

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$1.75 a copy; \$70 a year

© Entire contents copyright 1989 by Crain Communications Inc. All rights reserved

Disney D&O insurer, Reliance pay bulk of \$45 million settlement

NEW YORK—Walt Disney Co.'s directors and officers liability insurer and Reliance Group Holdings Inc. will pay the bulk of a \$45 million settlement reached in shareholder litigation stemming from an unsuccessful 1984 takeover attempt of Disney by Reliance Chairman and Chief Executive Officer Saul P. Steinberg.

Disney shareholders had filed two "greenmail" suits, which in part charged that Disney's buyout of Mr.

Continued on next page

Comp insurers in Minnesota face boycott trial

By MEG FLETCHER

MINNEAPOLIS—A group of Minnesota workers compensation insurers faces a federal court trial next year on charges that they violated federal antitrust law following the U.S. Supreme Court's refusal to consider the complex case.

The high court on July 6 denied a motion from 14 insurers to review a decision by the 8th U.S. Circuit Court of Appeals. The 8th Circuit had ruled that a group of employers had presented sufficient evidence to warrant a trial on whether the insurers had engaged in an agreement to boycott in violation of federal antitrust law.

Insurers are not granted immunity from charges of boycotting under the limited antitrust exemptions provided by the McCarran-Ferguson Act.

The 8th Circuit, however, did uphold a lower court judge's summary judgment that the McCarran Ferguson Act gives insurers immunity from price-fixing charges under federal antitrust laws.

However, attorneys involved in the case say the U.S. District Court judge who now will hear the case will have to consider the price-fixing allegations in order to rule whether the insurers engaged in a boycott.

A group of six Minnesota employers allege that the insurers violated federal and state antitrust laws by conspiring—as members of a state-mandated ratemaking organization—to stage a boycott against members that did not agree to charge artificially high workers compensation rates recommended by the organization between 1979 and 1983.

Insurers that did not follow the prescribed rates purportedly could be deprived of the group's services, according to the group's bylaws.

However, the defendant insurers and the local rating organization argue that they were in compliance with state insurance law.

In addition, the defendants note that, during the period at issue,

Continued on page 27

Kennedy bill

Senate committee approves revised health plan mandate

By JERRY GEISEL

WASHINGTON—A Senate panel for the second consecutive year is sending legislation to the Senate floor that requires employers to offer group health care plans meeting federal standards.

The Senate Labor and Human Resources Committee, on a straight party line 9-7 vote, last week approved legislation mandating employer-provided health care coverage.

"I'm more hopeful and optimistic than ever. The Senate will vote on this measure during this session," predicted committee Chairman Edward Kennedy, D-Mass., the chief sponsor of the legislation, S. 768.

Unlike last year, when a fiery and acrimonious debate between Sen. Kennedy and ranking minority member Sen. Orrin Hatch, R-Utah, preceded committee approval (BI, Feb. 22, 1988), Republican opponents were largely silent while Sen. Kennedy urged passage of the legislation.

Rejecting the word "mandate," Sen. Kennedy said: "This is a program to provide a minimum stan-

dard of decency."

While Republican committee members offered little vocal opposition, they did propose—unsuccessfully—a substitute for the Kennedy bill.

Sen. James Jeffords, R-Vt., on behalf of the absent Sen. Hatch, offered a substitute that would have, among other things, pre-empted the

The American Medical Assn. is drafting a proposal to require employers to provide medical insurance to all workers. See story, page 25.

myriad state laws that require health care policies sold by insurers to offer certain benefits. The amendment also would have given states about \$50 million in start-up funds for new risk pools to provide coverage for the uninsured.

The Jeffords amendment failed on a 9-7 vote.

However, the committee unanimously adopted—without discussion—a non-controversial amendment by Sen. Tom Harkin, D-Iowa, to give certain small employers more time before they would have to

comply with all aspects of the Kennedy legislation.

While the debate last week was restrained, opposition to the bill, both from the Bush administration and from employers, remains strong.

Last week, for example, Labor Secretary Elizabeth Dole sent a strongly worded letter to Sen. Kennedy describing the legislation as unwarranted interference in employer and employee relations.

"The proposal interferes with the rights of employees and employers to determine for themselves the most appropriate compensation package. . . . The costs of these mandated benefits could, for example, result in employers not having funds available to pay for other desirable programs," Secretary Dole said.

And, opposition from business groups has not softened.

"Our reservations about the bill are as great as ever. It makes the assumption that one size fits all," said Sharon Canner, assistant vp with the National Assn. of Manufacturers in Washington, D.C.

However, several large employers, like American Airlines Inc. and

Continued on page 24

Court strikes guaranty fund exclusion

By JUDY GREENWALD

DETROIT—A federal court ruling that strikes down a Michigan statute permitting the state guaranty fund to deny coverage to policyholders with a substantial net worth could affect guaranty funds nationwide.

At least nine other states use a policyholder's net worth as a criteria in determining eligibility for guaranty fund coverage, while other states are considering similar measures, observers say.

In addition, a provision limiting guaranty fund coverage based on a company's net worth now is included in the National Assn. of Insurance Commissioners' guaranty fund model law.

Attorneys and guaranty fund officials say these provisions may have to be reconsidered in light of the U.S. District Court's ruling in *Borman's Inc. vs. the Michigan Property & Casualty Guaranty Assn.*

"There's just a lot of things that will have to be looked at now," commented Jim Lane, who is general counsel to the Ohio Guaranty Fund Assn. and executive director of the National Committee on Insurance Guaranty Funds.

However, risk managers generally praised the decision, noting that because insurers factor guaranty fund assess-

ments in the premiums they charge larger companies, these companies should be entitled to benefit from the funds.

In her decision, which is expected to be appealed, Judge Barbara K. Hackett did not criticize the basic concept of denying guaranty fund coverage to policyholders that are capable of absorbing losses. However, she did agree with Detroit-based Borman's that net worth is an inadequate criteria to use in determining which policyholders should be excluded from guaranty fund coverage (see story, page 14).

"The classification of persons and entities entitled to recover from the association, based solely upon their net worth at a given time, is arbitrary and is not a classification which is rationally related to the Michigan Legislature's purpose of allocating loss to those best able to absorb loss," Judge Hackett stated.

