

business insurance

update:

Congress lets FTC retain authority over doctors

WASHINGTON—House and Senate conferees last week agreed to allow the Federal Trade Commission to retain its authority to stop doctors and dentists from price fixing and other anti-competitive practices.

The House earlier approved legislation curbing the FTC's power to investigate anti-competitive practices by medical care

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Coming up short

California can't find enough quake insurance for bridges

By RHONDA L. RUNDLE



Many of the bridges are in 'earthquake country' near San Francisco.

SACRAMENTO, Calif.—Despite a worldwide search by six brokers, the state of California is about \$350 million shy of the roughly \$1 billion in earthquake insurance it needs to protect eight toll bridges.

Four of the state-owned bridges span the 80-mile-long San Francisco Bay and three others cross one of its tributary rivers. "That's considered earthquake country by Eastern lenders," notes Eugene D. Marquart, the state's insurance officer.

The major U.S. financial markets, which raised the funds to build and maintain the bridges, require the state to carry earthquake insurance at 80% of current value if it's obtainable at reasonable cost. Most of California's other risks are self-insured.

"There's much more concern about earthquakes in the East than there is out here. And New York is the financial center so they tell us to buy earthquake insurance," sums up Mr. Marquart.

This mandate to have coverage for the bridges has made the state of California the largest single purchaser of earthquake insurance in the United States, if not the world.

The price for the state's physical damage and business interruption coverages to protect the bridges: about \$1 million a year.

"That's down substantially in recent years," says Mr. Marquart. "My report to the California Transportation Commission last year showed quite a reduction and in a couple of cases, when the rates went down, we were able to increase the coverage."

The state's persistent search for roughly \$1 billion in earthquake insurance puts a strain on worldwide markets. "The capacity we've been able to generate has been increasing, but demand still exceeds the supply," notes Miller Jensen, senior vp of Marsh & McLennan Inc.

M&M is the broker responsible to the state for placing insurance on the bridges. But a troika of brokers, including Johnson & Higgins and Emmett & Chandler, spread their fingers into domestic markets. Each of them in turn uses a London broker to scour Lloyd's of London and other foreign markets.

Each bridge is individually insured through placements orchestrated by one of the three U.S. brokers. The eight bridges boast a combined

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EEOC regulations on health benefits draw criticism

By JERRY GEISEL

WASHINGTON—Pending federal regulations on older workers' health insurance could have a devastating impact on benefit plans, but don't start worrying yet.

"These regulations never will see the light of day," predicts Andrew Webber, vp of the Washington Business Group on Health.

The regulations from the Equal Employment Opportunity Commission are supposed to help employers comply with a provision in the 1982 tax law that requires companies to offer workers ages 65 through 69 a choice of enrolling in the employer's group health insurance plan or keeping the federal Medicare program as their primary health insurer.

The regulations could require an enormous and costly expansion of employers' benefit plans, but experts say they are so far-fetched they almost certainly will be dramatically overhauled before they are officially published.

The Office of Management and Budget, where the regulations are pending, will force changes before March 1, the new deadline for employers to give older employees a choice of enrolling in the employer plan or sticking with Medicare, Mr. Webber predicts.

The most controversial part of the EEOC regulations requires an employer to spend the same amount of health care dollars on older workers who select Medicare for primary coverage as they do on other employees.

For example, a company that spends \$150 a month per employee for family coverage, would have to spend \$150 a month on health-related benefits for older workers who stay in the Medicare program, which provides extensive medical and hospital benefits.

Because EEOC rules prohibit an employer from directly supplementing any coverage provided by Medicare, experts question if employers could offer enough unrelated

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Employers improve benefit communications

By KATHRYN J. MCINTYRE

Most employers are making a concerted effort to explain their employee benefit plans to their workers.

Employers are using multiple methods of communicating benefits to employees. And, two out of three employers will update their benefit communications programs in the next year. Among those updating their programs will be many of the employers that updated their programs this year.

About two-thirds of all employers also are trying to explain the problem of rising health care costs to their employees.

These are the findings of the most recent survey of the Business Insurance Employee Benefit Board, a group of corporate executives in charge of employee benefit plans in a wide variety of corporations, institutions and government entities. Ninety of the 147 board members who have volunteered to respond to periodic surveys participated in this survey, a 61% response rate.

Eighty-six of the 90 respondents do more than is legally required or easily available to communicate employee benefits to their workers.

Only four of the respondents said their benefit communications with employees are limited to complying with minimum reporting as required under the Employee Retirement Income Security Act of 1974 and whatever pamphlets are provided by their insurers.

Under ERISA, employers must provide employees with summary plan descriptions which outline the corporate pension plans operations and benefits. This SPD must be distributed when an employee becomes eligible to participate in the corporate pension plan.

Companies also are required each year to provide pension plan participants with a summary annual report which describes the plan's financial operations.

The four employers who only meet these minimum requirements were: a hospital with

Multiple methods of benefit communications (Survey of 90 employers)

Type of communication	Number of employers
Custom-written benefit handbook(s)	75
Personalized benefit statements	53
Audiovisual program(s)	52
Insurer-provided benefit booklets	45

2,500 employees, a 100-person professional association for attorneys, a 100-worker manufacturing company and a 1,000-person law firm.

Three of the four did not disclose their costs; the manufacturing company said it spends \$400 annually on communicating benefits under ERISA requirements.

Among the 86 other survey respondents with extensive benefit communication programs, 15 said their programs go beyond

ERISA reporting requirements to include all of the following methods of benefits communications: personalized benefit statement; employee benefit handbooks or a series of booklets specifically prepared for their employees; an audiovisual program; booklets provided by their insurers; and memorandums to employees.

The other 71 employers used two or three of these four methods of communicating ben-

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FTC to keep power over doctors

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providers, like doctors, but the Senate rejected the curbs.

The conferees accepted the Senate's position, dealing a major blow to the American Medical Assn., which lobbied Congress to exempt doctors from FTC regulation.

Crum shareholders OK merger

NEW YORK—Crum & Forster, the nation's eighth-largest investor-owned insurer, will become a subsidiary of Xerox Corp. on Jan. 7 if regulators in New York and New Jersey approve the merger.

Crum officials also disclosed the insurer will reduce its workforce by about 5% or 500 employees through layoffs and attrition. The company says the reductions, which are mostly complete, will result 80% from layoffs and 20% from attrition. It blamed the cuts on the fierce competition in commercial property/casualty insurance, which has reduced profit margins for most large insurers.

About 75.2% of Crum & Forster's shareholders voted in favor of the merger at a Dec. 20 meeting at the company's New York headquarters and 1.5% voted against it. Holders of remaining shares didn't cast ballots. In Stamford, Conn., where Xerox is based, 64.4% of shareholders approved the takeover, and 5.1% voted against it.

Settlement possible in MGM fire

LAS VEGAS, Nev.—An out-of-court settlement of about 275 pending lawsuits against MGM Grand Hotels Inc. arising out of the November 1980 hotel fire may be possible before trial starts Jan. 17, company officers told stockholders at a recent annual meeting.

The hotel-casino company already has settled more than 2,000 claims, including a substantial number of lawsuits, for unspecified amounts believed to be largely covered by \$30 million of liability insurance in place before the fire. The remaining suits seek about \$600 million in compensatory and \$2 billion in punitive damages.

Even if a settlement is reached between the company and fire victims, MGM Grand's fire-related litigation will continue. The company has filed liability suits against hotel builders and also is suing property insurers that have refused to pay the full amount of the company's damage claim.

Hearing set in Hyatt dispute

KANSAS CITY, Mo.—A federal judge has tentatively set a hearing for Jan. 3 on a motion to hold defendants in the Hyatt Regency Hotel skywalk collapse litigation in contempt for negotiating a class settlement of victims' claims in a state court (BI, Dec. 13).

But U.S. District Judge Scott O. Wright says the hearing might not be necessary if the defendants can agree with plaintiffs' lawyers on a way to inform victims about the advantages and disadvantages of competing state and federal class actions.

At least 850 people present when the skywalks collapsed on July 17, 1981, have received checks of \$1,000 each from Commercial Union Insurance Co. under the tentative state-court class-action settlement. A Jackson County Circuit Court judge is scheduled to consider final approval of the settlement at a Jan. 4 hearing.

Commercial Union wrote a \$1 million primary and a \$10 million excess/umbrella liability policy for Hallmark Cards Inc., parent of Crown Center Redevelopment Corp., which owns the hotel.

BC/BS of Illinois now a mutual

CHICAGO—Blue Cross/Blue Shield of Illinois won approval from the state Insurance Department last week to become a mutual insurance company.

The switch in status from a tax-exempt, not-for-profit insurer to a mutual will free BC/BS of Illinois from regulations that required it to hold special hearings to raise rates for small group subscribers and individuals. As a not-for-profit insurer, BC/BS also had to get state approval for rate changes for groups with two to 22 employees.

The Insurance Department earlier this year recommended that BC/BS become a mutual to remain financially competitive (BI, Feb. 22). BC/BS of Illinois has about 30% of the state's group health insurance market with about 3 million subscribers.

Lloyd's opposes panel's report

LONDON—The Committee of Lloyd's of London says it doesn't agree with all the findings of a task force studying what information should be disclosed by Lloyd's syndicates to their names.

The panel, set up several years ago, recommends, among other things, that syndicates reveal all transactions, including the business they write, to their names. The committee, though, said the recommendations were "inappropriate since they would lead to names being burdened with too much potentially confusing information."

The new Council of Lloyd's is expected to consider the recommendations when it takes power next week.

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Illinois firms want court to ban third-party suits

By EILEEN NORRIS

CHICAGO—Illinois employers are seeking to reverse a state high court decision that opens them to third-party lawsuits if their actions contribute to a worker's injury.

The issue: If an injured employee sues a third party, like a manufacturer, whose product he believes caused his workplace injury, can that third party then sue the employer if it believes the company's negligence contributed to the accident? Or does the exclusive remedy provision of state workers compensation statutes hold the employer immune from such third-party suits?

A 1977 Illinois Supreme Court decision said an employer is liable in such situations even if he also has paid workers compensation benefits. But, the same court is being asked the same question again.

In September, the 2nd Appellate Court in Elgin upheld the 1977 ruling, and now the employer involved is appealing to the state Supreme Court.

Lloyd's to pay for damages in ship mishap

By STACY SHAPIRO

LONDON—Why would two ships equipped with sophisticated radar collide only two miles from shore?

That's what British government officials, underwriters and shipowners are asking as they investigate last week's collision of the British rail car ferry, Speedlink Vanguard, with a passenger ferry, European Gateway, owned by European Ferries, a Dutch company.

The two ships collided off the coast of Harwich, Suffolk, killing five people and causing the European Gateway to capsize.

While deciding which ship was liable for the accident may take a long time, paying for the damage to the ships' hulls will not.

The loss of the European Gateway's hull will cost Lloyd's of London underwriters 18 million pounds (about \$28.8 million) on three separate marine insurance policies for all risks, ticket sales and increased hull value.

"If she could be repaired at a value of less than the total insurance costs, then she may not be a total loss, but she has a huge gash on her side," said Malcolm Rumsey, chairman of the Lloyd's Underwriters Assn.

The Speedlink Vanguard is insured through Lloyd's for 6.5 million pounds.

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In this recent case, a motorist hit a flagman employee by a construction company. The flagman filed a complaint in the Circuit Court of Winnebago County alleging that the motorist was guilty of careless and negligent acts.

But Kathleen C. Rhodes, the woman who hit worker Charles L. Doyle, denied any wrongdoing and filed a third-party complaint against the flagman's employer road contractor Rein, Schultz & Dahl.

Ms. Rhodes alleged that the employer was negligent in its placement of warning signs and barricades, and thus contributed to the accident and should pay the damages.

Rein, Schultz & Dahl filed a motion to dismiss the third-party contribution complaint on the basis that it is protected from tort actions under the workers compensation act.

But the appellate court said Doyle vs. Rhodes was consistent with the 1977 high court decision.

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Congress gives states power to close METs

By JERRY GEISEL

WASHINGTON—State regulators will have the power to close poorly managed self-funded multiple employer trusts as soon as President Reagan signs legislation passed last week.

During the closing days of the special post-election session, Congress approved legislation that will force the self-funded trusts, which provide comprehensive medical benefits, to abide by state insurance laws, including reserve requirements.

At the same time, legislation, S. 1182, that would overhaul the federal Longshoremen's and Harbor Workers' Compensation Act, died in the House after clearing the Senate.

In addition, the Surface Transportation Act of 1982, S. 3044, which would ease liability insurance requirements for motor carriers as well as raise the gasoline tax by 5 cents a gallon, was still pending on the Senate floor late last week.

The MET bill, introduced by Rep. John Erlenborn, R-Ill., and Rep. Phillip Burton, D-Calif., was passed during the evening of Dec. 21 as part of unrelated tax legislation, H.R. 5470.

The measure was approved after months of lobbying by a special National Assn. of Insurance Commissioners' task force, chaired by Florida Insurance Commissioner Bill Gunter.

The state regulators said they needed the clear-cut powers contained in the Erlenborn-Burton bill to fill a regulatory vacuum that has allowed self-funded METs to operate for years outside state or federal regulation.

The collapse of self-funded METs has become a national scandal as many of the trusts—which are supposed to bring the advantages of group health insurance to small employers—failed, leaving behind millions of dollars in unpaid medical bills.

Rep. Erlenborn, who conducted extensive hearings on MET problems in Chicago earlier this year, labeled MET failures "one of the most far-reaching white-collar crimes in America."

For more than five years, state insurance departments have been fighting for the power to shut down mismanaged METs, saying they are no more than unauthorized insurance operations. But the administrators of the self-funded trusts say the trusts are employee benefit

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Should insurers be liable for loss-control advice?

By BILL DENSMORE

NEW YORK—A manufacturer is giving up its attempt to prove that insurers are liable for the precision of their loss-control recommendations.

Dow Chemical Co., subrogated against by an insurance company charging that the manufacturer's insulation product caused a fire at an egg farm to spread, had, in turn, sued the insurer for failure to warn its policyholder of the allegedly dangerous product.

However, after years of litigation in the unique case, Dow, based in Midland, Mich., agreed earlier this month to pay a six-figure settlement to end the litigation.

The case, involving Millers Mutual Insurance Co. of Harrisburg, Pa., was being watched closely by other insurers, who saw it as a test of the term "due care."

For example, When does due care require an insurer to notify a policyholder of dangerous conditions? Should the insurer threaten policy cancellation if a certain unsafe condition isn't repaired?

"The issue of providing loss-control services and the liability of insurers who fail to provide a sufficient

level of such services is becoming a very hot topic in tort litigation today," says Michael S. Wilder, general counsel of Hartford Fire Insurance Co., part of Hartford Insurance Group.

The question, Mr. Wilder says, is whether providing loss-control services carries with it a set of obligations to the policyholder greater than those of just an insurer-insured relationship.

The Dow-Millers Mutual case raised new questions about the legal liabilities of insurers who elect to provide "unbundled" services to their clients.

It also is believed to be the first time a court allowed a defendant to lodge third-party claims against the subrogating insurer.

Attorneys for Dow Chemical and Millers Mutual say if the case had gone to trial, a verdict unfavorable to insurers would have made them less eager to initiate subrogation actions because a defendant might accuse the insurer of providing inadequate loss control.

A decision holding insurers liable for the quality of their loss-control services also would have told buyers they could "really rely upon an insurer's fire-protec-

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15 years later, kidnapping still haunts executive

By BETSY SHARKEY

It was a winter Monday morning, still very early, when Bob Harris found the note:

"...We have your merchandise. Comply with our demands and your merchandise will be returned. If you do not, the merchandise will be VINDICTIVELY DESTROYED. Do not contact ANY law-enforcement officials. If you do, the merchandise will be destroyed immediately. Get \$250,000 in used \$100 bills by Wednesday. At 6 p.m. Wednesday, go to the phone booth..."

Ten-year-old Tommy Harris was the merchandise. The note lay in a crumpled heap of covers on Tommy's bed.

"Vindictively destroyed. The words just sit with you," said Mr. Harris, now chairman of the board of a large U.S. financial institution. He was president of the company at the time of the kidnapping in 1967.

"They never referred to Tommy as a human being, always merchandise."

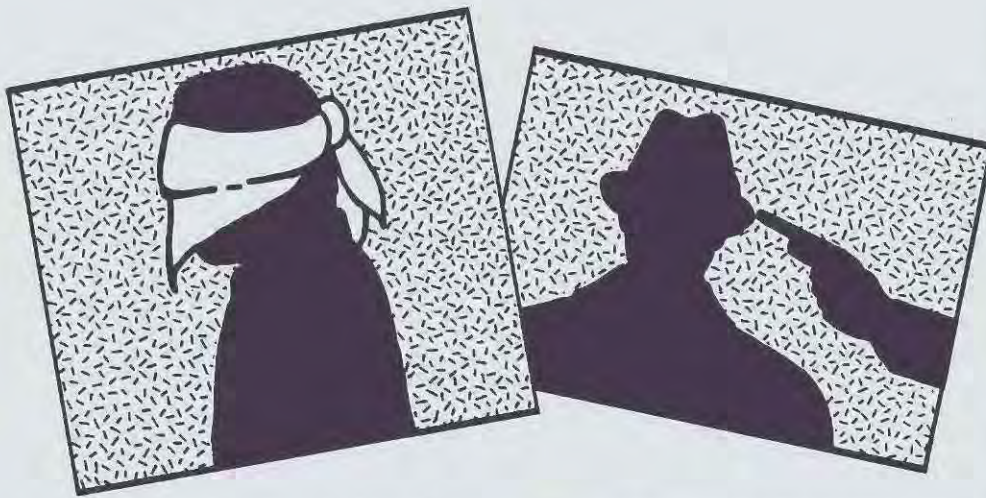
A kidnapping was the last thing Mr. Harris expected to have to face. "You always think, 'This won't happen to me.'"

The company had no crisis management plan. There were no emergency funds set aside. There was no kidnap/ransom insurance. "I'm not sure I even knew it existed," he said.

What Mr. Harris did know was that he had three days to get 2,500 used \$100 bills to an anonymous someone who had his son.

And even though he was the president of a financial institution, it was not as simple as walking into a vault and drawing out the \$250,000.

A substantial portion of the Harrises' assets were tied up in a variety of investments. Not many of those assets were liquid enough to



convert to cash in three days. And, even for a company president, a \$250,000 uncollateralized loan is not an attractive risk for a bank.

"In most of these situations, you've got this hard-nosed businessman who fought his way up and never would have considered paying a ransom," said Paul Chamberlain, president of Los Angeles-based Paul Chamberlain Agency, which specializes in domestic kidnap/extortion consulting.

"You've got guys that are having to consider things like 'In order to get the \$250,000 in cash fast, I'll have to sell off X stock that I bought for \$60 and now it's selling for \$20. So I'll lose the \$250,000 plus another \$500,000 on the stock. And if I don't do that, I'll have to go to my father-in-law and he hates my guts.'"

