge said "the video's message, 'benefits are money,' was good." Another judge said the video's ending of "employees teetering on the edge of choice is a very nice wrap-up." ■

## PG&E, Marine Bank videos runners-up; Sun recognized

The runners-up in the audiovisual category were:

• Second-place: Pacific Gas & Electric Co. in San Francisco.

After employees "heard it through the grapevine," rumors of PG&E's new flexible benefits plan were confirmed in a video entitled "Flex."

In the video, a few of the utility's 8,000 management employees discuss how the new plan will affect them after the presentation opens with background music similar to Marvin Gaye's "Heard It Through the Grapevine."

The 15-minute video, which cost \$75,000 to produce, was used as a meeting-starter to give employees a brief overview of the flexible

benefits plan, explained Sally Gottlieb, flex project coordinator for the utility.

"I had to collect a number of employees from different parts of the company—who had different benefits needs—to appear in the video, making candid comments about the plan. Before the video was produced, we had a meeting to explain the flex plan to them," Ms. Gottlieb said.

One EBC competition judge commented that the PG&E video "didn't make flex overwhelming. It was audience-friendly."

Production of the video was coordinated by Ms. Gottlieb and Janice Burnham, a consultant in the San Francisco office of Towers,

Perrin, Forster & Crosby, and Jeffrey Horn, a consultant in the Denver office of TPF&C.

• Third place: Marine Midland Bank of Buffalo, N.Y.

Marine Midland used its corporate logo of a clipper ship to emphasize to employees that they could chart their own courses under the bank's new flexible benefits plan.

In a sound and slide presentation entitled, "MarineChoice—Chart Your Own Course," a miniature sailboat takes employees on a voyage during which they visit benefit "islands" that can help them weather unexpected storms.

A miniature set and props were used to depict the voyage, complete with the hazards of the sea like sharks, which represent the Internal Revenue Service, and storms, which represent unexpected illnesses or accidents, said Bill Greene, a consultant with Lincolnshire, Ill.-based Hewitt Associates.

"We tried to build the analogy all along that you should evaluate your situation in life just as you would on the sea," he explained.

In the slide presentation, life preservers represent life insurance options and treasure chests represent reimbursement accounts, where employees can keep pretax dollars safe from the sharks.

"The slide presentation was used to soothe employees and make them relax and feel more comfortable about this big change," said Lana Lewis, vp and manager of indirect compensation.

One judge commented that "this is a nice, short presentation for a very detailed scenario of the flexible plan."

The 14-minute presentation cost about \$40,000 to produce, Mr. Greene said.

The production of the audiovisual was coordinated by Ms. Lewis, Mr. Greene and two other Hewitt consultants, Ed Skager and John Shillingburg.

• A special award was given to Sun Life Assurance Co. of Canada in Wellesley Hills, Mass., for its video, "The Sun Advantage."

The video was designed to introduce the company's 401(k) savings plan to two groups of employees: about 800 workers in the insurer's home office and about 700 agents in field offices across the country.

The video features a castaway on a deserted island, exaggerating the remote locations of some of the company's agents. But, even though the man has been stranded on a deserted island, the Internal Revenue Service still manages to send him a 1040 form to file his income tax.

And, that's where "The Sun Advantage"—the pretax savings plan—comes in. The narrator generally tells employees about this "less taxing way to save."

At the end of the 10-minute video, the castaway enjoys the rewards of his reduced taxable income by relaxing with a champagne and lobster dinner on his island.

"We decided the best thing was a light treatment just because we wanted the video to be a teaser," said Rebecca Hudson, senior public relations assistant, who helped produce the video.

The video was shown at the beginning of employee meetings, said Mac Bradford, a consultant in the Rowayton, Conn., office of Hewitt Associates. "This presentation can't stand on its own. There is a whole package of materials that went with it."

The video cost about \$20,000. Production was coordinated by Ms. Hudson and Mr. Bradford. ■

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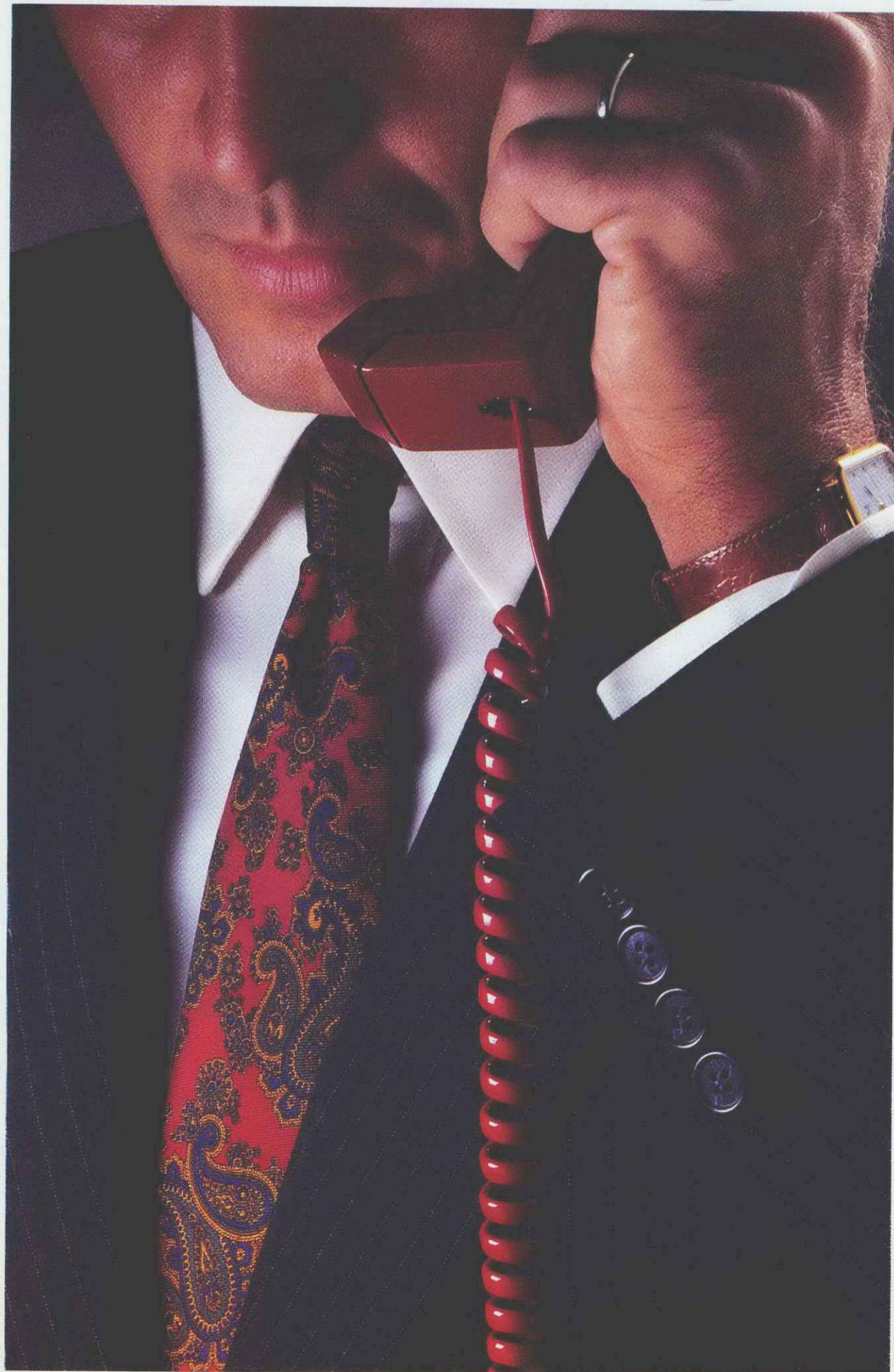
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# opinions



## A preconceived result

**T**HE BACKLASH against perceived price gouging by the insurance industry is going to give insurers a severe case of whiplash.

Already, as we have pointed out in past news articles and editorials, insurance departments are punishing insurers for their big rate hikes, midterm policy cancellations and last-minute decisions not to renew policies. States such as Florida, New York and New Jersey, to name a few, have adopted strict new rating controls and restrictions on policy cancellations and non-renewals.

Now we have judicial thrashing of insurers with the Oklahoma Supreme Court decision throwing out workers compensation rate increases in the state and ordering premium refunds.

With insurers' profits rebounding at the same time that corporations, municipalities and institutions can't find—or can't afford—insurance, defending insurers against judicial and regulatory retribution will not be popular.

Nonetheless, we feel compelled to criticize the Oklahoma Supreme Court for handing down a decision that is nothing more than a retroactive rationalization to support a preconceived result (see story, page 1).

The court reads Oklahoma's rating law to permit rate hikes only if rates are found to be inadequate. And, according to the court's reading of the law, "a conclusion that rates are inadequate necessarily depends upon a finding that (1) rates are unreasonably low... and (2) either the use of the rates endangers insurer solvency or the rates do, or will, adversely affect competition or create a monopoly."

One of the tests, it appears, means insurers in Oklahoma are not entitled to make a profit and may be granted rate hikes only to prevent insolvency.

We're not sure how insurers could justify workers

compensation insurance rate increases using the other test referring to competition and a monopoly, except to threaten mass withdrawal from the state, leaving workers compensation underwriting to the state fund and creating a monopoly. We expect that would open another proverbial can of legal worms.

Even if "endangers insurer solvency" is given a liberal meaning to permit insurers to earn profits and not just to prevent the erosion of surplus, the court's decision puts an impossible burden on the Oklahoma rating board.

The court expects the state's five-person rating board, assisted by a staff of only 13 people, to plow through detailed financial reports from all the insurance companies represented by National Council on Compensation Insurance to come to the conclusion that the use of current rates "endangers insurer solvency."

We are not, however, holding the NCCI blameless for this decision.

We appreciate, for example, the court's demand that insurers disclose information on investment income and insurance company expenses when requesting rate hikes—which the NCCI failed to supply at all regarding investment income and in insufficient detail regarding expenses.

Overall, however, we agree with the comment in a dissenting opinion written by Justice Robert Laverder, who wrote:

"The majority opinion has widely departed from the concept of allowing free market forces to govern proposed rates... The result of the majority's reasoning is to treat the insurance industry as a public utility."

"I find no authorization for such treatment in statutes governing insurance," he added.

We wonder how long that will be true.

## letters

### Demand quality monitoring from PPO networks

To the editor: We couldn't agree more with Samuel X. Kaplan's Perspective article, "Quality vs. Cost," concerning the quality of care provided by health

maintenance organizations and preferred provider organizations (BI, June 30).

The time is soon coming when employers will face the reality of controlling costs... without monitoring quality. Litigation and over-regulation will result if we do not demand initial and ongoing medical services quality monitoring from PPO networks.

Pacific Mutual Insurance Co. insists upon this as a cornerstone of its PPO networks. It's good for marketing, but it's much more than that... It established consistency throughout the PPO network and a level of trust with clients.

Mr. Kaplan has been outspoken for a



number of years on critical health care issues. He should not be alone in his concern for PPO quality.

**James W. Burke**  
Pacific Mutual Life Insurance Co.  
Newport Beach, Calif.

# business insurance

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# Communication key to 'Flex' success

By DONNA DiBLASE

SAN FRANCISCO—Pacific Gas & Electric Co. employees are getting the most out of their new flexible benefits plan partly because the company began its communication effort before the plan was designed.

The San Francisco-based utility began its award-winning communications program by surveying its management employees about their benefits.

"We had an overwhelming 91% of the 8,000 management employees who responded tell us that a flexible benefits plan would be good for PG&E," said Sally Gottlieb, flex project coordinator for the utility.

"Flex," the \$300,000 communication program that followed to

implement a flex plan, included employee newsletters, group meetings, audio-visual presentations and interactive personal computer software. The program won first place in the total benefits communication program category of the *Business Insurance Employee Benefits Communications Awards*.

The benefits survey revealed that most PG&E management employees really liked their benefits, noted Janice Burnham, a consultant in the San Francisco office of Towers, Perrin, Forster & Crosby, who worked on the project.

"The points that we got from the survey were that the benefits were one of the reasons many employees joined PG&E and stayed. But, they



said they wanted more flexibility," Ms. Burnham explained.

The seven-page, confidential survey asked employees to evaluate their benefits and briefly describe any changes they would make.

After the survey results were

announced to employees through the company's newsletter, "PG&E Week," the company began conducting focus group meetings with employees. Employees were introduced to possible flexible plan designs and possible enrollment procedures, said Ms. Gottlieb.

"We conducted a lot of focus groups on how we should communicate the program too. These were really important to the success of the program and we did make some changes in our communication plans as a result of the groups," she added.

After the meetings were held, the final plan was designed and PG&E's board of directors approved it. Then, the communica-

tion process of "Flex" began, Ms. Gottlieb said.

Along with announcements in the company newsletter, employees began receiving a series of seven "Flex Bulletins" two months before enrollment began, she said.

Beginning with a bulletin that gave a brief overview of the new plan, each bulletin covered a different topic, including:

- Three health care options.
- A health care reimbursement account and a dependent care reimbursement account.
- Four life insurance options.
- How to buy or sell up to three "FlexDays" for employees wanting more or fewer vacation days.
- How employees can "buy" different benefits with "FlexDollars."
- Examples of different benefit choices and how they worked.

The company selected 180 employees from all of its locations to be trained as leaders of employee meetings, Ms. Gottlieb said. These employees attended 2½-day training sessions.

"These meetings were a major factor in the success of the overall communication program," said Jeffery Horn, principal consultant in the Denver office of TPF&C.

"We held a panel question-and-answer discussion, where we had the trainees ask every question they thought they might be asked in the employee meetings. It turned into a competition to stump the experts," Ms. Gottlieb explained.

During the sessions, a court reporter recorded all of the questions the trainees asked. After the training was over, employees received copies of all of the questions and answers, she said.

"We tried very hard to let these people know that we were going to break all of the myths that benefits are boring. We encouraged heavy group participation and no segment lasted more than 30 minutes," Mr. Horn explained.

"If they left with questions unanswered, then the meetings would have failed," he said.

Once the leader training was over, employee meetings were held at all locations over a three-week period, Ms. Gottlieb said.

The meetings opened with a video in which several PG&E employees candidly discuss how they thought the new plan would affect them.

The video won second-place in the audio-visual category of this year's EBC competition (see story, page 6).

"When we were coming up with ideas for the video, one of the first things that came out as far as how people get information at PG&E was that it's through a grapevine," explained Ms. Burnham of TPF&C. "So, we designed the opening music to sound like the song 'Heard It Through the Grapevine,'" she said.

Since one of the main objectives of the program was to convince employees that "Flex" was not a reduction in benefits, "we used real employees in the videotape to get a positive response from our employees," said Ms. Gottlieb.

Employees then saw a slide presentation narrated by the meeting leaders that provided more details about the benefits options and the tax advantages offered by the flexible plan, she said.

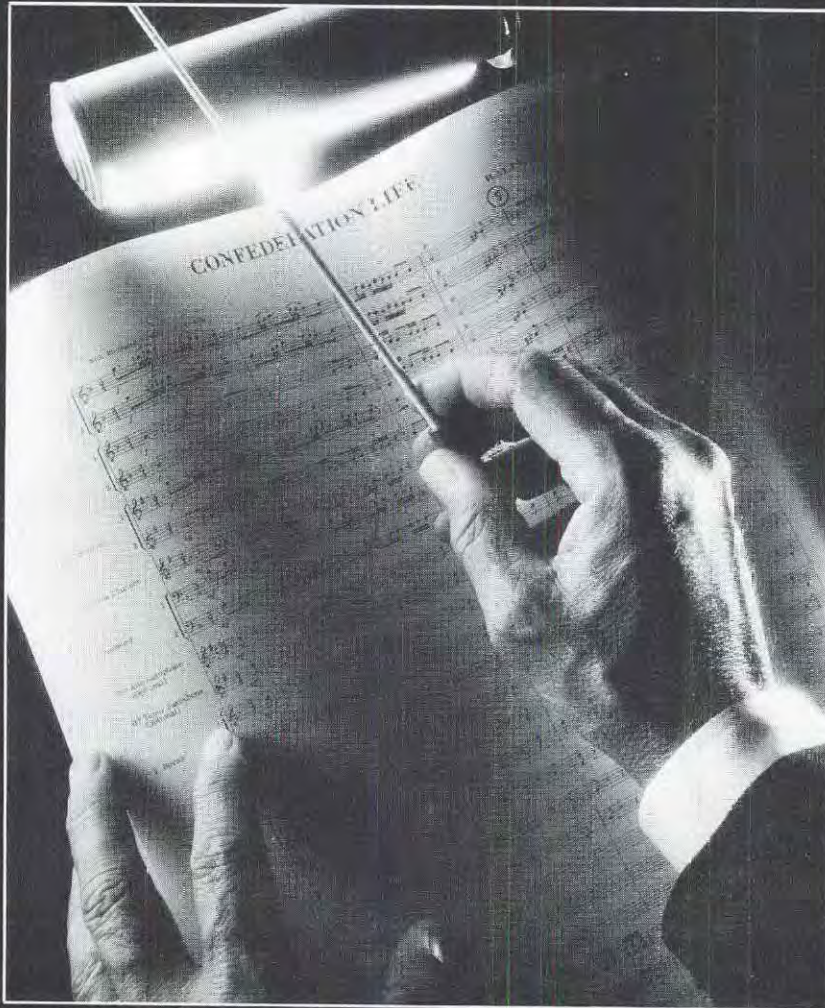
Each employee also received a personalized enrollment package which included:

- A "Flex" booklet that explains the enrollment process, how "FlexDollars" are allocated and all of the options offered by the plan.

- A personalized election form, computer-printed with the employee's name and the amount

Continued on page 12

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## PG&E communication plan

Continued from page 10

of "Flex-Dollars" he or she has been allotted.

In the first of the form's two sections, the cost in "FlexDollars" for each benefit option is listed.

In the second section of the form, employees total the cost of all of their choices to determine if they are entitled to unused "FlexDollars" or if they will incur an additional cost.

They can place unused "FlexDollars" in reimbursement accounts, a savings fund or receive the dollars as taxable income at the end of the year.

• An enrollment form for medical and dental plans. Employees listed the individuals to be covered on this form, which also could also be used to request changes in coverage after the plan year begins.

• A "FlexSelect" interactive personal computer diskette. Employees could use the diskette with a company-owned personal computer to see the results of different benefit elections.

For example, they could see what their tax savings would be if they deferred a portion of their salaries to tax-free reimbursement accounts. Or they could determine which benefits elections would allow them to receive unused "FlexDollars" as taxable income.

• A chart comparing coverages under the company's indemnity medical plans and health maintenance

organization options.

• An employee response card asking employees to rate various elements of the communication program.

About a month after enrollment, employees received personalized statements confirming their benefits elections, said Ms. Gottlieb.

The statement listed the benefits choices and their cost in "FlexDollars."

Ms. Gottlieb said employees were very satisfied with the plan and the way it was communicated.

"The feedback we received on the response cards was overwhelmingly positive," she said.

But there were other indicators of the program's success. "Eighty-five percent of employees chose benefits different than what they had before. That confirmed for us that the whole concept of the plan was a good idea," she said.

"A lot of employees also elected a number of the new options under the plan. For example, 23% chose to save in the reimbursement accounts. Fifteen percent bought "FlexDays," she said.

"One of our objectives was to make sure employees understood the plan so that they wouldn't make errors on their enrollment forms," TPF&C's Mr. Horr said. "In the end, less than 10% made errors."

One EBC judge said that PG&E's communication effort was "beautifully handled and produced. It made me wish I worked for a company like PG&E." ■

## Life insurer, Washington bank win honors for their programs

The runners-up in the total benefits communication program category are:

• **Second place:** The New England of Boston, formerly known as New England Mutual Life Insurance Co.

The New England wanted to convince its 4,000 employees that the benefits provided under a new flexible plan could be as individual as each employee's facial profiles.

The new benefits plan, dubbed "Profile," was introduced to employees last fall through a series of newsletters and posters. The company used a color logo of the profile of a face throughout its communications.

And, as part of the communication effort, employees saw the "501 Players" make their video

debut, said Larry Cutler, assistant vp in The New England's benefits planning and counseling department.

Members of the company's employee drama club—named for the company's street address—starred in a video that portrayed the diversity of the workforce and its varying benefit needs.

"We wanted to try a wide range of communication media because of the range of different people in our company," Mr. Cutler said.

Employees also could learn more about the plan by using an interactive software program run on personal computers, he said. And, a benefits hot line was set up to answer any questions.

The EBC judges agreed that The New England offered a communication medium for everyone.

"The program has good information and variety. Everyone is informed," said one judge.

The program, which cost about \$80,000, was produced in-house by Mr. Cutler and Jeanne Kristaponis, a communication consultant at The New England.

• **Third place:** First American Bankshares Inc., a Washington-based multistate bank holding company.

First American Bankshares was faced with a communications problem when it consolidated the benefit plans of its subsidiaries to establish a unified corporate identity, explained Anthony Torentinos, senior vp and director of human resources for the company.

Although the benefits of bank subsidiaries in five states were being consolidated into one flexible plan, the bank wanted its 4,200 employees to know that the new plan still took into account the diversity of the workforce.

To communicate "The American Choice" plan, the company developed a series of composite characters that represented the diversity of employees' lifestyles and their different geographic locations. These composite characters were used throughout the communication program, from a series of newsletters to a video.

"We held focus groups at the beginning and tried to key in on what we thought employees needed to know the most about under the new plan," explained Russ McNish, manager of compensation and benefits for the company.

"We came up with composites of employees and used those to communicate the choices under the plan," he added.

The six composite employees range from a middle-aged husband living in Virginia to a young couple from Maryland expecting their first child.

Each composite employee is featured in one of six newsletters. Each newsletter discusses a different benefit area of the plan and is color-coded to match explanations of benefit areas in an enrollment booklet.

"We aimed to try to get employees to think of some of the benefits in terms of the composites and color-coding," explained Arnold Malasky, a consultant in the Washington office of The Wyatt Co.

In addition to the newsletters and a video, a telephone hot line—called "ChoiceLine"—was available to employees with additional questions.

One EBC judge said, "The personalization of the program was impressive."

The program cost about \$250,000. It was coordinated by Mr. McNish and Anthony Torentinos, senior vp and director of human resources at First American, along with Mr. Malasky of Wyatt. ■



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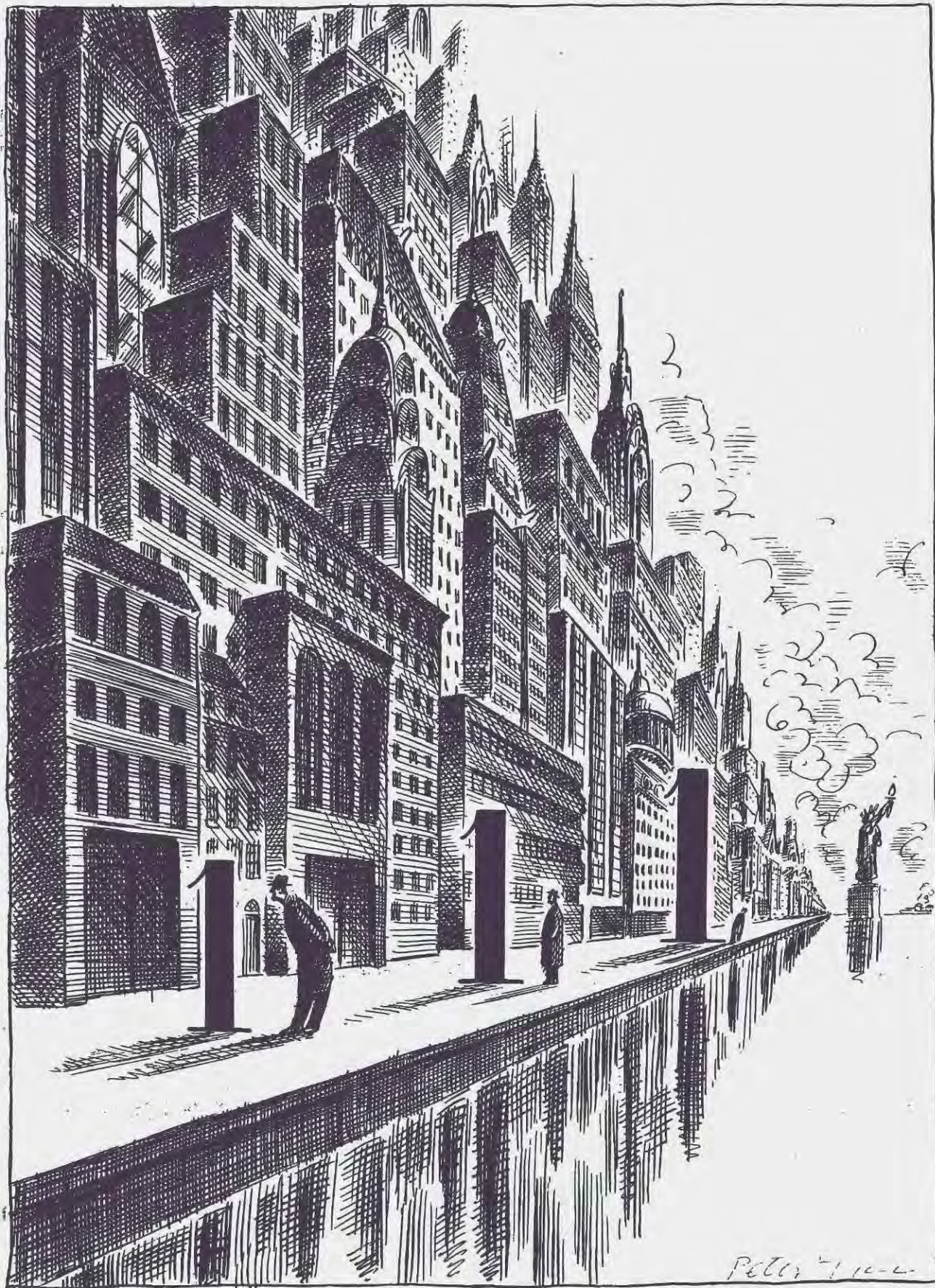
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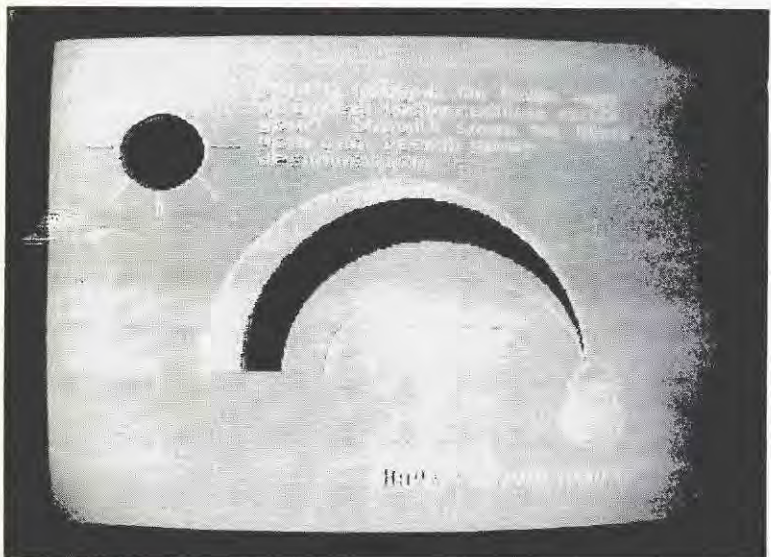
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# Hanes' interactive software explains 401(k)



By DONNA DiBLASE

CHICAGO—Hanes Group is using interactive computer software to help employees understand its new 401(k) savings plan.