"The court is also satisfied, with regard to the defendant's alternative or supporting argument, that (Borman's) has shown that there is no meaningful relationship between net worth and the ability of a person or entity to predict the insolvency of an insurer," she said.

Judge Hackett therefore ruled that the Michigan statute "violates plaintiff's right to equal protection under the law as provided by both the United States and Michigan Consti-

Continued on page 13

"The court agrees with the plaintiff's position and finds that the classification of persons and entities entitled to recover from the association, based solely upon their net worth at a given time, is arbitrary..."

—Judge Barbara K. Hackett

Proposed GASB standards won't hurt bond ratings: Experts
Page 3

Michigan court OKs criminal trial of employer for workplace death
Page 2

Rep. Rostenkowski offers new Section 89 reform package
Page 3

Update

Disney shareholder suit settled

Continued from previous page

Steinberg's 11% stake in Disney caused the stock's price to fall.

Reliance will contribute \$20.8 million the settlement, which will be charged against second-quarter earnings, a spokeswoman said.

The rest of the settlement will be paid by other defendants in the suit, including Disney's D&O insurer, with Disney itself contributing only a "non-material amount," according to Michael Diamond, an attorney with Skadden, Arps, Slate, Meagher & Flom, who represents Disney.

Although neither Mr. Diamond nor a Chubb Corp. spokesman would confirm it, industry sources identified Chubb as Disney's D&O insurer.

Drexel Burnham Lambert Inc., which acted as Mr. Steinberg's financial adviser, will also contribute \$1.7 million toward the settlement, a spokesman confirmed.

Reverse offset ruling: Court

LOS ANGELES—A state appellate court last week suspended a lower court's May 3 ruling that severely restricted Prudential Reinsurance Co.'s right to offset unspecified amounts due it and subsidiary Gibraltar Casualty Co. from insolvent Mission Insurance Group Inc. against amounts the Prudential units owed to Mission.

A three-judge panel of the California Court of Appeals ordered a Los Angeles Superior Court to voluntarily reverse by Aug. 15 its decision limiting the offsets or to show cause by Dec. 12 why the appellate panel should not reverse the ruling (BI, July 10; May 29).

The decision shifts the burden to Insurance Commissioner Roxani Gillespie to show why the lower court decision should be upheld, said Dean Hansell, an attorney with LeBoeuf, Lamb, Leiby & MacRae, who represents other Mission reinsurers.

The state Insurance Department "welcomes" the appellate court deliberations that likely will ensue if the Superior Court does not agree to reverse its decision because the department seeks a higher court's approval of strict restrictions on offsets, said attorney Karl Rubinstein of Rubinstein & Perry in San Francisco, who represents Ms. Gillespie.

The department estimates the restrictions on offsets will allow Mission to collect an additional \$300 million from its reinsurers.

Hall regains stake in Adjustco

NEW YORK—Broker Frank B. Hall & Co. Inc. has reassumed a 49% stake in its former claims adjusting subsidiary, Adjustco Inc., after Leonard J. Russo Insurance Services Inc. failed to honor the terms of its 1987 purchase agreement, a Hall executive confirmed.

"When we sold Adjustco to Leonard Russo, he pledged (Adjustco) stock as collateral for notes due. As a result of Russo's inability to honor those notes because of financial difficulties, we restructured the debt obligation, and instead of taking a pledge of stock, we have taken a minority interest in Adjustco," explained John A. Addeo, Hall's senior vp and treasurer.

Hall took the 49% minority interest "as of June 30th, when certain obligations were due under the (terms of the) original sale," Mr. Addeo said. He noted that Hall's exposure is limited to "the amount of money we have invested in the company," and any legal liabilities relating to Adjustco would remain with Leonard Russo.

Hall classified Adjustco as a discontinued operation in Hall's fourth-quarter 1986 results. At that time, the broker recorded a \$15.2 million loss from discontinued operations, of which Adjustco represented a significant portion, though it did not disclose the exact amount attributable to Adjustco.

Hall sold Adjustco to Emeryville, Calif.-based Leonard J. Russo Insurance Services in the fall of 1987 for an undisclosed sum (BI, Oct. 27, 1987; March 23, 1987).

ESOP tax breaks threatened

WASHINGTON—New restrictions on tax breaks related to employee stock ownership plans were approved last week by the House Ways and Means Committee.

As part of budget reconciliation legislation it is crafting, the committee approved repealing a provision in the Deficit Reduction Act of 1984 that allows banks and other qualified lenders to exclude from their federal taxes 50% of interest income received from an ESOP when an ESOP takes a loan to buy employer stock. The restriction generally would apply to loans made after July 10.

A similar bill has been introduced in the Senate (BI, July 10).

The committee also agreed to remove a tax break that allows employers to take tax deductions on stock held by an ESOP. The repeal of the tax deduction generally would apply to stock acquired by an ESOP after July 10.

However, these two restrictions would not apply to ESOPs that hold more than 30% of a company's equity.

AT&T benefit changes accepted

WASHINGTON—American Telephone & Telegraph Co.'s two labor unions earlier this month overwhelmingly ratified a new three-year labor contract that emphasizes managed health care.

The new contract approved by the Communication Workers of America and the International Brotherhood of Electrical Workers calls for implementation of preferred provider organizations, increased employee cost-sharing of benefits, flexible spending accounts and a \$5 million company fund to finance child care and elder care projects.

The pact, covering 175,000 employees, represents the first time the two unions jointly negotiated an agreement with AT&T (BI, June 5).

Satellite damage insured

NEWPORT BEACH, Calif.—Ford Aerospace Corp. has up to \$58 million of insurance to cover damage to a Ford-manufactured satellite due to be launched last month from Cape Canaveral, Fla.

Continued on page 29

Criminal charges allowed for safety violation: Court

By MARK A. HOFMANN

LANSING, Mich.—An employer can be criminally prosecuted for a workplace fatality, even if the death was allegedly caused by conduct governed by federal safety regulations, the Michigan Supreme Court has ruled.

The Michigan high court's 7-0 decision earlier this month marked the second time in the past six months that a state Supreme Court has rejected the argument that the federal Occupational Safety and Health Act of 1970 pre-empts state criminal laws for injuries or fatalities caused by workplace safety violations.