"They're having to face these kinds of questions at the same time their child's life is on the line. They cry, they throw up.

"You've got someone who can run a multi-million-dollar operation and all of a sudden he's not in control and he doesn't know what to do."

In 1967, Mr. Chamberlain was head of the FBI office that handled the Harris kidnapping. For those three days, he and two other FBI agents lived in the Harris house coordinating every move the family made.

After more than 20 years with the FBI, Mr. Chamberlain left a little more than a year ago to form his agency, a consortium of former Federal Bureau of Investigation kidnap and extortion specialists who now provide consulting services to corporations.

The Paul Chamberlain Agency is also on retainer to Professional Indemnity Agency, one of four major providers of kidnap/ransom/extortion insurance (BI, Nov. 15).

"In this case, Bob was only one of three targets on a list," Mr. Chamberlain recalls. "He was just the easiest to get to."

The Harrises lived in an affluent part of the city. The family cars were registered to Mr. Harris and the registration carried his home address. That information was available from the Department of Motor Vehicles to anyone with a dollar and the car's license-plate number.

There was no burglar alarm or security system at the Harris home. The house was on a quiet street and the children slept in a separate wing.

Over the years, weekdays for the Harris family had developed a sort of rhythm.

The family was usually up and about by 7:30 a.m. Mr. Harris left soon after in the same car, at the same time, driving the same route to work. Then the two older children left for school.

Like most families, blending everyone's schedules meant establishing routines.

In the three weeks prior to the kidnapping, newspaper photos of Mr. Harris and his wife at several social events appeared in the local paper. They were not highly visible, just noticeable.

Sometime during that Monday night, the kidnapers broke into Tommy's room. When he cried out, they pistol-whipped him into unconsciousness.

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Kidnapping. No corporate executive today is invulnerable. The chairman of the board of a major U.S. financial institution who lived through a kidnapping incident gives this candid look inside such an experience. The facts have not been altered, but his name has been changed to assure anonymity for his children, his wife and himself.

THE JAPANESE WAY

Traditions stymie introduction of risk management

By WILLIAM BOOTH

TOKYO—Japan has an International Risk Management Society but no risk managers.

Most Japanese companies do not even have insurance departments. Individuals in different corporate divisions buy insurance, but devote only part of their time to the task. In the end, it is the powerful insurance industry that controls what coverage companies buy.

The founding of the society just a year ago by 50 would-be risk managers is the first sign of recognition of risk management in this industrialized society that produces high-tech products for export and generates insurance premiums second only to the United States.

"Risk management is in its infancy in Japan," says Yasuhiko Ushiba, assistant general manager at Mitsubishi Corp. and the founder and chairman of the International Risk Management Society of Japan.

At his company, which is one of the largest conglomerates in Japan, there is no one with the title and responsibilities of a risk manager.

But, Mr. Ushiba believes Japanese businesses will soon have to recognize the need for risk management.

"The absence of risk management will soon become very serious in Japan," he says. "As Japanese firms move more and more overseas, we need to integrate our different insurance buyers. We need to coordinate our risk control. Otherwise, we won't be able to afford to take on such new risks as projects in the Middle East or Southeast Asia."

There also is concern that some Japanese companies are either underinsured or overinsured and may pay too much for their insurance.

The International Risk Management Society of Japan is attempting to develop risk managers. The society meets monthly for informal discussions and to mull over risk management texts written by such American risk management experts as George Head of the Insurance Institute of America and to listen to talks by Professor Yasushi Morimiya from the school of commerce at Meiji University in Tokyo.

Outside of the monthly meetings, these cor-

porate managers have little opportunity to practice risk management. The nature of the Japanese insurance market and traditional insurance buying practices preclude the development of sophisticated risk financing.

Risk identification, risk analysis and loss-prevention and control activities historically have been handled on division and local levels in Japan.

"In a nutshell, risk management just isn't happening in Japan," says William Smith, managing vp of Alexander & Alexander in Japan and a veteran of some 20 years in the Japanese insurance industry.

"When we're talking about risk management, we're really talking about a Western concept, an answer to the complex and highly competitive insurance market in the U.S."

"There is really no risk manager in the Japanese company right now because there is not yet the need for one. Of course, there are people buying insurance, but they're not risk managers in our sense of the term."

"I think in the U.S. the biggest job of the risk manager is to select the insurer with the best rates and services, but in Japan, we do not offer tailor-made policies," says Takeshi Mori, manager of North American regions for Tokio Marine & Fire Insurance Co. Ltd. "Each insurer has the same rates and services."

The insurance market in Japan is tightly controlled by Japanese insurers in collaboration with the government's Ministry of Finance. Insurance rates and policy terms are set by the Fire & Marine Insurance Rating Assn. of Japan, which is made up of 20 domestic non-life insurers, two reinsurance companies and 34 foreign associate members. Since the rating association is empowered by special statute to set tariffs, it is free to operate outside Japan's antitrust laws.

The insurers do not engage in rate competition; they agree on rates that generate an underwriting profit. The insurers do not compete on policy forms either. There are no individually designed policies. The would-be risk manager can't layer insurance coverages or direct the reinsurance of the company's risks. Self-insurance and captive insurance companies are virtually unknown.

The power of the rating association and its standardized terms are not the only impediments to a free and competitive insurance market in Japan.

The would-be risk manager usually sees only a small part of the company's risk since insurance is often purchased by factory directors or department heads. For example, the general affairs department purchases property/casualty insurance while the legal department buys liability insurance and the personnel department looks after employee benefits.

And, the purchaser must consider his company's "relationship" with an insurance company when he buys coverage. A Japanese company often buys its insurance from an affiliated insurance company or an insurer with substantial stock investments in the insured.

Asahi Glass Co. Ltd., a large producer of chemical and glass products, automatically buys its insurance from Tokio Marine & Fire Insurance Co. because both are members of the Mitsubishi group. Asahi Glass does not have an insurance department, but relies on Tokio Marine's agent for insurance financing and information, says N. Takamoto, Asahi's manager of corporate planning.

Tokio Marine fills about 90% of all the insurance needs for the Mitsubishi group companies.

"Of course, it's an incestuous relationship," says Mr. Smith of A&A. "But the pressure to do business with the group is enormous. It would be unthinkable to place insurance outside of the group."

A recent survey of 95 Japanese companies by Professor Morimiya proves the point. He found in his survey that 26% of the companies polled purchased their insurance on the basis of the insurer's stock investment in them.

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William Booth, who has worked in the New York bureau of Business Insurance, is now living in Japan. As a special correspondent for Business Insurance, he will be reporting regularly on commercial insurance, risk management and employee benefit management in that nation.



Take measures to cut disability claims: Attorney

By DOUGLAS McLEOD

NEW YORK—Taking preventive measures can eliminate, or at least limit, employee disability claims and lawsuits arising from occupational diseases, a lawyer says.

The stakes in such claims and lawsuits are high, and employers can ill afford to overlook statutes that may relieve them of some of the potential liability, according to Patrick Harnedy, a lawyer with the New York-based Special Funds Conservation Committee, which handles workers compensation claims referred to it by the state Workers Compensation Board.

Mr. Harnedy addressed the annual meeting of the Self-Insurers Assn. in New York earlier this month.

He reminded the self-insurers

that the connection between exposure to asbestos fibers and asbestosis is established only as a statistical probability, and that no direct causal link has yet been found.

Employers facing asbestosis or similar lawsuits should thoroughly investigate the exposure history of the employees in question, specifically studying:

- The frequency and duration of the employees' exposure to the toxic substance.
- The concentration of the toxic substance in the workplace.
- Any steps taken by the employer to control employees' exposure to the substance.

Employers should give this and other information to physicians to get a medical opinion on whether the exposure and disease are related, Mr. Harnedy told the self-in-

surers.

Under New York law, Mr. Harnedy added, an employee trying to collect partial disability benefits must prove he or she had at least 26 weeks of "injurious work exposure" to a toxic substance.

This 26-week requirement was added when state law was changed in July 1974 to allow partial disability claims. Previously, employees had to prove total disability to collect benefits.

Some employers and insurance companies may not be aware of this and other laws and may suffer for their oversight, Mr. Harnedy suggested. One insurer is currently appealing a state Workers Compensation Board decision to let stand a payment the insurer made on a 1973 claim for partial disability in a dust disease case.

If the insurer had been familiar with the law, it would have known that such a claim could be disallowed since only total disability claims were allowed prior to 1974, Mr. Harnedy said.

"They goofed. They didn't bring up the 1973 date," he said.

Mr. Harnedy also recommended that companies facing numerous occupational disease lawsuits in federal court take advantage of a federal statute allowing them to combine the cases rather than fight them separately. Legal costs associated with the suits could be reduced to a point where a company's profitability or stock price would not be affected, he said.

Employers could also take several preventive steps to reduce their own exposure to disability claims or employee lawsuits, Mr.

Harnedy pointed out. These steps might include:

- Identification of third parties—such as suppliers of toxic substances—who might bear some of the liability.
- Examination of workplace conditions by occupational disease specialists, improving conditions where necessary.
- Identification of workplace habits that may contribute to development of occupational diseases. For example, Mr. Harnedy said, an employee who wears work clothing home may be exposing his spouse and family to hazardous substances.
- A review of the lifestyle habits of workers, like smoking, to identify workers that may have a greater risk of developing cancer or other diseases.

Pay attention to state laws on disability

NEW YORK—Employers could cut disability claims costs if they paid more attention to the state laws governing disability payments, one expert says.

"A loose or liberal attitude toward policing disability claims can lead to more claims and longer-lasting claims," said Theresa Fay, a staff specialist with New York Telephone Co.

Speaking at the annual meeting of the Self-Insurers Assn. in New York, Ms. Fay emphasized a number of provisions in New York law that offer employers some measure of control over unjustified disability claims.

One provision is the definition of permanent disability, Ms. Fay said. In New York, permanent disability is defined as an inability of the employee to do his or her regular job or another job offered by the employer at the same wage.

Employers should not underestimate the value of the provision in defending against disability claims, since employees who refuse a second job at the same pay are not entitled to disability benefits, she said.

Employers should also insist on adequate proof of disability from employees, and state law provides guidelines for when such proof must be given, Ms. Fay pointed out.

In New York, employers must receive written notice of disability—including a doctor's report—within 15 days after the disability is suffered. The latest an employee can furnish proof of the disability is 20 days after disability leave commences, and evidence of continued disability must be offered "from time to time" at the employers' request.

Employers should also insist on having a doctor they designate examine employees filing for disability, Ms. Fay said. The refusal of a worker to be examined by this doctor may also result in a suspension of benefits, she added.

In addition to these checks on unjustified claims, workers are not entitled to disability benefits if they are still receiving income from another job or if they injured themselves deliberately or during a criminal act, she said.

Ms. Fay urged the self-insurers not to give in to pressure that judges sometimes place on employers to settle disability claims in the employee's favor.

She noted that many self-insurers in New York provide more than the minimum statutory disability benefit of \$95 per week.

"It's not necessarily just statutory pay of \$95 you are fighting over. It may be \$450 a week or more."

NORTH STAR REINVENTS THE UMBRELLA.

Up until now—professional liability umbrella policies for hospitals, doctors, nurses and other professionals were complicated by riders, attached to accommodate the different nature of underlying policies.

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editorial opinions

Inspections you can trust?

CHECK THE FINE print of your property insurance policy before you rely on your property insurer to alert you to hazards after a safety inspection.

Does your policy say that the insurer is not obligated to inspect your property, and if it does conduct an inspection, it is not obligated to tell you what it finds or stand behind its report?

It probably does. And, even if it doesn't, most state laws will prevent you from suing your insurer for a lousy property inspection job. The reasoning is that when insurers conduct safety inspections in conjunction with issuing an insurance policy, they are acting in their own interests, and, therefore, they should not be held liable when their safety inspectors miss a hazardous condition or fail to warn a policyholder about a hazardous condition (see story, page 2).

Insurers do admit that when they sell their expertise and provide only property inspections without an insurance policy, they should be liable for

the quality of the service.

We think insurers should be liable for the quality of their inspection services when acting in either capacity. To say insurers aren't liable for their inspection services when the inspection is conducted in conjunction with an insurance policy ignores the fact that a corporation is paying for the safety inspections, too—as a percentage of the insurance premium.

Insurance buyers are entitled to receive from their insurers property inspection services that can be relied on as complete. Property insurance buyers should not have to hire another insurance company or consultant to inspect their premises to rest easy that there are no

dangerous conditions. That would mean paying twice for the same service.

Insurers should stand behind the quality of their property inspection services, whether the inspections are conducted because the insurer is issuing an insurance policy or because the insurer has been hired to deliver the service.



letters

HMOs are a cure to health cost crisis

To the editor: In reading the article entitled "No health cost-containment method will cure all ills" (BI, Dec. 13), I was amazed that the consultants interviewed had only short-term recommendations for the long-term crisis.

It was extremely disheartening that no consultant mentioned health maintenance organization involvement as a method by which their clients could control health care costs. Where were these consultants and insurers in the early 1970s when HMOs were developing second surgical opinions, pre-admission hos-

pital testing, ambulatory surgery, preventive care, health promotion, concurrent hospital review, peer review and inclusive utilization review programs?

The article clearly portrays physicians and hospitals as the culprits in the health care cost crisis; obviously they are not without responsibility in contributing to the problem. However, the retrospective reimbursement system, which provides no incentives to providers to be cost effective and which was established by consultants and insurers, clearly has contributed significantly to the problem.

In essence, all of us have contributed to the problem of rising health care costs, consciously or unconsciously. I would hope that a presidential commission could be established that would include providers (both fee-for-service and prepaid),

hospitals, consultants and insurers, regulators, employer coalitions, unions, consumers and other organizations concerned with health care inflation to establish a strategy to deal with this crisis.

Thomas J. Garvey
President
The Garvey Group
Norwalk, Conn.

Misstatement of fact?

To the editor: It has come to the attention of this company that an article in the Dec. 6 issue of *Business Insurance* referring to problems in the insurance industry because of the activities of Jack Goepfert contained a misstatement of fact.

The story stated, "Several new reinsurers were brought into the Atlantic scheme. They included Dome Insurance Co., controlled by Mr. Goepfert."

The statement referring to Dome Insurance Co. as being controlled by Mr. Goepfert is false. Mr. Goepfert is not now and never has been an officer, director or stockholder in Dome Insurance Co.

Philip Bloom
President
Dome Insurance Co. Inc.
Christiansted, St. Croix
U.S. Virgin Islands

401(k) contribution rules based on averages

To the editor: I believe an error was made in your discussion of the "safe-harbor" tests designed to prevent discrimination in your article, "Employers' attention turns from IRAs to 401(k)s" (BI, Dec. 13). The article states that if the average contribution of the lower-paid two-thirds of employers is 3%, the higher-paid would be limited to a maximum 6% contribution.

I believe that if the average contribution of the lower-paid group is 3%, the upper-paid group would be limited to an average (not maximum) contribution of 6%. Given these circumstances, the maxi-

mum contribution for the higher paid group could be more than 6% as illustrated (see chart below).

Assuming no changes during the year in these figures, those employees desiring to continue 10% could do so since the test is based on an average.

Raymond C. Dubin
Corporate compensation manager
Wakefern Food Corp.
Elizabeth, N.J.

■ You are right; we should have said average, not maximum.

Contributions to 401(k) plan

Lower paid			Higher paid		
No. of employees	% of pay contributed	Total contributions	No. of employees	% of pay contributed	Total contributions
100	0	0	30	0	0
100	4	400	20	4	80
100	5	500	36	5	180
			64	10	640
300		900	150		900
3% average contribution			6% average contribution		

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Insurance programs bring home savings

By MARGARET LeROUX

RALEIGH, N.C.—North Carolina savings and loans are banking on a life and health care plan funded by a 501(c)(9) trust and a fidelity bond program rated on a statewide rather than national experience to save them money.

The life and health plan, which emphasizes cost containment by reimbursing outpatient services at a higher rate than inpatient care, has cut the premiums paid by members of the North Carolina Savings & Loan League from 12% to 15%, said Travis Shamel, executive vp of League Services, a wholly owned subsidiary of the S&L group that provides insurance and other business services to members.

The fidelity bond program, introduced 18 months ago, contains a "reverse retro feature" that has cut costs up to 35% for the thrifts, Mr. Shamel noted.

In addition, the league has recently switched underwriters for its group dental plan in hopes of lowering costs for members.

The attempt to cut costs was the rationale behind setting up the fidelity bond program.

"Our fidelity bond premiums had been increasing even though our losses weren't bad at all," said Mr. Shamel. "The savings and loan associations were subsidizing the bad experience of financial institutions in other states. What we needed was a program rated on our own experience."

Mr. Shamel designed the league's program and, with the help of broker Corroon & Black of Nashville, Tenn., took it to several fidelity bond insurers before finding one "willing to negotiate with us," he said.

The final plan was not his original idea of a self-insured fidelity bond program but "what I describe as an insured program with a reverse retro feature," Mr. Shamel said.

Underwritten by Pacific Employers Indemnity Co., a subsidiary of CIGNA Corp.'s Insurance Co. of North America, the program offers "a discount off the front end, rather than a dividend at the end of the policy year," he explained.

"If a savings and loan association incurs a loss during the term of the policy, it may have to pay a portion of the discount back, and if any member of the group suffers a catastrophic loss, everyone in the pool may have to contribute," Mr. Shamel explained.

The advantage of the plan is the cash flow generated by the early discount, he pointed out. "Even if a member had to pay back the entire discount, it would still have had use of those funds during the policy period, instead of the insurance company."



Mr. Shamel

The North Carolina savings and loans' fidelity bond pool was "the first group plan of its kind," Mr. Shamel said. Soon after its introduction, however, savings and loan leagues in several states endorsed a similar plan written by MGIC Indemnity Corp., now a subsidiary of Baldwin-United Corp. That program is now "highly competitive with ours in this state," he added.

Premiums for the three-year policy term are assessed annually and are based on several factors including an S&L's level of assets, its number of employees and its loss history. The premium is also based on whether the institution uses an outside data processing service, an additional fidelity exposure.

Thirty-eight savings and loan associations in the North Carolina league currently participate in the fidelity bond pool.

The league's 10-year-old group health program has attracted much wider participation: 135 S&Ls with 3,900 insured employees and 5,900 dependents.

League members pay premiums to a 501(c)(9) trust (BI, Dec. 13), which in turn buys group life and health coverage from Pilot Life Insurance Co.

The life and health programs are combined for experience rating in the retrospectively rated plan. The trust also purchases stop-loss coverage from Pilot Life so it does not have to ask for additional premi-

ums from members should the plan's loss experience exceed 110%. If losses do not exceed premiums, the fund receives a partial refund.

The coverage costs \$29.10 per employee per month for individual coverage and \$71.30 per month for family coverage.

The group health plan provides major medical coverage with a \$100 annual deductible per employee (\$300 maximum deductible per family) up to an annual limit of \$1 million.