Hanes employees can use a personal computer to judge how deferring a portion of their pretax salary to the Hanes Retirement Savings Plan affects their current take-home pay as well as their future retirement income.

The software program, which cost \$20,000 to develop, won first place in the computer communication category of the *Business Insurance* Employee Benefits Communications Awards. Computer communication is a new category in this year's EBC competition.

The Winston-Salem, N.C.-based subsidiary of Sara Lee Corp.

**'We wanted employees to be able to learn at their own pace,' explains Sara Lee's Gary Grom.**

implemented the 401(k) savings plan in July 1985, explained Gary Grom, director of human resources in Sara Lee's Chicago headquarters.

But, the company had some special concerns about how to communicate the plan, explained Karen Greenbaum, a principal consultant in the Chicago office of William M. Mercer-Meidinger Inc., who coordinated the computerized commu-

nication project. "First of all, we were communicating a change from an all after-tax savings plan to an all pretax plan," she said.

And, since all 18,000 salaried and hourly employees are eligible to participate in the plan, the apparel manufacturer wanted to be sure employees at all levels of pay and education understood the impact of contributing to the plan on a tax-deferred basis, she explained.

"One of the company's concerns was that employees felt that they couldn't afford to save," she said. "But, Hanes also felt that if employees didn't participate in retirement savings, they wouldn't have retirement income."

Hanes "also wanted to be sure that consistent messages about the plan were presented to employees at all locations," Mr. Grom explained.

"We wanted employees to be able to learn at their own pace," he added.

The interactive software program was an obvious choice, said Ms. Greenbaum. By using the system, employees could have fun while learning about the plan at their own speed, she said.

Two sets of meetings were held in June 1985 to introduce the 401(k) plan and the communication software to employees, she explained.

The company used an audiovisual presentation to introduce the change to a 401(k) program from an aftertax savings plan. Employees received brochures about the plan and a special 401(k) calculator, she said.

At the second meeting, employees met one-on-one with benefits department personnel and were shown how to use the interactive computer program to determine how much salary they should defer to the plan.

"We made the program as user-friendly as possible so that no knowledge of computers is really necessary to operate the program," Mr. Grom explained.

The program reports the effects of pretax savings on employees' take-home pay and future retirement income through the use of colorful moving graphics. Graphics also are used to illustrate other aspects of the 401(k) program, such as the plan's withdrawal provisions.

The software program begins with a graphic of a rainbow and the message: "Destination: Retirement Financial Security." Next, employees are warned through the computer that they need to plan ahead and make wise decisions to ensure a safe trip toward retirement.

Employees are asked to enter data such as the date, their birthdate, salary, marital status and whether they are a salaried or hourly employee.

Next, the program explains that under the new plan, they can defer between 1% and 10% of their salaries on a pretax basis and receive a company match of 35 cents on the dollar for the first 5% of salary deferred.

The software program then calculates the additional savings employees can realize under the new plan as a result of their reduced taxable income and the company matching contribution, which was inaugurated with the 401(k) plan.

Tax tables built into the program are used to estimate the income tax employees would pay on their reduced income.

The program tells employees that although they must pay taxes on the amount withdrawn from the

*Continued on next page*

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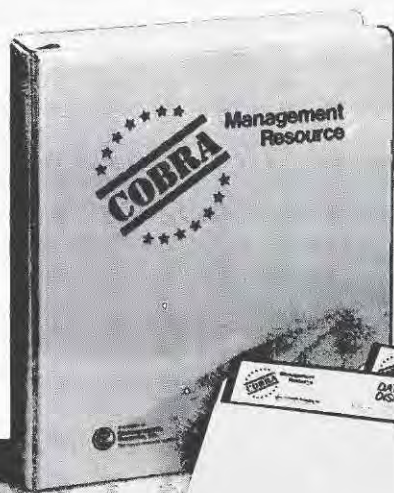
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WASHINGTON (April 7, 1986) — Congress today passed the Consolidated Omnibus Budget Reconciliation Act which becomes effective on employers' health plan anniversary dates following the 1st of July.

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# NCR, Santa Fe runners-up in computer category

Computer communication category runners-up were:

- Second place: NCR Corp. of Dayton, Ohio.

NCR Corp. thinks employees should take an active role in planning for their retirement.

To get employees involved, the company developed "EstiMATE," an interactive diskette for use with a personal computer, said Douglas Bartlett, NCR's director of benefits-United States.

EstiMATE helps employees project their retirement income by allowing them to enter personal data and assumptions on salary and savings. The program makes retirement income assumptions based on the entered information and tax information built into the program.

The program was introduced to employees in February 1985. Mr. Bartlett declined to reveal its cost.

The diskette is enclosed in a 12-page booklet that explains how to load EstiMATE into the computer.

EstiMATE is divided into eight "chapters" or screens, including a section that gives basic instructions for using the computer and program.

Other sections help employees estimate income from a 401(k) savings plan, a profit-sharing plan, a payroll-based

employee stock ownership plan and a pension plan. There is also a section on Social Security and savings.

By selecting a chapter and entering the necessary data, moving graphics show how an employee's retirement income increases or decreases under various assumptions.

Employees can obtain copies of the diskette from their division supervisors, said Mr. Bartlett. However, NCR has no objection to employees copying the diskette.

"Employee response has been extremely positive. We are eventually planning to make the program into a total financial planner," he said.

The project was coordinated by Mr. Bartlett and Steve Ramsey, a consultant in the Lincolnshire, Ill., office of Hewitt Associates and Kathy Collura, a Hewitt consultant based in Atlanta.

- Third place: Santa Fe Southern Pacific Corp. in Chicago.

Santa Fe's retirement planning program, Options Plus Opportunity, was intended to educate and prepare employees for retirement. It was introduced in December 1985. The company declined to reveal the cost of the program.

As part of the program—targeted to employees aged 55

to 65 and their spouses—employees used an interactive diskette to estimate their retirement income. The diskettes were used at several retirement planning seminars.

The program asks employees to enter basic information such as their birthdate, their spouse's birthdate, current salary, investment earnings and other income. Employees also enter their current contributions to the company's 401(k) plan and any other savings plans.

Then, with the use of colorful moving graphics—like stacks of money—the program makes retirement income assumptions based on the entered information and tax information built into the program.

At the end of the program, a graphic of a fireworks display over a city skyline—complete with music—appears. A printed message assures employees that they have just taken an important step in planning for their future.

The project was coordinated by Ronald Holden, senior retirement specialist, Russell Hagberg, director of compensation and benefits, and Al Mallet, senior retirement specialist of Santa Fe, and Barbara Gladman, associate consultant in the Chicago office of William M. Mercer-Meindinger Inc.

*Continued from previous page*

plan after they retire, they may qualify for favorable tax treatments like 10-year forward averaging.

Employees also are informed that they can withdraw their savings before retirement if they demonstrate a financial need like the purchase of a home.

The program then furnishes estimates of how employees' 401(k) accounts will grow over five, 10 and 20 years, assuming current salary and contribution rates and a 10% return on their investment.

A moving graphic of two pots of money then illustrates how much more retirement income can be generated by the pretax with the company match compared with the company's previous aftertax savings plan.

At the end of the program, employees can start again and enter different percentages to better help them determine how much they wish to defer to the plan.

"Employees have a chance to see the impact of various contribution levels," said Ms. Greenbaum. "That's why a PC program works better than a printed statement because employees can really play around a lot more."

When finished, employees can make a printout of their calculations.

"We included the printout capability because one concern that we had was that we would only reach employees with this system," said Ms. Greenbaum.

"This way, employees can share the printout with their spouses or financial advisers," she explained.

The program ends with a graphic of a rainbow. But, this rainbow leads to a pot of gold and a message that urges employees to enroll in the plan soon so they can reach their destination of retirement security.

Employees really liked the software program, Mr. Grom said.

"We have an excellent enrollment in the plan. Some of that is due to the communication tool, but I can't say it has been solely responsible for this. The enrollment would be up just because of the pretax nature of the plan," he explained.

Eighty-five percent of Hanes' employees participate in the plan.

The program also received enthusiastic comments from the judges of the EBC competition.

"This is an excellent program that was entertaining to look at. It presented information necessary for employees at all income and educational levels to make an informed decision," said one of the judges.

Another judge commented that while "it's unusual that the program is geared to hourly employees as well as salaried employees, it has a logical development and is easy to understand."

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# McDonald's folds history into personalized booklet

By DONNA DiBLASE

OAK BROOK, Ill.—“Nobody can do it like McDonald's can” the fast-food giant professes.

And, to remind employees of what the company does for them, McDonald's Corp. designed a personalized 1985 benefits statement, outlining not only the employees' different benefits, but also the history of the company.

A “timeline” featuring illustrations of milestones in the company's history is the highlight of “Your Benefits 1985; 1955-1985: McDonald's 30th Anniversary,” which captured first place in the personalized correspondence category of the *Business Insurance*

Employee Benefits Communications Awards.

“We look for a different theme every year,” said Sue Vander Horn, manager of employee benefits for the company. “But, since 1985 was the 30th anniversary of McDonald's, we thought it would be a nice opportunity to incorporate that in the statements. Plus, we thought longtime employees might enjoy seeing the history.”

The 12-page statement, which was prepared with the help of Lincolnshire, Ill.-based benefit consultant Hewitt Associates, was distributed to 8,000 full-time and store management employees last June, Ms. Vander Horn explained. She declined to reveal the cost of

the program.

Along with incorporating the company's history in the statement, several changes also were made in the format of the statement, she said.

“We usually distribute a single-sheet statement,” Ms. Vander Horn said. “But, this year, we decided to use a booklet format for a few reasons.

“First, we wanted to expand the description of benefits. We also had a new 401(k) plan, plus we wanted to give employees more information about our other capital accumulation plans,” she explained.

The company also decided to include an employee questionnaire in the 1985 statement for the first time, she said.

The questionnaire asks employees to rate their benefits and the usefulness of the statement itself. It also gives employees an opportunity to let the company know which benefits they would like more information about, she said.

“The company really wanted to solicit some response from employees,” said Wendy Rhodes, a Hewitt consultant who worked on the project. “McDonald's did everything it could to get employees to participate in the communication process.”

The booklet, which measures about 7-by-9 inches, features an illustration of company founder Ray Kroc surrounded by illustrations of McDonald's products and Ronald McDonald, the company's mascot.

On the inside of the cover, a folded flap holds two laminated personalized identification cards for the company's group health insurance plan: one for the employee and one for dependents.

The employee's or dependent's name and the group policy number of the health plan, which is underwritten by Travelers Corp., appear on the front of the cards. Plan highlights are on the back.

The employee questionnaire is included behind the flap holding the identification cards.

The statement itself opens with a one-page introduction from McDonald's President Edward Rensi and an explanation of the preparation and purpose of the booklet.

The timeline runs along the bottom of each page, beginning with an illustration of the first McDonald's restaurant, which opened in 1955. There are 13 illustrations in all, including graphics of three popular commercial jingles and the opening of McDonald's Hamburger University. A caption identifies each illustration.

The company's traditional red and gold colors are used to highlight headings that introduce each benefit area. The rest of the statement is printed in black, with color illustrations on the timeline.

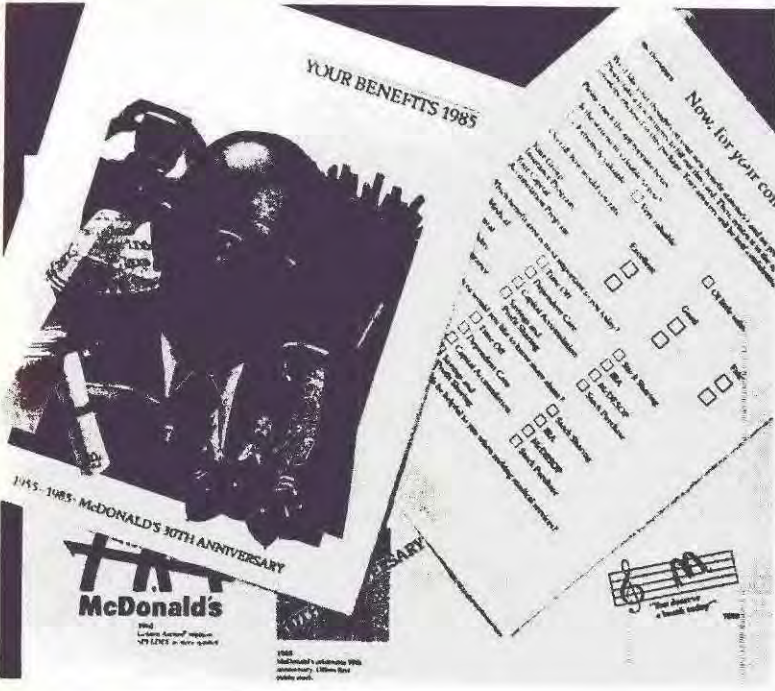
Personalized information was first printed in the booklets using a computerized impact printer, and then the generic content was printed conventionally, said Ms. Rhodes of Hewitt.

An explanation of the purpose of the benefits as well as personalized information about the employee's current coverage status precedes the actual summary of each benefit.

Included among the benefit descriptions are:

- The deductibles, copayments and limits for medical and dental benefit plans. Covered expenses as well as cost-containment incentives also are listed and explained.
- A brief explanation of

Continued on next page



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Continued from previous page  
McDonald's dependent care reimbursement account benefit. The section tells employees how they can defer up to \$2,400 annually to the account.

- Explanations of the company's short-term and long-term disability plan and statements of how much coverage they will receive.

- A section on survivors' benefits that shows employees' current coverage under a company-paid life insurance plan as well as any employee-paid supplemental life insurance.

Also explained are the amount of Social Security, accidental death and dismemberment and capital accumulation benefits payable to the employee's survivors.

- Summaries of all of the company's capital accumulation plans.

The statement tells employees how much McDonald's contributed to the profit-sharing plan, as well as the amounts of any forfeitures. The current vested amount and the value of any employee contributions to an investment savings plan are also shown.

In addition, projections of the values of both the profit-sharing and the savings plans in 15 and 30 years—assuming three different rates of return—are provided.

The statement also describes three different McDonald's stock plans.

The total value of the amount in each employees' "stock sharing" account, as well as the company's annual contribution to the TRA-SOP, are listed.

Employees also can purchase McDonald's common stock through payroll deductions under the company's stock purchase plan. Current account balances for this plan are listed in the statement.

In addition, similar information about a separate employee stock ownership plan—called a McDE-SOP—is provided. This plan contains the new 401(k) salary reduction option.

Employees also receive information about payroll-deductible contributions to a company-sponsored Individual Retirement Account.

- Estimates of what employees' Social Security benefits will be at age 65, based on their current salary. Social Security benefits payable to employees' spouses at age 65 also are estimated.

- How many vacation days and paid holidays they were eligible for in the previous year.

A brief explanation of a special McDonald's vacation benefit—called a "sabbatical"—follows this section.

Under this benefit, employees are eligible for eight consecutive weeks of paid vacation after every 10 years of service with the company.

The statement ends with a chart summarizing how much McDonald's and the employee contribute to the cost of these benefits.

Employees can then add the total cost to their yearly earnings to see their total compensation from the company.

McDonald's benefits statement took about six months to produce, said Ms. Rhodes of Hewitt.

"A lot of development went into the design of the illustrations on the timeline," she said. "We went on a field trip to a McDonald's museum during the development of the graphics."

"Deciding which illustrations to use was hard, but one of the trickiest parts of the production was getting the personal ID cards laminated and inserted into the statements," explained Ms. Vander Horn.

Employees have responded favorably to the statement, she said.

"We had about a 20% response rate on the employee response cards," Ms. Vander Horn said. "And, 96% of those who responded

**'The company really wanted to solicit some response from employees,' says a Hewitt consultant.**

said the benefits statement was valuable to them, but that they wanted more information on the capital accumulation plans."

Judges of the Employee Benefits Communications competition were also enthusiastic about the statement.

"The statement combines well the historical commemoration with the benefit details," said one judge. "It covers all areas adequately and includes a good employee survey form."

Another said the statement was "readable and attractive. It's something to keep." ■

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# Sara Lee cooks up booklet for execs

By DONNA DiBLASE

CHICAGO—Sara Lee Corp. wants its top executives to know their benefits are as distinctive as they are.

With this goal in mind, Sara Lee worked with benefits consultant William M. Mercer-Meidinger Inc. to produce "Rewarding Excellence in Management," a benefits handbook designed especially for key executives. The result won first place in the booklets category of the *Business Insurance Employee Benefits Communications Awards*.

The handbooks, which cost \$45,000 to produce, were distributed to 225 key executives last fall, explained Karen Batenic, senior manager of employee benefits at Sara Lee.

"All of the divisions within Sara Lee have their own separate benefits plans. But, our top executives have a core benefits program, so we wanted to produce a handbook exclusively for this group," she said.

Sara Lee considered several factors when designing the booklet, Ms. Batenic explained.

"We had to consider how much time executives have to sit down and read," she said. So, while the text had to be complete, it also had to be as concise as possible.

Ms. Batenic also pointed out that Sara Lee wanted the booklet to be distinctive, but not flashy. And, it was important that the booklet be easy to use and store, as well as easy to update, she said.

Finally, the booklet had to meet the reporting and disclosure requirements of the Employee Retirement Income Security Act, under which employers must provide employees with summary descriptions of their benefit plans, Ms. Batenic said.

"The company wanted its executives to know that the company was top-quality and so were they," said Karen Greenbaum, principal consultant in the Chicago office of Mercer-Meidinger, who helped design the booklet. "So, we took a real careful look at the design elements of the booklet as well as the ERISA requirements."

Since the booklet was targeted to top executives, the company chose a gray pinstriped three-ring binder as a format. The type on the cover and spine of the binder is embossed in gold.

"The gray pinstripes give the handbook a conservative look, but the gold was added to make it special for the executives it would be distributed to," explained Ms. Batenic.

The 9-by-12-inch binder stands easily on a bookshelf, making storage convenient, noted Ms. Greenbaum.

The binder also has a pocket on the inside of the front cover for storing annual benefits statements or other benefits materials.

Inside the binder, there are tabbed sections: health care; income protection; survivor protection; future financial planning; and benefit plan administration.

The tabs allow employees to easily locate information and are printed on heavy gray paper, continuing the theme set by the binder.

Individual booklets that detail benefits specifics slide into eight plastic sleeves that are punched with holes to fit in the binder.

The design of the booklet covers is similar to that of the binder. The title of each booklet and the name of the company also are embossed in gold.

Also embossed on each booklet cover is a logo that is used companywide by Sara Lee to symbolize each benefit area. For example, a cross inside a diamond symbolizes

health care benefits, while dollar signs inside a diamond symbolize financial planning benefits.

"Our symbols for benefits are the same for all employees. But they are embossed to distinguish communications for executives from other employee groups," explained Ms. Batenic.

Inside, descriptions of benefits are printed in black ink on heavy white paper. A single black pinstripe marks the far right margin of the right-hand pages.

The booklets, which range from

four to 26 pages long, include the following:

- A 12-page "Executive Summary," which concisely summarizes all of the four benefit areas.

The booklet opens with an introduction that discusses Sara Lee's benefit plan objectives and the company's commitment to quality management. A fold-out chart describes how particular benefits work in certain situations, such as retirement or illness.

"We included the summary

because we know that executives are used to getting large reports that include an executive summary," said Ms. Greenbaum.

"These are people who want the bottom line," Ms. Batenic added.

- A 22-page health care section, which details Sara Lee executives' medical and dental plans.

The booklet discusses eligibility requirements, coverages provided and any employee costs.

The booklet also explains how to file claims, how to continue coverage after retirement and termino-

logy such as coordination of benefits.

The health care booklet ends with details about plan administration, such as how it is funded and how to obtain a copy of the plan documents.

- Three booklets in the survivors benefits section.

The booklets detail death and accidental death and dismemberment benefits, a personal accident insurance plan and a travel accident insurance plan.

Continued on page 25

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# CLAIMS-MADE CGL FORM

## Revolutionary form will create turmoil for policyholders

By Thomas S. Bloom

THERE ARE several things the U.S. property/casualty insurance industry apparently does not understand about itself:

- Any industry that collects money today for the payment of obligations many years in the future has a fiduciary responsibility to its customers.

That responsibility is enhanced when the subject of the transaction is so technical and so arcane that the great majority of those buying it cannot be expected to understand it. And it is even further enhanced when the purchase of the coverage is a legal or practical necessity.

- If the industry is to fulfill its economic function, it is necessary that individual insurers cooperate to complete concurrent and coordinated placements.

- Privileges the industry has taken for granted are subject to change or cancellation at the will of its constituency when the industry fails to meet the needs of that constituency.

The introduction of claims-made forms for blanket use on general liability coverages challenges all three of these principles.

It is not a modification of form; it is a revolution in concept. And revolutions are easier to start than they are to control.

The Insurance Services Office, London insurers and other proponents of the claims-made form for general liability coverages offer the following arguments for its use:

- It will increase the predictability of loss by ensuring that only one policy will be called upon to respond to claims arising from a given occurrence and eliminating most of the exposure for incurred-but-not-reported losses.

- The increase in certainty and the elimination of the "tail," in turn, will allow certain lines—now all but abandoned by the industry—to be written again at a profit, thus alleviating both the affordability and availability crisis.

The claims-made form will accomplish none of these things and, further, its blanket use for general liability coverage is evidence of the industry's failure to understand the basic conditions under which it is allowed by society to operate.

It is true that a small percentage of liability classes have a sufficiently severe environmental impairment or latent injury exposure to warrant special treatment. The fact that the legal system has forced the industry to "stack" multiple limits of liability on "occurrences" that were not recognized or understood as such decades ago is a legitimate problem.

The ISO claims-made form, of itself, will not solve this problem and may, in

Thomas S. Bloom is president of McAlear Associates Inc., a wholesale brokerage based in Grand Rapids, Mich.

### speaking out

fact, serve to continue it.

A new definition of occurrence would have been a more constructive solution.

If increased predictability of loss is the objective then a much more basic problem must be addressed. The industry does not know how to measure its exposure to loss on commercial liability coverages. Changing the form on which coverage is written does nothing to address this problem. ISO is largely to blame for this failure.

ISO seems obsessed with simplified rating when it is exactly the opposite that the industry needs.

For example, the major reason that the admitted market has a hard time writing product and completed operations liability

coverage at a profit is because the ISO rating procedure for these classes does nothing to measure exposure to loss. The amount of current sales or current gross receipts has no relationship, in most cases, to the exposure to loss in the marketplace.

Likewise, the use of a single, easy-to-measure exposure base for most liability classifications ignores the fact that the actual exposure is the result of a complex combination of factors. The surplus lines industry has been able to write long-tail business with somewhat more profit than the admitted market not because it can charge higher rates but because surplus lines underwriters, not being bound to a manual, are free to make some effort to analyze the total exposure base.

By comparison, recall the tremendously complicated rating procedures traditionally used to establish fire rates for buildings and their contents. These systems are designed to recognize hundreds of factors that can affect ultimate exposure.

Liability exposure is no less complicated. Until the industry's inability to measure its exposure to loss in most liability classifications is addressed, any other solution is doomed to ultimate failure.

Two lines that have suffered both drastic underwriting losses and resulting restrictions in availability are directors and officers liability and errors and omissions. Both these coverages have traditionally been written on claims-made forms. The form did nothing to prevent an underwriting catastrophe. Also, in both cases, rating methods were oversimplified and unresponsive to exposure, which is the real reason that capacity collapsed.

A not insignificant side effect of this "brave new world" of the claims-made

form is a severe constriction in the market for agent's E&O coverage. Many insurers have stated that part of their reason for withdrawing from this market is the anticipated rise in litigation to be expected from the general use of the claims-made form. It is interesting to note that many of these same insurers are also leading proponents of the use of the form.

Society purchases liability coverage because it must—forced by either economic self-preservation or by the demand of third parties. The one thing society expects when a premium is paid is that exposure to loss will have been transferred, subject to as few conditions and exclusions as possible. Once transferred, it has never been part of the game that the risk can be transferred back, at the discretion of the insurer.

Yet this is exactly what the claims-made form allows. Even the ISO form, which—after much prodding from critics—now contains some attempt to build in protection for the policyholder, is subject to abuse. But worse, the introduction of the ISO contract has spawned the creation of a number of so-called stand-alone forms by the surplus lines industry and others that invite manipulation by the insurer to the detriment of the policyholder.