The Illinois Supreme Court ruled in February that federal safety regulations do not pre-empt state criminal prosecution of businesses and their officers for allegedly exposing employees to unsafe workplace conditions (BI, Feb. 6).

Attorneys for defendants in the Illinois case are seeking review by the U.S. Supreme Court.

The Michigan decision only reinforces the need for the Supreme Court to settle the pre-emption issue, say business groups that support pre-emption.

However, attorneys representing the Michigan defendant do not plan a similar appeal. Proponents of OSHA pre-emption are more concerned that the Michigan and Illinois decisions will open the door to a crazy quilt of state workplace safety standards and to abusive prosecution of employers.

But prosecutors and safety advocates, who are hail-

ing the Michigan and Illinois rulings, say that allowing states to bring criminal charges for injuries and deaths stemming from conduct governed by OSHA actually benefits safety-conscious employers.

The Michigan case stemmed from the Jan. 18, 1985, death of William Hatherill, an employee of Clayton, Ohio-based Jackson Enterprises, a contractor on a cable television installation project in Oakland County, Mich., who died of carbon monoxide poisoning while working in a company-owned van.

Oakland County prosecutors charged Patrick Hegedus, a Jackson Enterprises supervisor, with involuntary manslaughter and conspiracy to violate the Michigan Occupational Safety and Health Act.

An Oakland County Circuit Court judge granted Mr. Hegedus' motion to dismiss the manslaughter charges because the defendant had no duty to inspect the van or to take it out of service. However, the prosecution appealed.

After reviewing briefs addressing the question of whether criminal prosecution based on workplace conditions was pre-empted by either MIOSHA or federal law, the appellate court upheld the lower court, holding that criminal prosecution was pre-empted by OSHA. The prosecution then appealed to the state Supreme Court, which unanimously overturned the appellate court decision.

"We cannot construe OSHA, the stated purpose of which is 'to assure so far as possible... safe and

Continued on page 21

Regulator hits Mead Re Company in 'hazardous condition': California

By DOUGLAS McLEOD

SAN FRANCISCO—Mead Reinsurance Corp. officials say they are uncertain why the California Insurance Department issued a cease and desist order against the company, which stopped underwriting in 1987 and is running off its business.

In issuing the order—which forbids Mead Re from writing any new or renewal business—the California department cited Mead Re's "hazardous condition," noting among other things that Mead Re

has "impermissibly discounted" its reserves. If the effect of the discounting were reversed, Mead Re would have had a policyholder surplus deficit of \$47.4 million at the end of last year, the Insurance Department charged.

Illinois-domiciled Mead Re has discounted its reserves during the runoff with the permission of the Illinois Insurance Department, though without separate permission from California regulators, Illinois department and Mead Re officials confirmed.

John Fogg, senior counsel to the

California Insurance Department, conceded that the May 24 cease and desist order may have no practical effect because Mead Re has long since stopped underwriting.

The order, however, expresses a "philosophical point," Mr. Fogg said, explaining that for the California department not to take such action "kind of gives our stamp of approval (to Mead Re) despite what we know to be the case."

"I was a bit surprised at California's reaction," said Mead Re President Chester W. Richards, noting that the reinsurer has kept state regulators apprised of the status of the runoff through regular reports and quarterly financial statements.

"We were licensed in 42 states, and we have kept them all advised what is going on at least once or twice a year," he said.

A hearing on the order had been scheduled for June 21, though Mead Re asked for—and was granted—an indefinite postponement. The order meanwhile remains in effect.

Mead Re, a unit of Dayton, Ohio-based Mead Corp., halted all underwriting in January 1987 after three years of mounting losses on a book of business consisting mainly

Continued on page 29

BI lists 401(k) administrators

The deadline is rapidly approaching for companies to return questionnaires to be listed in the first *Business Insurance* directory of 401(k) plan administrators.

Companies that provide enrollment services, daily maintenance of participants' accounts, account manipulation and similar services (regardless of whether the company is responsible for investment management) are eligible to be included in the directory, which will appear in the Aug. 7 issue.

If your company provides these services for employers' 401(k) plans and you have not yet received a questionnaire, please request one immediately by calling Marilou Jones at 312-649-5279.

The extended deadline for returning completed questionnaires to *Business Insurance* is July 21.

Inside

✓ Strong economic incentives to prevent oil spills and to speed their cleanup are clearly needed, says this week's editorial. **PAGE 8**

✓ In Speaking Out, Alexander & Alexander Inc.'s Vince Catali contends current aviation insurance rating practices favor the short-haul air carrier. **PAGE 19**

✓ Employers are discovering that changing retiree health care benefits not only is difficult but may be severely limited by current law, report attorneys Lynn Shapiro Snyder and Linda Rosenzweig in Perspectives. **PAGE 19**

✓ Lloyd's of London must improve its business operations and overcome some major hurdles to remain a competitive force in the world market, Lloyd's Chairman Murray Lawrence warns. **PAGE 22**

✓ The American Medical Assn. is drafting a legislative proposal it hopes will lead to a federal law requiring employers to provide medical insurance to workers. **PAGE 25**

Departments

Advertiser index	21
At issue	10
Benefit beat	6
Classifieds	26
Comings & goings: buyers	15
Insurance services guide	30
Letters	8
Opinions	8
Perspectives	19
Speaking out	19
Ticker	31
Washington	23

Vol. 23, No. 29—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 800-992-9970 or 313-446-1611. Copyright 1989 by Crain Communications Inc.

New Section 89 changes

By JERRY GEISEL

Panel OKs Rostenkowski proposal

WASHINGTON—A dramatically revised Section 89 reform package approved last week by the House Ways and Means Committee would significantly ease employers' compliance burdens imposed by the much-assailed non-discrimination tests for health care plans.

The reform package, proposed by committee Chairman Daniel Rostenkowski, D-Ill., and attached to a budget reconciliation measure tentatively cleared by the committee last week, is a huge improvement over Rep. Rostenkowski's previous Section 89 measure, H.R. 1864, introduced in April, benefit experts say (BI, April 24).