The deductible and a 20% coinsurance payment are required for all inpatient treatment, but employees do not have to pay a deductible or co-payment for outpatient care.

The plan also pays 90% of all emergency room treatment without a deductible, but to deter employees from using hospital emergency rooms needlessly, employees are required to pay the emergency room admission charge.

"We want to discourage people from using the emergency room as their family physician," Mr. Shamel said.

"We're banking on the belief that insurance should cover the truly catastrophic situations," he contin-

ued. "We don't want the plan to be nickle-and-dimed to death with costs that could be avoided."

The plan also provides a cap so that no employee has to pay more than \$1,000 in out-of-pocket medical expenses during a year.

As head of the league's subsidiary that also provides member S&Ls with telephone systems, office machines, travelers check programs and other services in addition to insurance, Mr. Shamel designs and markets the league's insurance offerings.

When a new coverage is introduced or an insurance policy moved to a new underwriter, as the group's dental plan was this past October, he draws up the specifications and "puts them out to bid to a few selected companies."

Besides Mr. Shamel, an insurance committee made up of managing officers of 11 league members examines the bids and makes recommendations to the league's board of directors.

The board then discusses, approves and offers the program to member savings and loan associations.

Although the process is hardly streamlined, it is equitable, Mr. Shamel pointed out. "We may have

to go through several levels of approval, but it means the administration of the league isn't dictating what the benefit programs are for the individual savings and loan associations."

The group's dental insurance plan had been with Aetna Life & Casualty Co. since its introduction three years ago. "Our claims experience was abnormally low; even for the first year it was only 72% on an incurred basis, and we didn't think the premiums we were being charged reflected this," Mr. Shamel said.

The league's board decided to move the dental plan to Pilot Life, too. Like the group health plan, the dental insurance emphasizes prevention and cost containment.

It covers 100% of expenses for preventive care like oral exams, fluoride treatments and prophylaxis. The plan pays 80% of fees for corrective treatment, like fillings, and pays 50% of all other dental care up to a \$1,000 limit.

A \$50 per-person deductible is also required for all treatments except preventive care.

Twenty-seven savings and loan associations in North Carolina now participate in the group dental plan and 12 more will join on Jan. 1.

Employers learn to shape up health care, work comp plans

products & services

ROCKFORD, Ill.—A Rockford hospital is telling employers with bulging health care and workers compensation costs how to get in shape.

SwedishAmerican Hospital has spent three years developing a program to help employers diagnose their problems and reduce their expenses.

The program started with "Executive Health Decisions," an outreach program it launched several years ago to identify the health care needs of local businesses in Rockford.

But SwedishAmerican soon discovered the problem of burgeoning corporate health care and occupational health and safety costs reached far beyond the Rockford city limits.

A pilot study undertaken by the hospital found that many companies around the nation were found to have a similar problem: They lacked the tool to help them analyze where they could cut their workers compensation and health care costs.

The common, but yet totally individual, problems employers face demonstrated the need for another service the hospital could provide, says Dr. John Seward, medical director of occupational health services for SwedishAmerican.

The program that resulted, called Business Health Analysis, scrutinizes the state of an employer's workers compensation claims experience, safety education and health benefits, and provides an analysis with recommendations on how a company can improve in these areas to save money.

The analysis has to be industry-specific so companies can compare their experience against similar industries, he says. And, the recommendations that the hospital gives have to be tailored for each employer, whose problems are common but unique.

For example:
• A employer with 1,200 workers faced a 25% increase in its workers compensation premium. A thorough investigation of the company's claims experience and fu-

ture expected losses by SwedishAmerican indicated the employer should self-insure its workers compensation risks and retain a third-party administrator.

It paid off. The company saw a 56% savings from what would have been paid the insurer in premiums the first year.

• Another small manufacturer struggled unsuccessfully against yearly increases in its employee health benefit package. After being faced with the highest percentage increase to date, SwedishAmerican suggested the company self-insure and handle its own claims administration.

The company was so pleased with the 60% savings it realized in the first year that it reinvested a portion of that savings back into a wellness program for employees.

• The hospital learned that back strains accounted for 43% of the total number of lost-time accidents at a company. And, workers suffering back strains lost an average of three more days of work than other accident victims.

The loss data was presented to the chief executive officer, and a new education program dealing with proper lifting techniques was instituted.

The Business Health Analysis program can be broken into four parts, Swedish American says. First, a meeting is held between the hospital's health analysis team and the employer's chief executives and its directors of personnel, safety, health and risk management. General and demographic information is solicited at that time, including employee statistics and specific data about operations.

The meeting also includes a detailed discussion of what the employer hopes to achieve through the analysis, which costs about \$15,000 to \$20,000 for a company with 500 workers.

The second phase involves the investigation of lost-time and non-lost-time accidents, work-related

illnesses and workers compensation cases.

The third section of the analysis is geared toward scrutinizing the employer's safety education and benefit programs. Together, these two phases take about four weeks to accomplish.

The final phase of the analysis includes a critique of the company's medical programs and recommendations prepared in a written report by the health analysis team. If the team doesn't have the expertise to analyze a particular problem, outside consultants are brought in.

A meeting is then held between the team and company managers to discuss the results of the analysis and the team's recommendations.

Three months later, the team and the executives meet again to discuss the how the recommendations were implemented and their impact.

A re-evaluation of the recommendations, along with a written progress report, is generated 12 months later by the health analysis team.

The whole analysis, from first contact until the recommendations are given, takes about two to three months.

But if an employer needs quick action on a particular problem, the team can have some recommendations ready within one week. The team then resumes the remainder of the analysis.

"This system allows the business manager to look at the entire corporate health asset picture at one time and enables the manager to bring order and management to all health expenditures," says Dr. Seward.

"Our report can give employers tangible recommendations, all of which are geared to bottom-line costs," he adds.

For more information about the program, contact Dr. John Seward, SwedishAmerican Hospital, 1400 Charles St., Rockford, Ill. 61101; 815-968-4400.

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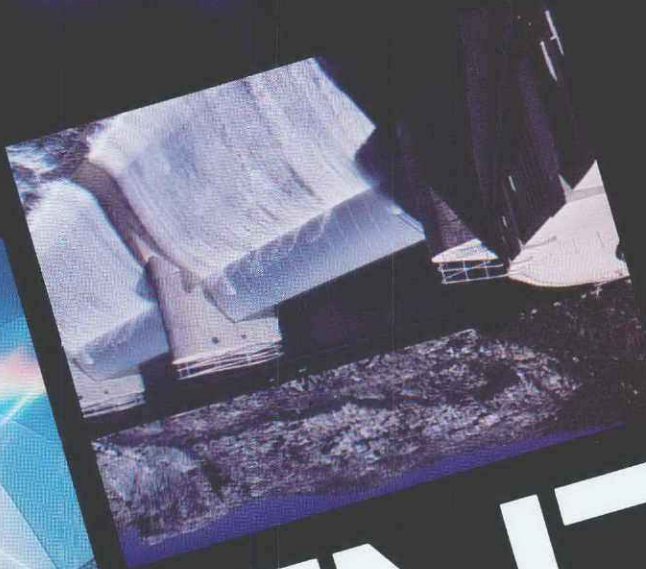
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JAN. 8. CPCU Exam Review Day in Chicago, sponsored by the Chicago and suburban chapters of the Society of Chartered Property/Casualty Underwriters; \$25. Louise Field, ICO Inc., 6330 N. Cicero Ave., Chicago, Ill. 60646; 312-685-3300.

JAN. 10-14. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; \$535. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

JAN. 13-14. Hazardous Waste Litigation program in Tampa, Fla., sponsored by the Practising Law Institute; \$325; 10% discount for PLI members. Also Feb. 17-18 in New York. PLI, Department BRC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

JAN. 20-22. Commercial Property institute in Sacramento, Calif., sponsored by Certified Insurance Counselors; \$195. Professional Insurance Agents of California/Nevada, 14114 Victory Blvd., Van Nuys, Calif. 91401; 213-988-9500.

JAN. 24-28. Fundamentals of Fire Protection Equipment course in Hartford, Conn., sponsored by Industrial Risk Insurers; \$500; free of charge to IRI policyholders. Also Mar. 21-25; Mar. 28-Apr. 1; Apr. 25-29; May 2-6; May 9-13; May 16-20; May 23-27. Ken Richardson, IRI, 85 Woodland St., Hartford, Conn. 06102; 203-525-2601.

JAN. 24-28. Total Loss Control Management seminar in Houston, sponsored by the International Safety Academy; \$570. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

JAN. 26. Risk Management Information Systems conference in New Orleans, sponsored by Corporate Systems; \$50. Also Jan. 27 in Memphis, Tenn. Matt Davis, Corporate Systems, Box 31780, Amarillo, Texas 79120; 806-376-4223.

JAN. 28-30. Risk Management seminar in Key Biscayne, Fla., sponsored by the National Pharmaceutical Alliance; \$175 for members; \$200 for non-members; \$25 late fee charged for on-site registration. National Pharmaceutical Alliance, 1200 New Hampshire Ave. N.W., Suite 300; Washington, D.C. 20036; 202-861-7845.

FEB. 2-3. General Liability and Workers Compensation Classification seminars in Los Angeles, sponsored by the American Insurance Assn.'s Premium Audit Advisory Service; \$75. Faye E. Styles, Premium Audit Advisory Service, AIA, 85 John St., New York, N.Y. 20038; 212-669-0400.

FEB. 7-8. Back Injury Symposium in Sunnyvale, Calif., sponsored by Back Dynamics Institute; \$95 to \$325, depending on number of sessions attended. Back Dynamics Institute, Box 8104, Foster City, Calif. 94404; 415-574-1087.

FEB. 7-9. Fundamentals of Employee Benefits seminar in New York, sponsored by the American Management Assns.; members, \$695; non-members, \$800. Also, April 4-6 in New York and Chicago. AMA, 135 W. 50th St., New York, N.Y. 10020; 212-246-0800.

FEB. 7-11. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; \$585. ISA, 10575 Katy Freeway, Box 19600; Houston, Texas 77224; 713-932-9400.

FEB. 8-11. National Insurance and Protection Conference of Financial Institutions in Orlando, Fla., sponsored by the American Bankers Assn.; members, \$415; non-members, \$515; \$40 additional to register after December. Shelly Davis, Insurance and Protection Division, ABA, 1120 Connecticut Ave. N.W., Washington, D.C. 20036; 202-467-4047.

FEB. 17-19. National Assn. of Rehabilitation Professionals in the Private Sector annual conference in Lake Buena Vista, Fla.; members, \$150; non-members, \$175; \$25-fee-for registration after Jan. 16. John Gruber, Rehabilitation Management Services Inc., Suite 101, Two Parkway Center, Pittsburgh, Pa. 15220; 412-921-7783.

FEB. 21-24. Inspector Training seminar in Houston, sponsored by the International Safety Academy; \$490. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

FEB. 21-25. Professional Consulting in Safety and Loss Control course in Atlanta, sponsored by the International Loss Control Institute; \$625. ILCI, Box 345, Loganville, Ga. 30249; 404-466-2208.

FEB. 22-23. Risk Management Concepts for the Safety Professional and Insurance Buyer course in Los Angeles, sponsored by the University of Southern California; \$225. USC, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523.

FEB. 27-MAR. 2. Bank Security annual conference in New Orleans, sponsored by Bank Administration Institute; \$425 for members; \$550 for non-members; \$250 for law-enforcement personnel. Keith Marshall, Bank Administration Institute, 60 Gould Center, Rolling Meadows, Ill. 60008; 312-228-6200.

FEB. 28-MARCH 2. Safety for the Oil Field seminar in Houston, sponsored by the International Safety Academy; \$395. International Safety Academy, 10575 Katy Freeway, Box 19600, Houston, Texas 77224; 713-932-9400.

MARCH 7-11. Assets Protection course in Dallas, sponsored by the American Society for Industrial Security; members, \$595; non-members, \$650. ASIS, 2000 K St. N.W., Suite 651, Washington, D.C. 20006; 202-331-7887.

MARCH 14-18. OSHA Guide to Voluntary Compliance course in Los Angeles, sponsored by the University of Southern California; \$500. USC, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523.

MARCH 21-25. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; \$425. John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

MARCH 23. Public Employee Benefit Plans workshop in New York, sponsored by the International Foundation of Employee Benefit Plans; member, \$130; non-member, \$155. IFEBP, 18700 W. Blue-mound Road, Box 69, Brookfield, Wis. 53005; 414-786-8700.



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P.C.W. says it's considering major reforms

By STACY SHAPIRO

LONDON—P.C.W. Underwriting Agencies Ltd., the underwriting subsidiary of Minet Holdings P.L.C. that has been embroiled in the scandals that have rocked Lloyd's of London, wants to make a fresh start in the new year.

The underwriting agency has already dismissed three of its underwriters for allegedly having personal interests in the reinsurance arrangements of its syndicates. It has also filed suit against the underwriters, along with its former chairman, Peter Cameron-Webb, and John Wallrock, who resigned as chairman of Minet last month.

P.C.W. is planning other changes, according to a letter it has sent to its syndicates' 1,600 Lloyd's names.

The letter says the agency and its syndicates plan to:

- Possibly replace its auditor, Arthur Young McClellan Moore. No decision, however, has been made on what firm would replace Arthur Young, which also has served as auditor to Alexander Howden Group P.L.C., which has been involved in the scandals.

- Eliminate its so-called "baby syndicates." Sources in the marketplace say that baby syndicates, used in place of an agency's major syndicates to insure specialized risks, are the source of some of the problems at Lloyd's. They charge that underwriters only allow certain names to participate in baby syndicates and then funnel only the best risks to those syndicates, assuring that the favored names will make a substantial profit.

- Review a statement that names had to sign when they joined P.C.W.-managed syndicates that said they would not sue P.C.W. directors, underwriters or employees accused of any wrongdoing.

P.C.W.'s letter to its names also asks if they wish to stay with its managed syndicates. The names were to reply by the middle of last week.

"The choice was difficult," said one member who had decided to leave the P.C.W.-managed syndicates even before he received the letter.

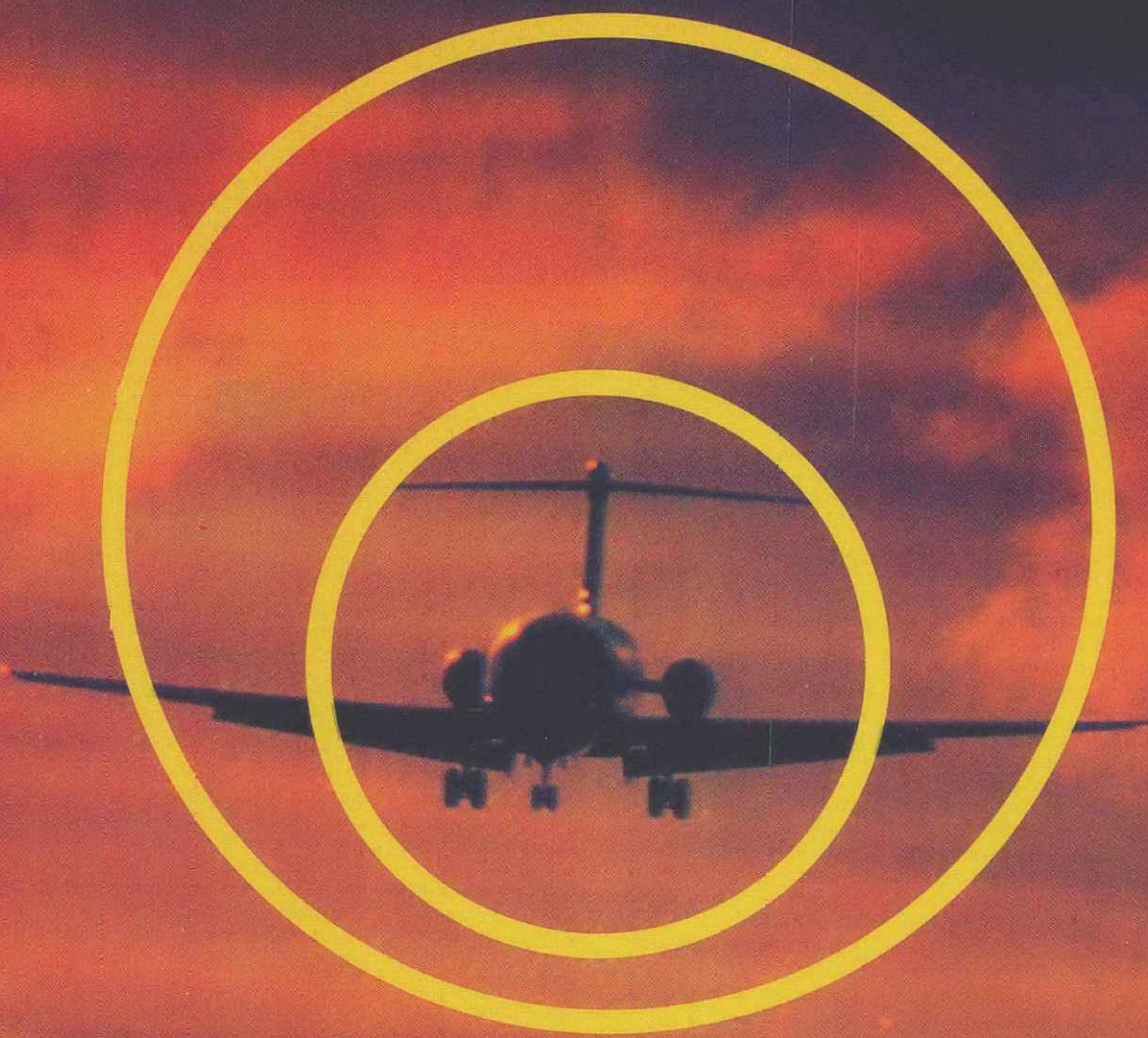
"It is too close to the end of the year," he said. "It would be virtually impossible to find a new underwriter now," he said, adding that names that do decide to leave P.C.W. now may have to sit out all of 1983.

Howden is also taking actions to solve some of the problems it is facing.

Specifically, Howden's parent, Alexander & Alexander Services Inc., has appointed its senior vp of finance, William Farley, to a new three-member board of Sphere Drake Insurance P.L.C.

Mr. Farley was one of the A&A officials involved in the discovery of a \$40 million shortfall in Sphere Drake and Howden's Bermuda underwriting operations, as well as uncovering the scheme in which five former Howden directors allegedly misappropriated some \$56 million.

The other two members of the board will be Ian Dean, who is the company's chief executive and general manager, and Michael Birmingham, who joined the firm in 1979. ■



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Most trying harder to communicate benefits

Continued from page 1

efits. The most popular is a benefit handbook or series of booklets, provided by 60 of these employers. Personalized benefit statements are provided by 38, audiovisuals are used by 37 and booklets provided by insurers are distributed by 30 of the employers.

Among the 65 employers that issued new communications in 1982, 10 did so only to communicate a change in benefits, 16 did so to improve understanding of existing benefits and 39 had both intentions.