Many of these forms contain a combination of three conditions that allow a risk to be written retroactively. Specifically, such forms require the policyholder to report to the insurer every incident that might lead to a claim as soon as the incident becomes known. Coverage is triggered, however, only by written notice of a claim.

Further, these forms offer no guaranteed discovery period. Typically, such forms allow the policyholder to trigger the discovery period only when the insurer cancels or refuses to renew. These forms then state, in a phrase that will enliven much future litigation, that "an increase in premium, a change in conditions or the addition of exclusions will not be deemed a failure to renew."

Policyholders with such forms are totally at the mercy of the insurer. Underwriters not wishing to provide coverage for incidents reported but that have not yet generated notices of claims can avoid future liability with ease by offering renewal terms sure to be unacceptable to the policyholder. In these cases, little has been transferred except the policyholder's premium.

Even when the discovery period is available in these claims-made forms, it rarely exceeds three years and, most often, is available for only 12 months. These periods are patently insufficient for most liability risks. As time

progresses, the number of policyholders with uncovered and uncoverable gaps in coverage will grow to proportions sufficient to cause a march on Washington.

And now a new wrinkle has appeared in ISO's seemingly unending series of amendments to its original form. The five-year "basic extended reporting period" is being touted as a built-in tail coverage, when, in fact, it is nothing of the sort. The ambiguity created by the use of this term is sure to haunt ISO and its subscribers in the future.

True extended reporting periods cover claims arising from occurrences after the retroactive date and before the expiration date, as long as coverage is triggered before the end of the discovery period. ISO's "basic extended reporting period" responds only to claims made during a five-year period arising from occurrences reported prior to the end of the policy period or within 60 days thereafter.

This is not a discovery period at all. It is a development period. If the occurrence was not reported to the insurer within 60 days after the coverage expired, there is no coverage for a subsequent claim. This is not a broadening of coverage, it is an additional restriction!

The fact that ISO chose to call this restriction of coverage an extended reporting period and the fact that they call the true tail coverage a "supplemental extended reporting period," will cause unending glee in the eyes of plaintiffs' attorneys, who may discover that ambiguities in insurance contracts are resolved in favor of the policyholder.

The quality of these new forms aside, the development of independent, claims-made contracts by virtually every insurer still active in the excess liability insurance market has created a serious structural problem for policyholders and brokers.

Non-concurrency of coverage is now almost a foregone conclusion on any layered placement.

These stand-alone forms offer different triggers of coverage, different conditions and exclusions, different discovery period provisions and different requirements for reporting losses or incidents. Some include defense within policy limits, some do not (BI, July 21).

In trying to plug every hole in the exposure dike, these insurers may have succeeded in doing exactly the opposite. These solutions ignore the very underlying cause that led to their creation in the first place—namely, the propensity of the courts to find coverage where the courts think it should exist. If the legal system has seen fit to rewrite policies that have been in use for many years and that were relatively well understood, what will it do when presented with uncovered claims arising from claims-made forms?

In a 1984 case that has been largely

Continued on next page



# Claims-made form triggers policyholder problems

Continued from previous page  
ignored by the industry, *Sparks vs. St. Paul Insurance Co.*, the New Jersey Supreme Court ruled a claims-made contract to be contrary to public policy simply because it had a retroactive date exclusion, even though that exclusion had nothing to do with the loss being litigated. The insurer was forced to adjust the claim as though the contract had been written on an occurrence basis.

This case may prove to be a harbinger of a flood of similar decisions.

Insurers may find that they have created the worst of both worlds—policies that can be either claims-made or occurrence at the policyholder's option.

There are other changes that complicate the matter further. The new policy forms go far beyond a change in the trigger of coverage.

In addition to an absolute pollution exclusion, many of these forms contain absolute policy aggregates and ISO may still amend its form further to include defense costs within the limit. This later restriction has already been included in many of the independent forms.

In "solving" some of their own problems, ISO and admitted insurers have created a world of new ones for the excess/surplus lines market. The addition of a policy aggregate or the inclusion of defense costs within limits may lower the primary insurer's exposure, but it increases the excess insurer's proportionally.

No risk has been eliminated; it has simply been shifted to a different contract or transferred back to the policyholder.

This shifting of risk has created immense new problems for the excess insurer. It is much more difficult to underwrite an excess policy above coverage subject to an aggregate limit, than if a per-occurrence limit applies.

For the first time, excess insurers must now routinely concern themselves with slip-and-fall claims. This problem is only exacerbated by the inclusion of defense costs within the limit.

Further, the nature of the underlying form, once a relatively easily established fact, now becomes tremendously complicated. One can sympathize with the drafters of the stand-alone forms, even if their solution only takes us into a new arena of problems.

A byproduct of these stand-alone claims-made forms is the inclusion of substantial "retained limits" on the part of policyholders. In effect, these are underlying retentions that may be insured, at the policyholder's option, but do not have to be. Only a small fraction of policyholders are prepared to handle the obligations involved with self-insured retentions.

It is inevitable that claims will be mishandled and unfunded within these retentions.

The excess insurers that think they

can write coverage to apply in a vacuum may have a world of problems laid on their doorstep in a few years as primary claims "blow up" and penetrate their layer.

Another problem brought about by the use of the claims made form is the routine mixing of claims-made and occurrence wordings in a single form. There are almost as many versions of these forms as there are underwriters who think that such a condition is not a problem.

Besides being one of the most difficult of all exercises in contract draftmanship in the industry, policyholders won't understand the resulting distinctions, even if the contract is properly written—a task many deem near impossible.

Even worse, many irresponsible or ignorant brokers are mixing claims-made and occurrence forms on layered placements without informing the policyholder about the significance of such action. But all is not lost; the children of thousands of attorneys will enjoy a better education because of this.

One of ISO's worst mistakes in designing its form was to build in an automatic retroactive date exclusion. Any broadening would then be the result of a conscious action of an underwriter.

As evidence of ISO's total lack of understanding of the mechanics of the form, it was the original intention that the form automatically provide full prior acts coverage in every

instance. Even ISO's supporters were quick to convince it that this was a less than good idea.

But the same thing is certain to happen, inadvertently, any

number of times in the future. Any insurer that fails to add a retroactive date condition upon issuance of a policy will pick up exposure to all prior acts. This problem will be complicated by the fact that many insurers will not have reinsurance for the resulting liability. Excess insurers may or may not be forced to follow form.

To the extent that an unlimited discovery period is available under ISO's form, the error cannot be remedied even if the contract is terminated, assuming that the policyholder is willing to pay the price to buy the tail.

Desperate policyholders will regularly search the marketplace to find an underwriter ignorant enough—or careless enough—to issue a contract without a proper retroactive date, thereby filling any number of gaps in the policyholder's previous program. In such situations, the payment of not more than 200% of the annual premium may be the biggest bargain since the penny postcard.

But, policyholders will find at some time in the future that they have become the victim of a new Catch-22. Most new excess forms require the insured to report as soon as possible every incident that can lead to a claim.

Now that almost all underlying contracts contain an absolute policy aggregate, any incident could ultimately become a claim to the excess insurer.

As claims develop years after the contract has expired, any claim may turn out to be the one that first penetrates the excess layer. This is, of course, a problem under either occurrence or claims-made contracts when written with absolute policy aggregates.

The ramifications are even more complex, however, in the claims-made scenario.

Imagine that primary and excess claims-made contracts are written and subsequently renewed with the original retroactive date preserved, with a large number of minor incidents occurring

and reported to the primary insurer during the initial policy period. The primary contract contains an absolute policy aggregate. As some of the incidents mature into claims, the primary insurer adjusts and pays them until its aggregate is exhausted, with unpaid claims still outstanding. The policyholder now has three places to turn for additional payment.

Let us follow as the policyholder pursues coverage with:

✓The old excess insurer.

Coverage is denied as none of the incidents or claims were reported during its policy period, thus no coverage was triggered before the contract expired.

✓The new primary insurer.

Coverage is denied, even though the original retroactive date has been maintained. If this insurer has simply renewed the previous contract, it will not honor claims already reported under the old contract. If this insurer is new to the risk, it will still decline either because the claims were not declared on its application, thus voiding coverage, or because they were, in which case they will have been excluded.

✓The new excess insurer.

Coverage is denied for the same reasons stated in respect to the new primary insurer and also because the underlying requirements have not been met in that the scheduled underlying insurer must satisfy its limits before the excess responds.

The only protection to the policyholder is to report every claim to every insurer, primary and excess. Claim managers at excess insurers writing high layers are sure to wonder as thousands of slip-and-fall cases begin to reach their desks.

Even this will not protect the policyholder when different layers have different coverage triggers. Imagine the scenario outlined above when the primary insurer's coverage is triggered by a report of incident and the excess insurer's coverage is triggered only by written notice of claim.

Our hapless policyholder, now wiser, reports every incident during the

initial policy period to both the primary and excess insurers.

When the primary insurer satisfies its obligations, the excess insurer still denies coverage for any loss for which the claim was not made in writing during its policy period. The subsequent primary and excess insurers still deny coverage for the same reasons stated above.

Even if the excess insurer renewed with the same retroactive date and did not exclude known incidents, it is still not obligated to respond under the renewal until the renewing primary insurer pays its limits because its wording will always assume that the

primary is concurrent—that is, has the same coverage trigger.

It is reasonable to assume that this is approximately the point in time when the policyholder calls his attorney.

How about that other argument of the claims-made form's backers—that the use of the form will open up markets now closed. The ISO claims-made form is now approved in almost 40 states. The surplus lines industry has been using the form for months.

Yet, there has been no discernable movement of new markets into the areas of public entity liability, medical malpractice, heavy products or excess liability. Whatever is being written in these areas, on either form, is being written by insurers that were active in these markets on an occurrence basis.

The fact is that insurers will not write risks that they do not know how to rate, regardless of the form available.

It is now apparent to many underwriters that they have never known how to rate these classes and they will avoid them until their confidence is increased either by a better rating plan or by the idiocy of a new soft market.

Finally, there is one last problem to examine. To the extent that the use of the claims-made form achieves its other objective—the elimination of reserves for incurred-but-not-reported claims—society will establish a growing, unfunded liability that will equal tens of billions of dollars in a relatively short period.

Will we now run the commercial liability business, this new brave world, like our Social Security system, constantly patching together "solutions" that only delay the day of reckoning to the next generation? What will be the response of the business community when it realizes that the insurance industry has left it holding the bag for unfunded obligations of this size?

Machiavelli said it best: "There is nothing more difficult of success, nor more dangerous to handle, than to initiate a new order of things."

**Claims managers at excess insurers are sure to wonder as thousands of slip-and-fall cases begin to reach their desks.**

**The new claims-made commercial general liability policy forms go far beyond a change in the trigger of coverage.**

William J Miner's "Ask a Benefits Actuary" column will appear in the Perspective section of the Aug. 18 issue.

## Sara Lee booklet

Continued from page 19

In the 10-page death and AD&D booklet, an introduction briefly discusses the purpose of these benefits. Then, the benefits and employees' options are described in detail. The booklet also includes other information, such as filing claims, coverage exclusions and plan administration details.

The eight-page personal accident insurance booklet also explains the purpose of the benefit and how it works. Information on exclusions under the plan, as well as details of plan administration, are included.

Another eight-page booklet details the company's travel accident insurance plan.

- Two booklets in the future financial planning section. One details the company's defined benefit pension plan and another describes the company's tax credit stock ownership plan.

The introduction to the 26-page booklet that discusses the defined benefit plan emphasizes the value of the plan to employees' retirement security.

The benefits under the plan are explained as well as the forms of payment, the procedure for application to receive benefit payments and circumstances that may affect vesting and benefit amounts. The booklet also includes a glossary of pension terminology and examples of benefit calculations.

A 10-page booklet summarizes the company's TRASOP.

It tells employees how and when company contributions are made to the plan, what rights employees have as shareholders and when stock is payable to them. Also discussed are procedures if the plan terminates, how changes in tax laws may affect the plan and how the plan is administered.

- A four-page booklet that informs employees of their rights under ERISA and is included in the section on benefit plan administration.

This booklet includes information such as the name and address of the plan sponsor, the employer identification number and how employees can obtain and examine plan documents.

"We thought this information was important enough to make it a separate booklet," explained Ms. Batenic. "And, since our whole theme in this project is devoted to clear, concise writing, ERISA would clutter the booklets by being included in every one."

An eighth booklet that will summarize the company's long-term disability plan will be included in the income protection section after plan revisions are completed, said Ms. Batenic.

The company decided on this special format for the executive benefits handbook for several reasons, explained Ms. Greenbaum.

"We wanted to give the employees booklets that were permanent, but updatable," she said. "We looked at the possibility of using boxes to store the individual booklets in, but we decided they weren't as efficient."

And, the company did consider using loose pages that could be added to the binder instead of the individual booklets contained in the plastic sleeves.

"But, we found that many employees don't actually update the books," said Ms. Greenbaum.

"We specifically didn't want the booklets punched with holes," said Ms. Batenic. "We decided we'd rather have them placed in a sleeve. This way, we didn't have to worry about words being cut off by the holes."

Sara Lee received favorable response from its executives, Ms. Batenic said.

"They were impressed that this was something we had done specifically for them," she said.

"It also seems to be well-



received by new executives—especially those who've been promoted within the company—because it's different from the rest of our communications." ■

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\*Lost Work Time and Employee Benefits—LSK Associates

# Bank, school district in runners-up spots

The runners-up in the booklets category were:

• Second place: The Marine Corp. in Milwaukee.

Marine, a banking institution, had several objectives in mind when it decided to update its annual summary plan description booklet.

"We wanted to provide a reference manual for employee benefits that was in 'English' so employees could understand their benefits and how they worked together," explained Katherine Klobuchar, the company's vp and manager of compensation and benefits.

With the help of Lincolnshire, Ill.-based consultant Hewitt Associates, the company produced "A

Secure Voyage."

The 8-by-10-inch three-ring binder includes four tabbed sections detailing the bank's health, disability, survivor protection and retirement benefits.

The bank chose the binder format so that the booklet could easily be updated, Ms. Klobuchar said.

Employees are led through the four sections of the booklet by Wally the Walrus, the bank's mascot. And, hypothetical situations involving employees with nautical sounding names, like Tom Tiller, provide easy-to-understand examples of how the benefits work.

Along with detailing each benefit area, the booklet also includes two fold-out charts that summarize all of the bank's benefits and explain how the benefits work together to protect employees and their dependents.

"We tend to think of benefits booklets like this as a benefits owner's manual," explained Phil Jensen, a Hewitt consultant who worked on the project. "We wanted it to be as user-friendly as possible, so we used Wally," he added.

The booklets were distributed to 3,000 employees in 75 locations via an internal mail system, said Ms. Klobuchar.

The booklet took about a year to produce and the final cost of each booklet was about \$15, she said.

• Third place: Los Angeles Unified School District.

The district set a two-pronged goal when it started to create its new benefits booklet: to communicate its benefits more effectively and to attract and retain quality employees, explained Dave Koch, business manager.

"We knew that our benefits package was one of our most attractive recruiting aspects," Mr. Koch said. "But we weren't communicating this effectively. We needed to develop an informational package."

The district's medical benefit options, as well as its dental, vision and life insurance plans, are detailed in the color-coded booklet, entitled "Benefits for You and Your Family."

The 21-page booklet is enclosed in a folder that opens out to form a chart summarizing the coverages under an indemnity health care plan, a preferred provider plan and three health maintenance organizations. Each plan listed on the chart is color-coded to the section of the booklet detailing the plan.

"We felt that by using the color coding, we had a system of communication. And the colors add to the aesthetic appeal of the booklet," Mr. Koch said.

And, as part of the district's strategy to reduce its benefits communication efforts to one package, a new one-page enrollment form also is included in the folder. Previously, employees had to fill out separate forms for different benefits, said Mr. Koch.

"We consolidated the form and that makes life substantially easier for employees and processors of the forms," he added.

One judge said the booklet was "very concise, compact and to the point. Most employees would be able to easily read and understand it."

The booklet, which cost about 90 cents per copy, took about four months to produce, Mr. Koch said. It was mailed to the homes of the district's 55,000 employees.

Production of the booklet was coordinated by Mr. Koch and Michael J. Flores, a consultant in the Los Angeles office of William M. Mercer-Meidinger Inc. ■

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**BI002 Computer Communications Panel**

These panelists represent companies on the cutting edge of communication technology, and discuss how they combined market trends with technological innovations to implement state-of-the-art interactive vehicles for benefit communications. Panelists—Pamela Keeler, Director, Advanced Benefit Communications, Metropolitan Life, introduces SHOWCASE, a communications program that enables employees to directly access information about their benefits from interactive computer terminals housed in kiosks; Douglas M. Bartlett, Director, Employee Benefits U.S., NCR Corporation, introduces EstiMATE, a software package that enables employees to do long-range forecasting of their future retirement income; Peter O'Donnell, Director, Employee Benefits, RCA Corporation introduces a system that is tapped

by employees almost 7,000 times a month and can be expanded to include interactive video, job postings, local health provider information and more; and, Gary Grom, Executive Director, Human Resources, Sara Lee Corporation, discusses how his company developed a program to introduce a new 401(k) feature to their Retirement Savings Plan.

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Don Olsen, Manager of Benefit Plans for Bell Atlantic Enterprises Corporation, gives an overview of Bell's award winning communication program, "A Wave In Benefits." His session concentrates on management objectives, budget considerations and strategies.

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Michael DiStefano, Manager of Domestic Benefits at Colgate-Palmolive Company and Pamela Kekich, a Principal with Kwasha Lipton, focus on how Colgate combined a-v and print materials to build an award winning communications program called "More Financial Power." Learn why Colgate chose a marketing approach to introduce a new 401(k) feature to their employee savings plan.

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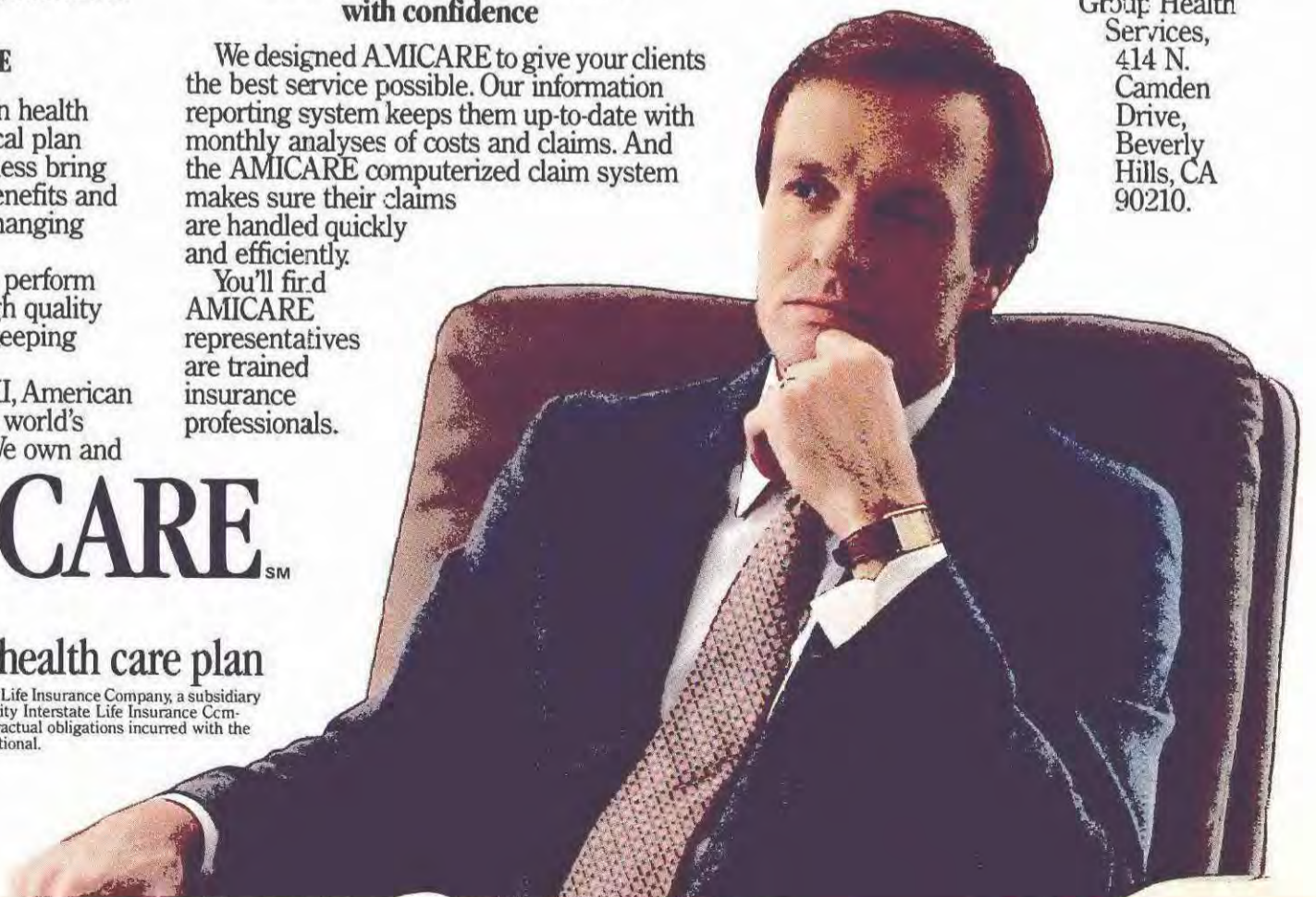
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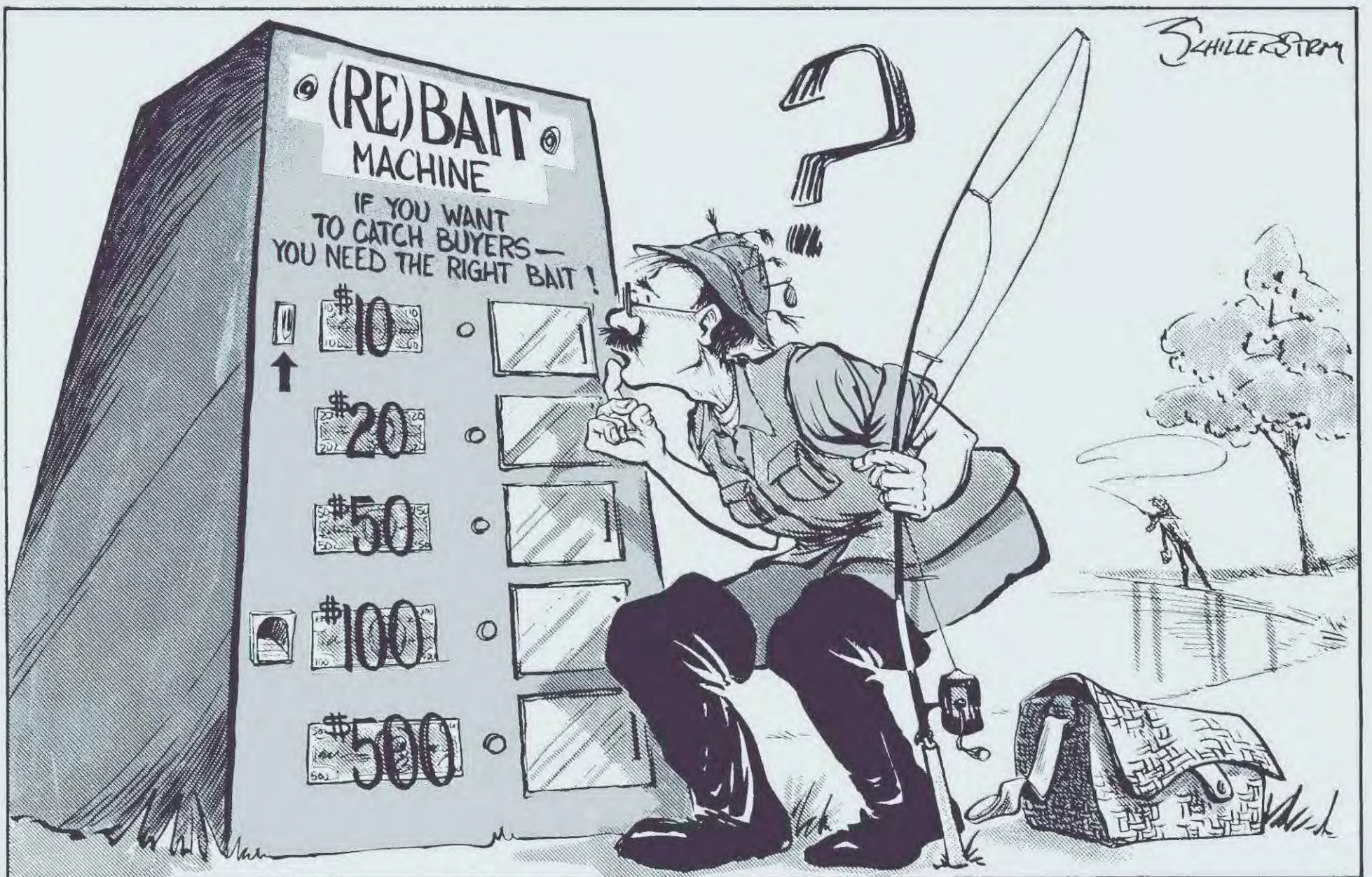
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# agent/broker topics

A monthly editorial section sent exclusively to agents and brokers



## The rebate debate:

### Will Florida decision help or harm insurance consumers?

By LINDA J. COLLINS

A recent Florida Supreme Court decision may open a whole new can of worms for the insurance industry.

On June 3, in a 4-3 decision, Florida's high court held that laws prohibiting insurance agents and brokers from rebating a portion of their commissions to clients constituted "an invalid exercise of the state's police power."

If the decision stands, producers in Florida will be able to offer commission rebates to lure prospects away from other agents.