Improvements in the package include a delay in Section's 89 effective date, a new and more liberal way to test whether health care plans are affordable and thus non-discriminatory, and a special, easier-to-pass test for flexible benefit plans that allow employees to make pretax contributions.

In addition, the package contains

special rules that will ease the burden of Section 89 compliance for small employers.

"This is a proposal that I was proud to see the Ways and Means Committee embrace, given the pressures on us to repeal Section 89. Fairness and simplicity don't always go together, but I would hope this proposal finds the middle ground," Rep. Rostenkowski said.

Benefit experts, who were extremely critical of the first Rostenkowski Section 89 package, are now saluting the Ways and Means Committee chairman.

"It is a giant step forward. We applaud the chairman for his willingness to accommodate employers in trying to make Section 89 a workable and effective statute," said Mark Ugoretz, executive director of the ERISA Industry Committee in Washington, D.C.

"With this proposal, we are much closer to getting a piece of

legislation that will be acceptable to employers," added Gerald Uslander, a principal with William M. Mercer Meidinger Hansen Inc.

Benefit experts say the revised Rostenkowski reform package is at

'Fairness and simplicity don't always go together, but I would hope this proposal finds that middle ground.'

— Rep. Daniel Rostenkowski

least as attractive for employers as the Section 89 reform legislation put together by Finance Committee Chairman Lloyd Bentsen, D-Texas. The Bentsen proposal was incorporated into child care legislation,

S. 5, which the Senate approved last month (BI, July 3).

"The two bills are coming closer together," said Denise George-miller, a consultant with Hewitt Associates in Lincolnshire, Ill.

"The House and Senate bills are moving in the same direction," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

With the differences in the two bills now sharply reduced, Congress is much more likely to pass Section 89 reform legislation this year, experts say.

"The latest changes make the Rostenkowski and Bentsen bills much more similar, which will expedite conference committee and ultimately final congressional approval," said Emmett Seaborn, a consultant with TPF&C, the employee benefits consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

"Certainly, while differences remain, especially in how flexible benefit plans are treated, these are differences that can be worked out," added Eric Grossman, a consultant in the Stamford, Conn., office of The Wyatt Co.

Much to the relief of employers, both the new Rostenkowski proposal and the Bentsen plan generally delay until Jan. 1, 1990 compliance with Section 89(a)—that portion of the law that sets non-discrimination tests for health care benefit plans. The original Rostenkowski proposal did not change the current Oct. 1 Section 89(a) compliance deadline.

However, some differences in effective dates still remain.

For example, the Bentsen bill proposes that employers would not have to comply with Section 89(k)—that portion of the law that lays down rules on how health care plans must be documented and communicated to employees—until three months after the Treasury Department issues regulations, or

Continued on page 30



Illustration: Roger Schiller/Storm

GASB proposal won't hurt bond ratings: Experts

By MICHAEL SCHACHNER

Most public entities' bond ratings will not be jeopardized by proposed accounting guidelines that would require self-insured public entities to report property/casualty claims and other liabilities on their financial statements on an accrual basis, experts say.

And, public entities can soften the blow to their balance sheets if the entities begin complying with the standard gradually over the next few years rather than waiting for the proposed standard to take effect, accountants and consultants note.

Under proposed Governmental Accounting Standards Board accounting rules, if a probable liability-causing event occurs or an asset is impaired and the amount of the loss can be reasonably estimated, it must be recorded in the current year's financial statements, said Suesan Monks, project manager with GASB in Norwalk, Conn.

The rule will probably take effect in 1993.

Financial Accounting Standards Board Statement No. 5 currently allows public entities a choice of reporting claims on either an accrual or a pay-as-you-go basis without qualifying their financial statements.

However, under the GASB proposal, entities that do not follow accrual accounting would have to publish qualified statements.

GASB also proposes that public entity risk-financing pools follow similar accounting standards, plus report premium deficiencies during the year in which they occur, as outlined in FASB Statement No. 60. In addition, pools must provide a 10-year loss history.

GASB's exposure draft calls for the requirements affecting pools to become effective for fiscal years beginning after June 15, 1990.

While pool officials are calmly gearing up for these standards, the standards affecting public entities are worrying some state and local officials since many self-insured public entities have not widely practiced accrual accounting for claims and other liabilities.

If GASB approves the exposure draft, some self-insured entities now recording their liabilities on a pay-as-you-go basis will see

Continued on page 10

2 U.S. insurers probe binding authorities

By CAROLYN ALDRED

LONDON—Two U.S. insurers allege that several U.S.- and London-based companies and individuals have attempted to bind business in their names without authorization.

State Surety Co., a Des Moines-based subsidiary of Old Republic International Corp., and United States Fidelity & Guaranty Co., a unit of Baltimore-based USF&G Corp., have obtained court injunctions against the companies and individuals.

Although officials of both insurers believe they discovered the ruse before business was written in their names without permission, they fear that other insurers—like Korean Reinsurance Co.—later became victims of similar fraudulent binding authorities (BI, July 10). At least two individuals named in court papers filed by State Surety in London's High Court also allegedly bound unauthorized business for Korean Re.

The injunctions, which bar the defendants from falsely representing themselves as agents of State Surety, were sought earlier this year after numerous intermediaries contacted State Surety to check whether purported binding authorities for the company were genuine, lawyers say.

Several companies were offered State Surety reinsurance, particularly for U.S. accident and health

risks, through the scheme, said a spokesman from the London law firm of Elborne Mitchell, which is representing State Surety in London.

So far, the company has found no evidence that any business actually was written, the spokesman added.

State Surety and its parent, Old Republic, obtained an injunction in London's High Court restraining 15 defendants from "holding out themselves... as authorized to act in any way whatsoever on behalf of" the insurers. The application for the injunction also claimed "damages for wrongful interference with the plaintiffs' business and/or fraud."

Among the defendants named were Colin J. Youell, David Cohen, Fitzroy Merchant Ltd. of London, Expand Investments Ltd. of London and Paducah, Ky.-based Sisson International Insurance & Surety Inc.

Mr. Youell and Mr. Cohen have been implicated in the unauthorized placement of business with Korean Re, but both have denied wrongdoing.