Of the 55 who were interested in improving understanding of existing benefits, a revised benefit handbook was the most popular method of communication, used by 37 of the respondents, three for the first time.

Twenty-five of these employers used more than one method of communicating the benefit plans. Among the other methods used were: summary plan descriptions, redesigned by 27 employers; personalized benefit statements, revised by 20 employers and introduced for the first time by eight; and an audiovisual program, updated by 13 employers and used for the first time by 11.

Employers noted they also used other methods to explain their benefits. Six said they placed items in the company newspaper, six said they held meetings, four said they passed out fliers, one said the company added a benefit bulletin and another said benefits were described in bulletin-board messages.

The efforts of a manufacturer employing 20,000 workers shows how far employers will go. The company added a personalized benefit statement, developed its first audiovisual program, sent memorandums to all employees, put staffers in pay envelopes, hung posters, passed out handouts and distributed "benefit calculators." The total cost of the communications program was \$90,000.

Two-thirds of the 90 employers responding to the survey also plan to update their benefit communications programs next year, including many of the same employers who revised their programs this year.

The manufacturer with 20,000 employees that revamped its program in 1982 plans to rewrite its benefit handbook in 1983.

Even two of the four employers with the most limited communications programs plan to improve them next year. The professional association for attorneys hopes to issue its first benefit handbook and perhaps a personalized statement, the personnel manager said. The 1,000-person law firm will issue literature on health awareness.

Among the other employers who plan to update their communications, 34 intend to revise their benefit handbooks, 26 will update an audiovisual program, 13 will add a personalized statement, 10 will redesign their personalized statements, seven will develop their first audiovisual program, five will issue their first benefit handbook and two

will develop benefit newsletters. These answers reflect multiple benefit communications changes by 26 of the 60 employers.

Almost two-thirds of the 90 respondents said they told their employees about the rising cost of health care during 1982. Of the 58 companies that did, 29 used more than one method of communication.

The most popular method used was a memo to all employees, used by 33 of the employers. Meetings were conducted by benefits personnel for employees at 26 of the companies. Not one company, however, reported bringing in a doctor or nurse to talk about health care costs. One employer did ask its insurance agent and insurer to send representatives to a meeting with employees.

Twelve employers said they placed articles describing the health care cost problem in the company newspaper and seven said they used a newsletter. Audiovisual programs on rising health care costs were shown to employees by 11 of the employers.

Ten employers distributed pamphlets, five of which developed their own and five of which obtained them from an insurer or consultant. Two employers said they set up committees of workers to study the issue.

Two other employers said, essentially, "money talks." One increased the employees' deductible and the other passed to employees a portion of the increased premium.

All these benefit communications are generally handled by the company benefits personnel. Of the 79 survey respondents identifying who handles benefit communications, 65 said it was the benefits/personnel generalist on staff. Twenty-six of these generalists handled the projects with no other help.

At the other 53 companies where someone other than or in addition to the benefits generalist is involved, 31 use a consultant to help with or handle the benefit communications. Twenty-nine use in-house public relations/advertising personnel to handle benefit communications. Only 15 employers have a benefit communications specialist on staff.

The cost of these communications programs varies greatly. Among the 51 respondents who discussed their costs, the highest noted was \$487,000 annually spent by a forest products company to communicate benefits to 35,000 employees. The cost is about 0.4% of what the company spends on benefits.

Next year, the company will spend \$600,000 on communicating benefits programs, or about 0.5% of the cost of the benefits. Staff in the company's employee benefits department, including a benefits generalist and a benefits communications specialist, work on the communications effort. The company also engages a consultant.

Other big spenders with 1982 communications budgets of \$200,000 include a communications/information concern with 14,000 employees, a consumer products company with

30,000 employees and an aerospace company with 39,000 workers.

The communications concern uses an in-house benefits communications specialist and a consultant to prepare its communications materials. The consumer products company relies on its own staff benefits generalist and benefits communications specialist to prepare its materials. The aerospace company uses its benefits generalist, its in-house public relations/advertising department and a consultant to prepare its material.

At each, the cost of communicating benefits is less than 1% of the benefits budget.

Only the communications/information concern, however, plans to spend more on benefit communications next year: \$219,000. The consumer products company is cutting its communications budget in half and the aerospace company hasn't set its budget yet.

Among the others reporting their 1982 benefit communications budgets, six spent from \$100,000 to \$200,000; seven spent from \$50,000 to \$99,000; and 34 spent up to \$50,000.

For 1983, 19 companies plan to spend more, six plan to spend less and 26 plan to spend the same amount. Thirty-nine respondents did not reveal their costs.

Nearly all the survey respondents said that employee feedback suggests that employees approve of their communications efforts.

Of the 74 survey respondents that said their employees had responded to the benefit communications, 67 said the reaction was favorable, two said the reaction was mixed and only one said there was an unfavorable reaction. Four did not answer the question.

"In attitude surveys, both benefit plans and benefit clarity received the highest positive rating out of 200 areas queried," said the director of employee benefits for a diversified holding company employing 75,000 people. The company spent \$30,000 last year communicating benefits via redesigned summary plan descriptions, redesigned personalized benefit statements, rewritten employee handbooks, memorandums to all employees and bulletin board notices.

The manager of employee benefits for a construction company with 5,000 workers says the employees appreciate the benefit statement the most. "Ninety-nine percent of the comments favor the benefit statement. Also, it's the older employees who take the time to comment."

The company spends \$10,000 annually on its benefits communications program, which also includes an employee handbook.

The manager of benefits planning and communication at the diversified consumer products company that spent \$200,000 on communications in 1982 said the best employee feedback was 64% participation among the company's 30,000 employees in a new salary reduction or 401(k) plan.

Of the two who admitted employees had

mixed reactions to the communications efforts, only the manager of personnel and benefits for an air shipment concern with 13,800 employees elaborated. He reported that employees said: "The employee benefit book is very good, as is the newsletter. Need: more 'how-to' information; written simply, but not enough explanation."

The company provides employees with a personalized statement, a handbook that was updated this year and an audiovisual program introduced this year. It also issues memos, a special benefits publication and places articles in the company publication.

The benefits administrator for a 850-person law firm said its employees "did not realize that they had that many dollars in the pension fund" and "did not know the benefit package costs so much." The firm added a personalized statement in 1982 to its previous communication efforts, which had been limited to meeting ERISA requirements and distributing booklets provided by insurers. The law firm's 1982 communications budget of \$20,000 will be doubled next year to pay for issuing its first benefit handbook.

The corporate benefits administrator for an oil drilling concern had hoped to provide comprehensive benefit statements in 1982 and an audiovisual presentation to the company's 1,500 employees. "However, softening of the energy industry market has curtailed all these 'nice-to-do' extras," the administrator said. Last year, the company had introduced a new handbook, which was "well-received by employees."

Not everyone, however, finds employees so responsive. The manager of employee benefits communications for the communications/information concern that spent \$200,000 this year says, "The only feedback is when an employee doesn't understand a change, or chooses not to understand."

And, not all employers are optimistic they can succeed in explaining benefits. "Our employees are thinly scattered. Written communications and occasional audiovisual presentations are the chief communications tools. People tend not to read written communications, so efforts are not very productive," said the vp of corporate affairs for a non-profit religious group that employs 800 people. Nonetheless, the group plans to redesign its summary plan descriptions, rewrite the benefit handbook and update the audiovisual program next year.

Employee benefit managers and others in charge of benefit plans are invited to join the Employee Benefit Board. Just tell us you are interested and send a card with your name, title, company and address to Kathryn J. McIntyre, Editor, Business Insurance, 740 Rush St., Chicago, Ill. 60611. You'll receive four surveys during 1983 on benefit issues.

One-third now offer pre-retirement programs

The term "pre-retirement counseling" is used rather loosely by many employee benefit managers, while others don't have the term in their benefits vocabulary.

More than one-third, or 32 of the 90 respondents to the recent *Business Insurance* Employee Benefit Board survey, said their companies offer pre-retirement counseling, but the cost and scope of the programs as described vary greatly.

Almost as many benefit managers, 28 or 31% of the respondents, said they do not operate a pre-retirement program and will not introduce one next year. Among the remaining respondents, 14 said they will begin programs next year, one said a program will be started in 1985, three said they're considering a program and 12 did not answer the question.

The pre-retirement counseling programs offered by 36% of the 90 respondents range from one-on-one meetings with retirees to programs costing the employer \$25,000 annually. Their common characteristic is some discussion of many of the issues retirees will encounter, including financial, personal and psychological adjustments.

One of the most modest plans described in the survey is offered by a manufacturer of graphic arts equipment employing 500 people. "Limited to annuity option counseling and medical insurance," says the employee benefits and services manager.

One of the most elaborate described is of-

fered by a manufacturer of hospital supplies with 10,000 employees. That corporate benefits director says, "I have conducted an eight-session seminar using 'Design for Living' workbook. Everyone in the home office age 55 or older has been invited to attend. These meetings have been held on company time. Have had one session of hourly employees at a nearby plant on employees' own time. Invited spouses to all seminars I have conducted." The annual cost: \$7,500.

One of the most expensive is cited by an aerospace company with 39,000 employees. It spends \$25,000 annually on the program, which the manager of benefits planning describes as covering "financial planning, health care awareness, lifestyle and employment opportunities."

In between the two extremes are a variety of programs, but many are limited to one-on-one meetings with benefits personnel:

- A bank with 2,200 employees offers "one-to-one counseling on documents giving options of retirement dates. These are automated estimates that are provided by our administrative office. Local top management has not approved expanding this program to group meetings." No cost was revealed.
- A consumer goods manufacturer employing 1,200 sets up individual meetings with benefits personnel for employees that will retire within six to 12 months. Topics discussed include pensions, health and acci-

dent insurance options, life insurance and general information on Social Security.

Among the more expansive programs is one offered by a chemical manufacturer employing 4,500. It spends \$7,000 a year to provide employees near retirement with supplemental personalized benefit statements and a set of 20 planning booklets.

A manufacturer with 50,000 employees provides all employees age 54 and older and their spouses a 2½-hour program in which eight topics are covered by a lecturer and a slide show. It is conducted on company time, but no cost was revealed.

An electronics company with 60,000 employees offers just four sessions to address pensions, profit sharing, retiree medical coverage, Social Security, Medicare, investments and financial planning. No cost was noted.

Among the others that said they offer pre-retirement planning programs were:

- A chemical and pharmaceutical manufacturer employing 10,000 workers that offers older workers six programs a year covering finance, health, leisure, company benefits, Social Security and housing. Each program costs the company \$1,000.
- An aluminum and chemical manufacturer with 20,000 employees that gives its training department responsibility for conducting a one-day seminar.
- A municipal government employing 1,900 that offers employees approaching re-

irement an eight-part lecture series. "Professionals speak regarding pensions, Social Security, legal, health, vocational counseling, consumer considerations, insurance and investments." The annual cost: \$2,500.

- A manufacturer with just 190 employees that sets up six meetings in the evenings, each two hours long, covering health, benefits, wills, hobbies, housing and taxes.

The manager of benefits communications at a forest products company noted that an existing program has been put on hold because of the current recession. "We have deferred using the program until the economy improves. We ran a pilot program in 1981. The cost is roughly \$60 per couple or person."

Fourteen of the 58 companies that currently do not offer pre-retirement programs said they are planning to start one in the future. Some of their plans include:

- A series of pamphlets and brochures for older workers at a cosmetics manufacturer employing 1,300.
- A workbook written by the benefits manager of a bank with 1,350 employees. The workbook is to be combined with weekly sessions to review work done at home.
- Distribution of materials prepared by retiree associations to older workers at a telecommunications utility employing 2,500.
- A one-day program with outside speakers for older workers at a retail company with 10,000 employees.

Pine Top to discontinue British underwriting

Pine Top Insurance Co. Ltd., a London-based subsidiary of Greyhound Corp., is discontinuing its underwriting activities.

"Past results and recent market conditions" led to Greyhound's decision to halt the operation, according to Greyhound's chairman, John W. Teets.

Greyhound must now transfer about 6.6 million pounds (\$10.7 million) to fully fund Pine Top Ltd.'s paid-in capital. British securities laws allowed Pine Top Ltd. to be formed in 1972 without full funding of the insurer's equity, a spokeswoman for Greyhound explained.

Pine Top Ltd.'s London offices and staff will be maintained to handle the runoff on the company's current business, Mr. Teets commented.

Pine Top Ltd. is one of several insurance subsidiaries of Greyhound, including Pine Top Insurance Co., Pine Top Life Co. and Pine Top (Bermuda) Ltd.

A&A International

NEW YORK—Alexander & Alexander International, a subsidiary of Alexander & Alexander Services Inc., has purchased a 40% interest in Bekouw Mendes Holdings B.V. of Amsterdam, Netherlands.

Bekouw Mendes, with 275 employees, is the third-largest insurance brokerage in the Netherlands and a long-time A&A correspondent, said John C. Sienkiewicz, president of A&A International.

"We have been working together since the early 1970s," Mr. Sienkiewicz said, "and our purchase of equity interest is really a cementing of the security and commitment of full-fledged partnership in the future. We both felt this could not be guaranteed in an ordinary correspondent relationship."

Although A&A originally initiated the earlier working agreement between the two brokers to serve multinational clients, the U.S. brokerage expects more leads on Dutch corporations needing service for U.S. branches.

"We have always received some leads and tips from Bekouw Mendes as well as serving their clients in the U.S. We now expect to generate more new business from foreign multinationals with their help," Mr. Sienkiewicz noted.

A&A would not disclose the cost of the transaction.

Subsidiary acquired

Intercontinental Re Inc. of Los Angeles, a subsidiary of Frank B. Hall & Co. Inc., has been acquired by Insurance Corp. of Hannover.

Effective Jan. 1, Intercontinental Re will serve as underwriting manager for its new parent, as well as maintain a portfolio of reinsurance business for Puritan Insurance Co. and Summit Fidelity & Surety Co.

Risks written by Intercontinental Re in the name of Rhineland Reinsurance Corp. of America Inc. will be assumed by Insurance Corp. of Hannover.

Insurance Corp. of Hannover, with home offices in Chicago, is a subsidiary of Hannover Rueckversicherung A.G. of Hannover, West Germany.

Adjusting franchise

Underwriters Adjusting Co. has signed a franchise agreement with Idaho Intermountain Claims Inc., of Cheyenne, Wyo.

UAC provides claims services to 1,400 insurance companies through 350 offices and 100 drive-in claims centers nationwide.

New name

Phoenix Life Insurance Co. will

markets

change its name to Phoenix American Life Insurance Co. effective Jan. 1.

Phoenix Life is a stock insurance subsidiary of Phoenix Mutual Life Insurance Co. of Hartford, Conn.

Acquisitions

Milliman & Robertson Inc., an actuarial and employee benefit consulting firm, has acquired the actuarial valuation and consulting segment of Pacific Mutual Life Insurance Co. The acquired business represents about \$700,000 in annual fees.

Olliver/Pilcher Insurance, based in Phoenix, Ariz., has an-

nounced its merger with Dave Bryce Agencies of Pine Top, Ariz.

Frank B. Hall & Co. Inc. has announced the acquisition of Flesher-Lawrence-Pruefer-Dodds Inc., an Oxnard, Calif., general insurance brokerage that specializes in construction industry risks.

Fireman's Fund Inc., the holding company for Fireman's Fund Insurance Cos., has announced the acquisition of Wisconsin Employers Group Inc., another insurance holding company based in Green Bay, Wis. Wisconsin Employers' subsidiaries include a life insurance and two small property/casualty companies.

New offices

Aneco Marketing Co. Ltd., a risk management subsidiary of Aneco Reinsurance Co. Ltd. of Hamilton, Bermuda, is opening a new regional office at 44 Montgomery St., San Francisco, Calif. 94104; 415-433-8020.

Pacific Compensation Insurance Co. of San Francisco has opened two new offices. The company's new administrative headquarters is located at Bayhill Office Center, 959 Elm Ave., Suite 200, San Bruno, Calif. 94066. The new Southern California administrative center is located at 11827 Ventura Blvd., Studio City, Calif. 91604.

Crum & Forster Underwriters Group has moved its offices to 500 Winding Brook Drive, Box 8000,

Glastonbury, Conn., 06033; 203-659-3561.

Johnson-Rast & Hays Insurance has moved to new offices at Suite 1850, Financial Center, Birmingham, Ala., 35203; 205-324-1000. Two subsidiaries, Employee Benefit Consultants and Insurance Adjusters & Appraisal Inc., are also affected by the move.

Insurance Co. of the West has opened a new branch office at 1083 S. Winchester Blvd., San Jose, Calif., 95128; 408-985-1700.

AVEMCO Insurance Brokerage Inc. has moved to new home offices at 411 Aviation Way, Frederick, Md., 21701; 301-694-5700.

Penn-America Insurance Co. has moved its home offices to 420 S. York Road, Hatboro, Pa., 19040; 215-443-3600.

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Panel report favors federal tort reform

By JERRY GEISEL

washington

WASHINGTON—The first Senate committee report on product liability says only a uniform federal tort reform law can reduce manufacturers' tort litigation problems.

The Senate Commerce Committee report says state product liability reform laws are not going to reduce uncertainties in the tort law, a factor in unstable product liability insurance rates.

"Individual states cannot address the uncertainties of product liability law effectively because certainty within one state does little to resolve the tort litigation problems facing those who deal in an interstate market," the committee report says.

The report also notes that tort reform statutes passed by about two dozen states during the last five years differ widely.

"Most are not comprehensive and fail to address the key issues that arise in product liability litigation. Further, no two state statutes are alike," the report says.

Refunds to employers

Refunds of Social Security and unemployment compensation taxes the federal government wrongly collected from employers are running sharply below expectations.

The refunds were ordered by a June 1981 Supreme Court ruling that said employers do not have to pay Social Security and unemployment compensation taxes on meals and lodging they provide to employees (Bi, June 15, 1981).

At the time of the ruling, some experts predicted that the Internal Revenue Service might have to refund about \$2 billion in overpayments to employers.

But at the close of fiscal 1982, which ended Sept. 30, the IRS had

approved refunds of \$91.2 million, plus interest. The refunds are averaging \$570 per employer.

Medicare contributions

The financially ailing Medicare program will receive a shot in the arm from federal workers this week.

Federal workers, who, unlike private employees, have not been automatically covered by Medicare, will have to begin on Jan. 1 to pay 1.3% of salary—up to the first \$35,700—for Medicare coverage.

Those contributions from federal workers, which were mandated under legislation passed by Congress last year, are expected in 1983 alone to bring in \$350 million to \$400 million in new revenues.

Hazardous occupations

Firefighting is the most hazardous occupation in the United States, the International Assn. of Fire Fighters says.

In 1981, the on-the-job death rate of firefighters was 58 per 100,000, the highest death rate of any occupation, according to a survey.

The firefighters' death rate compares with a death rate of 55 per 100,000 in the mining industry, which is the second most-hazardous occupation.