Insurance industry representatives fear the increased competition generated by consumer demand for rebates might lead to policyholder discrimination, higher administrative costs, insurer insolvencies and regulatory burdens.

But, their greatest fear is that rebating will reduce the number of agents.

"A lot of independent agencies that are father/son shops or sole proprietorships will probably end up going out of business," predicts Wayne L. Soward, Idaho's director of insurance and vice chairman of the National Assn. of Insurance Commissioners' Market Condition Surveillance Task Force.

"Large agencies and brokerages can afford to take business at a reduced first-year commission rate. Smaller ones will have to have a fairly consistent income," he said.

However, a Florida consumer advocate believes the competition will be healthy.

If the decision stands, "We will see a lot more hustling among agents—a different market than there is now," said Walter Dartland, Dade County's consumer advocate, who is currently on leave while campaigning for the Florida attorney general post.

While most insurance industry representatives concede that there would be some short-term benefits to consumers if anti-rebating laws were abolished, they argue that, in the long run, the average consumer and the insurance industry will suffer if rebating is allowed.

In response to the ruling, the Florida Department of Insurance filed a motion June 30 requesting a rehearing. The department also asked that the court grant oral arguments on whether the case deserves a rehearing.

The insurance industry's position on rebating "has never really been heard," contends Robert R. Treweek, executive vp of the Florida Assn. of Insurance Agents in Tallahassee.

When the original court case was filed, he explained, the presiding judge issued a summary judgment upholding the anti-rebate statute—that is without holding a court hearing. In subsequent appeals, "no one was ever able to argue for or against the case," Mr. Treweek said, noting that no oral arguments were heard.

"We feel that the burden of proof was improperly shifted from the defendant to us," added James C. Fogarty, legislative vp for the Florida Assn. of Life Underwriters in Tallahassee.

The Florida anti-rebating law has been on the books since 1915. Similar laws exist in all states and Washington, D.C.

Anti-rebating laws were enacted to curb unfair competition and discriminatory trade practices among insurance producers, following a rash of such activities around the turn of the century. The laws apply to both property/casualty and life insurance agents.

The Florida Supreme Court decision states: "We find these statutes unnecessarily limit the bargaining power of the consuming public and, in accordance with prior consumer decisions of this court, we affirm the decision of the district court and hold that these

*Continued on next page*

## Rebate debate

Continued from previous page

statutes are unconstitutional to the extent they prohibit rebates of insurance agents' commissions."

The judgment acknowledged arguments made by the insurance department and by industry trade associations that filed amici curiae (friend of the court) briefs contending that rebating could:

- Affect insurer solvency.
- Result in discrimination among similar policyholders because rebates would be offered in a non-uniform manner.
- Encourage consumers to turn over their policies more frequently in search of larger rebates.
- Threaten the quality of service agents offer consumers, since commissions also compensate agents for services rendered to the client after a policy is sold.
- Force many smaller agents, who cannot afford to rebate, out of business, ultimately resulting in reduced competition.

However, the court dismissed these arguments and concentrated instead on the constitutionality of the statute.

"We are concerned with the narrow issue of whether a statute that prohibits an insurance agent from reducing the amount of commission he or she will earn from selling the insurance is valid. Historically, this court has carefully reviewed laws that curtail the economic bargaining power of the public," the court said.

The Florida court said that even the U.S. Supreme Court has struck down governmental statutes or regulations that it determined "restrict the competitive pricing of consumer services," such as in the 1977 *Bates vs. State Bar of Arizona* decision, which held that a disciplinary rule prohibiting attorneys from advertising the cost of their services violated the First Amendment.

The recent Florida high court decision stems from a Florida lawsuit initiated in 1977 by a semiretired Palm Beach life insurance agent who was frustrated because he could not legally launch an advertising campaign offering cash rebates to consumers who purchased their policies through him.

The agent convinced the Public Citizens' Litigation Group, a consumer advocacy group, to file suit against the Insurance Department and its director challenging the constitutionality of the anti-rebating statute.

"We came in as a party to the suit," explained Mr. Fogarty of the Florida Assn. of Life Underwriters, one of groups that filed the friend of the court briefs.

The insurance department won the case initially, then won it a second time upon appeal, he said.

The Palm Springs agent appealed the decision a third time to the Florida Supreme Court, but when he died in 1979, the Court dismissed the case.

But in 1981, the Dade County Consumer Advocate's Office re-filed the case, which it lost before the circuit court.

Then, the Consumer Advocate Office appealed the case to the First District Court of Appeals. In August 1984, that court ruled in favor of the Consumer Advocate's Office.

This decision was upheld by the Florida Supreme Court in June. It said: "We find the



district court properly found no relationship between the enactments and any legitimate state interest and, therefore, it was not called upon to determine the degree to which the anti-rebate statutes advance a state interest."

However, contrasting sharply with the six-page court decision was the 17-page dissenting opinion of the three remaining judges.

"The Florida decision was interesting in that the dissenting opinion was longer than the decision and in fact made (the insurance industry's) argument for the case," noted Marjorie M. Berte, executive vp of the PIA of California/Nevada in Van Nuys.

The dissenting judges point out that implicit in the court's decision are the assumptions that:

- Florida courts have the broad authority to "determine whether acts of the Legislature serve the public interest."
- Courts "may generally scrutinize legislation to determine whether it achieves a stated legislative purpose with sufficient success or precision."
- If laws do not serve the public interests to the court's satisfaction, the court may nullify them.

However, the dissenting judges said the error in the majority opinion "results primarily from the fact that it implicitly places the burden on the State Department of Insurance to demonstrate that the law in question is reasonably related to the achievement of some proper objective."

The dissenting judges argued that an existing law should be presumed valid by the

court, and that the burden of proof should be placed upon those challenging the law to demonstrate that it does not achieve the state's objective.

"There has been no evidence presented in this proceeding in support of the challenge to the constitutionality of the statutes," the dissent said.

In the opinion of the dissenting judges, since no constitutional rights were involved: "It is the Legislature's prerogative to determine that insurers and insurance agents should be protected from the economic detriment that would occur if purchasers of insurance were in a position to negotiate for rebates from premiums."

"I believe the Department of Insurance has stated a much stronger case for the anti-rebate statutes in terms of general economic stability of the industry," said Judge C.J. Boyd, who wrote the dissenting opinion. "But, even if mere protection of agents at the expense of consumers were the only justification offered, there would be no constitutional impediment... the courts have no authority to pass on the validity, legitimacy or permissibility of the state's purpose when constitutional rights or restrictions are not involved."

The Florida Supreme Court decision curtails the state's policing power, said Jay H. Berman, director of state affairs for the National Assn. of Professional Insurance Agents.

"The Florida decision begins to raise everyone's attention to that issue," he said, pointing out that the very fact the decision

was split 4-3 "seems to say something" about the conflicting opinions on the subject.

Mr. Fogarty of the Florida Assn. of Life Underwriters contends that had the insurance industry been allowed to orally present its arguments for maintaining current anti-rebate statutes, the court might have viewed the statutes differently.

"We felt we had never been given due process. We were not able to argue our case before the court or present witnesses," he added.

Mr. Treweek of the FAIA said that "the Florida Insurance Department feels very strongly that there is a reason for the anti-rebate law... and will be pursuing that argument in court" if its request for a rehearing is granted.

The decision "suggests that there is no competition in the insurance industry," he said. "There is already a mechanism to take into consideration schedules, experience, age and other factors when pricing an insurance policy," he stressed.

If the Insurance Department's request for rehearing is unsuccessful, "We hope to have rules enacted to regulate the way rebating is handled" in Florida, stressed Michelle McLawhorn, public information director for the Florida Department of Insurance in Tallahassee.

And, because consumer groups may initiate similar actions in other states in the wake of the Florida decision, insurance industry groups nationwide are paying close attention to further developments in that state.

Industry groups expect the next test of anti-rebating statutes to take place in California, where the Consumers Union in San Francisco already has filed a lawsuit against the California Insurance Department (see story, this page).

"There is no question about it. If the Florida Supreme Court decision is upheld, California will go next and the rest of the states will fall over like a row of dominoes," Mr. Fogarty said.

While other industry representatives are not quite as emphatic as Mr. Fogarty, "The insurance industry is keeping a close eye on the situation in Florida," said Ms. McLawhorn.

She added that if the court permits a rehearing, and if it reaffirms its decision, it "is certainly likely that waves of (similar) lawsuits would occur across the country."

"The rest of us are waiting with bated breath to see how the Florida court ultimately rules. This will likely go all the way to the U.S. Supreme Court," said Director Soward.

Consumer groups argue that anti-rebating laws should be repealed because they bar consumers from shopping for the best commission rate. In a free market environment, they speculate, insurance rates would automatically go down.

Consumers Union, publishers of Consumer Reports, charged in a letter sent to California senators that anti-rebating laws "prevent insurance agents from voluntarily discounting their commissions or offering other valuable consideration as a competitive device to attract consumers. The anti-discount laws prevent competition at the agent

Continued on next page

# Consumer group tackles anti-rebate laws

By LINDA J. COLLINS

The Florida Department of Insurance is not the only insurance department involved in litigation over anti-rebate laws. Consumers Union, the San Francisco-based non-profit publisher of Consumer Reports, currently is challenging the constitutionality of California's anti-rebating laws in a lawsuit brought against the California Insurance Department and its commissioner.

However, in California a legislative act may assist the department in its defense of anti-rebate laws.

Assembly Bill 1487, recently passed 22-7 by the California Senate and sent to the assembly, would clarify legislative intent supporting the anti-rebate statutes in that state.

Bill 1487 reads, in part: "The Legislature hereby finds and declares that the continued regulation of the business practices of insurers and their producers is in the interest of the citizens of the state and that the control and limitations of unlawful rebates, profits and commissions is an essential component of that regulation, which is necessary to effectuate an adequate and complete system and regulation of insurer and producer business practices."

It emphasizes that these statutes "continue to provide critical protection to insureds in this state from the numerous consequences that would occur in the absence of such regula-

tion."

The bill cites those consequences as including: "company insolvencies, unfair discrimination between insureds with identical risks creating subsidies from small purchasers of insurance in favor of large purchasers of insurance, decreased quality of services to insurance consumers, increased concentration of insurance distribution and sales mechanisms, and misrepresentation and unethical sales practices such as improper replacement or twisting to the detriment of the public."

If the bill is passed by the Assembly, the fact that it clarifies the intent of the law "would certainly be a favorable development to those seeking to uphold anti-rebating statutes in California," said H. James Douds, senior vp and general counsel for the National Assn. of Life Underwriters in Silver Springs, Md.

The bill would "lend support to the department's arguments" in defense of existing anti-rebating statutes, agreed Diane M. Nash, Washington counsel to the Independent Insurance Agents of America. "The fact that it is attached to a current vehicle gives note that the law is still pertinent today and is not an outdated notion," she added.

Jay H. Berman, director of state affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va., said that the bill would establish legislative history and elim-

inate any ambiguity concerning existing laws.

It could "only help" the department's defense against the lawsuit. "It couldn't hurt," he added.

Although a recent Florida Supreme Court decision abolished that state's anti-rebate statutes, sources say the two cases differ.

"Florida did not have the ability to have the case tried on fact because there was no trial. On appeal they couldn't introduce new evidence," said Betty Combs, executive vp of the California Assn. of Life Underwriters in Oakland.

"We'll have a trial, and we're trying to get all our information out up front," she said.

Representatives of other trade associations involved in the California litigation also plan to vigorously defend the statutes.

The Independent Insurance Agents and Brokers of California plans to find someone outside of the insurance industry, preferably someone "with an economics background, to explain why these laws are on the books in the first place," said Joseph J. Annotti, administrative vp of the IIABC in San Francisco.

"The California case should have a better constructed trial from the beginning that closely examines the issues," added Marjorie M. Berte, executive vp of the PIA of California and Nevada.

# Work comp reform

## California rating bureau to put price tag on legislation

By CAROL CAIN

SACRAMENTO, Calif.—The California Workers' Compensation Insurance Rating Bureau is scrutinizing legislation that would significantly change the state's workers comp system.

The rating bureau's task: to calculate the cost of provisions in the legislation, S.B. 1617, which would increase benefits to injured workers while also implementing reforms intended to reduce litigation and improve rehabilitation programs.

No one involved in drafting the

measure was able to estimate those costs. However, observers agree the legislation ultimately would "cost something," most of which would be borne by employers.

The cost estimates are expected this week, said Casey Young, a consultant to the Senate Industrial Relations Committee and one of the principal drafters of the bill.

Meanwhile, employer groups, labor organizations, attorneys' associations, physician groups and insurers also are examining the bill before taking a stand.

When the Legislature reconvenes Aug. 11 from a summer recess, S.B. 1617 will be taken up by the Senate Industrial Relations Committee, which amended the bill on July 10, the day before the Legislature recessed. The committee is chaired by Sen. Bill Greene, D-Los Angeles, who introduced the measure in January.

Besides considering comments from interested parties, the Senate committee also will look closely at the rating bureau's cost estimates to determine what provisions might be whittled from the bill, capital observers say.

S.B. 1617 proposes an expanded role, funded in part by assessments on employers, for the Division of Industrial Accidents, which administers the state work comp system. It also proposes increased benefits to injured workers and a new permanent disability rating schedule. The bill would:

- Increase the maximum weekly benefit to 200% of the statewide average weekly wage, about \$875 in 1988, with the minimum set at the lesser of 30% of the SAWW or 80% of the employee's gross earnings. The current maximum weekly temporary total benefit is \$224.

- Maximum and minimum amounts would be adjusted annually without legislative action.

- Repeal the current permanent disability rating schedule and replace it with a new schedule

developed by a six-member labor-management commission.

The amount of benefits would not change, but objective standards would be required in evaluating the extent of permanent disability.

The new permanent disability rating schedule would be required to include adjustments for the workers' age and occupation, but not for the workers' education.

- Allow for supplemental permanent disability benefits to injured workers who have a disability rating of 70% but less than 100%.

However, these workers would be entitled to supplemental benefits only if they qualify for vocational rehabilitation, if the wage loss is greater than 5% of the worker's pre-injury average weekly pay and if the worker registers for work with the Employment Development Department.

For these workers, the income protection period would be 10 years and the monthly benefit payment would be calculated in accordance with the replacement rate and maximum weekly benefit level for temporary disability benefits.

- Integrate vocational rehabilitation with permanent disability benefits to reduce vocational rehabilitation costs.

Among the changes would be earlier identification procedures and the allocation of up to 80% of the employee's permanent disability benefits for income maintenance during rehabilitation.

The legislation also limits the role of the Rehabilitation Bureau to consultation and mediation of disputes, rather than giving approval to rehabilitation plans.

- Make the employer liable for reasonable attorneys' fees necessarily incurred by the worker in proceedings before the appeals board in certain cases.

- Authorize employers and insurers to contract with health care providers to provide health

care services to workers at negotiated rates or fees. Standards would be set for treatments to assure quality care.

Changes are expected in the bill as it winds its way through the Senate and the Assembly, Mr. Young said. "No bill is written perfectly the first time," he added.

This latest effort was the result of two months—80 hours according to one estimate—of intense negotiations between four employer representatives, four labor representatives, Mr. Young and John Lewis, a Coconut Grove, Fla., attorney and nationally known engineer of state workers compensation reform.

"There's a bill, but that bill is still a vehicle... and negotiations will continue as long as the process is going on," Mr. Lewis said.

"At this point... there's something there for everybody to have a problem with," Mr. Lewis said.

In fact, at a meeting last month of the California Chamber of Commerce's workers compensation committee, "there were a lot of different positions stated," said John Wilson, risk manager for DiGiorgio Corp. in San Francisco, and vice chairman of the Chamber's work comp committee.

The committee decided to support the bill "in principle," realizing that amendments still are being negotiated.

The missing cost factor was a key reason the Chamber's committee did not fully back the bill, Mr. Wilson noted. "It's hard to take a position without that," he noted.

Other business and labor groups throughout the state, as well as insurer, attorney and physician groups, were sizing up the 68-page bill to plot lobbying strategy for the last three weeks of the legislative session.

Plaintiffs' attorneys were mustering opposition to the workers comp bill, which was tabbed "the worst take-away for injured workers in the history of workers com-

ensation," according to Richard Cantrell, president of the California Applicants Attorneys Assn.

Not one labor group has come out in favor of the bill, he noted.

However, none has come out in opposition, either.

For instance, Barry Broad, legal counsel for the California Teamsters Public Affairs Counsel, said: "At this point, the amendments in the bill reflect compromise that was worked out between management and labor... but, I don't think the process is anywhere near completed."

Employer groups also are hesitant to take a stand.

"Before we come out with a position, we need to touch base with our constituents," said Linda Brodt, assistant executive director for Californians for Compensation Reform, a coalition of some 1,000 employers, insurers and municipalities that has been working for a reform measure since last year.

CCR members will discuss the bill at a series of meetings slated this week.

However, on the surface, the bill has more positive than negative features, Ms. Brodt said.

CCR called for legislation like S.B. 1617 with the aim of stabilizing skyrocketing cost increases and lessening the need for attorney involvement to come closer to restoring the system to its original no-fault philosophy.

When the Legislature reconvenes, S.B. 1617 is expected to hold center stage. The last major amendment to the California workers compensation law was in 1982, though business and labor leaders have introduced numerous reform measures since then. ■

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B184

## New York panel proposes overhaul

By CAROL CAIN

ALBANY, N.Y.—The more than 70-year-old New York workers compensation system should be overhauled to coordinate its provisions and update benefits provided, a special commission recommends.

"There's no question about it... The system needs a revamp," said Paul Magaril, director of state government relations for the New York Chamber of Commerce.

"Due to the literally 1,000 amendments since the law was first enacted... it is incomprehensible. You can't pick up our workers compensation law and make any sense out of it," he said.

The result is an inefficient system "filled with inequities," Mr. Magaril said.

This realization came years ago in New York and attempts have been made to change the system. But all that resulted, if anything, was another amendment.

In 1983, however, the Legislature called for the governor to appoint a special 12-member panel. That group—known as the Temporary State Commission on Workers' Compensation and Disability Benefits—was to scrutinize the strengths and weaknesses of New York's system and develop recommendations for change to be considered by the Legislature (BI, Feb. 27, 1984).

The commission's task was completed in late June with the release of a report and accompanying research documents, which only now is making the rounds to interested parties. The commission disbanded with the release of that report—taking seriously the word "temporary" in its title.

However, Donna Freireich, who served as executive director and counsel to the commission, currently is drafting legislation to be offered to various legislative committees that will meet prior to the next legislative session, which is slated for January.

Perhaps the commission's most important finding, according to the report, was "the interrelation of seemingly discrete topics."

For instance, "rehabilitation, adjudicatory procedure and administrative delay cannot be considered without reference to benefit structure; occupational disease cannot be understood apart from administrative and adjudicatory delay. Rather, these issues together form a matrix whose meaning lies precisely in the interrelationship of its elements," the commission noted.

And, labeled a "second major finding," the commission noted: "The system, as designed, does not integrate its various elements so as to best achieve its objectives, (namely) prompt, adequate and equitable provision of medical and indemnity benefits; return, whenever possible and appropriate, of injured claimants to the workforce; and prevention of occupational accidents and diseases.

"Indemnity benefits are utterly inequitable and, in cases involving more serious injury, are often neither prompt nor adequate," the commission noted.

"On the other hand," it continued, "flagrant cases of over-compensation also abound."

Further, the report said, "Rehabilitation currently is more a vision than a reality. Occupational disease cases, the few that make their way into the system, are tangled in a morass of controversy and delay."

And, in this finding, the commission also pointed out that "the incidence of work-related injuries and diseases is increasing."

But just as the system itself is a compilation of interrelated elements, so too are the commission's recommendations.

"One point cannot be overemphasized... Only if implemented together can they have the salutary effect intended. The commission most strongly urges, therefore, that all the benefit proposals outlined... be adopted," notes the report.

However, the commission recognizes that some of its recommendations can be enacted sooner than others.

For instance, among recommendations that the commission cites for immediate legislative action are:

- A requirement that the Workers' Compensation Board adopt regulations using uniform medical guidelines for the evaluation of impairments and functional limitations of injured workers.

- Enactment of a phased increase in the statutory maximum for partial disability benefits, so that within three years there would be a single maximum for total and partial disability benefits that is either fixed at an amount equal to or not less than 75% of the state average weekly wage or an amount that automatically increases or decreases so as to remain equal to a specific percentage, but is still not less than 75% of the SAWW.

- Limitations on, and continued study of, lump-sum settlements. Such a study would attempt to determine the reasons for entering into lump-sum settlements, the number of

Continued on next page

# Modular video programs grow popular

NEW YORK—Modular video communications programs may be gaining popularity as a benefits communications tool.

The number of modular video communications programs entered in the *Business Insurance* EBC competition is increasing, points out Ronnie I. Drachman, director of communications for *Business Insurance* and coordinator of the competition.

Modular video communications programs involve separate video presentations using the same moderator and style. They can be used together or separately.

"A number of the audio-visual programs were done as modules in an overall communication program as opposed to being done as completely separate programs," she explained.

Some were used as "meeting-starters," intended to introduce new benefits or changes in current benefit plans to employees without overwhelming them with details.

The videos were usually backed up with booklets or discussions held in group meetings.

A record of 174 communication programs submitted to the 14th annual EBC competition by more than 145 different U.S. and Canadian companies were judged, Ms. Drachman said.

Of these programs, 149 were prepared with the assistance of outside benefit consulting firms.

Twenty-two different consultants submitted programs to the competition on behalf of their clients.

The other 25 entries were prepared in-house.

The one entry prepared in-house to win an award this year was the total communications program prepared by the benefits staff of The New England in Boston, which won a second place award.

"Overall, the two communication categories that have really grown are the total communication pro-

grams category and the booklets category. The number of entries in this year's total communication category was about the largest since the 1970s," Ms. Drachman said.

This year, 72 booklets were entered, compared with about 40 in recent years, and 20 total communication programs were entered, which is about double the number of such entries in recent years.

Entries in the total benefits communication program category feature programs that include audio-visual presentations, booklets, posters and, in some cases, interactive personal computer software.

Most of the total communication programs submitted were used to introduce flexible benefits plans, she added.

This year's competition included a new category to reflect a new trend in benefits communication: interactive computer communication programs.

The computer communication programs—which use diskettes inserted in personal computers or programs downloaded to VDTs—help employees to understand complex benefits, such as flexible benefits plans and retirement savings plans. They allow employees to enter personal data into the computer and then receive personalized benefits information.

For example, the software programs can help employees predict their retirement income based on the amount they contribute to a savings plan and varying interest assumptions.

"Last year, four or five computer communication programs were submitted. But, I don't think the judges were really ready for that last year," Ms. Drachman said.

"There were nine entries this year, but I know this will be a category that will really grow in the future," she predicted.

"In general, the computer programs submitted this year were of

a better quality than last year's entries. They were more user-friendly," she noted, meaning that employees usually do not need any knowledge of personal computers in order to use the programs.

The other two categories in the competition are personalized correspondence and audio-visual programs.

The entries to the EBC competition were judged by a panel of 11 employee benefits or communication experts.

The judges were:

• Charles R. Acklin, director of benefits planning for Schering-Plough Corp., a pharmaceutical company in Madison, N.J.

• Jeanne Askerberg, benefits administrator for American Medical International, a hospital management company based in Atlanta.



Mr. Ayre



Ms. Gambol



Ms. Marshall



Ms. Megery



Ms. Ragonesi

• J. Brent Ayre, benefits counsel and manager of pension and profit-sharing plans for Beatrice/Hunt-Wesson Inc. in Fullerton, Calif.

• Hazel Baumann, associate manager of benefits planning at General Foods Corp. in White Plains, N.Y.

• Janice F. Dales, director of employee benefits for Aviall Inc., a Dallas-based company that provides maintenance services to the aviation industry.

• Donna Gambol, director of corporate communications for Corroon & Black Corp., a New York-based insurance broker.

• Wendy Levins, manager of

benefits for Avon Products, a manufacturer of cosmetics and toiletries in New York.

• Phyllis Marshall, manager of corporate communications for the New York Insurance Exchange in New York.

• Brian McNamara, corporate production systems director of Crain Communications Inc. in New York.

• Barbara C. Megery, manager of employee benefits for The Lubrizol Corp., a chemical manufacturer in Wickliffe, Ohio.

• Jeanne Ragonesi, vp-human resources for National Westminster Bank USA in West Hempstead, N.Y.

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## datebook

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**AUG. 14-15. Joint Florida Risk & Insurance Management Society Conference** in Palm Beach, Fla.; \$35; \$50 for registering at the door. James Taglia, Tampa Electric, P.O. Box 111, Tampa, Fla. 33601; 813-228-4111.

**AUG. 18-19. Application of Microcomputers to Occupational Health & Safety** course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; \$375. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523.

**AUG. 18-22. Modern Safety Management** course in Boston, sponsored by the International Loss Control Institute; \$695. Also Sept. 8-12 in Atlanta. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; within Georgia 404-466-2208.

**AUG. 20. Insuring the Farm** seminar in Bridgewater, Conn., sponsored by the Professional Insurance Agents of Connecticut; \$15 for PLA members; \$25 for non-members. Professional Insurance Agents of Connecticut, P.O. Box 98, Glenmont, N.Y. 12077; 800-252-2726.

**AUG. 22. MCA: Managing and Controlling Asbestos Contamination/Exposure** course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; \$150. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523.

**AUG. 24-27. Benefit Communication Institute** in Atlantic City, N.J., sponsored by the International Foundation of Employee Benefit Plans; \$450 for members; \$525 for non-members. IFEBP, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

**AUG. 24-29. Accredited Safety Auditor**

course in Houston, sponsored by the International Loss Control Institute; \$775.50. Also Sept. 22-26 in Atlanta, Sept. 29-Oct. 3 in San Francisco. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-554-6001; within Georgia 404-466-2208.

**AUG. 25-27. Industrial Hygiene Sampling Strategies** course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; \$450. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523.