The injunction was sought following a search of the premises of Fitzroy Merchant in London by lawyers from Elborne Mitchell, who had obtained a court order late last year allowing them to search the offices. British law prevents disclosure of the search's findings.

Both Lloyd's of London and the British Department of Trade and Industry are continuing to investigate the

Continued on page 4

Growing legal bills spur new Dupont settlements

By LINDA J. COLLINS

SAN JUAN, Puerto Rico—Staggering defense costs have prompted several companies facing claims in the 1986 San Juan Dupont Plaza hotel fire litigation to settle before the trial to determine liability for the fire resumed last week.

The most recent settlements, which total nearly \$9 million, involved at least 20 defendants that either provided products used in the hotel or provided services to the hotel. These settlements bring to more than \$150 million the total amount paid so far by defendants named in the fire litigation.

"We settled principally because of the absolutely astronomical defense costs that were imposed because of the joint defense activi-

attorney for Nevamar Corp., one of the defendants that settled.

For example, all of the defendants in the litigation—even those only peripherally involved—were required by the U.S. District Court for the District of Puerto Rico to equally contribute to the cost of a joint document depository. As of April, those costs alone amounted to \$34,000 per defendant.

Nevamar's decision to settle "was simply a business judgment," said Mr. Warin, a partner with Steptoe & Johnson in Washington.

"We determined that to win the case would have been more expensive than to settle, and many of the peripherally involved defendants were unable to effectively have the cases against them disposed by motion," he added, declining to discuss settlement terms.

before the portion of the trial began last week to determine the liability of approximately 87 remaining product and service provider defendants.

The first stage of the trial, which was to have determined the liability of the hotel's liability insurers and current and former owners and operators, ended in May when out-of-court settlements were reached with those defendants.

Corporate and individual owners, operators and alleged affiliates of the Dupont Plaza hotel; the hotel's insurers, units of New York-based American International Group Inc.; and former owner Sheraton Corp., reached settlements in May totaling more than \$140 million with the Plaintiffs Steering Committee that represents all plaintiffs in the litigation.

Injunctions

Continued from page 3

matter, sources say. However, neither Lloyd's nor the DTI would comment.

In addition, State Surety and USF&G are pursuing related litigation in the United States, confirmed James W. Smirz, a partner with the Lexington, Ky., law firm of Landrum & Shouse, which represents both insurers in Kentucky.

USF&G was added to an action begun by State Surety in Kentucky after State Surety advised the USF&G that it had evidence that the defendants also purported to have binding authority for USF&G, said a spokesman for USF&G.

State Surety and USF&G earlier this year obtained an injunction in the U.S. District Court for the Western District of Kentucky in Paducah precluding Sisson International & Associated Refiners Corp., Sisson International Insurance & Surety Inc., Dan Anderson, Jerry Owen and Don-

ald Knight from representing that they were authorized agents or had binding authority for the two insurance companies, said Mr. Smirz.

The injunction still has not been served on Mr. Knight because he has not been located, said Mr. Smirz.

According to court papers filed in federal court in Paducah, State Surety received numerous telephone calls in November and December 1988 from intermediaries seeking confirmation that State Surety was a reinsurer of the Sisson companies.

The Sisson companies, which acted as insurers, said State Surety fully reinsured them, Mr. Smirz said.

According to court papers, the Federal Bureau of Investigation and the Kentucky and Iowa insurance departments are investigating.

On Dec. 13, 1988 State Surety Vp Samuel Perschau "received a call from one Michael Hughes (of Lloyd's broker Ian McCall & Co. Ltd.), who indicated that a colleague of his had been offered a piece of business by Colin Youell. . . who indicated that

they were obtaining lines of business from Sisson, re underwriting on behalf of State Surety," court papers say.

Mr. Hughes said he was given "a letter ostensibly signed by R. Nelson of (State Surety), a non-existent person, granting Sisson broad authority without restrictions either as to lines of business or as to amount" that could be written on behalf of the insurer, the papers add.

Messrs. Anderson, Knight and Owen could not be reached for comment last week.

However, in an interview last week, Mr. Youell explained that he and his company, Fitzroy Merchant, were "innocent parties" who had been led by David Cohen to believe that Sisson "had a binding authority with State Surety."

When Mr. Youell found that the binding authority was "fraudulent," he refused to bind any business on behalf of Sisson and State Surety, Mr. Youell said.

Mr. Cohen again approached him

earlier this year to assist in placing business through a company called McDonald Financial Management (U.K.) Ltd., which he claimed had binding authority to write on behalf of Korean Re, said Mr. Youell.

Korean Re earlier this month warned companies against obtaining coverage from three firms, including McDonald, that falsely claimed to have binding authority for it.

Mr. Cohen also purported to have binding authorities for Seoul, South Korea-based Hyundai Marine & Fire Insurance Co. Ltd. and Peoples Insurance Co. of China in Beijing, Mr. Youell said, adding that he declined to do business with Mr. Cohen.

Mr. Cohen could not be reached for comment.

After severing ties with Mr. Cohen, Mr. Youell said he then "dissolved" Fitzroy Merchant because "I was innocent and I didn't want to become associated" with fraudulent business.

Mr. Youell has since formed Consortium of '89 Ltd., a London-based managing agent for several reinsur-

ance companies located worldwide.

Although he would not identify any of the reinsurers Consortium of '89 represents, Mr. Youell said that among the risks the reinsurers will write are U.S. accident and health business and trucking, financial guarantee and aviation risks.

Meanwhile, Simon Few, managing director of London brokerage Simon Few & Co. Ltd., said that Mr. Youell and Fitzroy Merchant offered to place reinsurance with State Surety for several books of U.S. business the company brokered.

Mr. Few said he became suspicious of the alleged binding authority with State Surety, though, and did not place business with Fitzroy Merchant.

However, Mr. Youell claims that he, not Mr. Few, discovered the binding authority Sisson purported to have for State Surety was fraudulent and refused to provide any coverage.

Simon Few & Co. also issued reinsurance cover notes under purported binding authority for Korean Re earlier this year to two U.S. insurance companies.

Since then, however, Mr. Few claims he has "severed connections" with Mr. Youell.

In addition, British broker A.J. White Insurance Consultants Ltd. of Swanley, Kent, also may have reinsured U.S. accident and health risks through binding authorities purported to be held by Sisson and Fitzroy Merchants, sources say.