About 45% of firefighters suffered on-the-job injuries in 1981. Some 578 firefighters were forced to leave their jobs because of injuries in 1981, up from 293 injury-related retirements in 1980.

Some 43.8% of their on-the-job deaths resulted from heart attacks. Building collapses and apparatus accidents each accounted for 11% of the deaths, while 8.2% resulted from inhalation of hazardous smoke or gases.

Confined space study

The Occupational Safety and Health Administration has released a new study that analyzes on-the-job fatalities caused by fire and/or explosions in confined spaces.

The OSHA confined space study examines 76 work-related fatalities that occurred between 1974 and 1979. The fatalities are categorized by the factor most likely responsible for causing the incident, like operating procedures, equipment or environmental conditions.

Copies of the OSHA confined space fire and explosion study are available for \$12 each from the National Technical Information Service, 5285 Port Royal Road, Springfield, Va. 22161; 703-487-4650. Specify publication No. PB-82-237314.

Lead exposure

The Occupational Health and Safety Administration says it is amending its lead standard that will assure that respirators are properly fitted to provide workers with protection against lead exposure while saving employers money.

Under the new rule:

- Employers must offer lead workers respirators with at least three sizes of face pieces and models made by at least two manufacturers.

- Employees must wear a respirator at least five minutes before testing. If within two weeks the worker finds the face piece is uncomfortable, he or she must be given a chance to select another model.

- Each test exercise must last for at least one minute.

The new regulations, which also specify the substances that are to be used when testing the respirators, could save employers as much as \$6.3 million per year, says OSHA chief Thorne G. Auchter.



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PULLING IN THE REINS

Employers look for ways to reduce benefit demands

By Karin Allport

FROM THE COST consciousness of the recent economic recession, companies are developing a questioning awareness of the money they spend on employee benefits.

Forty-three percent of the 600 companies responding to the sixth annual Mercer survey, "Employer Attitudes Toward Compensation and Benefits in the 1982 Economic Environment," reported having instituted extraordinary constraints on compensation and benefits in the last 12 months (*BI*, Nov. 22).

The emerging trend appears to run counter to past practices, which have raised worker expectations to a level where they feel entitled to full benefit coverage for a variety of necessities they are likely to encounter in the course of their adult lifetimes. Employers, for the most part, have delivered on those expectations.

This statement applies in particular to major employers whose comprehensive benefit packages are an added attraction for employees and are generally better able to afford comprehensive plans.

Not surprisingly, the cost of employee benefits as a percentage of payroll has been escalating to a point of great discomfort for many employers as a result. Obligations entered into years ago, in a time of lower benefit costs and greater profit margins, have come back to haunt companies.

The days of adding benefits just because there was a new round of bargaining and a new benefit needed to maintain the good will of employees, or because a competitor had come up with another "tidbit" to keep its competitive edge, are fading.

In most cases, it was money unwisely spent since little or no thought was given to the value of those benefits to employees or to the organization. This era of entitlement ended under the corporate cost-cutting knives of 1982.

Although benefits were less severely affected than salaries by 1982 cost-cutting measures, 8% of the companies that have implemented cost-reduction programs reported reducing health benefits. Five percent reported reducing vacation time and approximately the same percentage indicated reducing the number of paid holidays. Another 11% reported negotiating union givebacks, which many times include both salary and benefit reductions.

Projecting into 1983, 13% of the sample said they are contemplating extraordinary constraints on employee benefits in the new year. Of this group, 37% contemplate actually reducing benefits—generally viewed as a very undesirable step by organizations. Another 24% anticipate increased employee contributions, while 18% look for increased deductibles and 8% are contemplating cost-containment measures.

The 13% reflects the general resistance on the part of corporations to trim their "fringes."

There is, at the same time, an interesting conflict of emotions expressed by management on this issue: A deeply felt sense of responsibility to protect employees on one hand and mounting costs on the other, lead to a realization that something has to give somewhere, soon.

This general sense of uneasiness is further heightened when companies find out through surveys that employee perceptions of the value of benefits fall considerably short of actual value, whether that value is expressed in terms of costs, benefit design or competitive position.

Experience with benefit plans shows that they are only as good as what the employee perceives he or she is getting from them. After all, what good is a health plan to an employee who is already covered elsewhere? Or, what is the value of extra vacation time to employees who

already have all they choose to take?

Value as perceived by the employee is the difference between money well-spent by a corporation and money wasted. Plans that are designed for the masses may end up having little real value to individuals.

Such observations may lead some down the path to flexible benefits, but solutions require more than choices. It is a question of rethinking assumptions.

This includes considering whether the employee or the organization is responsible for decisions concerning how to collect and spend employee income, particularly if those decisions look imprudent. It also includes a realistic assessment of the company's ability to pay and the long-term impact of its obligations to employees. They have a great impact on the company's strategy.

Fifty-four percent of the 600 major industrial and service companies surveyed by Mercer indicated that the current economic recession has changed their perspectives on compensation and benefit-plan strategy.

What might this mean? One aspect is that companies have become increasingly—and painfully—conscious of the liabilities incurred as a result of generous approaches to cash compensation and benefits, particularly since those liabilities affect their ability to remain profitable, or even to survive.

Companies expect value for their money. This expectation of getting their money's worth manifests itself, at least philosophically, in a shift away from automatic or cost-of-living increases toward pay for performance.

When given multiple choices for selecting an appropriate criterion on which compensation increases should be based, an overwhelming majority, 77%, chose either productivity or profitability. Thirty-five percent of the corporations chose cost reductions and 26% chose output.

These are all criteria of performance. Some are appropriate for production environments, others for service organizations.

Different criteria may also apply to different levels of employees, a desirable distinction.

What is needed now is a systematic effort to improve performance-measurement systems to truly allow differentiation based on effort or contribution since the value of a reward, such as a salary increase, is only as good as the measurement system on which it is based.

With fewer dollars available, who receives the money is an important decision. The size of the reward increasingly depends on the company's ability to pay, an internal measure, rather than from competitive pressures.

The value of a compensation and benefit plan, as the employee sees it, is contingent on its usefulness. Employees have widely different needs depending on a number of complex factors such as age, sex, marital status and tax position. If employees are to be motivated, their compensation, including benefits, must be meaningful and within their control.

There are many different ways in which an organization can compensate employees. The value of the total package to the employee is a direct result of the degree to which it meets personal needs. Consequently,

Continued on page 19

Salary freeze
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MEMO

To: all employees
From: J.B. Smith, president

Annual health
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increase

The deductible for a
coverage will be raised
January 1, 1983. A
benefit booklet will

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#123

NOTICE OF
NEGOTIATED
CONCESSION

It has been necessary to
certain concessions to
this company. Understa
the financial situation
these changes may sa



Karin Allport is a senior human resource consultant with William M. Mercer Inc. in New York.

PERSPECTIVE



Spending money now
to save employees later

The reasons for rehabilitation

By Grace Gianforte

ITOLD A client once that to be the best, we have to be willing to start at the beginning, progress to being average and persevere in spite of mistakes. It occurred to me recently that I ought to take my own advice.

Rehabilitation of the industrially injured is 15 years old. I suspect it's significant that the industry is in its adolescence, both literally and figuratively.

The insurance industry model of rehabilitation grew around the idea that getting people back to work and off the claims adjuster's desk would save the insurer money. Good medical management through rehabilitation was cheaper than paying for continuing, expensive hospitalization. Economic issues are, after all, the bottom line.

Rehabilitation services are another expenditure, a critical resource in medical management and a pain in the neck for employees who don't want rehabilitation and for adjusters who see no changes except for the additional bill each month from the rehabilitation specialist. Industrial rehabilitation is frequently maligned for promising roses and, in many cases, delivering thorns.

Are states with mandatory rehabilitation saving money? Looking at some cost per rehabilitation case statistics from the California Workers Compensation Institute, it appears that rehabilitation can increase or decrease costs depending on how a case is managed, documented and what goals are pursued.

There are two reasons why someone would want to use rehabilitation services. First, the employee had a traumatic incident and needs restorative services to regain the ability to function optimally. Second, he has been unable by his own efforts to succeed at functioning optimally and intervention services are needed to restore optimum functioning.

What is optimal functioning? Insurers define it differently from federal bureaucrats and consumers of services have their own ideas, as

well. Who's doing it right and acceptably depends on who's receiving the services and who's footing the bill.

The bottom line for the insurance company and policyholder is, "Did the guy go back to work?" Some bureaucrats, like the Rehabilitation Services Assn. in Washington, want to know whether the person is better off after receiving the services. Formerly, job placement was the criterion for the bureaucrats; now they consider independent living in a community facility an acceptable alternative for the severely disabled. The employees being treated are concerned with whether the services they receive are satisfactory.

Another major difference in the federal statutes is the 1973 Rehabilitation Act. It expands the delivery system of vocational rehabilitation services to assist those individuals in regaining their optimal level of vocational functioning. Optimal level is the critical phrase here, because in some cases it means the authorization of long-term, costly training to restore the employee to his or her previous ability.

It gets more complicated with the industrially injured, since few employees refer themselves for rehabilitation. They are referred by their attorneys, who want an evaluation of their client's vocational status. Or the referral is initiated by the insurer who wants to mitigate losses, like lost time, future medical costs or the degree of disability. Many employees want to settle their cases as soon as possible and get on with their lives. Yet, many employees trying to return to work in this depressed economy feel they would have to settle for unemployment compensation; employers simply aren't hiring or are even laying off workers.

Mandatory rehabilitation, by interpretation of states with such a statute, requires the employer and the insurer (or their representatives) to provide rehabilitation services to industrially injured workers. The rehabilitation services are mandatory when they would be helpful in returning an injured party to gainful employment or, at

least, in restoring their job skills.

Are states with mandatory rehabilitation doing a more effective job of returning injured workers to gainful employment than states with voluntary, optional rehabilitation? One way to judge effectiveness is to look at the annual number of state cases referred for rehabilitation and the percentage of those cases where the employee returns to work each year.

One measure for judging effectiveness is the time it takes an individual to return to work from date of injury and the benefits costs to cause that return. There seems to be a consensus that an essential criterion for judging effectiveness is restoration of employability.

Workers have a legal right to rehabilitation in these mandatory-rehabilitation states: California, Georgia, Hawaii, Michigan and Minnesota. In Pennsylvania and New York, statutes provide for voluntary participation on the part of the employer or representative. In Oklahoma and Illinois, the statute can be interpreted as either voluntary or mandatory.

Mandatory means that the employer must legally provide rehabilitation but it is not mandatory for the employee to participate in it.

There are four critical areas that affect the success of any rehabilitation approach, mandatory or voluntary:

- Can rehabilitation services be delivered in a fair, effective and professional manner when the private rehabilitation specialist is viewed as an "agent of the insurer"? Does the role of "agent or representative of the insurer" create a conflict of interest that would disallow an objective, impartial opinion? Or should referrals for rehabilitation be subject to the state agency for vocational rehabilitation supervision?

- What are the criteria for determining an approved and acceptable plan

of rehabilitation?

- When disincentives for rehabilitation occur, how does the employee's disinterest in rehabilitation affect continuation of the service?

- What constitutes employability and what guidelines are used to assess this?

It can be argued that vocational rehabilitation services should be treated as medical services related to the restoration of function. Rehabilitation specialists would fall into the same category as physicians who are providing treatment or consultation.

Determining criteria for when vocational evaluation should be initiated varies from state to state but, apparently, there are some common elements. The responsibility would seem to rest with the insurer, and therefore the claims adjuster, to determine if it is likely or unlikely that the claimant is returning to the same job or the same employer but a different job. If the employee is not returning to the same job and employer, the professional opinion of a certified rehabilitation counselor should be sought to compile the vital statistics, education, work history, physical limitations, functional capabilities, transferrable skills, suitable alternative occupations and their availability in the labor market and potential employers.

Although most people in the field would agree that 90 days after an accident is a suitable time to initiate referral, this is not a widespread practice. Typically, cases are referred after a year or more of lost time.

Criteria for an approved or acceptable plan of rehabilitation are set forth voluntarily by each state. Those states that have established a separate bureau within the workers compensation division delegate those bureaus to determine if a plan meets the criteria.

Continued on facing page



Multiple savings found in rehabilitation

Continued from facing page

There are vocational rehabilitation professionals who believe that rehabilitation does not and cannot occur without the employee's cooperation and motivation. It may be in the employee's best interest physically and psychologically to have the benefit of professional assistance. Financial reasons, however, along with the promise of a large settlement or the continuation of temporary total benefits, Social Security benefits, the disability insurance benefit provision for their mortgage and car payment are substantial disincentives to improve.

This is particularly true for those who had a low opinion of themselves prior to an injury. They do not believe that returning to work, which they may have been doing "only for a paycheck," is going to make their lives better. Many times these same individuals believe that external rather than internal factors create happiness or the lack of it. This

attitude often becomes a roadblock to an employee's recovery.

What determines employability ought not to be the presence or absence of a job in one's life, which is the view taken by some arbitrators at the hearing level. There is no consensus in workers compensation for determining the employability status of an injured worker.

One approach is borrowed from the guidelines set up for certified counselors and experts on contract to the Social Security Administration for hearings on disability claims. The counselor or expert is required to take the facts postulated by the hearing judge on age, education, work history, physical capacity and limitations, impairments and transferable skills. The judge must establish, on the basis of this information, what suitable occupations the individual could perform, in what numbers those jobs exist and whether the numbers represent a reasonable employment opportunity for the disabled

employee. Because the wages earned before injury are an issue in workers compensation cases, it might also be added as a consideration in assessing suitable occupations.

Whether mandatory rehabilitation achieves a reduction in costs to the insurer or returns an individual to work is goal-dependent. What does the insurer want to accomplish, what is the respondent attorney aiming for and, most importantly, what does the employee want to accomplish and what is the basis for that goal?

The role of the certified counselor or other vocational expert requires knowing:

- What model for determining employability will be used? How will facts be gathered?
- If rehabilitation services are required, what is the basis for them, or how has the injury prevented the employee from working?
- What is the employee's goal and level

of motivation for achieving rehabilitation, if it's recommended?

• What costs and length of time are involved?

It can be argued that rehabilitation, mandatory or voluntary, is in the best interest of those who must pay the bill and of no interest to those employees who do not see how it will be of benefit. Ultimately, the challenge rests with the providers of services to demonstrate through skill, integrity and performance that what they do makes a difference in people's lives, and that the quality of that difference is worth the cost and commitment.

Grace Gianforte is a certified rehabilitation counselor in Chicago.



Insurer must pay for gutted building, according to wording of fire coverage

ACTUAL CASH value" is the same as "fair-market value," according to the Supreme Court of Washington in a decision on a fire insurance policy.

Cosmopolitan Enterprises Co. was issued a fire insurance policy by National Fire Insurance Co. of Hartford. A building Cosmopolitan owned was totally destroyed by fire during the policy period. The policy valuation clause provided for full repair or replacement cost, not to exceed the actual cash value if the insured did not replace or repair. It also provided for a non-judicial appraisal if the parties could not agree.

Cosmopolitan claimed National made an appraisal of \$1.5 million along with application for coverage. National brought suit for reformation of the policy. Cosmopolitan countersued for full benefits. The court denied National's request to delay the suit until the appraisal was finished.

The appellate court affirmed. It said the policy was a replacement-cost policy, without depreciation, and did not require rebuilding for the insured to receive benefits. The court said the insured had

legal briefs

the option, which it exercised, of requesting payment in accordance with the valuation clause. *National Fire Insurance Co. of Hartford vs. Solomon*, Supreme Court of Washington, Jan. 14, 1982 (BI/02/S.-\$5).

Dependent parents

Establishment of surviving parents in the workers compensation law as a separate class, apart from that of surviving spouses and children, for purposes of awarding death benefits was not an unconstitutional distinction nor in violation of equal protection under the law, according to the Court of Appeals of New Mexico.

Earl Gallegos was killed in a mine explosion while employed at Homestake Mining Co. His parents sought to recover workers compensation death benefits. Under the New Mexico law, only a dependent widow, widower or children could receive benefits. The Gallegoses were denied benefits and appealed.

On appeal, the parents argued that the provision of the law imposed an arbitrary limitation on the recovery of dependent parents and they were not accorded equal protection under the law allowed other categories of dependents. The court said the Legislature's intent to create separate dependent categories was not arbitrary. "It has a reasonable basis prescribing a maximum recovery in the case of dependent parents different from those allowed a surviving spouse or children. It is a rational distinction and falls within permissible scope of legislative policy," the court said. *Gallegos vs. Homestead Mining Co.*, Court of Appeals of New Mexico, March 16, 1982 (BI/05/O.-\$5).

Physician services

Treatment provided by an unlicensed physician or physiotherapist in the state was not covered by a group health policy, according to a Louisiana appellate court.

Oscar Richard III, a state employee, had

family coverage under a state group health program. Mr. Richard's wife had a cervical laminectomy. Her physician suggested that she receive acupuncture treatment for pain. He referred her to Dr. Li Chang Wang, a physiotherapist not licensed in Louisiana. Insurance coverage provided payment only for services of a licensed physiotherapist. When the insurer discovered the treatments were given by Dr. Li, it denied coverage and sought credit for payments made. Mr. Richard sued the insurer and won in court.

On appeal, the court rejected Mr. Richard's contention that treatments prescribed by a physician were covered by the policy. The court said the treatments were not "services of a physician" as required. *Richard vs. Board of Trustees*, etc. Court of Appeals of Louisiana, March 2, 1982 (BI/01/O.-\$5).

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for \$5.00 to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please list the number for each opinion.

Employers consider slower benefits growth

Continued from page 17

the greater the individualization of compensation, the greater the value to the employee.

How can individualization be achieved? Primarily by directly involving employees in the process of designing plans or programs through attitude surveys, climate reviews or other appropriate diagnostic techniques.

It would be foolish to guess or speculate on the needs of a work force as diverse as the one in today's

organizations. Employee participation is critical.

Involving employees directly in the decision-making process is an essential step in making the workplace a "democratic" environment and improving the quality of working life.

Value to the employee also increases in terms of using pretax, rather than aftertax, dollars to the greatest extent possible. Policymakers should devote more attention to take-home pay. Company-sponsored thrift and savings

plans are examples of utilizing several of the features mentioned: participation, tax effectiveness and long-term value.

Finally, there is a need to integrate compensation and benefits considerably beyond any attempts made so far. If for no other reason, total compensation planning must become a reality to simplify the communication of compensation/benefit values to employees.

The entitlement expectations of the past required employers to focus on

innovation and competition. The challenge of the future in employee compensation and benefits is to attain an effective balance between program costs and the value of these programs to both the employee and the company.

For copy of Mercer's "Employer Attitudes Toward Compensation and Benefits in the 1982 Economic Environment," write William M. Mercer Inc., Box 99, 1211 Ave. of the Americas, New York, N.Y. 10036.