**AUG. 27-29. Constructive Negotiation in the Health Care Arena** seminar in Baltimore, sponsored by the Group Health Assn. of America Inc.; \$400 for GHAA members; \$465 for non-members. Group Health Assn. of America, P.O. Box 50586, Washington, D.C. 20004; 202-737-4311.

**SEPT. 3-5. Succeeding in Today's Insurance Market** seminar in New Orleans, sponsored by the South Louisiana Chapter of the Risk & Insurance Management Society; \$90 for RIMS members; \$115 for non-members. Gary W. Kern, National Tea Co., 5110 Jefferson Highway, Harahan, La. 70183; 504-733-6610.

**SEPT. 3-5. Employee Benefits—Concepts, Planning and Administration** course in New York, sponsored by the Risk & Insurance Management Society Inc.; \$490 for RIMS members; \$590 for non-members. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**SEPT. 4-5. Longshoremens' and Harborworkers' Compensation Act Advance Seminar** in Seattle, cosponsored by the Northwest Longshore Administrators Assn. and the U.S. Department of Labor; \$100. Bill Shepard, Shepard Consultants, P.O. Box C-34201, Seattle, Wash. 98124; 206-443-8416.

The Datebook is compiled from notices sent to *Business Insurance*. Notices should be sent at least eight weeks in advance to Datebook, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611. *Business Insurance* reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

**'We found that the arguments made by agents and the insurance industry were similar to arguments made against deregulation of other industries. People are for deregulation in every industry but their own,' says Mr. Dartland.**

Continued from previous page level in the sale of insurance."

Consumer groups cite life insurance commissions in particular in their arguments for rebating, charging that first-year life commissions are in some cases in excess of 100% of the annual premium.

"Anytime anyone has a chance to save money, human nature is to go out and get bids. Agents will have to get leaner and more efficient," said Mr. Dartland, Florida's consumer advocate.

"In our processing of this case, we found that the arguments made by agents and the insurance industry were similar to arguments made against deregulation of other industries. People are for deregulation in every industry but their own," he added.

Mr. Dartland said that while he has heard statistics on how much consumers could save per household if rebating were allowed, any prediction would have to be a "guesstimate," because it is not possible to determine how much consumers will save until agents began to rebate.

If the ruling stands, he said, the primary challenge will be in educating consumers about rebating. Mr. Dartland acknowledged that it would take awhile for the average consumer to realize that he needs to ask for the wholesale cost of the policy as well as what the agent receives in commission, but "once they know how to negotiate the commission... they should benefit."

But the industry argues that the average consumer will not benefit in the long run.

"We fear a return to conditions that led to enactment of anti-rebating laws in the first place—cutthroat ruinous competition. In the short run, it may result in some monetary benefits to the consumer. But, in the long run, it will be to the detriment of both the industry and the consumer," said H. James Douds, senior vp and general counsel for the National Assn. of Life Underwriters in River Springs, Md.

"When you look at who's going to benefit and who's potentially going to be harmed, it's a different matter," said Joseph J. Annotti, administrative vp for the Independent Insurance Agents and Brokers of California in San Francisco.

"I've been in this business for 40 years, and when I came into the business, other agents told me horror stories about what it was like before anti-rebating laws were established," said Mr. Fogarty of the Florida Assn. of Life Underwriters.

"The little guy starting out won't be able to afford to rebate. These agents will go out of business," Mr. Fogarty said.

In fact, agents who can afford the highest rebates "will be able to outbid others to the point where it may be possible that only one or two agents exist in each geographic area. Then those monoliths in the area will have no inducement to rebate, and may charge the consumer even more in the long run," Mr. Douds predicted.

FAIA's Mr. Treweek agreed. "Human nature being what it is, when one agency drives out the competition through rebating, there would be no need for that agent to rebate further and he will seek out his original commission," he said.

If consumers save money on their premiums through rebating, they will benefit initially, said James T. Harrison Jr., a consultant to the PIA of Florida and president of Security Bond Associates, an agency in Tallahassee. "But, if rebating reduces the competition, it will be harmful to consumers in the long run," he added.

Mr. Fogarty said that agencies remaining in business after this

shake out are going to be far more compelled to offer rebates to their commercial lines clients or to personal lines clients whose businesses are also insured through the agency than they will be to offer rebates to the average consumer. These are the clients from whom agencies make their profit, he explained.

"Large agencies can afford to lose the little guy and will concentrate on providing rebates to their larger clients," Mr. Fogarty said, while the small consumer "will not be offered a rebate."

And, the decision could affect other laws designed to protect consumers, one source said.

"There is a threat that the Florida decision could make further enforcement of anti-discrimination laws difficult," explained Diane M. Nash, Washington counsel for the Independent Insurance Agents of America.

She explained that since consumers in the same risk classification might be charged different prices for their insurance coverage as a result of rebating, "it will create serious ambiguities" in the

enforcement of those statutes.

Director Soward said that the way Idaho's anti-rebating law is structured, it already allows agents to rebate a portion of their commission as long as the rebate applies equally to all policyholders within the same rate classification.

"That's really more beneficial to consumers than putting the burden on policyholders to negotiate," he said.

Sophisticated, industry-savvy insurance buyers who have the time to negotiate are the ones who will benefit from rebating, "not the average, middle-class citizen," the director said. "I believe anti-rebating laws should be upheld on the basis of being consistent regulatory policy."

But, if the decision invalidates the anti-rebating laws, life insurance companies may be forced to restructure their entire system of agent compensation, some sources speculate.

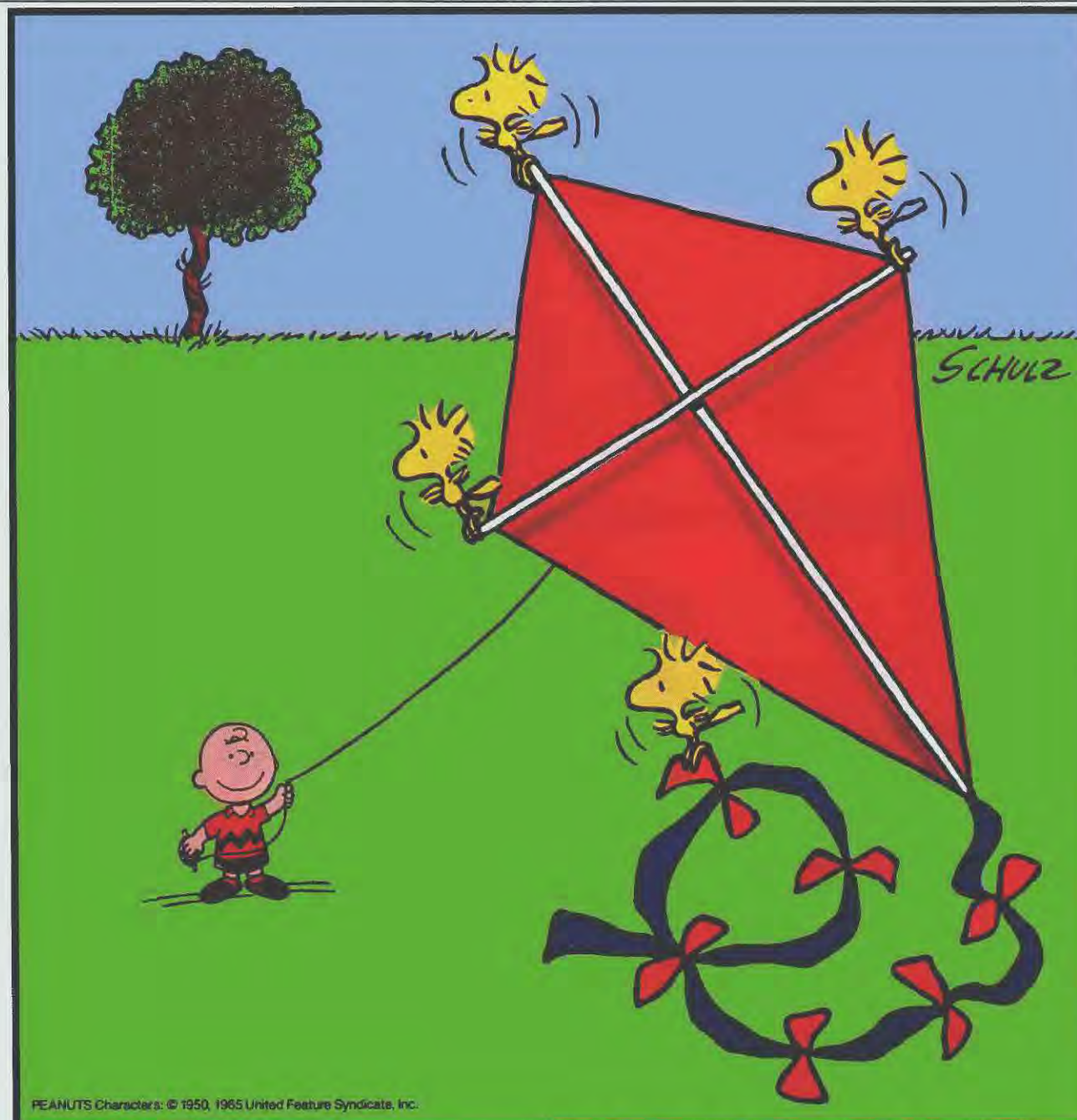
Under the current system of compensation, life insurance agents receive large first-year commissions, but much smaller commissions when the policies renew.

Because of this commission structure, life insurance companies often do not make a profit on a life account until three or four years into the life of the policy. Industry sources fear that consumers looking for higher rebates from those first-year commissions will be tempted to go to a new insurer on each renewal.

"This will cause true adverse selection, because healthy policyholders will move their coverage from one insurer to another, while the ones who are sick will hold onto their policies," Mr. Fogarty warned.

"If customers switch policies every one or two years to get the higher commission rebate, the

Continued on next page



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## Rebate debate

*Continued from previous page*  
insurers can't make money and ultimately premiums will go up for everyone," said Mr. Soward.

And, since insurers base their rates on the law of large numbers, insurance company solvency would be threatened by this activity. "The whole insurance company solvency issue is in question if insurers can't be sure of the policy being in place for a length of time. It will create chaos in insurer reserve levels," said Betty Combs, executive vp of the California Assn. of Life Underwriters in Oakland.

Ms. Combs pointed out that not only could policy turnover affect premium rates, it could also jeopardize the policyholder's eligibility for coverage under a life policy.

"The fallout of this situation" is that so-called contestable clauses in life insurance policies that limit coverage during first several years a policy is in force will always be contestable if the policy is frequently rewritten with a different insurer on renewal, she said.

Changes also may occur in the property/casualty industry, where some predict a possible switch from commission to fee-based compensation to eliminate the issue of rebating.

"With property/casualty business, much of the commission pays for service after the policy is purchased. Clients may have to eventually pay outright for the cost of their service," Mr. Berman said.

And in both the property/casualty and life industries, sources say agencies and insurers will incur more expenses and spend more time in negotiating and recording different commissions for every account.

In addition, they say that insurers who bill customers directly may have to revert to agency billing so that the agent can factor in the rebate when collecting the premium from the policyholder.

"That will raise the base cost of the policy, which will end up costing consumers more money," Mr. Fogarty said.

"This could have a negative affect without consumers realizing that they are being charged more for their coverage despite their rebate," Ms. McLawhorn agreed.

For insurance departments already overburdened by the pressures of the current marketplace, "I see a much larger problem looming in the background. We can now go directly to the insurance company and ask it to pay its premium tax, and they can calculate that," Director Soward said.

"Insurers have a record of their agent commission percentages. If anti-rebating is overturned and agents can negotiate with each individual policy, the company can say to us, 'Look. We don't know how much of a rebate the agent gave to the customer. You find out,'" he explained.

Insurance departments may be forced to hire more people to collect premium taxes and to handle any collection problems that insurers might incur when the agents who represent them revert to agency billing, he added.

And Mr. Harrison said that Florida agents may be faced with yet another problem if rebating is upheld in their state. Some out-of-state agents already have called his association to inquire about obtaining non-resident licenses.

"They want to fly into Florida to place business so they can offer rebates to their customers," he said. ■

# Insurers use subjective criteria when rating agencies: Survey

By PAUL D. WINSTON

Lacking formal evaluation programs, most insurers use subjective criteria to select agencies, a recent survey found.

However, some insurers employ strict quantitative measures when selecting an agency, including use of specified levels of gross written premiums and loss ratios, the survey also revealed.

The Assn. Planning Committee of the Professional Insurance Agents of Texas conducted the survey of "How Insurance Companies Evaluate Insurance Agencies" late last year.

The survey polled 46 regional or branch marketing managers of insurance companies doing business with independent Texas agents. Forty-five companies responded to the request for the criteria used to evaluate independent insurance agencies.

Most insurers do not have a formal evaluation program in place for selecting insurance agencies, the survey found. Many decisions about agency selection are made on the basis of recommendations from marketing personnel, special agents and branch managers, the survey found.

And, many of these individuals have little or no training in formal evaluation techniques, the survey reported.

When evaluating agencies, insurers most often consider the agency's "professionalism," the survey found. "Professionalism" was cited by 20 of the insurers as one of the three most important criteria they use to evaluate agencies.

Professionalism, however, is a very subjective term, the PIA of Texas noted. And, insurers answering the survey define it differently.

For example, American States Insurance Cos. defined the term as the "experience of agency principal and employees," while The Travelers Insurance Co. defined professionalism as "quality of management/principles."

The most common definition of professionalism, however, hinged on education and training.

Zurich-American Insurance Cos. responded: "Pro-

fessionalism—has the agency made a commitment to continuing education for its staff?"

The second and third most often cited criteria used by insurers are less subjective than "professionalism" and involve financial and business-related criteria.

"Profitability" was cited as the second most important criteria, with 18 responses, and financial stability was the third, with 14 responses.

Agency location, book of business and business reputation also were frequently cited criteria.

In its analysis of the survey, the PIA of Texas noted, "This emphasis on the specific and, for the most part, quantitative criteria shows how the current hard market cycle has altered traditional relationships between most insurance companies and insurance agents."

Theo Van Eeten, director for education and technical services at the PIA of Texas, said that these changes are here to stay, regardless of any change in the current market. "No question about the fact that this is how business will be conducted from now on."

"Instead of conducting their business 'on a handshake,' agents and their companies are likely to view their joint relationship in a much more businesslike manner," said Fred Wilkerson, a Fort Worth, Texas insurance agent and chairman of the Assn. Planning Committee of the PIA of Texas.

Interestingly, several characteristics that might be thought to be highly desirable in an agency were infrequently listed in the insurance companies' top three responses: market penetration, with two responses; clientele, one; automation, one; and understanding of client needs, one.

The PIA of Texas also concluded:

- Often, the opinion of regional or branch marketing managers differs significantly from those of corporate leadership.

- Many insurers formulate their underwriting strategies based on the agency's location, which is not strictly red-lining, but often creates the same result.

Copies of the survey are available to members of the Professional Insurance Agents of Texas for \$35, \$50 for non-members. To obtain a copy contact PIA of Texas, P.O. Box 3175, Austin, Texas 78764; 512-474-6066.

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## Agents should realize potential: Consultant

CHICAGO—Potential alone does not make a successful agency, a consultant says.

"Potential is a dirty word," Roger H. Sitkins, president of Sitkins Group Inc., an agency management consulting firm in Fort Myers, Fla., told agents attending a seminar on "Secrets of Successful Agency Management" held last month in Chicago.

After analyzing hundreds of agencies, Mr. Sitkins says he has found that most have the correct resources at hand, but they aren't using them properly.

"People who get labeled with 'potential' are losers," he said, explaining that agents should work to realize their agency's potential.

This can be done through "redeployment management—the art of redeploying your agency's assets," Mr. Sitkins explained. "Agencies have to be analyzing and constantly redeploying their resources."

Agents need to "get back to the basics" and examine and evaluate their agency's "four P's," Mr. Sitkins said. These are:

- Professionalism.
- Proficiency.
- People.
- Profits—not including the agency's contingency checks and interest income.

Mr. Sitkins described proficiency as "the agency's ability to handle something one time and get it done."

For example, he said that agencies frequently submit incomplete applications to insurance companies, even though it is common knowledge in this tight insurance market that insurers will not accept applications that are not complete.

"Why send them something that's incomplete? You'll have to handle it more than once. If you only get paid once, only handle it once," he advised.

Agency employees, the "people" part of the formula, are extensions of the agency's image, Mr. Sitkins stressed. "Do they look professional, act professional and talk professional? Do they know about their job? How do they talk to your customers?"

A simple way for agents to evaluate employee performance is to ask a friend to call the agency once a month for a quote, Mr. Sitkins said. This person can then provide the agent with feedback on the image projected by agency employees.

There are several other ways for an agency to take inventory of its performance, Mr. Sitkins stressed.

Agencies can conduct informal customer surveys by randomly calling five customers a month. "Ask them: 'How are we doing? What do you like most about dealing with our agency? What do you like least? What would you do differently?'"

"This gives you live information that is crucial to an agency."

Agencies also should survey their insurers. Mr. Sitkins urged agents to mail questionnaires to the underwriters they deal with and request that they take the time to evaluate their agency. He suggested that agents let the insurer return the questionnaire anonymously to make sure the responses are candid.

"This will increase your professional image in the eyes of the company" while providing valuable feedback, he added.

Agents also need to conduct a "profit-center analysis" of their operations, examining their income and expenses, he said.

"It is crucial that all agencies

examine themselves from a profit-center standpoint," he stressed.

Studies conducted by Mr. Sitkins to determine the statistical breakdown of accounts and commissions show, on the average, that:

- Personal lines clients represent 83% of an agency's accounts, but only 31% of its revenues.

- Commercial lines clients that generate less than \$10,000 in annual premiums represent 14% of an agency's accounts, but only 13% of its revenues.

- Commercial lines clients with more than \$10,000 in annual premiums represent only 3% of an agency's accounts, but provide 56% of its revenues.

Continued on page 28G

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## Agency potential

Continued from page 28E

He pointed out that 29% of the revenues an average agency earns on large commercial accounts goes to cover sales expenses, 49% is used to cover service expenses and the agency retains 22%.

On personal lines, 21% of the revenues pays for sales expenses, 75% covers service expenses and the agency keeps 4%.

Smaller commercial accounts are a different story, Mr. Sitkins stressed. On the average, these clients cost an agency 161% of its revenues—54% to cover sales expenses and 107% to cover service expenses.

The reason these accounts generate losses for most agencies is simple, he said.

Small commercial clients "demand a lot of service, because they think they are a big account," Mr. Sitkins explained.

They are more expensive to service because they tend to call an agency more frequently and demand to talk to the owner or producer rather than to a customer service representative.



Mr. Sitkins

But, these clients bring an agency an average annual commission of \$225, compared with the average large commercial account's \$3,314 in annual commissions. Personal lines accounts average \$72 in annual commissions.

Large commercial accounts are not only more profitable because they generate larger commissions, but also because they "know how to handle their business," Mr. Sitkins explained.

The key executives delegate more responsibility to their employees and are more apt to let them handle routine service matters, he said.

Mr. Sitkins suggested that agents develop more large commercial clients because of their higher profit potential.

"If you have an area that's profitable, why not expand on it?" he said.

But, rather than disposing of the small commercial clients, agents should "just make them profitable" by handling them in a cost-effective manner, Mr. Sitkins said. "You can still give them good service. The question is who gives the service, the agent or the agency."

And all of these clients should be on direct billing from the insurance company, he added. Smaller commercial clients tend to cause collection problems for agents, which can be avoided if the client is billed directly by the insurer.

To ensure that the agency's entire book of business is profitable, agencies should emphasize account selling, Mr. Sitkins stressed.

He said that for the average insurance agency, 66% of the personal lines accounts are one-policy accounts and 24% are two-policy accounts. Of the average agency's smaller commercial accounts, 25% are one-policy monoline accounts and 24% are one-policy package accounts.

This is not a profitable scenario, he pointed out. The disadvantages of one-policy accounts include lower account retention, higher service expenses as a percentage of commissions, lower average commissions and low or no profit.

"If you increase the number of policies per account, it increases client retention, and service expenses as a percentage of income on each account goes down," Mr. Sitkins said. "Don't confuse activity with results."

He said that the best way for an agency to see how fully each client's account has been developed is to randomly pull every 10th file for personal lines accounts and every third file for smaller commercial accounts until 100 files are pulled, then count the number of policies in each account.

It is a good idea for agency customer service representatives to help pull the files so that they become more aware of the condition of their own files, Mr. Sitkins said.

Agents also should analyze their producers' performance, he said. "Inventory your producers and find out what they are doing for you."

"Sales management studies have found that if you get rid of unsatisfactory producers and spend your time with your producers who have potential, they will soon out-produce the other

Continued on next page

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## Agency potential

Continued from previous page

producers five to six times," Mr. Sitkins explained.

Agents must be willing to commit their resources to sales management and training if they want to have successful producers, he stressed. They also must dismiss producers who are not creating a profit for the agency. If unsuccessful producers are kept on the agency payroll, they cost the agency money and management time.

"It's the squeaky wheel that gets the grease, and then the people who have potential are never allowed to reach it," he explained. After agents have inventoried their agency's current situation and its potential, they should develop the agency's "unique selling proposition" or USP, Mr. Sitkins said.

"An agency's unique selling proposition is that distinct, appealing idea that sets you and your business apart from every other 'me too' competitor," he explained.

The more specific the USP, the better, he said. If the agency has expertise in specific market areas, specialized insurance programs or other claims to fame, they should be included in the USP.

"Once you have identified your agency's USP, everyone in your agency should know what it is so they

know that you're all on the same team. Then you need to build your advertising and all of your operations around it," Mr. Sitkins said.

To develop target market areas, which Mr. Sitkins views as crucial to the success of an agency, agents need to first meet face-to-face with insurance company underwriting personnel to solidify the agency/company relationship, find out what types of business the insurers want to write and identify the types of business they do not want to write.

Agents should then find out as much as they can about the books of business of their five top competitors to determine what makes them unique. Agents need to know the strengths of their competitors to compete effectively against them, Mr. Sitkins explained.

An agency can gain a competitive advantage if it develops target markets and areas of expertise that differ from its competitors.

The "largest builder of confidence in an agency is product knowledge," Mr. Sitkins said, and if an agency focuses on target areas, its knowledge of those markets increases with each account written.

The seminar was co-sponsored by Insurance Marketing Services, an agency marketing organization based in Santa Monica, Calif., and Hartford, Conn.-based Aetna Life & Casualty Co. ■

## a/bt info

• Variable Protection Administrators Inc., a company specializing in the administration of both insured and self-insured health care plans, is offering agents three free brochures that explain the company's services and its toll-free numbers. "Call the Close Line," explains VPA's group insurance sales services. "We Want to Underwrite" explains the underwriting answers that VPA can provide. "The Claims Cord" explains claims services the company provides. To order, contact VPA, 7123 Pear Road, Cleveland, Ohio, 44130; 800-VPA-SALE.

• The Independent Insurance Agents of America and the Surety Assn. of America are jointly distributing a new brochure that explains how to avoid fraudulent

bond selling. "Surety Companies—What They Are and How to Find Out About Them" is available from the IIAA, 100 Church St., New York, N.Y. 10007.

• "The Epson PC and Printer Guide for Agents," developed by Epson America Inc., is designed to give insurance agents step-by-step instruction on common insurance applications of personal computers and printers. Chapters explain word processing, spreadsheets, data base files, interfacing and other programs. The book, written by Kenniston W. Lord Jr. and published by Merdyne Publishers, is available at book stores and from Epson computer dealers. Call 800-421-5426 or 213-539-9140 in California.

• A new monograph from the Society of Chartered Property Casualty Underwriters, "Keys to Survival," includes 19 articles designed to help agents and brokers survive and thrive in the current market. Topics include market access, control and profitability; financial services packages; target markets; management decisions; company-agency relationships; clustering; mergers and acquisitions; agency evaluation; perpetuation; and hiring and training. The articles are written by leading agents, consultants, industry officials, insurance company executives and a banker. The monograph is available for \$30 from The Society of CPCU, Kahler Hall, 720 Providence Road, Malvern, Pa. 19355. Pennsylvania residents add 6% sales tax.

• The first edition of "Judging Electrical Hazards" is now available from the Alliance of American Insurers' property protection subcommittee. The 80-page, illustrated text explains basic electrical concepts, writing methods, preventive maintenance and personal safety. A bibliography also is included. The cost of the book is \$7.50 for Alliance members and \$12.50 for non-members. To order, send check for publication LC-PM-06-1185 to Publication Order Department, Alliance of American Insurers, 1501 Woodfield Road, Suite 400 W., Schaumburg, Ill. 60195-4980.

• A report examining the agency underwriting authority agreements of major insurance companies represented by independent agents is now available to members of the Independent Insurance Agents of America. The report, compiled by the IIAA's Agency Contracts Committee, discusses such subjects as: the criteria used by insurers in granting underwriting authority; specific target market areas where special underwriting authority may be granted; training and other support services insurers offer agencies granted underwriting authority; and company underwriting authority termination procedures. Copies are \$5 to IIAA members, and can be obtained from the IIAA, 100 Church St., New York, N.Y. 10007; 212-285-4282.

• The Insurance Information Institute has published a 96-page monograph, "Financial Guarantee Insurance," which explains how financial guarantee coverages work. The eight contributing authors discuss the marketing, underwriting, reinsurance and regulation of financial guarantee insurance and give tips on rating the creditworthiness of bond issuers and insurers. Copies are \$20, and can be purchased from the IIA, 110 William St., New York, N.Y. 10038; 212-669-9200. ■

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## N.Y. comp reform

Continued from previous page  
claimants who successfully return to work after entering into such settlements and the relationship between lump-sum settlements and system delays.

- A requirement that the Workers' Compensation Board enact rules of adjudicatory procedure that would reduce unnecessary adjournments and continuances by denying employers or insurers more than one opportunity to present evidence, except in extraordinary circumstances, and, penalizing claimants' attorneys or representatives who fail to present timely evidence or who otherwise cause unnecessary delay.