Managing Director A.J. White said he is "going through mountains of paperwork" to ensure that two brokers who previously worked for A.J. White Insurance Consultants did not write any business through Sissions and Fitzroy Merchants.

Mr. Youell said that Fitzroy Merchant never provided coverage to A.J. White Consultants' clients.

A.J. White Consultants was established by Mr. White last year. He also is managing director and proprietor of A.J. White & Associates Ltd., a personal automobile and life insurance brokerage.

Mr. White contracted with Barry Toomey and David Gale to run A.J. White Consultants after they promised to secure U.S. reinsurance business, he said. Mr. White continued to support Messrs. Toomey and Gale financially throughout 1988, although no broking commissions ever passed into A.J. White's bank accounts, according to Mr. White.

However, "we have good information that (Messrs. Toomey & Gale) are earning commissions from U.S. transactions" secured in the name of A.J. White Consultants, he said.

Mr. White now plans to seek compensation for the 50,000 to 60,000 pounds (\$80,500 to \$96,600) in expenses and debts he claims he is owed by Messrs. Toomey and Gale, who now are employed by Mr. Youell's Consortium of '89.

Mr. Gale last week could not be reached for comment, while Mr. Toomey did not return phone calls.

Mr. Youell last week also said he no longer has a business relationship with Expand Investments Ltd.—one of the defendants in State Surety's London lawsuit—or Geoffrey Greenlees, who worked for Expand.

Expand had been employed by Fitzroy Merchant last year to help establish the brokerage and to permit Fitzroy Merchant to use its client bank account until Fitzroy Merchant could establish its own account, said Mr. Youell.

Last week, lawyers acting on behalf of security firm Brinks-Mat Ltd. secured a High Court injunction freezing a bank account in the name of Geoffrey Greenlees in a Dublin, Ireland-based bank.

Sources say the injunction was secured as part of Brinks-Mat's investigations into the robbery of a Brinks-Mat warehouse in 1983. The robbers escaped with about \$40 million worth of gold bullion and diamonds (BI, Dec. 5, 1983).

Mr. Greenlees could not be reached for comment.

What's in a name?

Financial security and reliability — if the name is Dorinco Reinsurance Company.

Dorinco Reinsurance Company is recognized by industry professionals as a financially solid and reliable reinsurance carrier that offers all levels of property and casualty treaty insurance.

More than 300 insurance companies make up its growing client list. That's why Dorinco Reinsurance Company expects to write premiums approaching \$70 million in 1989.

A reassuring name in reinsurance.

The key to Dorinco Reinsurance Company's financial strength is its stable capital base. Since 1977, assets have climbed to \$430 million. And, most importantly, its policyholders' surplus has soared to \$118 million.

Armed with this financial clout, Dorinco Reinsurance Company will be there to see you through — whatever the economic climate, whenever the need.

A name to remember.

Dorinco Reinsurance Company is qualified as a reinsurer in most states and is on the U.S. Treasury List of approved reinsurers. Dorinco has also been rated "A-Excellent" by the A.M. Best Company since 1981.

Other professionals have taken notice. Shouldn't you? Remember Dorinco for reinsurance.

Dorinco: A Professional Reinsurer For Insurance Professionals.



EVER WONDER WHERE YOUR EMPLOYEE BENEFIT DOLLARS GO?

Down the never-ending drain?

You have every reason to feel that way. After all, health care is often one of your biggest single expenses. Yet the costs seem out of your control.

And worse, they just keep rising. Last year alone, they went up an average of almost 19 percent.* And that was after steep increases in 1987.

So what can you do about it?

You can start by working with an insurance company that is doing something about controlling employee benefit costs without sacrificing the quality of the plan.

At NWNL Group, our Health Information Consulting Services is a prime example.

We take a flood of claim information on your employees and their dependents. Then through computer analysis, we turn it into a management tool that helps reduce and control health care costs.

Based on that information, we can also give you some advice on how to make a good plan better. Some of which might surprise you.

Of course, we realize not everyone wants that from their insurance company. But then, we're not the insurance company for everyone. Nor do we try to be.

The fact is, we work best with companies that are willing to make smart but tough choices in order to control costs.

Our special booklet—10 Ways To Cut Employee Benefit Costs—tells you how we do it. Call or write Rick Naymark, NWNL Group, Box 20, Minneapolis, MN 55440, (612) 342-7137 for a copy.

But do it soon, before too many more health benefit dollars disappear from view.

*"Health Benefits Survey: 1988," A. Foster Higgins & Co., Inc.

NWNL GROUP

Northwestern National Life Insurance Co.

Boise Cascade unveils new 401(k) plan

By MICHAEL SCHACHNER

Benefit beat

- A diversified stock portfolio or mutual fund.
- Boise Cascade common stock, which currently is valued at nearly \$44 per share.

In addition to the 401(k) plan, Boise Cascade's union employees also will see their weekly accident and sickness benefits under the company's short-term disability plan gradually increase to \$255 from \$230 in \$5 annual increments over the next five years.

Term life insurance benefits will increase to \$25,000 per year from \$22,000 in annual increments of \$1,000 through 1992.

And, pension benefits will increase to \$23 per month per year of

service from \$21.

Boise Cascade, which self-insures and self-administers its employee health care plans, also increased the maximum lifetime health care benefits offered to \$500,000 per covered individual from \$300,000.

Boise Cascade's health care plan pays 80% of covered services above a \$250 per-person deductible. Employees' out-of-pocket expenses are capped at \$1,500 per year, per covered individual.

In exchange for the sweetened benefits, employees with dependent care coverage will pay a monthly premium for the first time, and limits will be placed on

mental health care benefits.

Beginning May 1, 1993, employees will be required to contribute \$30 per month for dependent health care coverage, which now is fully paid by Boise Cascade.

But individual coverage will continue to be fully paid by the company.

Also effective immediately, a \$15,000 annual limit and a \$50,000 lifetime limit will be placed on mental health care benefits.

Previously, no limits were placed on mental health care benefits, which include inpatient and outpatient services for mental and nervous disorders and alcohol and substance abuse.