15 years later, kidnapping still haunts executive

Continued from page 3

The boy was taken to a room somewhere in the city. Its location was never determined. His head was shaved and electrodes were placed up and down his spine. Wires from the electrodes were connected to a black box positioned over the door in the room where he was kept.

"They told Tommy if he cried out or made noise and someone came through that door, he would be electrocuted," Mr. Chamberlain said. "Then they left him. Tied up and lying on a bed. Now, this is just a 10-year-old boy."

If the kidnapers made one mistake, it was to keep Mr. Harris waiting for three days before contacting him, he said. It gave him needed time to deal with the crisis.

"I knew that I had to talk to someone who knew about these things," Mr. Harris said. "So I made the decision very quickly to call the police chief, who was also a friend."

The police quickly contacted the FBI and for three days everybody scrambled to get the money together, set up a strategy to monitor all phone calls and figure out the best way to keep track of the car that Mr. Harris would drive to drop off the ransom.

"You have to make it look like there is nothing unusual going on at the house, in case they are watching you. They had said not to contact anyone," Mr. Harris said. "You've got to get the money worked out, but you don't want to leave the house because they might call and you don't want to alarm them with a stranger's voice."

"By this time you're going crazy," he said. "There is this im-

mense shock that stays with you. You are operating under the most unbelievable stress.

"Will my child be returned? Will he be whole if he is returned? Or vindictively destroyed? A lot of things go through your mind."

Finally, Mr. Harris went to his brother-in-law, who was the president of a local bank. They made arrangements with the Federal Reserve to secure the used \$100 bills.

"There are so many little complications you never think of," he said. "It's not that easy getting used \$100 bills. I was just thankful they didn't want \$5s or \$10s."

At 6 p.m. Wednesday, Bob Harris was at a nearby gas station nervously waiting for a call at the phone booth there. His car had been equipped to emit radio transmissions so the FBI could track his location.

"There were no negotiations, they just directed me to another phone booth and hung up," recalls Mr. Harris. "At the second phone booth, I didn't even get a call. I stood there for 40 minutes. Waiting. Finally a car pulled up and someone motioned for me to follow. We got to a flat area next to a freeway, then they motioned for me to pull in front of them."

Someone got out, came up to the car from behind and demanded the money.

"I asked them, 'How do I know my son is alive and well?'"

A hand grabbed the money and a voice told Mr. Harris to go home and wait for a call. He never saw a face.

"I was home by 7:20 p.m. By 10 p.m. there hadn't been a call. At midnight, the phone rang, but it was just a relative calling to see if

'You've got someone who can run a multimillion-dollar operation and all of a sudden he's not in control and he doesn't know what to do,' Mr. Chamberlain says.

we'd gotten Tommy back. Then it was 1 (a.m.), then 1:30. By 2 . . ." Mr. Harris shudders with the memory.

"A 3:15 the phone rang. It was Tommy. He had been drugged and dropped at a subterranean garage. The cold finally roused him," Mr. Harris said. "They had taped his feet and his wrists together, but he broke loose, found the building security guard and told him he'd been kidnapped and he wanted to call his dad."

The money was not recovered, but one of the kidnapers was. He was an investigator for the Internal Revenue Service and had access to much of the Harrises' personal financial information.

"He (the kidnapper) said they had planned to kill Tommy," Mr. Chamberlain said. "He never could tell us why they didn't."

The man served 11 years before being paroled about three years ago.

The kidnapping is still vividly etched in Bob Harris' mind.

Within a few weeks after Tommy's return, the chief financial officer of his company had secured kidnap/ransom/extortion insurance. A former FBI agent now heads up the company's security program and a crisis management plan for virtually any incident of this type is set out in detail.

For the first six months after the kidnapping, Mr. Harris slept with a gun at his pillow.

He filed the \$250,000 ransom as a casualty loss with the Internal Revenue Service that year. It was not the usual sort of casualty loss claim and at first it was denied.

"They said I had an option on whether or not to pay the \$250,000. I said I didn't," Mr. Harris said.

Within a few months after his claim was filed, the IRS changed that policy and set forth guidelines for such claims. In most cases, if a kidnapping is reported to a law-enforcement agency and the agency certifies that a payoff was made, the claim will be accepted.

It's been 15 years now, but the rhythm of the Harris' lives will never be the same.

Registrations of any type no longer lead to Mr. Harris' name or address.

Every day he varies his route to and from work. The rest of the family does the same in their comings and goings.

"It's simple, you just turn left at one corner instead of right—it doesn't take that much time," he said.

Mr. Harris and his wife avoid having their picture printed in the newspaper. He never appears on television unless his corporate responsibilities mandate it, and they

rarely do.

He always walks facing traffic.

"I still check the house and street every day when I leave," he said. "If there is a car I don't recognize or someone that I think looks suspicious, I'll call the police. I can't tell you how many times I've circled the block just to check out a car that didn't look familiar."

In all of the recent kidnapping cases the Chamberlain agency has worked on, the victims, like the Harrises, were picked by the kidnapers.

The agency has established a network of former FBI agents with kidnap experience that blankets the country to enable Mr. Chamberlain to always have someone on the scene who has worked a kidnapping.

"Everybody thinks these things happen to the international corporate guys," Mr. Chamberlain said. "How many kidnappings did you hear about in Italy last year? Maybe one?"

"Well, there were around 225 (in the United States) and another 4,800 extortions, so it's happening to somebody."

Tommy is 25 now, but he still visits Mr. Chamberlain's office almost weekly. Mr. Harris is in touch with Mr. Chamberlain by phone almost as frequently.

"The bonds you build with people in these situations never break," Mr. Chamberlain said, explaining why he opened the agency after leaving the FBI.

"I picked Tommy up out of that garage and carried him back to his folks myself. He was the first we'd gotten back alive in the history of this type of kidnapping. It's something you don't forget."

EEOC health plan rules criticized

Continued from page 1

supplemental health benefits to equal the amount the company spends on health insurance for younger workers.

Even if a company paid the older workers' \$12.20 a month Part B Medicare premium, which covers certain physician services, and also offered them unrelated supplemental benefits like outpatient prescription drugs and vision care, it still probably couldn't bring its older workers' health benefit costs up to those of employees under 65.

"An employer can't comply with the EEOC dictum," said Philip Alden, vp at Towers, Perrin, Forster & Crosby in New York. "How can a choice be provided? It can't be done."

And even if it could be done, it would defeat the goal of reducing the government's Medicare costs by trimming the number of participants.

If employers somehow could add enough health-related benefits for older workers to bring their costs up to younger workers, "every astute employee would opt for Medicare as the primary payer," Mr. Alden points out.

As a result, the federal government would not be able to cut Medicare costs since older workers would continue to select Medicare coverage to take advantage of supplemental benefits offered by their employers.

"The EEOC has created an inducement for the older worker to reject the employer plan and opt for Medicare primary coverage, which is not the intent of Congress," said Mr. Webber.

"None of this was what Congress intended," added Janet Shepherd, a partner at Hewitt Associates, a benefits consulting firm based in Lincolnshire, Ill.

The Senate Finance Committee is worried about just that point. Committee members are lobbying the EEOC to overhaul its regulations to remove any incentive for older workers to opt for primary Medicare coverage rather than their employers' plans, Washington sources said.

Without striking such incentives, the federal government would not save anywhere near the \$350 million it thought it would save when the Reagan administration first proposed requiring companies to offer the same group health insurance benefits to older workers as they provide younger employees.

One possible change would be to simply require an employer to offer older workers a choice of opting for Medicare or the employer's group health insurance plan and not require that companies spend the same amount on older workers as is spent on younger workers.

Since corporate plans tend to be more generous than Medicare—which, for example, requires high coinsurance for extended hospitalization—most older workers would select the employer plan for primary coverage rather than Medicare.

Experts also see other problems with the EEOC regulations. For example, if employers are required to offer their older workers a wide array of supplemental

health-related benefits, like vision care, younger workers could charge that they are being discriminated against since they are not receiving as favorable a benefit package as older employees, said TPF&C's Mr. Alden.

Meanwhile, as reported earlier (BI, Dec. 20), the EEOC regula-

tions bar employers from passing the higher costs of including older workers in their group health insurance plans onto employees.

The "interim regulation does not allow employers to modify existing policies to mitigate the cost of compliance," the EEOC says.

As a result, anytime an employer made a benefit change, like raising a deductible, it would have to justify that the change was made for reasons other than complying with the EEOC's regulations. That would lead to a tremendous paperwork burden for employers, said Mr. Webber, who believes the OMB also will kill that proposal.

The EEOC also said employers will have to offer the spouses of older workers the same health insurance benefits they offer younger workers' spouses in their dependent plans. The cost impact of the spouse provision is expected to be minor because many older workers' spouses already are covered by employers' plans.

The EEOC's pending regulations also bar employers from making older workers pay more than younger workers for their health insurance coverage. For example, a company could not make older workers contribute \$10 a month for health insurance while charging younger workers \$5.

'The EEOC has created an inducement for the older worker to reject the employer plan and opt for Medicare primary coverage, which is not the intent of Congress,' said Mr. Webber.

Illinois firms want court to ban third-party suits

Continued from page 2

In late 1977, the high court ruled in *Skinner vs. Reed Prentice Division* that employers may be liable for contributing to a worker's injury—despite the exclusivity of the workers compensation act.

In the *Skinner* case, a worker was injured and collected workers compensation benefits before filing a product liability lawsuit against the manufacturer of the punch press he was using.

The punch press manufacturer then sued the worker's employer, alleging the company did not properly train the worker to use the press and, thus, contributed to the injury. The high court agreed.

Despite that decision, Rein, Schultz & Dahl has asked the state Supreme Court to hear its case. However, it is expected to be at least a year before the court even decides if it will review the case.

Employers fear the high court will refuse to hear the appeal, pointing to the 1977 *Skinner* decision.

"The effect of the Doyle case in Illinois case law is that employers may be held for unlimited liability for common law damages," says Tom Nyhan, executive secretary of the Illinois Self-Insurers Assn.

In any suit charging an employer didn't properly train a worker or used faulty equipment or improper safety techniques, the plaintiff could use this decision to hold the employer liable, he added.

Illinois is one of four states, along with North Carolina, Minnesota, and New York, that allow such suits.

While most insured employers are covered under the employers liability section of the workers compensation policy for these types of damages, self-insured employers may be caught unprotected. They may decide they need to buy extra insurance to protect themselves from third-party suits, added Mr. Nyhan.

Ekco Products Inc. of Wheeling, Ill., another employer named in a similar third-party suit, contends the appellate court has never answered the issue of whether the workers compensation statute bars a third-party lawsuit against the employer, said John J. Foley, a Chicago attorney for the company.

"The *Skinner* case establishes a new cause of action for contribution available to manufacturers on a theory of comparative liability where it is alleged that the employer's misuse of the product and/or assumption of risk contributed to the employee's injury," he said.

"If the *Skinner* court had intended that any negligence or wrongful conduct on the part of the employer will permit an action for contribution, it would have so indicated," he states in a brief asking the court to dismiss the action against Ekco Products.

"But nowhere in the *Skinner* decision does the court indicate an intention to render employers strictly liable for the unsafe condition of tools and machines used in the workplace."

As a result of workers compensation's exclusive remedy provision, the employer is not "subject to liability in tort," and, therefore, cannot be liable for contribution, Mr. Foley contends.

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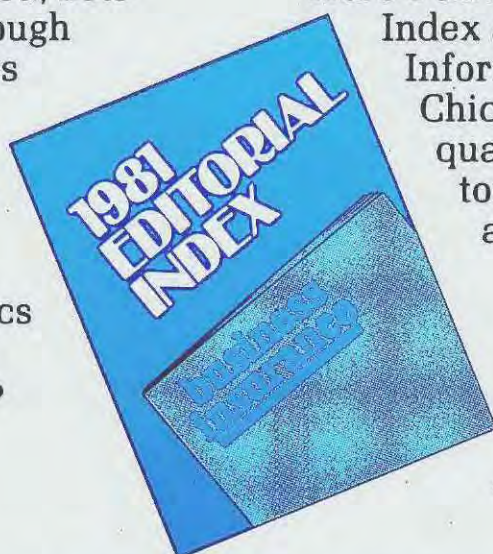
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Should insurers be liable for loss-control advice?

Continued from page 2

tion services," says Joseph G. Manta of the Philadelphia law firm of Frumkin & Manta, which represents Dow Chemical. "It's not just a sales gimmick." It would have given the insurer greater motivation to exercise due care, he added.

The case involves a June 16, 1977, fire at the Mountain Pride Farms Inc. egg farm in Woodbourne, N.Y., in which several buildings and many chickens were destroyed.

Millers Mutual paid a \$538,000 claim to Mountain Pride for the fire loss.

Then Millers Mutual, in Mountain Pride's name, sued Dow Chemical in U.S. District Court in New York, alleging that Styrofoam insulation manufactured by Dow and used in the ceilings of the gutted chicken coops contributed to the spread of the fire.

Under the subrogation agreement between Mountain Pride and Millers Mutual, the insurer would have received the first \$538,000 of any award.

But before the case reached trial, Dow Chemical requested to add Millers Mutual to the suit as a named defendant.

Dow alleged that Millers Mutual had a duty to warn Mountain Pride about the dangers of the Styrofoam insulation that Millers Mutual allegedly inspected.

Mountain Pride's insurer-hired attorneys say Millers Mutual had no fire-protection services agreement with Mountain Pride and was thus blameless.

However, Judge Morris E. Lasker on Sept. 16 granted Dow's request to file its claim against Millers Mutual and attempt to prove that Millers "undertook" the loss-control and fire-prevention engineering task.

"One who undertakes action, as it is alleged that Millers did, may be held liable in certain circumstances if he fails to act with due care," said Judge Lasker. Millers Mutual, through Mountain Pride, chal-

lenged Judge Lasker's ruling.

Dow Chemical has now agreed to pay Mountain Pride a "six-figure" settlement, says Patrick J. O'Connor, a lawyer with the firm of Cozen, Begier & O'Connor in Philadelphia, who was hired by Millers Mutual to represent Mountain Pride. Under the agreement, each side will pay its own legal costs.

But while the case was pending, camps were building on both sides of the controversy.

Insurance lawyers argue it is poor public policy for the maker of an allegedly dangerous product to be able to transfer the cost of that liability to someone else for allegedly failing to warn a third party that the product was dangerous.

Dow's attorneys, on the other hand, say it is poor public policy for an insurer to be able to avoid responsibility for verifying the safety of property it insures, regardless of whether the cause of the alleged problem is a defective product.

A similar issue arose in the litigation following the 1977 Beverly Hills Supper Club fire in Southgate, Ky., in which 165 people died.

In that case, says plaintiffs' attorney Fay E. Stiltz of Cincinnati, insurers had hired an inspection company to check the safety of the club prior to the fire, which plaintiffs have blamed on an electrical short in aluminum wire near a closet wall plug. The inspection company and the insurers were among named defendants in the case.

"But the issue was never decided by the court because the insurers settled for in excess of \$4 million," says Ms. Stiltz, an associate at Waite Schneider Bayless & Chesley.

Although most states bar such actions against insurers on public policy grounds, such suits have been allowed in Alabama and Michigan, insurance lawyers say. However, having the defendant in a subrogation suit rather than an injured party turn around and sue the insurer made the Dow-Millers Mutual case unusual.

"There are a lot of cases in which

insurance companies have been brought in as third-party defendants because they negligently performed services," says Joel Schneider, a partner in the firm representing Dow. But, that's not what made this case different, he added. "In this case, the insurance company which was joined is the plaintiffs' subrogating insurer."

Suits alleging an insurer duty to the policyholder to perform adequate inspection and loss-prevention services have generally been unsuccessful, says George H. Tinker, general counsel of Kemper Group.

Insurers that provide unbundled services, however, should expect to be treated like any other independent contractor, he adds.

"But, when the services are part of the underwriting function, that, at least by design, is for the benefit of the insurer," he adds. "There is no expectation of assuming any responsibility for the insured."

The Factory Mutual Engineering Assn. also does not view loss-control as an "undertaking" for the insured when offered as part of the insurance agreement, says Joseph R. Olshan, vp, general counsel and secretary.

In fact, Allendale Insurance Co., one of the FM companies, last year won a case before the Michigan Supreme Court to prove the point. The case involved six plaintiffs injured in a Zilwaukee, Mich., flour mill explosion.

"An insurer's inspection of an insured's premises for fire hazards does not in itself demonstrate an undertaking to render fire inspection and prevention services to the insured," Justice Charles L. Levin, writing for the majority, said in a March 30, 1981, opinion. The case was decided 5-2.

However, Fireman's Fund's American Insurance Co. lost a similar 1980 Alabama case. In Fireman's Fund vs. Coleman, the Alabama Supreme Court declared unconstitutional a provision of state law that offered work comp insur-

ers immunity from lawsuits.

In that case, the court rejected arguments by Fireman's Fund that the immunity was designed to eradicate unsafe working conditions by allowing insurers to inspect premises free of any fear they could be held liable for safety hazards.

The court ruled, instead, "that to hold a person liable for his carelessness is to make him more careful."

"It's a very sensitive area for Fireman's Fund," says Karl A. Maser, a Fireman's Fund claims vp.

Industrial Risk Insurers, the Hartford, Conn.-based pool of 45 insurers that writes highly protected property risks, protects itself with policy language that prevents the policyholder from arguing that an IRI inspection of premises estab-

lishes any legal "undertaking" by the insurer to point out safety problems, says Steve Rogers, IRI's general counsel.

The endorsement reads:

"The companies shall be permitted but not obligated to inspect the insured's property and operations at any reasonable time. Neither the right to make inspections nor the making thereof, nor any advice or report resulting therefrom, shall constitute an undertaking on behalf of or for the benefit of the insured or others, to determine or warrant that such property or operations are safe or healthful, or are in compliance with any law, rule or regulation."

The endorsement says nothing about IRI's responsibilities to third parties, however, such as an equipment or material supplier like Dow.

British investigating collision of two ships

Continued from page 2

lion pounds (\$7.4 million) under a package insurance policy for British Rail, its owner. Since only the ship's bow is damaged, Mr. Rumsey said he doubted if the full limit of the policy would be spent.

Liability insurance for both vessels is written by protection and indemnity clubs, which pay unlimited liability costs for their members and would probably pay any claims for loss of life, cargo and other liability losses.

The owner of the European Gateway belongs to the West of England P&I Club, which is taking active part in investigating the accident, a spokesman for the club said.

The amount of cargo lost in the collision is not yet known.

Besides wondering why the ships collided, officials also are investigating claims made by the survivors of the accident that lifejackets and lifeboats aboard the passenger ferry were unusable.

Underwriters, too, are wondering why "roll-on, roll-off" vessels, like the European Gateway, tip over so easily after they have been damaged. Underwriters have been insuring "ro-ros" at higher rates than other types of vessels for some time because of their high loss experience.

"Shipowners will probably spend years trying to settle on who is to blame," he said. "It is like two motorcars colliding and the owners just keep on arguing. This will take some years and may involve going to court."