- A requirement that employers or insurers that unsuccessfully controvert or appeal shall pay claimants' attorneys' fees incurred to defend against the controversion or appeal. Attorneys' fees also should be assessed against employers or insurers that raise frivolous controversies or issues before a law judge or that frivolously appeal to the Workers' Compensation Board.

- A requirement that hospitals "promptly" release patients' records for use in Workers' Compensation Board proceedings.

- The adoption of a clearer definition of occupational disease that would define coverage more precisely when there is evidence of multiple causation of an injury or disease by work-related and non-work-related factors; of aggravation of a pre-existing, non-work-related condition by a work-related injury or disease; and that the injury or disease is not defined only as a result of the peculiar nature or type of employment.

- The creation of an occupational disease task force to study problems and issues relating to occupational disease, including causation and administrative delay.

The commission also recommended adoption of what it termed a "hybrid" system of benefits. Such adoption would require repealing the current system of scheduled and non-scheduled awards for permanent partial disability benefits and for total disability.

The new system would:

- Eliminate subtraction of temporary total benefits from subsequent benefits.

- Establish, for all types of permanent injuries of sufficient severity, presumed disability awards based upon medical impairment ratings.

These ratings would not attempt to serve as surrogates for total, lifetime wage loss and would be substantially smaller than current scheduled awards.

- Establish, for all types of permanent injuries of sufficient severity, potential continuing disability—or wage-loss—benefits, provided the loss of wages is due to the injury.

- Base continuing wage-loss benefits on earning capacity evaluations.

Such evaluations would be based upon relevant medical and non-medical factors such as age, education, labor market conditions and residual capacities, like vocational assessments.

- Utilize the Rehabilitation Bureau to render vocational assessments.

This hybrid system should be adopted along with a number of changes in the rehabilitation process as soon as uniform medical guidelines are adopted, the commission suggests.

Among changes in the rehabilitation process, the commission recommends:

- The employer or insurer be obligated to identify each employee who loses 60 days' work following injury (30 days in the case of back injuries) and to evalu-

**The New York workers compensation commission warned that 'unless the system is carefully analyzed and finely tuned, its parts may play against each other (and) work at cross-purposes.'**

ate such employees as rehabilitation candidates.

- Rehabilitation be broadly defined to include physical restoration, physical evaluation, work evaluation, job modification, solutions to access problems, counseling, guidance and placement, and retraining.

- Injured workers be entitled to receive temporary total benefits and other reasonable and necessary expenses during the period they are receiving rehabilitation services.

"The rehabilitation of injured workers is a primary goal of the

workers compensation system," the commission noted in the report.

Injured workers who testified at one of the commission's seven hearings said they were disappointed by the few rehabilitation opportunities provided to them. Several had not even known of the Workers' Compensation Board's existing program, the commission learned.

The commission recommended fashioning "a vigorous" rehabilitation scheme that is fully integrated with the workers compensation benefit structure.

It also called for additional legislative action that could be undertaken immediately, or in conjunction with the hybrid benefit system.

Among those recommendations are:

- Adoption of an offset of old-age Social Security benefits from permanent disability workers compensation benefits.

- Increased supplements for recipients of permanent total and death benefits.

- Adoption of flexible minimum benefits equal to 10% of the state average weekly wage in death cases and for temporary total, scheduled permanent partial and permanent total injuries.

In its report, the commission also warned that "unless the system is carefully analyzed and finely tuned, its parts may play against each other (and) work at cross-purposes."

"Not every one of us agrees with each recommendation, but all of us

were able to support this blueprint for a series of highly interactive reforms," said Karen S. Burstein, chairwoman of the commission. She also is president of the New York State Civil Service Commission.

"We leave specific parameters to be negotiated by those in the Legislature and the Executive who are charged by citizens to enact and implement statutes," Ms. Burstein said in a cover letter with the report.

Other groups represented on the New York work comp commission included: the New York AFL-CIO, the Business Council of New York State, the New York State Professional Firefighters, the New York Committee for Occupational Safety and Health, American International Group Inc., Utica Mutual Insurance Co., the Workers' Compensation Board, the New York Insurance Department and the New York State Department of Labor.

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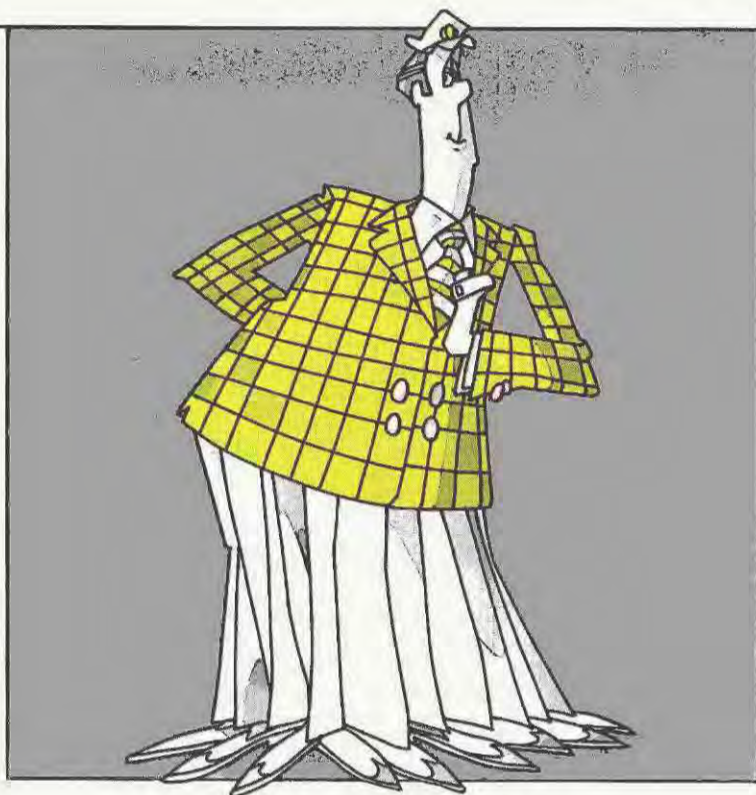
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# Panel approves ban on forced retirement

By JERRY GEISEL

WASHINGTON—Mandatory retirement would be eliminated under legislation passed by the House Education and Labor Committee.

The measure, H.R. 4154, approved late last month on a voice vote, would overhaul the Age Discrimination in Employment Act, which now allows employers to force workers to retire at age 70.

Amendments added to ADEA in 1978 raised the mandatory retirement age to 70 from 65 and also eliminated mandatory retirement for most federal workers.

House Rules Committee Chairman Claude Pepper, D-Fla., sponsor of the legislation, wants the House to consider the proposal under a rule that would bar any floor amendments.

A similar bill, S. 1054, introduced by Sen. John Heinz, R-Pa., is pending before the Senate Labor and Human Resources Committee.

## Disability benefits

The Reagan administration is asking the U.S. Supreme Court to review a series of lower-court decisions that struck down federal rules making it more difficult for applicants to collect Social Security disability benefits.

Those rules are used to determine whether employees' disabilities are so severe that they cannot work and thus qualify for Social Security disability benefits.

The rules say only medical evidence—and not a person's age, education and work experience—is the sole basis for deciding whether an applicant is disabled.

A medical evidence-only test is needed to screen frivolous claims without conducting vocational evaluation of every claimant, the government contends.

However, employers don't like the new rules because many long-term disability plans offset benefits payable with Social Security payments. Enforcement of the rules will increase benefits paid under LTD plans, increasing employers' costs.

## Non-discrimination

The American Council of Life Insurance and the Health Insurance Assn. of America are urging Congress to delay the effective date of benefit plan non-discrimination rules contained in the House and Senate tax bills.

Under those proposed non-discrimination rules—by far the most complex benefit provisions in the bills—a benefit plan would lose its tax-exempt status if it covers too great a proportion of a company's highly compensated employees or too low a percentage of a company's total workforce.

The non-discrimination rules could especially hurt companies with many divisions and different geographic locations that have designed separate plans to meet the specific needs of those divisions (BI, Dec. 16, 1985).

Both the House and Senate tax bills set a Jan. 1, 1987, effective date for the non-discrimination rules. The effective date should be set no earlier than plan years beginning on or after Jan. 1, 1989, to give employers time to comply, the Washington-based trade groups say.

"A delay in the effective date is essential since the new rules, in whatever form they actually emerge, will contain many concepts which must be implemented by regulations," the groups said in

## washington

a letter sent to members of several congressional committees.

And, employers will need time to gather the data to determine if their plans comply and to comply with the rules.

"The few months remaining until Jan. 1, 1987, are clearly inadequate for all this to be accomplished," the trade groups said.

According to the ACLI and the HIAA, the final non-discrimination rules that emerge from the conference committee should conform to these principles:

- Geographic diversity. Employers that operate in different geographic locations should be allowed to adapt health care plans to local conditions.

"Otherwise, the employer may be put in an adverse competitive position vis-a-vis local companies and possibly even prevented from expanding into new locations," the letter said.

- Multiple tests. Because of the diversity of health benefit programs, it is difficult to imagine that a single non-discrimination test could be hammered out to deal fairly with all plans.

"Thus it would appear desirable to have multiple tests under which a plan could qualify," the letter said.

- Administrative simplicity. If the rules are too cumbersome, employers might terminate their benefit plans and give employees cash to buy their own health care coverage.

"This would clearly lead to less rather than more coverage, and coverage that is likely to be purchased (would be) by the higher compensated," the letter said.

## VEBA ruling

A federal appeals court decision last month overturning a Treasury Department regulation that barred national trade associations from sponsoring tax-exempt Voluntary Employees Beneficiary Assns. will greatly benefit VEBAs, a trade association says.

In that decision, involving a VEBA sponsored by the Lisle, Ill.-based Water Quality Assn., the 7th U.S. Circuit Court of Appeals invalidated a portion of a 1981 Treasury regulation that said trade association VEBAs could be offered only if employees of trade groups worked in the same geographic area. The appeals court said the Treasury had no authority to place geographic restrictions on VEBAs (BI, July 21).

The decision—unless reversed by the Supreme Court—will benefit VEBAs and trade groups, says Douglas Oberhamer, executive director of the Water Quality Assn., a national trade association representing manufacturers, suppliers and dealers of water quality improvement devices.

National VEBAs—at least those operating in Illinois, Indiana and Wisconsin, the states that make up the 7th Circuit—should be able to obtain refunds for taxes paid for the years 1981 through 1985, Mr. Oberhamer notes. In addition, the decision will give national trade associations added incentives to start VEBAs.

"Personally, I feel much satisfaction from WQA's being able to benefit other trade associations as a group, but in the final analysis it is the association member and rank-and-file employee that will derive the greatest benefit from this case," Mr. Oberhamer said. ■

# Report finds dishonesty in PCW affair

By STACY SHAPIRO

LONDON—An interim report by the British Department of Trade and Industry into the problems at PCW Underwriting Agencies Ltd. says three men acted dishonestly when placing reinsurance for PCW syndicates.

However, the report exonerates Sir Peter Green, the former Lloyd's chairman, from allegations that he covered up any wrongdoing.

The director of public prosecutions is currently deciding whether to press criminal charges against the three men: ex-Lloyd's underwriters Peter Cameron-Webb and Peter Dixon and Lloyd's broker David P. D'amburmenil, says a spokesman for the director.

In the meantime, Mr. D'amburmenil, managing director of Lloyd's broker J. Besso & Co. Ltd., has been suspended from working at Lloyd's for six months by the Lloyd's Council. Lloyd's also has begun a disciplinary investigation into Mr. D'amburmenil's actions.

Mr. D'amburmenil could not be reached for comment, though he stated through his lawyers that he was "amazed" at the DTI's findings and "vehemently denied" the allegations.

Lloyd's already has expelled Mr. Dixon from Lloyd's and charged him 1 million pounds (\$1.5 million) for his role in the alleged misappropriation of at least 39 million pounds (\$58 million) from the PCW syndicates. Mr. Cameron-Webb has not been charged by Lloyd's because he resigned before Lloyd's

began disciplinary proceedings into the PCW scandal.

Both Mr. Dixon and Mr. Cameron-Webb now live in the United States.

The 88-page interim DTI report is part of a wider investigation begun in 1982 of underwriting units of Minet Holdings P.L.C., including PCW. The report, published July 23, deals specifically with the involvement of Monaco broker Unimar S.A.M. with reinsurance placed for PCW syndicates between 1979-1981.

The department claims that between 1979-1981, a 5% quota-share reinsurance agreement for PCW syndicates 810 and 869 was placed with reinsurers through Lloyd's broker Seascope Insurance Services Ltd.

PCW, Seascope and Unimar officials agreed that 10% of the premium should be paid to Unimar S.A.M. and transferred, on Mr. Cameron-Webb's instruction, to Unimar Marine Trade United Inc. in Panama, which owned 25% of Unimar S.A.M., the report said.

Mr. Cameron-Webb, Mr. D'amburmenil and a Unimar official said the funds were paid to Unimar to generate "new profitable reinsurance business for the PCW syndicates," the report says.

Altogether, about \$1 million was paid to Unimar in Panama in overriding commissions between 1979-81, the DTI claims.

An overriding or ceding commission is usually deducted from the premium paid to reinsurers by the ceding company to defray its

administrative costs in acquiring the original business.

The reinsurers believed that the 10% was being held by PCW syndicates as a ceding commission, when in fact, the money was being siphoned to Unimar in Panama, according to the DTI report.

"The agreement to pay 10% of the premium to Unimar S.A.M., looked at in the most favorable light, was extremely unusual," the report says. "Had its existence been disclosed to the reinsurers... they would undoubtedly have been reluctant to accept the business."

Mr. D'amburmenil, then chairman and chief executive of Seascope and "an old friend" of Mr. Cameron-Webb's, knew about the payments to Unimar, but did not tell Seascope directors or the reinsurers, the DTI alleges.

But the DTI is not exactly sure why the funds were transferred to Unimar in Panama. "We consider that we have insufficient evidence to reach a conclusion as to the purpose of the 10% paid to Unimar Panama," said the report.

However, the report says Mr. Cameron-Webb and others:

- Deliberately concealed the reinsurers' payments to Unimar.
- Failed to report to the Bank of England movements of money outside the United Kingdom, as required at the time.
- Did not record in writing any of the arrangements, apart from letters between Unimar S.A.M. and Seascope.

In addition, the report says Mr.

Cameron-Webb failed to make sure the sums held by Unimar in Panama were recorded as an asset in the syndicates' accounts.

The report further says that in 1980 about \$445,000 paid to Unimar in Panama was invested in International Reporting Information Systems Holding B.V. in the Netherlands to benefit Mr. Cameron-Webb and Mr. D'amburmenil.

IRIS was established to provide information on political and economic risks to insurers in exchange for substantial commissions. It was created by Anthony Stout, chairman and chief executive of Government Research Corp., a Washington-based political intelligence-gathering agency.

IRIS ran into financial difficulties "almost immediately" and entered liquidation in September 1983, the DTI report says.

The report concludes Mr. Cameron-Webb used money that should have been returned to the syndicates to benefit himself.

The report also says that Mr. D'amburmenil requested that advances be made to IRIS from Unimar in Panama while knowing the advances were unsecured and interest-free "loans."

"Mr. D'amburmenil cannot possibly have believed that the money lent to finance IRIS came from any source other than the syndicates," said the DTI report. "We accordingly find that Mr. D'amburmenil acted dishonestly... and in serious breach of his duty as a broker."

"We are sure that Mr. Dixon knew of the origin of the funds of Unimar," the report continues, pointing out the Mr. Dixon and Mr.

Cameron-Webb worked closely together. "We therefore find that Mr. Dixon acted dishonestly and in serious breach of his duty... to the names of the relevant syndicates."

When Sir Peter—in his role as chairman of Lloyd's—began a personal investigation of Unimar in early 1982, Mr. Cameron-Webb returned most of the money to the syndicates, the report said.

The DTI claims, however, that at least \$130,000 more should have been returned.

Sir Peter's investigation of Unimar has been criticized because he concluded the transactions were not dishonest and no disciplinary measures were taken by Lloyd's (BI, Dec. 9, 1985).

However, the DTI rejects that Sir Peter "was guilty of a cover-up."

"Whatever doubts Sir Peter may have had about the whole affair, he had insufficient evidence to make a finding of dishonesty against anyone connected with the transactions or to justify a formal investigation..."

But, the DTI is critical of Sir Peter's conclusion that "there was no dishonesty on the part of anyone connected with the transactions."

"The proper conclusion would have been that the evidence available to him was insufficient to justify a formal investigation into allegations of dishonesty," the report says.

Sir Peter said he is pleased with the DTI's conclusions, though he noted that "the inspectors have suggested that I made some errors of judgment and, with benefit of hindsight, these comments may be justifiable."

## Maxicare plans to acquire Nashville-based HMO firm

Maxicare Health Plans Inc., a Los Angeles-based health maintenance organization company, will acquire HealthAmerica Corp. of Nashville under an agreement in principle reached by the two HMO companies.

The transaction is expected to be completed by the end of November.

About 900,000 people in 18 states currently are enrolled in HealthAmerica HMO operations, a spokesman for Maxicare said.

Maxicare, which currently has more than 850,000 members in 14 states, last month announced an agreement to acquire Healthcare USA Inc. (BI, July 21). Healthcare USA has about 200,000 members and operates HMOs in California and Michigan, the spokesman said.

"After these two acquisitions are completed, Maxicare is going to be the largest HMO company in the country" after Kaiser-Permanente Foundation Health Care Inc., the spokesman said.

Under the terms of the Maxicare-HealthAmerica agreement, Maxicare would pay a total of \$400 million for all 23.3 million shares of HealthAmerica stock, said the Maxicare spokesman.

HealthAmerica stockholders would receive \$16 in cash plus one-quarter of a five-year stock warrant for each HealthAmerica share. The warrant would allow holders to acquire one share of Maxicare common stock at 125% of its value at the closing of the transaction, the spokesman explained.

### Captive manager

Hickok & Boardman Inc., a Burlington, Vt.-based insurance agency, has formed a captive insurance company management unit.

Champlain Risk Services Inc.

### markets

will conduct feasibility studies and prepare license applications for businesses and trade associations interested in setting up captives in Vermont.

In addition, Champlain will provide captive management services including accounting and record-keeping and claim and policy file maintenance. It also will help arrange reinsurance and banking, legal and auditing services.

The new unit is headed by George Chaffee, a former commissioner of the Vermont Department of Banking and Insurance. Mr. Chaffee most recently was president of Vermont Insurance Management Inc., a Montpelier-based captive management company.

Champlain Risk Services Inc. is located at 346 Shelburne St., P.O. Box 729, Burlington, Vt. 05402-0729; 802-658-0729.

### New excess facility

Old Republic International Corp. of Chicago has formed a new subsidiary to underwrite excess workers compensation insurance.

Wexford Underwriting Managers Inc. will specialize in writing excess workers compensation insurance for self-insured mining companies, self-insured Fortune 1,000 companies and large self-insured workers comp pools, said A.C. Zucaro, president and chief financial officer of Old Republic.

Wexford will write up to \$5 million in limits on behalf of Old Republic insurance subsidiaries, he said. The coverage will be marketed nationwide.

"Wexford will write excess coverage for mostly non-Old Republic primary accounts, but we will also

write for our own primary accounts," he explained.

While he would not be specific, Mr. Zucaro said "each risk that is submitted to Wexford has to meet our requirements, but there are some risks we will not write."

The principal officers of Wexford are Edmund N. Pascoe, president, and Stephen J. Jones, executive vp.

Wexford operates from offices in New York and San Francisco, Mr. Zucaro said. The East Coast office is located at 111 John St., Suite 2320, 10038; 212-962-3030. The San Francisco office is located at 260 California St., Suite 1200, 94111; 415-397-2962.

### Acquisitions

Brokerage Concepts Inc., a third-party administrator based in King of Prussia, Pa., has acquired three Blue Bell, Pa.-based third-party administrators. The companies—Office of the Administrator, PJR Inc. and C.W. Burke Inc.—will retain their current mailing address of P.O. Box 324, Blue Bell, Pa. 19422; 215-643-1320.

National Settlement Consultants Inc., a national structured settlement firm in Minneapolis, has acquired Settlement Planning Inc., also of Minneapolis. Settlement Planning will change its name to National Settlements Consultants, but will remain at 6800 France Ave. S., Minneapolis, Minn. 55435; 612-920-6166 or 800-922-6800.

### New offices

Towers, Perrin, Forster & Crosby has opened a new consulting office at 4141 North Belt, Suite 280, Houston, Texas 77032; 713-590-9231.

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# Proposed Canadian facilities attract buyer interest

By MICHAEL BRADFORD

TORONTO—Johnson & Higgins Willis Faber Ltd.'s plans to form three insurers to provide excess liability insurance coverages are bringing a flood of response from potential Canadian clients, says one of the developers of the proposed facilities.

Brian W. Jones, J&HWF senior vp said the broker has had "tons" of discussions with potential policyholders about the facilities, which would provide Canadian-based companies with general, professional and directors and officers liability insurance (BI, July 28).

"There is strong support from industry in Canada," he added.

The proposed insurers would be owned by policyholders and capi-

talized at \$25 million each.

The first of the facilities, Canadian Excess Liability Insurance Co., should offer limits of \$25 million excess of \$10 million for general liability risks by Jan. 1, says Mr. Jones.

If the first insurer is successful, J&HWF plans two similar facilities: one for D&O liability insurance and another for professional liability coverage. Both would offer limits of \$25 million excess of \$10 million.

Those insurers would be called Canadian Excess Directors & Officers Liability Insurance Co. and Canadian Excess Professional Liability Insurance Co.

Mr. Jones said J&HWF hopes for about 100 participants in each of the facilities.

J&HWF has assurances from

regulatory authorities in Canada that the facilities will be approved if surplus requirements are met, he said.

The facilities will be managed by Zurich Insurance Co. in Toronto, which will provide underwriting, claims administration, investment management and other services.

J&HWF will prepare applications, develop policy wording, handle billing, collect premiums and place necessary reinsurance.

Financial and accounting services for the facilities will be provided by the Toronto office of Coopers & Lybrand, while legal services will be handled by Toronto law firms Fasken & Calvin and Lilly McClintock Bowman.

Prospective investor-policyholders in Canadian Excess Liability must submit an application

through J&H to Zurich. The facilities will be accessible through any broker, but commissions are not payable by the insurer. Applicants will be responsible for negotiating commissions if they do not apply through J&HWF.

A \$2,000 fee will be charged for obtaining a quote, but the amount will be credited to the first-year premium if the quote is accepted.

Buyers will have to purchase the full \$25 million limit.

To capitalize the insurer, policyholders will be assessed a one-time charge of 50% to 100% of the first year's annual premium.

If the insurer does not have sufficient reserves to pay claims in any policy year, policyholders can be assessed up to 100% of that year's premium. Any profits will be returned to the shareholders.

Each policyholder will be a voting shareholder and will be able to participate in the election of the advisory board of directors.

Canadian Excess Liability would write coverage on a claims-made form and would cover legal liability for bodily injury and property damage, including product liability. The coverage will apply to products produced in Canada but sold elsewhere, including the United States, if litigation arises there.

The policy would exclude coverage for punitive damages, sudden and gradual pollution, nuclear risks and professional liability.

The proposed facilities to write professional liability and D&O insurance will function in much the same manner as Canadian Excess Liability, according to J&HWF.

Canadian Excess Professional Liability also will provide the same limits of coverage, primarily for insurance agents and brokers, chartered accountants and law firms.

The purpose of forming the professional liability insurer, according to J&HWF, is to fill the void created after Lloyd's of London and U.S. underwriters severely restricted writing coverage for professional liability risks in Canada.

Canadian Excess Directors & Officers Liability would write D&O insurance for private and public Canadian-based companies, providing the same limits of coverage as the other two companies. ■

## Court upholds regulating land use

WASHINGTON—A recent U.S. Supreme Court decision reaffirms the high court's previous position that municipalities have the right to regulate land use.

In the past 10 years, lawsuits that challenge public regulation of land use and seek monetary damages have become an increasingly significant municipal liability exposure.

However, the decision in *MacDonald, Sommer & Frates vs. Yolo County et al.* did not establish specific rules for land-use regulation, which public entities nationwide have been seeking, said C. Lee Humes, assistant county counsel for Yolo County, Calif.

Still unresolved is how to determine when municipalities' justifiable control of land use "goes too far" and violates a landowner's constitutional rights under the Fifth Amendment by taking control of property or the 14th Amendment by violating due process guarantees, he said.

In the California case, three landowners sued Yolo County and the city of Davis after proposals to develop a 159-lot subdivision were rejected for several reasons, including lack of public street access. The landowners claimed their Fifth and 14th Amendment rights were violated.

Although three successive California state courts upheld the public entities' rejection of the subdivision plan, the case was brought before the U.S. Supreme Court from a judgment sustaining a demurrer, Mr. Humes said. The landowners sought declaratory relief and an unspecified amount of damages.

But the high court pointed out that the landowners did not exhaust all means of remedying the deficiencies cited by the municipalities in rejecting the proposed subdivision. Consequently, the justices did not specify guidelines for municipal regulation of land use, Mr. Humes said. ■

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**business insurance**

## Guaranty fund

Continued from page 1

Guaranty funds assessed about \$344 million in 1985, "the most ever assessed in one year by the guaranty fund system," says Richard J. Marcus, executive secretary of the National Committee on Insurance Guaranty Funds based in Schaumburg, Ill.

The previous record assessment was in 1984, when the funds assessed \$74.1 million, Mr. Marcus added.

These figures exclude New York's unique pre-assessment fund and payments made by individual insurance companies under insolvency provisions of the uninsured motorists' endorsement, Mr. Marcus added.

State guaranty funds respond to their residents' claims not paid by insolvent insurers licensed in their state, subject to a per-claim cap.

Licensed insurers in the state are assessed the amount as needed to cover the guaranty fund claim payments, with assessments capped at 1% to 2% of an insurer's net direct written premiums in the previous year.