Cost containment

Premier Hospitals Alliance Inc.,

a nationwide network of 68 private hospitals, expects to reduce employee health care expenses under its new medical cost containment program launched July 1.

The hospital alliance has contracted with Orange, Calif.-based August International Corp. to provide claims management and utilization review services to curtail member hospitals' health care expenditures for non-union employees.

The agreement marks one of the first arrangements between an alliance of private hospitals and a health care cost management firm, according to Jeffrey Klein, president of Premier New York, a group of five hospitals acting as the launching point for the cost containment program.

Long Island Jewish Medical Center in New Hyde Park became the first Premier hospital to implement the plan on July 1, Mr. Klein said.

If the other four New York-area hospitals follow suit, Premier stands to save approximately \$3.3 million annually, including \$2.5 million in claims processing, \$600,000 from coordination of benefits and \$200,000 through utilization review, Mr. Klein estimated.

Premier New York has 11,700 non-union employees.

The savings would be even greater if all of the alliance's member hospitals implement the cost containment plan.

While participation in the program is optional, the alliance hopes to see at least 50% of the network using the August-provided services within three years, a spokeswoman for Westchester, Ill.-based Premier said.

The cost of implementing the program varies by member, Mr. Klein said.

However, the Premier-August contract will provide member hospitals with a special group rate as low as 4% of total health care claims paid, he noted.

Normal market rates for health care claims administrative services are 9% to 12% of claims paid, he added.

Premier hospitals employ varying health care benefit financing methods, including self-insurance, purchasing coverage from commercial insurers or hybrid combinations of self-insurance and commercial coverage, according to Mr. Klein.

AIDS costs

The cost of treating AIDS patients covered under Blue Cross of Western Pennsylvania plans has dropped approximately \$9,000 per case since January 1987, when the plans implemented a specialized case management and education program.

The case management program, which emphasizes home health care and hospice care for patients with acquired immune deficiency syndrome, realized daily savings of approximately \$600 to \$800 per case, the Pittsburgh-based Blue Cross plan reported.

The average cost per admission dropped to \$13,521 in 1988 from \$16,700 in 1987.

Despite the savings, AIDS-related hospital inpatient charges for plan subscribers still rose 6% to \$2.4 million in 1988 from \$2.3 million in 1987.

Blue Cross attributed the cost increase to a surge in AIDS patient admissions to 178 in 1988, a 31% jump from the 136 admissions reported in 1987.

Blue Cross provides health care coverage to about 18,000 employees in western Pennsylvania and nationwide.

Crawford's Light Duty Return-to-Work program saves indemnity dollars.

Another bright idea from Crawford & Company!

If you're in the dark about what Crawford & Company can do to help you introduce a formal light duty program in your company and reduce your Workers Compensation costs, call (404) 847-4470 or mail the coupon below.

When Crawford & Company introduced its Light Duty Return-to-Work program, its first client company was recognized by the National Association of Rehabilitation Providers in the Private Sector as the Employer of the Year for this innovative program. Our client returned its injured employees to work quickly and productively. You can, too.

Crawford earns your confidence . . .
one assignment at a time.



Send me information on your new
Light Duty Return-to-Work
program to reduce my Workers
Compensation costs.

Name _____
Title _____
Company _____
Address _____
Phone _____

John H. Potter, Assistant Vice President
5620 Glenridge Drive (Zip 30342)
P.O. Box 5047
Atlanta, Georgia 30302



Sweet Spot for Specialty Risks

Get an advantage on risk placement. For primary and excess liability and property coverage, call the underwriting pros at General Star today.



**GENERAL
STAR**

- Market Stability
- Financial Strength
- Underwriting Quality

General Star Management Company, Stamford, CT • Specialty underwriting for primary and excess risks through appointed surplus lines brokers
New York (212) 770-0150 • Chicago (312) 207-5400 • Hartford (203) 297-4100 • Los Angeles (213) 383-7734 • Stamford (203) 328-5700
A member of General Re Group

Opinions

Speed oil spill cleanups

STRONG ECONOMIC INCENTIVES to prevent oil spills and speed their cleanup are clearly needed.

The rash of oil spills damaging U.S. waters and killing wildlife demand that the federal government and the oil exploration and transport industries adopt far more effective loss prevention and loss control programs (BI, July 3).

From requiring experienced pilots to be on board vessels in certain waterways to mandating safer tankers to certifying cleanup plans, there are plenty of loss prevention and control regulations that need to be strengthened.

But the only way to effectively enforce these regulations is to create an economic incentive for industry to adopt these programs and follow them. We have to make the results of a cost-benefit analysis of these programs overwhelming.

To do this we have to make it more expensive to spill oil in our waterways than it is to adopt the programs needed to prevent such spills in the first place.

And we have to make it more expensive to delay cleaning up an oil spill than it is to use every means available to clean up a spill as quickly as humanly and technologically possible.

That means adopting much stiffer penalties for killing fish, birds and other wildlife.

It's clearly inadequate to simply assess damages for slaughtered wildlife at the market value of the fish or fowl. It must be some larger multiple of market value to make it prohibitively expensive to kill fish.

And where there is no market value—a loon diving into the Narragansett Bay or a sea otter playing in the waters off Prince William Sound or a



great blue heron flying over Delaware Bay—a very large price indeed should be placed on the lives of wildlife.

Furthermore, the penalties for spilling oil should escalate with every day that the spill is not cleaned up. The immediate threat of killing wildlife otherwise may be too low to encourage a quick cleanup, permitting unforeseen damage to occur.

Until we make it economically imperative to prevent oil spills and speedily clean up those that occur, we will continue to see the oil industry and those who transport its products pollute our waters, kill our wildlife and destroy our precious environment.

Letters

RIMS voices 'deep concern' over COBRA

To the editor: As an organization of more than 4,300 employers that offer their employees extensive health coverage, the Risk & Insurance Management Society Inc. must express deep concern over the changes to the Consolidated Omnibus Budget Reconciliation Act health care continuation provisions that the House Ways and Means Committee is considering. This controversial law, passed with little or no input from plan sponsors, has taken on a life of its own that continues to stretch the parameters of employer-employee relationships.