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TOTAL 41,232

*Source: Business/Occupational
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Japanese traditions stymie risk management

Continued from page 3

Another 21% of the companies bought insurance from companies that belong to their group of companies. These groups of companies, historically referred to as Zaibatsu groups, are bound together by stronger ties than just stock investment.

Companies in these groups do not have common management such as in a U.S. conglomerate, but each company in the group has a common history, as part of large companies that were broken up after World War II. They often use the same name and the same bank.

There are few insurance brokers in Japan. American brokers operating in Japan, such as A&A and Johnson & Higgins, mainly serve multinationals with operations in Japan.

There is some disagreement over whether the strict rates and insurance-buying patterns produce good insurance programs for Japanese businesses.

"I hear there is something like an excess profit margin of 5% allowed," says William Krall, resident vp of AFIA in Japan, "but I haven't ever seen it really enforced. Insurers, though, are not robbing anybody. Generally, rates are neither too high nor too low, though there are some exceptions."

The rating association instituted a 10% across-the-board rate cut last year because, as one insurer put it, "very good results had been enjoyed." This year, however, rates are back up due to Japan's sagging economy and a general increase in loss experience.

Besides the cost, there is concern

about the amount of insurance Japanese businesses buy. Mr. Ushiba of Mitsubishi believes that many Japanese businesses, perhaps as many as 50%, are drastically underinsured.

"Of the 1,500 major companies in Japan, I think at least half of them have not even begun to insure their real exposures," Mr. Ushiba said. "Many companies in Japan are either terribly overinsured or terribly underinsured. The society's greatest task now is to get through that ignorance."

Others say privately that Japanese companies pay too much for insurance, but they also don't foresee any sudden changes, since Japanese insurers are not prepared to throw themselves into cash-flow underwriting.

There are some signs of attention

to the risk identification, analysis and control functions of risk management. Asahi Glass, for example, has established a safety control committee, in which top management from all the areas of the company meet to assess safety hazards and attempt to eradicate them. The company also has small safety groups in its factories and offices.

While the lack of risk management does create some problems for Japanese businesses, so far the system works for two reasons:

The Japanese are not litigious. Product liability cases and workers compensation claims are almost always settled by compromise, says Mr. Ushiba.

In addition, the close relationship between the insurer and the insured serves as a kind of "shock ab-

sorber," according to Professor Morimiya.

Since the insurer and insured are related both financially and historically to the same company, there are more efforts to compromise on higher premiums in one instance and to pay losses in the other.

Professor Morimiya believes that many Japanese firms understand in theory the importance of risk management techniques, but find them difficult to practice in the present insurance market.

"The concept of risk management should exist in Japan," he says, "even though price competition among insurers does not. The areas of risk management, such as the control, assessment and identification of risks, should be integrated."

Newspaper found liable for libeling ex-hostage

LOS ANGELES—A recent Los Angeles Superior Court ruling has pushed the \$60 million libel suit filed by former Iranian hostage Jerry Plotkin one step closer to a resolution.

The decision handed down by Superior Court Judge Sara K. Radin Dec. 17 established that civil liability does indeed rest with the defendants in this case, allowing the damage phase of the trial to proceed.

However, defense attorney Anthony Liebig is expected to appeal the ruling.

The defendants included in the default ruling were Van Nuys Publishing Co., which publishes the Los Angeles Daily News, and reporters Arnie Friedman and Adam Dawson. The suit also names the Chicago-based Tribune Co., the newspaper's parent company, as a defendant, but the judge's ruling did not include the Tribune Co.

The company would not discuss its libel insurance.

The suit resulted from an article that ran in the Daily News on Jan. 21, 1981, the day after the U.S. hostages were released by the Iranian government. The article implied that Mr. Plotkin was involved in drug trafficking in Iran.

Mr. Plotkin's attorney, Steven A. Nissen, sought the court ruling after the reporters ignored an Oct. 7 order by Judge Radin that they answer questions under oath identifying the sources of statements

linking Mr. Plotkin to drug contacts in Iran.

The article contended that 48-year-old Mr. Plotkin was under investigation by the Los Angeles Police Department before he went to Iran. It further suggested that a federal agency might be looking at Mr. Plotkin's activities while he was at the U.S. Embassy in Tehran.

Both the federal Drug Enforcement Agency and the police department later denied there had been any investigation of Mr. Plotkin.

"When you go to trial you have to prove two things as the plaintiff," said Mr. Nissen. "You have to prove that the other side libeled and you have to prove how much it's worth to you in damages. We've accomplished the first phase as a result of the judge's ruling. Our next step is to go into court and prove the amount of damage done to Mr. Plotkin."

Citing the California Evidence Code and First Amendment rights, Mr. Liebig argued unsuccessfully that the request to identify sources had been too general and that Mr. Plotkin had failed to specify which sources should be identified and to establish why he needed the information.

"They (the reporters) turned over the bulk of their notes and sources," Mr. Liebig said. "They refused, however, to divulge their confidential sources."

Malpractice suit settled

IRVINE, Calif.—An 11th-hour settlement averted a trial in a medical malpractice suit that alleged a hospital staff and three doctors failed to diagnose a vitamin deficiency that left a 35-year-old woman partially paralyzed.

The \$1 million settlement, approved by Orange County Superior Court Judge Robert Banyard Nov. 22 for general and special damages, will be proportionally assessed among the four defendants and will be paid in a lump sum to plaintiff Mary Truett, 35.

The University of California at Irvine Medical Center's portion of the claim is \$500,000. UCI's primary insurer is Truck Insurance Exchange, a subsidiary of Farmers Insurance Group, which wrote a \$125,000 policy. UCI Medical Center's excess insurance, which will cover the next \$375,000, is provided by the California Hospital Assn. excess insurance program underwritten by Lloyd's of London.

The other four hospitals in the University of California system

also participate in the CHA excess insurance program.

Dr. Duane Peterson and Dr. Robert Simon, neurologists who treated Ms. Truett, will pay \$200,000 each. Coverage for both doctors was underwritten by Southern California Physicians Exchange.

Ms. Truett's surgeon, Dr. William Hardy, whose coverage is provided by The Doctors' Co., a reciprocal insurance company in Santa Monica, Calif., is responsible for the final \$100,000.

The original suit, filed in April 1980, requested \$1.3 million to cover all medical expenses, out-of-pocket expenses, wage loss, other expenses and pain and suffering incurred by the plaintiff.

In a series of incidents between April and August 1979, a vitamin B-12 deficiency went undetected, resulting in temporary paralysis throughout most of Ms. Truett's body. After corrective action, her condition improved somewhat, but she still has limited movement and control in her lower extremities.

States to get authority to close METs

Continued from page 2

plans protected from state regulation by the Employee Retirement Income Security Act of 1974.

When state regulators have gone to court seeking permission to examine a MET's books or force a trust out of business, the METs have said the states have no authority to do so because ERISA pre-empts state laws.

While these legal battles were being waged, the METs continued to operate. By the time the U.S. Labor Department or a court ruled whether a MET really was an ERISA benefit plan, the MET, in many cases, had gone bankrupt.

Under the Erlenborn-Burton bill, which the president is expected to sign, a MET still could apply to the Labor Department for ERISA certification, but even if it were granted, the trust still would be subject to state rules governing reserves and contributions.

And while Labor Department approval is pending, the MET still would have to meet all state insurance regulations or the state could force it out of business. Under the bill, a self-funded MET is presumed not to be an ERISA plan until it is certified as such.

For the Labor Department to recognize a self-funded MET as a bona fide employee benefit plan, the MET must prove, among other things, that it is controlled by participating employers, not a third-party administrator. Few self-funded METs can meet this test.

Those that are not approved by the Labor Department would be subject to all state rules governing insurance operations. Few self-funded METs can currently meet those rules.

The provision in the bill that would allow a state to close down a MET even while it is awaiting certification as an ERISA plan will greatly reduce the number of people stuck with unpaid medical bills when METs collapse, supporters of the measure say.

In addition, allowing states to quickly step in will eliminate the problem of poorly managed self-funded METs continuing to operate by taking their cases to court and then using delaying tactics to prolong a decision.

For example, the Idaho Insurance Department in

1977 tried to gain jurisdiction over the Boise-based National Assn. of Independent Businesses, a self-funded MET with 6,100 participants.

That legal battle was still going on three years later when the MET filed a petition for bankruptcy, leaving behind possibly hundreds of thousands of dollars in unpaid medical bills (BI, Sept. 7, 1981).

Under the Erlenborn-Burton bill, fully insured METs, like those marketed by licensed insurers, would continue to be regulated by the states.

In addition, employee benefit plans offered by employers, rural electric cooperatives or plans provided through collective bargaining agreements still would be covered under federal law.

"Passage of the legislation is an important first step in closing the regulatory loophole that has allowed unscrupulous METs to operate," said Beth Kravetz, the NAIC's Washington counsel.

The legislation strengthens the "working partnership" of the states and the federal government to protect consumers, Rep. Erlenborn said.

Self-funded MET problems emerged in 1977 with the collapse of several trusts. But by 1979, the problem abated as some states began to battle the METs while insurers started to aggressively court smaller firms with new health insurance plans.

But as health insurance costs began to soar, small employers last year were again lured by self-funded METs that charge lower premiums than commercial insurers.

Many small businesses lack the insurance sophistication to know if a self-funded MET is properly managed or if premiums paid to the trust are used to pay for high administrative fees and commissions instead of claims.

As a result, small employers and the self-employed were the biggest victims of the MET failures reported in Illinois, California and Texas during the past year.

MET failures in Illinois alone may have cost state residents \$1.2 million, Rep. Erlenborn said.

The bill passed by Congress last week also contains a provision that a 1974 Hawaii law imposing certain benefit requirements on employers is not pre-empted by the Employee Retirement Income Security Act.

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Quake capacity for bridges falls short

Continued from page 1

value of about \$1.36 billion. Although the property insurance policies are issued for three-year periods, the values are revised every 18 months.

Most of the eight bridges are named after the cities they link. They are: the Benicia-Martinez, Carquinez Strait, New Dumbarton, Richmond-San Rafael, San Diego-Coronado, San Francisco-Oakland Bay, San Mateo-Hayward and the San. John A. Nejedly (Antioch) bridges. All of the bridges are administered by the California Transportation Commission, a state agency.

The Golden Gate bridge is separately owned and operated by a special district made up of Northern California counties.

A ninth bridge, the Vincent Thomas near the Los Angeles harbor, is also operated by the commission. But, the bonds issued to fund the bridge were recently retired and insurance was dropped.

"We just insure them to meet the requirements of the bond resolution," stressed Mr. Marquart.

Although some of the other bridges have been fully paid off, their revenues have been pledged to build or improve other structures. Revenues from the San Francisco-Oakland Bay bridge, for example, were pledged to collateralize bonds to construct the underwater Bay Area Rapid Transit tunnel.

California carries about \$633 million in physical damage insurance for the bridges, which includes earthquake coverage. Another \$338 million in physical damage protection excludes earthquake coverage.

Deductibles for earthquake damage range from \$1.3 million to \$7.6 million. For perils other than earthquake damages, deductibles range from about \$500,000 to \$1.6 million.

The 8.3-mile-long cantilevered San Francisco-Oakland Bay Bridge is the biggest risk, valued at more than \$482 million. But it has no earthquake coverage because it was not available.

It is insured to \$300 million in six layers for physical damage, excluding earthquakes, above a \$2 million self-insured retention.

Three of the other bridges also are short of earthquake coverage to bring them up to the stipulated 80% level. More coverage might be available at a premium, but terms of the bridge bond resolutions do not require insurance to be purchased at unreasonable cost.

The Golden State has opted to apply \$50 million in earthquake capacity to insuring use and occupancy of the Bay bridge. If a tremor knocked out the bridge, the toll revenues would be replaced by the business interruption insurance, although physical damage to the bridge would have to be repaired at state expense.

Both the physical damage and business interruption coverages would respond in the face of such calamities as an airplane or ship crash into the bridge, bomb threats or explosions or a chemical spill that weakened the structure.

The other bridges also carry business interruption coverage in amounts up to 80% of the toll revenues paid by vehicles and other users. That adds up to a total of \$76.2 million in use and occupancy insurance for all the bridges.

"Fifty to 80 insurers are involved in each of the bridges—depending on which one," estimates Mr. Jensen. Approximately two-thirds of the risk is placed in U.S. insurance markets, the remainder is spread throughout foreign markets, including Lloyd's.

"A couple of times major U.S. participants have said they'd like to take more of the risk, but we've resisted that," says Mr. Marquart. "We've wanted to preserve the world market for the time when the domestic markets start pulling in their underwriting."

Insurance Co. of North America, now a unit of CIGNA Corp., is probably the largest U.S. underwriter on the bridges, notes Larry Lawrence, president of broker Emmett & Chandler in Los Angeles.

Other major participants include Mission Insurance Co., American Insurance Group, CNA Financial Corp., Aetna Casualty & Surety Co., Fireman's Fund Insurance Cos., Hartford Insurance Group and St. Paul Fire & Marine Insurance Co.

"We have a capacity problem here, so we expect our London brokers to be tapping every single syndicate at Lloyd's," declared Mr. Jensen.

Marsh & McLennan turns to its British subsidiary, C.T. Bowring, Johnson & Higgins uses Willis Faber and Emmett & Chandler uses Hogg Robinson to shop the London and international markets for California bridge coverage.

About two-thirds of the foreign participation is through Lloyd's, and the rest is placed through diverse world markets, including European, Japanese, Romanian, Soviet and other insurers.

Some markets are reluctant to participate because their reinsurance treaties specifically exclude risks whose total insured value exceeds a certain amount. That means the insurer must retain all or most of the risk if it underwrites a bridge.

Mission has probably done a more aggressive job than the others in arranging specific (facultative) reinsurance on these bridges, noted Mr. Lawrence.

"Everybody underwrites the bridges on the basis of earthquake exposure, but that's not been the cause of our losses," observes Mr. Lawrence.

Indeed, the bridges are built tough.

"According to the engineering reports, to really knock one down would take a quake up in the eight category," Mr. Marquart says. That's about the magnitude of the 1906 San Francisco quake, which would have registered about 8.3 on the Richter scale, seismologists estimate.

Severity dissipates geometrically, adds Mr. Marquart. "The bridges are not all going to fall into the Pacific at once." A quake measuring 8 on the Richter scale might knock down one bridge, but damage to nearby bridges in the Bay would probably be less severe.

The highway approaches, which guide vehicle traffic onto the bridges, are more vulnerable. They are constructed of reinforced concrete and are not part of the bridge engineering. Physical damage insurance for the bridges includes the approaches, however.

Over the years, the most common damage to the bridges has been caused by ships colliding with the fender systems that protect the piers. The fenders act like a fence. They are designed to absorb the impact of a large ship and collapse to the channel bottom.

"Last year, we had two collisions in the month of November—one with the Benicia-Martinez and the other with the Richmond-San Raphael Bridge," recalls Mr. Marquart. Both were about \$1 million losses.

The state's subrogation unit expects to be reimbursed for the losses by the owners of the ships



Photo: San Francisco Visitors Bureau

California does not buy physical damage quake coverage for the San Francisco-Oakland Bay Bridge.

that caused the damage.

Catching the culprit gets interesting when the ship is outbound, notes Mr. Marquart. The damage can be detected by another vessel pilot, the U.S. Coast Guard or an electronic sensor on the pier that sends a signal to a control station.

The Coast Guard will stop a ship that collided with a bridge before it gets to the territorial limits, said Mr. Marquart.

The largest loss he can recall since 1968 when he assumed his current duties was a ship collision that caused about \$2.25 million in damage to a fender of one of the bridges.

"As far as I know, there's never been a sinking or major damage to a ship as a result of a collision," adds Mr. Marquart.

"There have been revenue losses when caustic substances have been dropped on the bridges and they have had to be closed to clean up," said Mr. Marquart. These use and occupancy losses typically are not large enough to pierce policy deductibles, however.

It is not too uncommon for the state to be sued by injured motorists who claim that a design defect in a bridge caused an accident. California has been very successful in defending these, but Mr. Marquart believes the state has paid out substantial sums on two such claims in recent years.

"We've had some claims on the old Dumbarton Bridge, which had some rather narrow lanes and sharp turns that created problems," said Mr. Marquart. The Richmond-San Raphael Bridge also has been a target for negligence lawsuits.

The Dumbarton Bridge, privately constructed in the 1920s, was recently taken out of use and will be torn down. It has been replaced by a new bridge, which parallels the old one within a few hundred yards in some places. Insurance on the old bridge was canceled in February.

California is self-insured for workers compensation and most liability losses. Losses are paid out of current tax revenues.

"Bridge maintenance is a very dangerous occupation—and terribly cold," points out Mr. Marquart. "We just lost a worker on the Carquinez Bridge six months ago."

But the state does buy a \$300,000 all-risk fidelity bond to protect its toll revenues against the three Ds—dishonesty, disappearance and

destruction. California uses armored cars to transport the coins from Bay-area bridges to a collection counting room at the San Francisco-Oakland Bay Bridge.

As the state's risk manager, administering the bridge insurance program is just one of Mr. Marquart's myriad duties. He also is responsible for California's self-insurance programs and insurance planning for the state college system and the California veteran loan program.

Through the Cal Vet loan program, the state makes low-interest

home loans to its veterans. But California retains ownership of the residences until the loans are paid off. Mr. Marquart administers a blanket insurance program that protects about 115,000 such homes while they are still state-owned.

Like other state administrators, Mr. Marquart is feeling the effects of a severe budget squeeze in California. His staff of 20 is short-handed by two positions.

"We've been slower to fill some positions, but I don't think my unit has been affected more than other state operations," he says.

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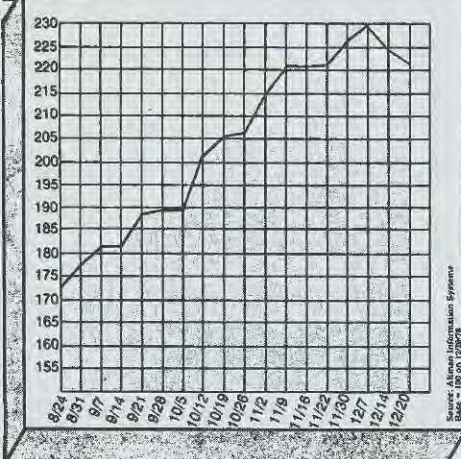
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BI Insurance Index



Insurance industry stocks slid again during the week ending Dec. 21, with the *Business Insurance* stock index dropping 2.2 points from 224.9 to 222.7. Eight stocks gained, 36 closed down and 23 were unchanged. The largest gains were reported by Equifax Inc., 8.0%; American Indemnity Financial Corp., 3.7%; Optimum Holding Corp., 3.1%; Zenith National Insurance Corp., 2.7%; and American International Group Inc., 2.6%. The largest losses were reported by Crawford & Co., 8.3%; Hanover Insurance Co., 8.0%; Mission Insurance Group Inc., 6.9%; Combined International Corp., 6.1%; and Old Republic International Corp., 5.8%. The 1.0% drop in the BI index was greater than the drop in the NYSE composite index.