These guaranty fund assessment costs are passed on to policyholders in the form of higher premium charges, or else they drain insurers' profits.

In its declaratory judgment action filed July 11 in state court in Hartford, CIGA is asking the court to rule on its liability for claims filed by Raymark. The claims have not yet been filed, but are expected.

Raymark currently faces more than 30,000 asbestos claims, and more than 1,000 new claims are being filed every month.

Raymark has exhausted its primary insurance and virtually exhausted its first-layer excess coverage, resolving 15,000 claims for a total of \$125 million in payments and \$30 million in legal fees. Monthly payments by Raymark's insurers total \$10 million.

Raymark was in state court last week in Chicago seeking a court order that its second-layer liability insurers, including Transit, begin funding asbestos claims.

Transit wrote \$12 million of Raymark's second layer of insurance.

As of this spring, Raymark had about \$250 million in liability insurance remaining from the almost \$400 million in limits it had purchased since 1941.

Of the \$400 million, Transit wrote \$32 million of coverage between 1979 and 1982, providing six insurance policies on the second, third and fourth layers of Raymark's excess coverage.

However, CIGA is asking in its declaratory action in Connecticut that when Raymark files claims against it for coverage under the Transit policies that CIGA's liability be limited to \$300,000 per policy, less a \$100 deductible for each policy.

In Connecticut, CIGA's liability for covered claims against insolvent insurers is \$300,000.

However, CIGA does not explain in its suit why each claim paid to an asbestos claimant should not be considered a covered claim under the guaranty fund.

Paul M. Gulko, executive secretary of CIGA, says "I think if you look at the law, you don't know who the claimant is. It's ambiguous."

Where a guaranty fund has a portion of an excess policy, it is uncertain who the claimant is under the statute—whether it is the policyholder (Raymark) or the underlying claimant suing the policyholder, he said.

"It is a preposterous complaint," contends Frank K. Heap with the Chicago law firm of Bell, Boyd & Lloyd, which represents Raymark in insurance coverage litigation.

"Basically, Raymark is seeking

reimbursement for claims filed against it covered by insurance and these are individual claims," Mr. Heap said.

"There is nothing to justify lumping them together other than to reduce the obligations of the guaranty fund," he added.

Another issue raised by the CIGA lawsuit is at what point the association must respond to the Raymark claims.

The association contends that it should respond only after all of Raymark's other primary and excess insurance has been exhausted, even though the Transit policies were written on various lower layers.

State law provides that the guaranty fund is a "court of last resort," Mr. Gulko said.

However, some attorneys say that when CIGA must pay depends on the language of the excess policies in the layers above the Transit policies.

CIGA also asserts in its suit that if each individual claim against Raymark is a claim covered by the fund then, according to its state law:

- The \$100 deductible applies to each claim.

- CIGA's obligations should be reduced by any amounts claimants receive or could receive under other insurance policies, including workers compensation or medical insurance.

- CIGA should not be liable for subrogation or other recoveries by any insurer, insurance pool or underwriting association.

- That CIGA has no duty to defend Raymark and its affiliates and that any amounts paid by CIGA attributable to the cost of providing a defense to the Raymark affiliates for covered claims shall be applied to the Transit policy limits.

CIGA's suit names in addition to Raymark: two Raymark subsidiaries; Raymark's 10 primary and excess liability insurers; Lewis Crist, the director of the Division of Insurance of the state of Missouri, as receiver of Transit Casualty; and The Connecticut Bank & Trust Co., a national banking association that is assignee of certain rights to recover under the Transit policies. ■

## Several guaranty funds paying asbestos claims

While the Connecticut Guaranty Insurance Assn. is contesting its liability for asbestos claims that will be filed by Raymark Corp., other state guaranty funds are paying asbestos-related claims filed against insolvent insurers.

However, claims filed and paid to date in other states are relatively few in number and for relatively small amounts, according to the guaranty funds.

Raymark's claim against the Connecticut fund could total \$32 million (see related story).

The Florida Insurance Guaranty Assn., for example, is paying about 60 or 70 asbestos claims on behalf of Midland Insurance Co., which insured Jim Walter Corp. of Tampa.

Midland is being liquidated in New York.

The association is paying the claims on the basis that each claim filed by a person against Jim Walter is a covered claim, said Philip J. Meunier, claims manager of the association.

Florida's guaranty fund pays up to \$300,000 for each covered claim.

Thus, if there were 10,000 asbestos claims, each of which cost at least \$300,000, the guaranty fund would theoretically have to pay \$3 billion for the claims.

However, Florida's fund is limited to assessing insurers 1% of premiums written.

Also, the Ohio Insurance Guaranty Assn. has already paid about 250 to 300 asbestos claims for relatively small amounts on behalf of Ideal Mutual Insurance Co., which insured Childers Products Co. Inc. of Cleveland.

Ideal Mutual also is in liquidation in New York.

Ohio's guaranty fund pays up to \$300,000 per covered claim.

The Colorado Insurance Guaranty Assn., which pays claims against insolvent insurers up to \$50,000 per claim, could be hit with massive claims by Manville Corp., formerly the world's largest asbestos producer.

Manville purchased at least \$75 million in liability insurance limits from Midland.

However, Denver-based Manville has not yet filed a claim with the Colorado fund, in part because the company has been mired in bankruptcy for the past four years and has not paid asbestos claims, pointed out Manville General Counsel Richard B. Von Wald.

When Manville emerges from bankruptcy and begins paying claims and cannot recover from Midland, it likely will seek recovery from the Colorado fund and perhaps other state guaranty funds, Mr. Von Wald said.

There is little, if any, legal precedent governing how guaranty funds should respond to multiple claims against an insurance policy that exceed the fund's per claim cap, guaranty fund spokesmen and lawyers say.

Caps on claims payments by guaranty funds range from a low of \$50,000, such as in Colorado, Missouri and Kentucky, to generally \$300,000. New York and Maryland do not cap guaranty fund claims payments.

While noting that he is unaware of any litigation over whether multiple claims arising out of a single policy should be paid by a guaranty fund, lawyer Thomas B. Ridgley said guaranty associations have paid more than their \$300,000 cap on a policy due to multiple claims.

Mr. Ridgley is a partner with Vorys, Sater, Seymour & Pease in Columbus, Ohio, and outside counsel to the Ohio Insurance Guaranty Assn.

An attorney for the Illinois Insurance Guaranty Fund said it has never faced multiple claims that together exceeded the fund's per-claim cap.

"The guaranty fund law is a little bit ambiguous as to how these claims can be handled," said Thomas Jenkins with the Chicago law firm of Lord, Bissell & Brook.

Currently, the New Jersey Insurance Guaranty Assn. is faced with multiple claims under one policy, said Jesse Benton, executive director. "I don't know how it will turn out. It's never been litigated. I've never heard of any case on this subject."

The fund is being asked to respond to claims filed by 180 persons who became ill from ingesting salmonella poisoning at a hotel, Mr. Benton said.

He declined to name the hotel or its insurer, saying the information was confidential.

There may, however, be a legal argument for guaranty funds to limit their liability for multiple claims filed against a policyholder that exceed the fund's claim payment cap, some attorneys say.

It may be possible, especially under excess indemnity policies, to find the policyholder is the covered claimant with the guaranty association rather than the individuals suing the policyholder, they say.

If the policyholder is the claimant, the fund would owe only one payment, subject to its claim payment cap, for each policy.

"It might be the insured rather than the individual claimant" making the claim, says Richard J. Marcus, executive secretary of the National Committee on Insurance Guaranty Funds based in Schaumburg, Ill.

"There is an uncertainty there," he said.

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## New Jersey rules

Continued from page 2  
employers' liability; accident and health; and fidelity, surety, performance and forgery bonds.

The most controversial amendment to the regulations would restore substantive Insurance Department control over non-renewals, according to Mr. Sullivan.

The new proposed amendment requires property/casualty insurers to list in their policies the reasons they would invoke for non-renewal.

The July 7 regulations only require insurance companies to state in their policies why they would cancel a policy.

Mr. Sullivan said he is "unalterably opposed" to the controversial proposed amendment, calling it "a major, major change" in the regulations from the July 7 version.

Insurance companies oppose the amendment because they do not want to be limited by contract to specific reasons for non-renewing a policy.

Further, insurers do not want to face possible court interpretations of their reasons for not renewing an insurance policy, Mr. Sullivan explained.

However, "by providing the policyholder with prior notice of the insurer's standards for non-renewal, terminations of important coverages may be avoided," the Insurance Department said in its summary of the new proposed amendments.

Under New Jersey's current regulations, the department says acceptable reasons an insurance company may cancel or not renew a policy can include, but are not limited to:

- Non-payment of premium.
- Moral hazard.
- Material misrepresentation or non-disclosure of a material fact.
- Increased hazard or material change in the hazard.
- Substantial breaches of contractual duties.
- Lack of policyholder cooperation.
- Increase in exposure.
- Insurer's loss of reinsurance.

The recent amendments add "adverse loss experience" as an acceptable reason for not renewing a policy.

Other amendments proposed to July 7 regulations are:

## Capacity for three risks provided by MAP

TRENTON, N.J.—The New Jersey Insurance Department expects the state's Comprehensive Commercial Lines Market Assistance Program, established June 2, to provide needed insurance capacity for three types of risks: municipalities, day-care operations and liquor-serving establishments.

"The MAP was quid pro quo for the (regulation) changes," said Wes Caldwell, vp of the American Insurance Assn. in New York.

A key provision of the MAP, which makes it more stringent than some MAPs in other states, is that each participating insurer agrees to quote a price on at least one of every five applications it receives, according to a department spokesman.

Eligible for the MAP are risks in the three hard-to-place lines that have not been able to obtain even a single insurance quote, according to the Edward Gray, the MAP's general manager in Parsippany.

Mr. Gray, who managed a New Jersey MAP program eight years ago, was the commercial lines manager for Travelers Insurance Co. in New Jersey before his retirement.

His supervision of the day-to-day operations of the MAP is reviewed by a 10-member board of governors.

The MAP is accessible through agents or brokers, but potential insurance buyers must pay a \$75 application fee.

Mr. Gray praised the "terrific" cooperation of members of state chapters of both the National Assn. of Professional Insurance Agents and the Independent Insurance Agents of America in informing their members about the MAP's operation.

Mr. Gray declined to comment on the number of insurers participating in the MAP or the number of risks for which coverage has been found. The MAP is still in the "push, pull, shove and jawboning" stage, he said. "It's still shaking down."

"The MAP just got off the ground," noted AIA's Mr. Caldwell. "So it is too early to say how it is doing." However, it should work because enough major insurers are involved, he explained.

"The MAP is proving to be effective," said Peter Strauss, the Alliance of American Insurers' governmental affairs representative for the eastern region.

Other lines of insurance may be added to the MAP after consultation between New Jersey Insurance Commissioner Kenneth Merin and the MAP's board of governors, according to an Insurance Department statement.

- A 10-day limitation on oral binders. Written binders are limited to a maximum of 60 days for fire insurance and 90 days for other lines subject to the regulations.

"Some insurers are issuing successive binders, sometimes providing coverage in this manner for several months," according to an Insurance Department summary of the proposed amendments.

"It's news to me that the problem exists," Mr. Sullivan said, but he said the proposed amendment was "not terribly troublesome" for insurers.

- A requirement that insurers issuing estimated premium quotes provide the policyholder with the actual quote within 60 days.

If the actual premium is less than the estimated premium, the amount billed the policyholder must be calculated using the actual premium applied to the policy from its inception.

If the actual premium exceeds the estimated premium, the higher premium can apply only to the unexpired portion of the policy, the department says.

In addition, the policyholder must be given at least 30 days' notice of any additional premium, and the policyholder can cancel the

coverage.

The insurance company's earned premium would be calculated in accordance with the estimated premium charge.

Mr. Sullivan described this amendment as "cumbersome and unnecessary."

Under the July 7 regulations, policyholders must receive notice of a renewal premium and any change in contract terms at least 30 days before, and not more than 120 days before, the premium due date.

The same notice must be given if an insurance company wants to cancel a policy, other than for non-payment of premium or a moral hazard.

The latest proposed amendments to New Jersey's regulations governing policy cancellations and non-renewals surprised insurance trade groups.

They thought the insurers and the department had finished negotiating over New Jersey's regulations of the July 7 regulations and the creation of the MAP.

The emergency regulations issued in September helped to stem the flood of policy cancellations and non-renewals and brought some stability to the marketplace

in which arbitrary non-renewals and cancellations had reached crisis proportions, according to Insurance Commissioner Kenneth Merin.

The regulations were adopted under the guidance of former Insurance Commissioner Hazel Frank Gluck, who served a short term as commissioner between Mr. Merin's two terms.

New Jersey state judges three times upheld the controversial regulations, which were challenged by insurers that disputed the department's authority to adopt them (BI, Feb. 10).

However, with the July 7 regulations, the department rescinded some of the more controversial provisions of the September regulations in addition to the regulation governing non-renewals of insurance policies.

Among the July 7 changes to the September regulations that are not subject to the new proposed amendments are:

- Deletion of a provision that requires an insurer to offer similar terms and conditions when renewing a policy.

Now, the regulation recognizes that a change in the insurer's position, like a loss of reinsurance, may make it impossible for an insurer to meet that requirement.

- Deletion of a requirement that insurers file for approval with the Insurance Department their underwriting standards for non-renewal 90 days in advance of a proposed non-renewal.

Now, insurers must file their underwriting guidelines with the department, which does not have to approve them but does have the authority to disapprove guidelines it considers inappropriate.

Insurers and their trade groups praised the July 7 regulations as reasonable.

"They are a significant improvement," said Wes Caldwell, vp of the American Insurance Assn. in New York.

"They generally give companies greater flexibility in terms of non-renewals."

Peter Strauss, the Alliance of American Insurers' governmental affairs representative for the eastern region, said the July 7 regulations "provide adequate protection for policyholders without unduly inhibiting insurers from making insurance available in the state."

However, Mr. Strauss questioned why commercial automobile insurance continues to be included in the regulations.

The Insurance Department statement accompanying the regulations said: "The relaxation of these requirements is expected to promote more nearly normal market conditions, particularly the writing of new business." ■

## Railroads find cover with captive

By MEG FLETCHER

HAMILTON, Bermuda—An off-shore insurer writing excess liability insurance for railroads is rolling ahead with new members three months after it began operation.

Last month four more rail lines linked up with Railroad Assn. Insurance Ltd., bringing the number of participants to 15.

The new members are the Chicago-area Metropolitan Rail passenger line, known as Metra, and three Canadian railways—Canadian National, Canadian Pacific and VIA Rail—according to Alan Chilvers, group vp for International Risk Management Ltd., RAIL's manager.

The other members include most of the major freight-carrying railroads and a few passenger lines, including Amtrak, the Southeastern Pennsylvania Transportation Authority and Illinois Central Gulf Railroad.

Railroad executives announced the formation of the captive last fall after the commercial liability insurance capacity crunch left many major freight and passenger lines without adequate liability coverage (BI, Oct. 7, 1985). The captive began operating April 30.

RAIL provides \$50 million excess of \$50 million of liability coverage for third-party liability, evacuation, sudden and accidental pollution and liability under the Federal Employers' Liability Act, said Louis W. Biegler, president of Corporate Advisors Inc. in Northbrook, Ill. Mr. Biegler was hired by International Risk Management as an underwriting consultant for RAIL.

Coverage is written on a claims-made form.

Optional coverage also is available for bill of lading and foreign rolling stock liability.

Some RAIL members are seeking even higher limits through other facilities like A.C.E. Insurance Ltd., but they are doing so on an individual basis, Mr. Biegler noted.

RAIL has been capitalized through one-time policyholder contributions equal to 2½ times the first-year premium, Mr. Biegler said.

For instance, Metra paid \$471,000 in annual premium and a \$1.18 million capitalization charge to join RAIL, said Dennis Gallivan, head of Metra's general administration department.

Besides the \$50 million limits excess of \$50 million from RAIL, Metra has bought \$35 million in excess coverage above a \$5 million retention, he said. This coverage, primarily written by Lloyd's of London underwriters, cost \$4.2 million, he said.

However, Metra, currently does not have coverage for the \$10 million layer excess of \$40 million.

Metra may cancel the \$35 million layer if a self-insurance pool offering up to \$50 million in limits is established by the two other transit units that make up the Chicago-area Regional Transportation Authority, Mr. Gallivan said.

The units, which are both operating without liability insurance, are the Chicago Transit Authority and the Pace system, which operates suburban buses (BI, Dec. 9, 1985).

Legislation signed by Gov. James Thompson last month authorizes the RTA to sell about \$45 million or \$50 million in bonds to capitalize the pool, said a spokesman for the RTA.

"I think it will be fairly innovative," Tad Weigelt, the RTA's executive director, said of the bond sale. ■

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# Senate votes to continue benefits for LTV retirees

By DAVE LENCKUS

WASHINGTON—LTV Corp. retirees are receiving additional guarantees that their health and life insurance benefits will continue.

The Senate last week approved legislation, S. 2690, that requires LTV to continue post-retirement life and health care benefits until a court decides whether the company can terminate the benefits.

A companion bill, H.R. 5283, was pending in the House last week.

In a related development, a federal bankruptcy court in New York last week gave LTV permission to continue the retiree benefits for six months (see story, page 2). LTV had canceled the benefits when it filed for reorganization on July 17 (BI, July 28).

"Termination of life and health insurance benefits has created an intolerable situation for LTV retirees," said Sen. John Glenn, D-Ohio, one of the Senate bill sponsors.

Meanwhile, the House Ways and Means Committee late last month passed legislation that would guarantee that retirees, spouses and dependents covered under a health care plan would continue to receive benefits if the plan sponsor files for reorganization.

The bill also encourages states to establish high-risk health insurance pools in which all employers with 20 or more employees would be required to participate or face an excise tax on gross wages.

These provisions are contained in legislation approved by the committee to amend the Consolidated Budget Reconciliation Act.

The provision that would extend health care coverage to retirees applies to companies filing for Chapter 11 reorganization on or after July 1, 1986.

Under the provision, all retirees and their spouses and dependents would have the option to continue in the employer-sponsored plan until the death of the retiree, after which the widowed spouse and the dependents can elect for continued coverage for 36 additional months as provided under COBRA; re-employment of the retiree or the spouse by an employer that provides health coverage; remarriage by the widowed spouse; or failure to pay the premium.

Plan participants could be charged up to 102% of the premium for the coverage.

Currently under COBRA, which was signed into law in April, most public and private employers are required to provide health coverage to employees' widowed or divorced spouses for up to three years. And, except when terminated for gross misconduct, employees have the right to obtain coverage for up to 18 months after employment ends.

However, the law as now written addresses active employees, not current retirees.

The health care risk pool provision of the budget reconciliation amendments establishes voluntary guidelines for states to follow.

Under those guidelines, all state residents, regardless of health, would be eligible to obtain health insurance at a premium no higher than 150% of the average premium charged to individual standard risks for comparable coverage by insurers in the state.

If a state's pool is not self-supporting, losses would be covered by equitable assessments against all participating employers.

Employers that do not participate in a state's pool would be charged a 5% excise tax on gross wages paid or incurred during the current tax year.

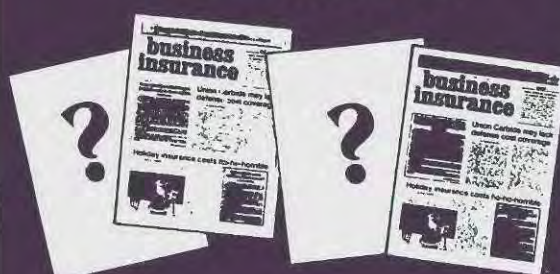
The legislation does not mandate

that states establish health insurance pools, but encourages the states to do so by enabling them to require employers—including self-insurers—that provide health care benefits under the guidelines of the Employee Retirement Income Security Act to participate in the pools, explained a Ways and Means Committee staff member.

The health insurance pool provision was the only provision from a comparable Senate bill, S. 2402, that the House panel considered (BI, May 12).

The Senate bill is scheduled to be marked up this week, at which time the sponsor, Sen. Edward M. Kennedy, D-Mass., is expected to offer substitute legislation that may omit several of the provisions included in the original bill. ■

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#### Business Insurance Circulation Breakdown\*

##### Commercial Consumers

**Administrative:**  
CEO's presidents and owners...2,983  
Vice-presidents, general managers and other administrative personnel .....2,758

**Financial:**  
Chief financial officers and vice-presidents of finance .....2,018  
Secretaries, treasurers, controllers and other financial personnel...6,484

**Risk/employee benefits:**  
Vice-presidents, directors, managers, and other related department personnel of insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations .....8,111

**Sub-total** ..... **22,354**  
Associations ..... 483  
Government, unions and educational Institutions .....1,252

**Commercial Consumers**  
**Sub-total** ..... **24,089**  
Insurance agents and brokers 10,285  
Insurance companies .....6,739  
Financial institutions ..... 748  
Actuaries, attorneys, adjusters, appraisers and consultants .....3,808  
Others allied to the field .....1,308  
**TOTAL** ..... **46,977**

\* Source: Business/Occupational breakdown of qualified circulation, Nov. 25, 1985 issue, as submitted to BPA for December 1985 BPA Publisher's Statement.

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## Superfund provisions

Continued from page 2

both the House and Senate bills that would have limited citizen suits to cases where there was an "imminent and substantial endangerment" to public health or the environment.

• Require the president and the EPA to establish procedures that would facilitate settlements in government-ordered cleanups by those responsible for a toxic dump site.

Further, this provision requires the EPA to notify these responsible parties if a decision is made by the agency not to use these settlement procedures and to explain why the procedures are inappropriate.

However, the provision specifically says an EPA decision not to use settlement procedures is not subject to court review.

The provision also requires the EPA to develop guidelines for preparing non-binding preliminary allocations of responsibility among companies identified by the agency as responsible for a hazardous waste site, though the EPA is not bound to use such guidelines. Such allocation of responsibility also cannot be reviewed by the courts.

The conferees rejected Senate-passed language that would have permitted this kind of judicial review.

Insurer and business groups had lobbied for acceptance of the language, arguing that the judicial review of the EPA's settlement efforts would result in more settlements and reduce litigation over cleanup costs.

Insurers favored the Senate language because it would have forced the EPA to consider upfront settlement offers by polluters, the AIA's Mr. Stark explained.

While the language adopted by the conferees does not force EPA to consider settlement offers, it does

offer "an incremental step forward" by requiring the EPA to set up settlement procedures, Mr. Stark said.

"There is in this document some very affirmative, positive language, which really indicates that the Congress has urged EPA to be more aggressive with respect to settlements. . . . That set a tone that EPA must pay some attention to," he added.

Insurers also had hoped to persuade the conferees to reject House-passed language that made the pre-emption of statutes of limitations retroactive to 1980.

Mr. Stark said insurers could have accepted such a pre-emption on a prospective basis, but applying the pre-emption retroactively would open up old case files that insurers had thought were closed. "It's bad enough to have this happen, but to rub salt in our wounds by going back six years and picking up claims that would otherwise be extinguished by state statutes of limitations makes it more irritating to us."

Several other liability-related issues remained to be ironed out by Superfund conferees late last week, including: the liability of cleanup contractors; the scope of a study of the environmental impairment liability insurance market; and limits on the liability of persons who unknowingly bought contaminated land.

Congressional staffers said they expected conferees to complete work on the remaining issues late last week or early this week. "We're within striking distance of finishing this bill," one House staff member said.

Rep. John Dingell, D.-Mich., chairman of the Superfund conference committee, urged a separate group of conferees working on the tax issue to wrap up their work on the reauthorization bill before Congress' Aug. 15 recess. But staffers say it is unclear whether tax conferees will meet that goal. If they do, Congress likely will take a final vote on Superfund in early September. ■

## LTV continues retiree benefits

Continued from page 2

ever, he said that the period "would provide some transition for retirees to make other arrangements."

The retirees are covered by 25 different uninsured plans involving a variety of contribution, copayment and deductible requirements. The company paid claims from general corporate funds.

LTV told the bankruptcy court it will cost the company \$70 million to reinstate the retiree benefits for the six-month period. The average annual cost of providing the health and life benefits was \$120 million, according to the LTV spokesman.

The company will continue to pay retiree benefit claims from corporate funds during the six-month period, the spokesman added.

In a related development, the Senate last week approved legislation that would require LTV to continue the retiree benefits until a court rules whether the company can terminate the benefits (see, story, page 35).

In addition, a House committee approved legislation that would guarantee that retirees would continue to receive health benefits if their employer files for bankruptcy. However, the retirees would have to pay up to 102% of the cost of the coverage to receive benefits.

Last week, before the bankruptcy court permitted LTV to continue the retiree benefits, both the company and the United Steel Workers of America offered separate health benefit packages to retirees to replace the canceled coverage.

However, retirees would have had to pay all premium costs under both proposals.

The coverage offered by LTV, which would have been underwritten by Metropolitan Life Insurance Co. of New York and John Hancock Mutual Life Insurance Co. of Boston, would have required annual deductibles of \$500 per individual or \$1,000 per family and 20% copayments. Benefits would have been reduced by the amount of Medicare benefits payable.

The program proposed by the labor union would have been underwritten by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. Retirees would have had a choice of several coverage options. ■

## the professional marketplace

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Jun 9	May 28
Jun 16	Jun 4
Jun 23	Jun 10
Jun 30	Jun 18
Jul 7	Jun 24
Jul 14	Jul 1
Jul 21	Jul 8
Jul 28	Jul 16
Aug 4	Jul 23
Aug 11	Jul 29
Aug 18	Aug 6
Aug 25	Aug 13
Sep 1	Aug 19
Sep 8	Aug 26
Sep 15	Sep 3
Sep 22	Sep 9
Sep 29	Sep 16
Oct 6	Sep 24
Oct 13	Oct 1
Oct 20	Oct 7
Oct 27	Oct 15
Nov 3	Oct 22
Nov 10	Oct 28
Nov 17	Nov 5
Nov 24	Nov 11
Dec 1	Nov 18
Dec 8	Nov 25
Dec 15	Dec 3
Dec 22	Dec 9
Dec 29	Dec 16

# business insurance

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## Work comp rates

Continued from page 1

brought the case, said the Rating Board approved last year's work comp rate filing without enough financial information from the NCCI.

The NCCI submitted the rate proposal on July 1, 1985, on behalf of its approximately 130 member insurers in Oklahoma, including the State Insurance Fund, a competitive state work comp fund.

The NCCI filed for an average 41.9% rate increase, noting that work comp insurers had suffered substantial losses in Oklahoma, thereby creating a potential threat to the solvency of some insurers.

The attorney general and three employer groups subsequently presented testimony from actuaries—including insurance consumer advocate J. Robert Hunter—that specific lower rate increases—8.1% and 15.2%—were more in line with what was actually needed.

The Rating Board also retained an outside actuary, who determined a 25.9% average rate increase was in order.

The Rating Board adopted this actuary's finding, noting that the recommendation was "fair and reasonable in establishing a rate, which is neither excessive, inadequate nor discriminatory. . . (the) recommendations have the effect of balancing the interests of policyholders, the insurance industry and the state in establishing a fair rate."

But the Supreme Court said that finding "clearly lacks the specificity that is expected of a board's order rendered upon a hearing."

Other conclusions by the Rating Board were "unsupported by actual findings of fact," the court also noted.

"The attorney general's primary contention is that the board erred by failing to compel the production of and hence to consider sufficient evidence about the financial condition of the insurers represented by the NCCI. We agree," said Justice Marian Opala in the 16-page majority opinion.

"The statute's foremost mandate for ratemaking is that rates . . . shall not be excessive, inadequate or unfairly discriminatory." When NCCI, by its filing, requested an increase in rates, it essentially asserted that the rates in effect at that time were inadequate," Justice Opala said, citing a state statute that "explicitly" governs how the Rating Board should determine rate adequacy.

That statute provides: "No rate shall be held to be inadequate unless (1) such rate is unreasonably low for the insurance provided and (2) the continued use of such rate endangers the solvency of the insurer using the same, or unless (3) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same, has, or if continued will have, the effect of destroying competition or creating a monopoly."

Justice Opala said this provision's basic standards must be read in the disjunctive and that it prescribes two distinct measurements, either of which must be used to determine whether rates are inadequate.

"Hence, a conclusion that rates are inadequate necessarily depends upon a finding that (1) rates are unreasonably low—a factor common to both gauges, and (2) either the use of the rates endangers insurer solvency or the rates do, or will, adversely affect competition or create a monopoly," he said.

In addition, Justice Opala noted that the statute requires the Rating Board to consider various other factors in making such a determination, including past and prospective loss experience within and outside the state; dividends and premium deposits; investment

income; and insurer expenses.

"Upon examination of the record, we cannot conclude that NCCI tendered for the Board's consideration sufficient evidence about the actual financial condition of the insurers it represented to warrant a finding that the rates at the time of the filing were inadequate," Justice Opala wrote.

"Although the materials included in NCCI's filing contain numerous tables and exhibits, we have found no information from which the actual financial state of any NCCI member company may be reasonably ascertained.

"We have long held that one of the most important factors in determining whether rates are inadequate is the financial soundness of the insurer," he continued. "Evidence considered by the Board may include annual financial statements or other data forms from which net profit and dividends actually paid may be considered. Among the other relevant factors that the Board must consider is income from unearned premium and loss reserves."

Because insufficient information was provided by the insurers, the Supreme Court ruled the approval of the 25.9% average rate increase could not be affirmed, and it remanded the rate proceeding back to the board.

The case heard by the Supreme Court was a consolidation of two separate cases: the case brought by the attorney general challenging the rate hike and a case brought by the NCCI against the board to seek approval of the full 41.9% average rate increase.

But the court rejected the NCCI's argument that the entire requested increase should have automatically gone into effect after a 30-day waiting period because that 30-day period was legally extended by the Rating Board during its hearing process.

The NCCI termed the Supreme Court's overall decision "an unusual interpretation of the rating law."

The NCCI is expected to ask for a rehearing, said Mr. DeCarlo. The court currently is recessed, making it uncertain when the court would act on such a request.

If the state high court does not reconsider the ruling, the NCCI may consider asking the U.S. Supreme Court to review the "outrageous" decision, he added.

However, the NCCI may pursue other options, including refiling rates with the Rating Board or asking the Oklahoma Legislature to overturn the Supreme Court decision, said Mr. Derryberry, the NCCI's outside counsel.

The NCCI's law committee, attorneys for its six largest insurer members and Mr. Derryberry were scheduled to meet late last week to determine what action to take.

Some observers say the decision could lead to the withdrawal from Oklahoma of commercial workers compensation insurers.

"That's the speculation," said Bert Marshall, general counsel of the Oklahoma Insurance Department, which now oversees the Rating Board following a reorganization of state government earlier this summer.

Others note the decision could apply to all types of property/casualty insurance rates, not just workers compensation rates.

"We believe it is rather encompassing. . . and more than likely will encompass all (property/casualty) rates," said J. Angela Ables, the Rating Board's outside attorney.

The statute cited by the Supreme Court is nearly identical in language to statutes applying to other lines of property/casualty insurance, she explained.

"I will advise the board that it applies to all rates," she said, adding that "it's going to change the way the NCCI and insurers

make rate filings."

It "will be a whole new ball game," said Julius Kubier, vp of the recently consolidated Oklahoma State Chamber of Commerce & Associated Industries.

The Oklahoma decision also could influence rate regulation in other states, some observers say.

"This is going to have real ramifications for the NCCI and for those who set rates across the nation," said the Insurance Department's Mr. Marshall.

Victor Bird, Oklahoma's administrative assistant attorney general, agreed. "In one sweeping opinion, our Supreme Court moved insurance ratemaking ahead 60 years," said Mr. Bird, who tried the case. "I think this case will have national implications.

"Our Supreme Court said this case has the public interest," he said, noting that it embraces principles commonly used in approving public utility rates.

In fact, Oklahoma Supreme Court Justice Robert Lavender, who dissented from the majority opinion, said: "The result of the majority's reasoning is to treat the insurance industry as a public utility. I find no authorization for such treatment in the statutes governing insurance."

However, Mr. Bird said, "the same thing is happening to insurance rates that happened to utility rates in the mid-'70s."

SkYROCKETING utility rates during that period increased public outcry for rate control, he explained, adding the same thing is happening now because of the "liability insurance crisis."

The Rating Board now is trying to determine how much premium should be returned to workers compensation policyholders under the decision, which said: "The excess over the existing rate which has been collected by the affected insurers must be refunded."

Although the NCCI and others observers believe this does not include consent-to-rate agreements, which fall under right-to-contract statutes in Oklahoma, others like Ms. Ables are not sure.

A consent-to-rate agreement allows an insurer to negotiate with a policyholder a premium higher or lower than the approved manual rates would dictate. Such agreements are permissible in states other than Oklahoma and frequently are used in a tight insurance market when insurers otherwise would not write at existing manual rates because of their alleged inadequacy.

It's also unclear whether the State Insurance Fund, which observers say is exempted from the high court ruling because it is not obliged by law to file its rates with the state, will refund any premium to policyholders.

"We really don't know at this

time what we will do," said Dave Elenburg, the fund's commissioner.

While the fund does not have to file its rates, it is an NCCI member and has used the same manual rates and policy forms as commercial workers compensation insurers, said Mr. Elenburg.

The fund is required by law to remain solvent, he said, noting that the rates charged by the fund were about 23.8% too low last November.

The fund is the largest writer of workers compensation insurance in Oklahoma, with between 15% and 20% of the market. The fund reported about \$48 million of the \$304 million in workers compensation premiums earned in Oklahoma in 1984, the latest year for which the NCCI has statistics.

Meanwhile, the Oklahoma attorney general's office is considering whether to challenge the consent-to-rate agreements used by workers compensation insurers.

Specifically, the office is concerned whether Oklahoma statutes allow insurers to charge higher rates under consent-to-rate agreements than would be required by the current policy year's loss experience, said Mr. Bird, the assistant attorney general.

The office also is particularly concerned that insurers, upon learning of the challenge to last year's rate increase, wrote every new and renewal work comp policy as a consent-to-rate agreement.

Mr. Bird said Mid-Continent Casualty Co. of Tulsa, a major Oklahoma workers comp insurer, has sold thousands of policies under consent-to-rate agreements.

Every workers compensation policy sold by Mid-Continent after Nov. 1, 1985, was written under a consent-to-rate agreement because the Rating Board only approved an average 25.9% rate increase, rather than the full 41.9% increase sought by the NCCI, said Perry "Bud" Inhofe Jr., the insurer's president.

"I could not see intentionally writing a large volume of workers compensation business at a huge loss, nor could I see leaving all our customers out there looking for new carriers," Mr. Inhofe said.

Oklahoma is located in an oil patch and many national workers compensation insurers "have a fear" of writing oil-related coverages, he explained. If Oklahoma-based insurers don't write this business, employers would be forced to buy coverage from the state fund, Mr. Inhofe said.

If the attorney general brings legal action against Mid-Continent or other Oklahoma insurers that use consent-to-rate agreements, Mr. Inhofe said he could make no other decision than to stop writing in the state.

"I could not gamble the company's surplus," he said. ■

## insurance services guide

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# Insurance stocks

Continued from page 1  
 insurance policy to avoid further contributions to medical malpractice loss reserves, which the company judged to be inadequate to meet future claims (BI, Jan. 20).

"They positioned themselves in those lines of business, such as directors and officers liability insurance, where the price increases are very large" and which many other companies have not re-entered, says Mr. Weinhoff.

He noted that the strategy could mean profits for Chubb for some time.

Chubb has a "fabulous underwriting record," adds June I. Hoffer, an analyst with Prudential/Bache Securities in New York City.

In addition to its commercial insurance business, Chubb's personal lines book of business is also "very favorable," according to Mr. Stradtner.

"We think it's got one of the best managements in the industry," he added.

Further, Mr. Stradtner said he was "very pleased" with Chubb's second-quarter performance, citing its 98.0% combined loss and expense ratio.

"The second-quarter results back up the fact they're already profitable," says Ms. Vogel.

In addition to having good leverage, Chubb's stock is "attractively priced," Ms. Vogel noted. Chubb was trading at around \$72 a share last week.

Also evoking favorable comments from stock analysts was American International Group.

AIG is a "prime beneficiary of all that's going on vis-a-vis significant rate increases" in hard-to-place lines, says A. Michael Frinquelli, an analyst at Salomon Bros. Inc. in New York.

Not only does AIG benefit from its large participation in the excess/surplus lines market, where large rate increases are widespread, but it also has one of the industry's largest foreign exchange exposures at a time when the dollar is weakening, according to Ms. Hoffer.

AIG will generate an estimated \$8.50 of earnings per share in 1986, but will post close to \$20 in earnings per share by 1990, predicts First Boston's Mr. Seifer.

Mr. Seifer predicts above-average growth for General Re as well.

The reinsurer, which Mr. Seifer estimates will earn \$3.25 per share this year, will boost its earnings to an estimated \$10 a share by 1990, he says.

The stock is "very much undervalued," adds Mr. Seifer.

"I think they're the premier reinsurer in the United States," says Shearson Lehman's Mr. Weinhoff, whose "buy" list includes Gen Re.

"Price increases in the reinsurance area

# Portfolio tracks analysts' touts

Business Insurance is tracking the recommendations of insurance industry stock analysts by creating the BI Model Portfolio of commercial property/casualty stocks.

The hypothetical Model Portfolio, based on "buy" recommendations from a half-dozen analysts, periodically will be compared with another hypothetical portfolio that was randomly selected by Business Insurance by picking names of stock property/casualty companies and numbers of shares out of a hat.

Both the Model Portfolio and Random Portfolio were begun with an imaginary \$10,000 in seed money.

These two portfolios will be reviewed periodically to gauge their performance. The Model Portfolio occasionally will be restructured to match analysts' changing recommendations. The Random Portfolio will remain the same to judge the long-term performance of the random picks.

While commissions were not deducted for these initial picks, the Model Portfolio will have to pay commission on any subsequent trades.

Business Insurance does not recommend any of the stocks in either portfolio. BI editors and reporters do not invest in insurance industry stocks. Readers should consult a licensed stockbroker or investment adviser before making any investment.

Based on analysts' recommendations, eight stocks were selected for the Model Portfolio. Prices shown are those at the end of trading on July 25:

- 37 shares of Chubb Corp. stock at \$72.125 each, or a total investment of \$2,668.63.
- 33 shares of General Reinsurance Corp. at \$61.875 each, or \$2,041.88.
- 15 shares of American International Group Inc. at \$134.25 each, or \$2,013.75.
- 28 shares of Fireman's Fund Corp. at \$38.125 each, or \$1,067.50.
- 15 shares of USF&G Corp. at \$40 each, or \$600.
- Seven shares of Ohio Casualty Corp. at \$81 each, or \$567.
- 13 shares of American General Corp. at \$41.625 each, or \$541.13.
- Eight shares of CNA Financial Corp. at \$55.50 each, or \$444.

Altogether, the purchases cost \$9,943.89. The remaining \$56.11 will be invested in an imaginary money market fund.

Five property/casualty stocks were randomly selected for the Random Portfolio:

- 40 shares of CIGNA Corp. at \$62.50 each, or a total investment of \$2,500.
- 40 shares of CNA Financial Corp. at \$55.50 each, or \$2,220.
- 35 shares of Aetna Life & Casualty Co. at \$60.50 each, or \$2,117.50.
- 40 shares of Continental Corp. at \$46.625 each, or \$1,865.
- 40 shares of The Home Group Inc. at \$23.75 each, or \$950.

Altogether, these purchases cost \$9,652.50. The remaining \$347.50 will also be invested in a fictional money market fund.

are the most dramatic," Mr. Weinhoff explains, adding that Gen Re also will benefit from the fact that "it'll be a number of years before we see any significant capacity in the reinsurance area."

Gen Re is "one of the few pure players in the reinsurance business," with excellent underwriting results and return on equity, according to Prudential/Bache analyst Ms. Hoffer.

It is "the Tiffany of the reinsurance business," which gives it an "unusually strong competitive position," says Salomon Bros.' Mr. Frinquelli.

Both Mr. Frinquelli and Mr. Seifer are touting Fireman's Fund as well.

Mr. Frinquelli noted that American Express Corp. "would not let loose a crumple," referring to the spinoff of Fireman's Fund by Amex last year (BI, Oct. 28, 1985).

He also points to John J. Byrne, Fireman's Fund's chairman and chief executive officer, who is credited with turning around the fortunes of GEICO Corp.

Mr. Byrne "hopefully" will do the same with Fireman's Fund, "only it will be a long-term situation," Mr. Frinquelli adds.

Fireman's Fund had an "improving" second quarter, says Mr. Seifer.

He added: "We just think they are one of the better-reserved companies."

Fireman's Fund reported consolidated operating earnings of \$40 million during the second quarter, compared with an \$84 million operating loss for the comparable period a year ago.

Based on estimated earnings per share of \$2.50 this year, \$4 in 1987 and \$6 in 1988, First Boston believes that Fireman's Fund, whose stock is now selling in the high 30s, "has a long way to go," Mr. Seifer says.

Ms. Vogel says she has recommended Fireman's Fund for some time. "It's gotten a lot of its problems behind it, and I like the management team."

She also cites as positive influences the company's employee stock ownership plan and Mr. Byrne's holdings in the company.

"I like to see management in on a piece of the action," Ms. Vogel says, because it gives it a "personal stake" in the company's results.

Mr. Frinquelli also recommends CNA, particularly because of its "remarkably strong balance sheet."

With other insurers struggling to maintain a 2.5-1 or 3-1 premium-to-surplus ratio, CNA is intent on maintaining a 2-1 ratio, he says.

In addition, Mr. Frinquelli says CNA's reserve position is "extremely strong."

First Boston's Mr. Seifer touts American General, predicting annual earnings growth of close to 20% through 1988.

Mr. Seifer also likes Aetna, which he says "has a very good primary property/casualty operation as well as a reinsurance operation."

While he anticipates Aetna's group health insurance-related earnings will decline "from what we consider peak 1985 earnings," its direct and reinsurance property/casualty operations will "more than make up the slack."

He estimates Aetna will post earnings per share of \$5.20 in 1986, \$6.70 in 1987 and \$8.75 in 1988, so "it's still got a long way to go."

USF&G was recommended by Ms. Vogel. "A lot of the cloud that was hanging over them in regards to their investment income is really behind them at this point," she says, noting the company has become more conservative in its investment policy after restating its earnings (BI, April 14).

Ms. Vogel also says the new tax law will make dividend income more desirable, and USF&G's 6% yield "may make it more attractive in the future."

Ms. Vogel also likes Ohio Casualty, noting that she anticipates its combined ratio will be better than the industry's aggregate in the future.

One stock, Continental Corp., is on both "buy" and "sell" lists.

Mr. Frinquelli recommends Continental, noting that it is a traditional company that will benefit from increasing rates.

In addition, he points to a relatively new management team—put into place in 1982—that has embarked on a lengthy program of repositioning how the insurer markets its insurance products.

If the program works, he says, it will position Continental ahead of other insurers.

If it does not, the company will still benefit from rate increases.

But Shearson/Lehman's Mr. Weinhoff has put Continental on his "sell" list. "The reason is that each of the company's segments underperforms in its market," he says, noting that Continental stock has underperformed as well.

"We continue to see it underperform," he says, adding that a turnaround will "take longer than people think."

## BI Industry Stock Report

July 30, 1986 7/24/86 thru 7/30/86

Brokers	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)	
Alexander & Alexander Svcs	NYSE	37.13	-1.0	0.4	1.00	2.7	37.38	35.88	278.7
Baldwin & Lyons Inc	OTC	26.00	19.1	70.0	0.16	0.6	28.00	23.00	16.5
Corroon & Black Corp	NYSE	36.00	-7.7	19.3	0.65	1.8	36.75	36.00	113.6
Crump E W Cos Inc	OTC	28.75	0.0	22.3	0.25	0.9	28.88	28.13	144.5
Gallagher Arthur J & Co	OTC	27.13	0.5	21.9	0.20	0.7	27.50	27.00	87.7
Hall Frank B & Co Inc	NYSE	25.75	3.5	0.0	0.00	0.0	26.38	24.75	116.6
Marsh & McLennan Cos Inc	NYSE	63.88	-1.0	22.5	1.50	2.3	63.88	62.88	382.6
Poe & Assoc Inc	OTC	12.50	0.0	0.0	0.53	4.3	12.50	12.50	1.6
AGENTS/BROKERS	AVERAGE								1.7
<b>Conglomerates &amp; Holding Cos.</b>									
American Express(Fireman's Fd)	NYSE	59.25	-2.1	11.3	1.36	2.3	62.00	58.25	3,550.0
American Clayton(Ranger/PanAm)	NYSE	55.88	-7.6	31.9	0.00	0.0	0.00	0.00	0.0
Arco Inc	NYSE	6.75	-6.9	0.0	0.00	0.0	7.25	6.75	1,089.2
Berkley W R Corp	OTC	32.50	-3.0	25.2	0.24	0.7	34.75	32.50	499.1
Berkshire Hathaway Inc Del	OTC	286.00	0.5	29.9	0.00	0.0	287.50	283.50	1.1
CIGNA Corp	NYSE	61.25	-2.2	0.0	2.60	4.2	62.50	61.25	1,399.5
CNA Finl Corp (CNA)	NYSE	56.75	1.3	17.9	0.00	0.0	56.75	53.38	407.4
General Re Corp	NYSE	62.75	2.9	38.7	0.88	1.4	62.75	61.38	587.7
ITT (Hartford Group)	NYSE	54.00	-0.5	29.3	1.00	1.9	54.00	52.25	3,985.2
Sears Roebuck & Co. (Allstate)	NYSE	42.13	0.3	12.3	1.76	4.1	43.88	41.00	3,289.7
Teledyne Inc (Argonaut)	NYSE	317.00	7.3	11.6	0.00	0.0	320.88	295.00	241.6
Transamerica Corp (Occidental)	NYSE	34.75	-1.4	15.2	1.68	4.8	35.38	34.50	599.6
CONGLOMERATES/HOLDING COS.	AVERAGE								27.7
<b>Insurers</b>									
Aetna Life & Cas Co	NYSE	60.25	-0.4	12.0	2.64	4.4	60.50	59.13	1,133.8
American General Corp	NYSE	39.88	-3.9	12.1	1.12	2.8	42.00	39.88	1,219.1
Ameri Heritage Life Invnt Co	NYSE	42.50	0.9	15.3	1.32	3.1	42.50	42.00	2.8
American Intl Finl Corp	OTC	18.00	-8.9	0.0	1.12	6.2	19.50	17.50	29.4
American Intl Group Inc	NYSE	134.38	1.2	25.0	0.44	0.3	134.38	131.00	654.7
Aneco Reins Ltd	OTC	1.88	-11.8	0.0	0.00	0.0	2.13	1.88	10.6
Avenco Corp	NYSE	28.50	0.9	15.0	0.50	1.8	28.88	27.25	11.7
Business Mens Assurn Co Amer	OTC	37.50	0.0	16.6	1.10	4.0	28.00	27.50	69.7
Chubb Corp	NYSE	70.50	2.4	52.6	1.56	2.2	72.13	69.00	580.9
Combined Intl Corp	NYSE	54.75	-2.2	11.0	2.24	4.1	55.50	54.75	221.5
Continental Corp	NYSE	44.25	-0.6	0.0	2.60	5.9	46.63	44.00	541.6
Crown Life Ins Co	OTC	350.00	0.0	3.5	6.40	1.8	350.00	350.00	0.5
Duham Corp	OTC	44.00	-3.3	11.8	1.36	3.1	45.00	44.00	14.0
Farmers Group Inc	NYSE	36.75	-6.3	13.9	1.00	2.6	41.00	38.75	1,018.2
Fairmont Finl Inc	AMEX	16.75	-4.3	21.2	0.00	0.0	17.50	16.75	17.8
Fireman Fd Corp	NYSE	37.88	0.0	0.4	0.30	0.8	38.13	37.38	690.1
Freemont Gen Corp	OTC	23.75	-3.1	0.0	0.68	2.0	23.75	23.13	407.0
Great West Life Assurn Co	OTC	850.00	0.0	8.5	18.00	2.1	850.00	850.00	0.0
Home Group Inc	AMEX	23.00	-9.4	109.5	0.00	0.0	23.88	20.50	711.6
Hanover Ins Co	OTC	59.50	-0.4	31.8	0.56	0.9	59.50	59.25	11.7
Hartford Steam Boiler Insptn	OTC	95.00	-1.6	15.1	2.40	2.5	97.00	95.00	22.7
Kans City Life Ins	OTC	33.00	0.0	13.0	0.87	2.6	33.00	33.00	16.5
Kemper Corp	OTC	32.00	4.1	16.9	0.60	1.9	32.25	30.88	361.4
Liberty Corp S C	NYSE	39.00	-0.6	16.5	0.72	1.8	39.38	38.50	15.3
Lincoln Natl Corp Ind	NYSE	52.38	1.0	11.8	2.00	3.8	53.13	51.50	383.8
Mission Ins Group Inc	PAT	3.50	0.0	0.0	0.00	0.0	4.38	2.88	18.4
Monumental Corp	OTC	55.00	0.7	19.6	1.40	2.5	55.25	54.75	220.2
Nac Re Corp	OTC	33.50	-4.3	0.0	0.00	0.0	34.25	33.50	357.8
Nobel Ins Ltd	OTC	15.50	-4.6	20.4	0.25	1.6	15.75	15.50	48.7
Northwestern Natl Life Ins	OTC	29.00	-4.9	12.7	0.86	3.0	30.25	29.00	183.0
Ohio Cas Corp	OTC	79.50	-5.6	12.0	3.00	3.8	81.00	79.50	158.0
Old Rep Intl Corp	OTC	34.00	2.3	12.5	0.78	2.3	34.00	31.88	206.9
Grion Cap Corp	NYSE	33.00	-0.8	0.0	0.76	2.3	33.13	32.88	145.3
Protective Corp	OTC	21.75	-5.4	11.9	0.70	3.2	22.00	21.25	86.2
Provident Life & Acc Ins Co	OTC	27.50	0.0	9.6	0.84	3.1	27.88	27.50	95.5
St Paul Cos Inc	OTC	41.25	-4.1	25.0	1.50	3.6	43.00	41.25	676.6
SAFECO Corp	OTC	55.88	2.8	13.3	1.68	3.0	55.88	53.88	401.1
Seibels Bruce Group Inc	OTC	16.75	-8.2	0.0	0.80	4.8	17.75	16.25	33.9
Selective Ins Group Inc	OTC	21.75	6.1	0.0	0.80	3.7	21.75	20.75	32.9
Statesman Group Inc	OTC	5.75	0.0	41.1	0.05	0.9	5.88	5.75	71.2
Tokio Marine & Fire Ins Co	OTC	499.00	7.0	860.3	0.00	0.0	499.25	482.00	22.6
Torchmark Corp	NYSE	30.25	-4.0	12.2	0.60	2.0	30.25	29.00	1,153.1
Travelers Corp	NYSE	44.25	-6.6	11.2	2.16	4.9	46.75	44.25	3,560.1
Tremick Group Inc	OTC	21.50	-6.5	0.0	0.00	0.0	22.75	21.50	197.3
United Fire & Cas Co	OTC	26.00	-1.9	20.6	0.80	3.1	26.00	26.00	62.1
United States Fid & Cty Co	NYSE	38.88	0.0	0.0	2.32	6.0	40.00	38.88	736.3
USLife Corp	NYSE	42.38	-2.3	11.1	1.12	2.6	43.00	42.00	162.5
Washington Natl Corp	NYSE	29.63	-6.5	13.1	1.05</				



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