British Issues

20 Dec Companies	Price	P/E	Div.	Yield	High—Low
Comml Union	125	20.8	16.86	13.5	128—125
Eagle Star	338	13.5	21.43	6.3	338—325
Genl Accident	354	11.8	23.21	6.5	354—350
Gdn Royal Exch	362	10.3	25.00	6.9	364—360
Phoenix	284	14.9	24.00	8.5	284—278
Royal	435	10.6	36.07	8.3	440—430
Sun Alliance	860	14.3	61.43	7.1	860—855

Brokers	Price	P/E	Div.	Yield	High—Low
CE Heath	280	8.0	18.71	6.7	280—265
Hogg Robinson	95	7.3	8.57	9.0	95—91
JH Minet	110	10.0	5.43	4.9	110—100
Sedg Grp	177	10.1	8.57	4.8	178—173
Stenhouse Hldg	99	9.2	7.86	7.9	99—96
Stew Wrightson	230	8.2	18.57	8.1	230—217
Willis Faber	490	12.2	21.43	4.4	490—475

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitecat & Aitken Stockbrokers, London

Underwriting deterioration worries Tokio Fire & Marine

By WILLIAM BOOTH

FOR THE FIRST time since 1977, underwriting income at Tokio Marine & Fire Insurance Co. is declining.

The world's largest marine insurance underwriter and Japan's oldest and largest property/casualty insurer is suffering the effects of a sluggish economy at home and a competitive insurance market overseas.

Although net written premiums increased 5.7% in fiscal 1982 to \$1.97 billion from \$1.87 billion a year earlier, underwriting income dropped 28% in 1982 to \$58.8 million from \$81 million the previous year. The pure loss ratio climbed to 64.8% from 60.9% and the expense ratio crept up to 31.4% from 30.8%, yielding a combined ratio of 96.2% from last year's ratio of 91.7%.

Tokio Marine made modest gains in net investment income, up 5% to \$253 million from \$238 million last year. Investment income after expenses was \$177 million.

In the U.S. market, where Tokio Marine shares are traded over the counter, the company's stock has rebounded from a record low of \$74.50 posted in early October, but the \$98.25 bid last week is still far below the record high of \$117 the stock commanded at the beginning of the year. In comparison, the *Business Insurance* stock index closed at 224.9 last week, compared with 183.1 at the beginning of 1982.

Tokio Marine attributes its present lower underwriting income to an international combination of economic woes, including such factors as the severe devaluation of the yen. But perhaps most serious for Tokio Marine are the economic conditions at home.

Both the Japanese shipbuilding industry and the export business had a tough year as worldwide demand for ships decreased and exports of Japanese goods dropped suddenly. Premiums for hull and cargo insurance, which combined make up about 18% of Tokio Marine's net written premiums, grew only slightly on domestic risks.

Tokio Marine's real gains in both hull and cargo premium are attributed to increases in overseas underwriting. Total net premiums underwritten, both overseas and domestically, increased 7.8% for hull risks to \$127

BI ticker

million, while cargo premium jumped 9.4% to \$241 million.

Company spokesmen attributed these increases in premium mainly to more vigorous marketing efforts abroad. Overseas underwriting comprises roughly 16% to 17% of total premiums written, with about half of that business being written in the United States, both through direct underwriting and reinsurance. The \$316 million in net premiums derived from overseas accounts was an increase of 13.9%, compared with fiscal 1981. However, loss ratios also increased, reflecting deteriorating direct underwriting results in the United States.

Tokio Marine did not suffer any catastrophic losses in fiscal 1982, but it did take something of a beating from claims caused by the war between Iran and Iraq, when six Japanese ships were damaged. The total amount lost by several Japanese insurers is estimated at \$48 million. Tokio Marine would not release its share of the total loss, but insurance observers in Tokyo believe it held a majority of the risk.

Large insurance limits are not layered in Japan as they are in the United States. Instead, Japanese insurance companies offer subscription policies in which several different insurers assume vertical percentages of the risk.

Tokio Marine also may see some claims from the recent hurricane in Hawaii, although the amount and extent of coverage under the policies aren't clear yet.

A combined ratio that is still less than 100% won't solicit any sympathy from a U.S. insurer for Tokio Marine's so-called rough year, but within the context of the strictly regulated Japanese insurance market, a decrease in underwriting income is not to be ignored.

Competition in the Japanese insurance is markedly different from in the United States. Rates and policy forms are set and standardized by the Ministry of Finance in collaboration with the Insurance Rating Assn. of Japan. Japanese insurers expect to

make their money in underwriting and not just investments.

"Cash-flow underwriting is not a factor in Japan. Forget it," says Bill Smith, managing vp of Alexander & Alexander in Tokyo.

In addition, Japanese companies consider factors different from U.S. companies when purchasing their insurance. A Japanese insurance buyer is more concerned about buying insurance from a company with which it has some financial ties, either through equity ownership or as part of a conglomerate. Cost is a far less important consideration.

Japanese conglomerates, immense business groups called Zaibatsu, are not monopolistic, but the ties binding the member companies are very strong.

Tokio Marine is a member of the Mitsubishi group. Although only 10% of its total premiums comes from the group, about 80% of the companies within the Mitsubishi group purchase their insurance from Tokio Marine.

In its U.S. operations, Tokio Marine plans to continue to concentrate on workers compensation and liability insurance. Until the market begins to harden, Tokio Marine is not aggressively pursuing personal lines in the United States, although in Japan personal lines generate approximately 60% of all business written.

Tokio Marine describes its underwriting policy in the United States as prudent. "We are reasonably competitive but, admittedly, our rates are substantially higher," says a spokesman.

Its wholly owned subsidiaries in the United States are Houston General Insurance Co. in Dallas, Tokio Re Corp., Tokio Marine Management, The Tokio Corp. and Trans Pacific Insurance Co., all based in New York.

Of the overseas accounts that Tokio maintains, more than 70% are Japanese-oriented businesses, either projects directly owned by Japanese companies, joint ventures involving Japanese companies or businesses owned by Japanese-Americans, largely along the West Coast.

"Our fundamental overseas underwriting policy is to take care of Japanese companies doing business in foreign countries," the Tokio Marine spokesman commented.

The reason is twofold. First, Tokio Marine says it feels a responsibility to Japanese accounts overseas because they often handle much of the same companies' insurance needs domestically. And second, Tokio Marine says it believes Japanese businesses are better risks.

"Japanese are just more sensitive to risk," the spokesman says. "We even used to build all our houses of paper and wood so they could easily be rebuilt. In Japan, safety is very much an idea of great importance."

BI Industry Stock Report

DEC. 20, 1982 12/15/82 THRU 12/20/82

Insurance Cos.		Price	% Chg	P/E	S Div	% Yld	High	Low	Vol (000)
Aetna Life & Cas Co	NYSE	36.13	-2.7	5.9	2.52	7.0	37.38	36.13	800.4
American Bankers Ins Group	OTC	10.75	0.0	8.4	0.50	4.7	10.88	10.50	109.6
American Gen Ins Co	NYSE	53.13	-3.0	7.3	2.20	4.1	54.38	53.00	160.1
American Indty Finl Corp	OTC	21.00	3.7	16.0	1.12	5.3	21.00*	20.25	13.1
American Intl Group Inc	OTC	78.00	2.6	11.5	0.24	0.3	78.00	72.50	600.3
American Natl Ins Co	OTC	14.50	-0.9	6.4	0.84	5.8	14.50	14.00	28.9
American Sls Life Ins Co	OTC	23.00	0.0	6.9	0.80	3.5	23.00	23.00	1.5
Aneco Reins Ltd	OTC	2.50	0.0	0.0	0.00	0.0	2.50	2.50	20.7
Avenco Corp	ANEX	14.25	0.9	8.2	0.58	4.1	14.25	13.38	4.4
Banks Iowa Inc	OTC	42.00	-1.2	10.3	1.48	3.5	42.00	42.00	5.6
Bitco Corp	OTC	30.50	0.0	5.0	1.92	6.3	30.50	30.50	3.8
Carolina Cas Ins Co	OTC	7.25	0.0	8.8	0.32	4.4	7.25	7.25	2.6
Chubb Corp	OTC	52.38	-0.5	8.5	2.92	5.6	52.38	49.25	243.3
Combined Intl Corp	NYSE	26.75	-6.1	8.1	2.00	7.5	28.63	26.75	341.6
Continental Corp	NYSE	29.75	-2.1	9.4	2.60	8.7	30.00	29.75	187.3
Crawford & Co	OTC	16.50	-8.3	12.0	0.56	3.4	18.00	16.50	3.3
Crown Life Ins Co	OTC	88.25	0.0	5.8	3.10	3.5	88.25	88.25	2.0
Crum & Forster	NYSE	52.63	1.9	10.9	1.76	3.3	53.00*	52.00	480.6
Employers Cas Co	OTC	32.00	-2.3	14.5	1.20	3.8	32.50	32.00	3.6
Equifax Inc	NYSE	25.38	8.0	13.4	1.32	5.2	25.38	23.50	30.3
Excelsior Ins Co	OTC	11.25	0.0	0.0	0.70	6.2	0.00	DID NOT TRADE	
Farmers Group Inc	OTC	36.25	-3.0	10.1	1.24	3.4	36.38	36.13	404.2
Foremost Corp Amer	OTC	39.00	-1.9	11.9	1.12	2.9	39.50	39.00	22.5
Great West Life Assurn Co	OTC	190.00	0.0	15.5	10.00	5.3	190.00	190.00	0.0
Hanover Ins Co	OTC	31.50	-8.0	4.6	0.88	2.8	32.75	31.50	56.9
Hartford Steam Boiler Inspn	OTC	39.00	0.0	8.3	2.80	7.2	39.50	38.25	6.5
Jefferson Natl Life Ins Co	OTC	39.50	-1.3	11.0	0.76	1.9	39.50	39.50	12.6
Kemper Corp	OTC	37.50	-1.6	7.1	1.80	4.8	37.63	37.38	24.0
Lincoln Natl Corp Ind	NYSE	46.75	-0.5	8.4	3.00	6.4	46.75	45.50	90.8
Mission Ins Group Inc	NYSE	28.50	-6.9	6.7	0.80	2.8	30.88	28.50	148.6
Nationwide Corp Ohio	OTC	40.50	0.0	12.0	0.70	1.7	40.50	40.50	0.5
Northwestern Natl Life Ins	OTC	28.38	-0.9	15.5	1.50	5.3	28.63	28.25	17.7
Ohio Cas Corp	OTC	42.50	-1.7	8.0	2.36	5.6	42.63	42.25	77.4
Old Rep Intl Corp	OTC	24.25	-5.8	5.6	0.92	3.8	24.50	23.63	51.1
Preferred Risk Life Ins Co	OTC	25.00	0.0	7.4	0.92	3.7	25.00	25.00	4.6
Provident Life & Acc Ins Co	OTC	50.00	1.0	7.6	2.44	4.9	50.00	49.50	8.6
St Paul Cos Inc	OTC	59.75	-0.8	7.4	2.60	4.4	59.75	56.25	106.2
Safeco Corp	OTC	51.88	-1.9	8.9	2.40	4.6	51.88	50.50	118.8
Sri Corp	OTC	36.00	-2.0	7.5	1.12	3.1	36.25	35.50	42.5
Seibels Bruce Group Inc	OTC	26.13	-2.3	19.2	1.00	3.8	26.38	26.13	12.0
Statesman Group Inc	OTC	7.13	0.0	6.3	0.15	2.1	7.13	7.00	18.6
Tokio Marine & Fire Ins Co	OTC	98.25	-0.5	15.7	0.92	0.9	98.75	97.75	7.5
Travelers Corp	NYSE	24.25	-0.5	6.6	1.64	6.8	24.63	23.75	355.7
United Fire & Cas Co	OTC	32.00	0.0	8.6	0.88	2.8	32.00	32.00	0.2

DEC. 20, 1982 12/15/82 THRU 12/20/82

		Price	% Chg	P/E	S Div	% Yld	High	Low	Vol (000)
United States Fid & Gty Co	NYSE	41.75	-0.9	10.2	3.60	8.6	42.75	41.75	57.0
United Svcs Life Ins Co	OTC	19.25	-1.3	6.2	1.00	5.2	19.25	19.00	19.2
UsLife Corp	NYSE	22.63	0.0	5.0	0.88	3.9	23.00	22.25	141.1
Washington Natl Corp	NYSE	22.50	-4.3	11.1	1.08	4.8	23.75	22.50	85.6
Zenith Natl Ins Corp	OTC	18.75	2.7	8.5	0.80	4.3	18.75	18.25	19.0
INSURANCE COMPANIES	AVERAGE			9.0		4.3			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	23.63	-0.5	10.6	1.94	8.2	23.75	23.13	461.4
Baldwin & Lyons Inc	OTC	39.00	0.0	6.4	0.80	2.1	39.00	39.00	0.0
Corroon & Black Corp	NYSE	26.50	-1.9	13.1	1.80	6.8	26.63	26.50	7.7
Crump & H Cos Inc	OTC	9.63	-4.9	16.3	0.40	4.2	10.13	9.63	9.8
Emett & Chandler Cos Inc	OTC	9.88	0.0	32.2	0.00	0.0	9.88	9.88	3.5
Hall Frank B & Co Inc	NYSE	28.13	-1.3	12.1	1.70	6.0	28.88	28.13	117.2
Integrated Res Inc	AMEX	33.88	-4.6	10.2	0.00	0.0	33.88	32.13	69.2
James Fred S & Co Inc	NYSE	33.25	0.0	16.8	1.60	4.8	33.25	33.25	0.0
Marsh & McLennan Cos Inc	NYSE	40.25	-3.6	12.5	2.20	5.5	42.00	40.25	136.6
Penncorp Fincl Inc	NYSE	13.13	-0.9	8.2	0.16	1.2	13.13	13.00	316.8
Poe & Assoc Inc	OTC	11.50	0.0	11.3	0.80	7.0	11.50	11.50	0.3
Reed Stenhouse Cos Ltd	OTC	13.50	-0.9	13.4	0.60	4.4	13.50	12.88	3.3
Rollins Burdick Hunter Co	OTC	24.38	0.0	20.1	0.00	0.0	0.00	DID NOT TRADE	
AGENTS/BROKERS	AVERAGE			11.4		3.9			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	61.88	1.6	10.6	2.40	3.9	62.63	58.00	1,760.9
Anderson Clayton(Ranger/PanAm)	NYSE	26.50	-0.9	7.3	1.32	5.0	27.13	26.50	46.7
Arco Inc	NYSE	14.88	0.0	28.1	1.20	8.1	14.88	14.88	687.9
City Investing Co. (Home Ins.)	NYSE	28.63	3.2	8.9	1.70	5.9	28.63	27.38	214.6
CNA Finl Corp (CNA)	NYSE	17.50	-0.7	6.8	0.00	0.0	17.50	16.88	11.3
Control Data (Comm. Credit)	NYSE	37.75	1.3	9.3	0.55	1.5	39.25	37.13	494.2
General Re Corp	NYSE	57.25	-0.9	12.6	1.08	1.9	57.25	56.00	216.9
Gulf Utd Corp	NYSE	24.50	-1.0	8.6	1.32	5.4	24.88	24.38	71.3
Cigna Corp	NYSE	42.00	-2.3	6.1	2.30	5.5	43.50	42.00	410.5
ITT (Hartford Group)	NYSE	29.88	1.3	6.7	2.76	9.2	30.13	29.38	557.4
Optimum Hldg Corp	OTC	8.38	3.1	8.1	0.00	0.0	8.38	8.13	12.4
Sears Roebuck & Co. (Allstate)	NYSE	30.00	6.7	13.6	1.36	4.5	30.13	27.63	2,498.3
Baldwin Utd Corp	NYSE	27.50	-20.9	5.4	0.88	3.2	34.25	27.50	824.2
Teledyne Inc (Argonaut)	NYSE	128.00	1.1	7.7	0.00	0.0	130.25	125.25	481.8
Transamerica Corp (Occidental)	NYSE	23.38	5.6	8.1	1.50	6.4	24.00	22.13	430.8
CONGLOMERATES/HOLDING COS.	AVERAGE			8.4		3.3			

*Record high/low since Jan. 1, 1982

System design: Altman Information Systems

Financial briefs

Frank B. Hall

Frank B. Hall & Co. Inc. has declared a quarterly dividend of 42.5 cents per share of common stock, payable Feb. 7 to shareholders of record Jan. 17.

SRI Corp.

SRI Corp., the holding company for Selected Risks Insurance Co. of Branchville, N.J., has filed a shelf registration with the Securities and Exchange Commission to cover \$25 million face value of convertible debentures due in 2008.

"The Hartford's top-notch underwriters bring special skills to standard commercial lines."

An interview with Tony Lubimir, Senior Vice President, Office of Underwriting, The Hartford.

Q. The Hartford is known for the quality of its underwriters. Why is that?

A. Our whole approach to the market depends upon developing and keeping outstanding underwriters. That's why we give top priority to specialized training and career incentives that make underwriting both challenging and rewarding. For example, we created the position of Executive Underwriter for our most experienced professionals. They have broad underwriting and pricing authority coupled with production responsibility. The position may be unique in the industry.

Q. How do insurance buyers benefit from the specialized training of Hartford underwriters?



A. Their insurance needs are addressed by an underwriting professional with in-depth experience and expert knowledge of the particular type of coverage involved. That high level of underwriting expertise is just what brokers and agents tell us

they need to help their clients—especially in the current business environment, where quality of protection is as important as price.

Q. How does that underwriting expertise help insurance buyers get high-quality, cost-effective protection?

A. The more underwriters know about available programs, the better they can put together a plan that is truly responsive to a particular situation. This is especially true in complex areas such as Workers' Compensation, where a superficial approach may not produce a program that works in a buyer's best long-term interest.

Q. What happens when insurance buyers need specialized underwriting help on both the Property and Casualty sides?

A. They get it. The Hartford has a well-coordinated team approach that gives brokers and agents unlimited access to specialized underwriting and loss control assistance—in effect, our best corporate underwriting resources—when called for.

Q. Do Hartford underwriters in the field have adequate authority to accept or reject risks without consulting the home office?

A. Because of the superior training and experience of our underwriters, we're able to give them significant authority within which to operate. In fact, over 95% of underwriting decisions are made in our regional offices. Of course, our field underwriters are encouraged to utilize all corporate resources to develop the best approach to a given situation.



Q. Is The Hartford consistent in its underwriting program?

A. It is our policy to be. We don't cover a particular type of risk one year and drop it the next. This will become an even more important factor as the market starts to respond to adverse underwriting results.

Q. How can insurance buyers take advantage of Hartford underwriting capability?

A. By contacting a broker or independent agent who represents The Hartford.



Don't make a decision on business insurance without a quote from The Hartford.



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