Paramount among our concerns is a proposal to allow former employees to maintain COBRA coverage even when the employee becomes covered under another employer's plan. RIMS views this as an unwarranted expansion of the COBRA concept. The specifics of a potential employer's benefit plan should be weighed by individuals who consider changing jobs. If a person has a pre-existing condition, he or she should make sure that a potential employer's plan offers coverage for that condition before accepting employment with the employer. This is especially true where an employee leaves his present job voluntarily.

Allowing COBRA coverage where another plan exists also may force an employer to directly subsidize a competitor. For example, a computer programmer is likely to leave employment with a computer firm for a position with another firm. Allowing the individual to keep the COBRA coverage would, in essence, be requiring that employer to subsidize the loss of an employee to a competitor. This contradicts the foundation of the American economic system—encouraging vigorous and open competition.

Employers are concerned that COBRA is being used as a back-door method of instituting mandated benefits. They are mindful of efforts to expand the scope of COBRA to cover disabled persons and those who take early retirement and are awaiting Medicare eligibility. Such changes will only serve to confirm deeply rooted beliefs that once Congress opens the door a crack, the crowbar is never far behind.

RIMS has stated openly its willingness to discuss benefit mandates as part of a solution to the uninsured problem. However, COBRA expansion would impose new benefits without a proper discussion in the context of mandated benefits. Furthermore, although the employer-employee nexus may be a legitimate basis for mandates, expanding COBRA stretches the principle since the relationship between employer and former employee is distant.

If the Ways and Means Committee is set on allowing double coverage, RIMS asks the committee to at least allow a premium substantially above 102% in such cases. Anyone continuing COBRA coverage under these circumstances will likely submit significant claims, exposing COBRA plans to the worst of adverse selection.

It is also our understanding that new, duplicative non-compliance penalties are being weighed. Unlike the present penalties, which are under the Internal Revenue Service's jurisdiction, these new penalties would be imposed by the secretary of labor. We have seen no evidence that present penalties are insufficient and RIMS

would therefore view the imposition of new ones as excessive.

We thought the question of effective and appropriate penalties was settled when Congress, led by the Ways and Means Committee, changed the draconian penalty provisions proposed by the IRS. Indeed, RIMS members wrote more than 200 letters to the IRS opposing its proposed penalties. We see little reason to reopen the issue.

RIMS appreciates your considering the views of employers. We hope the final Ways and Means Committee proposal will reflect these very real concerns.

Howard W. Greene

Associate Legislative Director
Governmental Affairs Department
Risk & Insurance
Management Society Inc.
New York

■ *Editor's note: The Risk & Insurance Management Society Inc. sent a copy of this letter to House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill.*

Risk control yields greater dividends

To the editor: Congratulations on your editorial "Broker Judgment Day" (BI, June 26). Suggesting that risk managers "dedicate more time to broker selection" is right on target: Simply taking on a new broker because the firm is "cheaper" will inevitably lead to disaster! A point not specifically raised in the editorial: Many risk managers are also looking for far more sophisticated risk assessment and risk control services. In the long run, more intelligent risk assessment and more highly sophisticated risk control will pay far greater dividends to the organization than simply bidding insurance periodically.

H. Felix Kloman

Principal
Tillinghast
Stamford, Conn.

Business Insurance®

Reporting weekly for corporate risk,
employee benefit and financial executives

Publisher: Alfred Malecki (New York)

Associate Publisher/Editor: Kathryn J. McIntyre, A.R.M.
(Chicago)

Managing Editor: James M. Burcke (Chicago)

Senior Editor: Jerry Geisel (Washington)

Assistant Managing Editor: Dave Lenckus (Chicago)

CHICAGO: Stacy Adler (Associate Editor)

Jeanne M. Bartels (Graphics Editor)

Kari Berman (Associate Editor)

Karen Brown (Assistant to the Editor)

Linda J. Collins (Agent/Broker Editor)

Meg Fletcher, A.R.M. (Associate Editor)

Mark A. Hofmann (Associate Editor)

Karen Huelsman (Copy Editor)

Marilou Jones (Directory Editor)

Jacqueline LaSota (Assistant Copy Editor)

Laura Mazzuca (Agent/Broker Topics Associate Editor)

Amy Palmer (Graphic Artist)

Roger Schillerstrom (Editorial Cartoonist)

Paul Winston (Copy Editor)

Joanne Wojcik (Copy Desk Chief)

Christine Woolsey (Associate Directory Editor)

DALLAS: Michael Bradford (Associate Editor)

LONDON: Stacy Shapiro (International Editor)

Carolyn Aldred (Associate Editor)

LOS ANGELES: Donna DiBlase (Bureau Chief)

Glenn Huntley (Associate Editor)

NEW YORK: Douglas McLeod (Bureau Chief)

Judy Greenwald (Associate Editor)

Collin Nash (Editorial Assistant)

Michael Schachner (Associate Editor)

WASHINGTON: Adrienne C. Locke (Associate Editor)

Deborah Shalowitz (Associate Editor)

Advertising Director: Donald A. Walsh (New York)

Midwest Sales Manager: Robert L. Niesse (Chicago)

CHICAGO: Deborah D. Neale (District Manager)

Margaret Hikido (District Manager/

Classified Sales)

Elmer Kerstowski (Production Manager)

Eastern Advertising Manager: Martin J. Ross (New York)

NEW YORK: Charles A. Horvath (District Manager)

Jack Forrest (District Manager)

Kathryn Premetz (District Manager)

Cynthia Bykowski (District Manager)

LOS ANGELES: Michael J. Sharpe (Western Advertising Manager)

Director of Communications: Ronnie I. Drachman
(New York)

EDITORIAL: Chicago: 312-649-5398

Dallas: 214-363-1066

London: 01-404-4228

Los Angeles: 213-651-3710

New York: 212-210-0140

Washington: 202-662-7200

ADVERTISING: New York: 212-210-0133

Chicago: 312-649-5276

Los Angeles: 213-651-3710

COMMUNICATIONS: New York: 212-210-0132

CIRCULATION: Detroit: 313-446-1611

Published by Crain Communications Inc., Chicago

G.D. CRAIN JR.

Founder (1885-1973)

MRS. G.D. CRAIN

Chairman

S.R. BERNSTEIN

Chairman-executive committee

RANCE CRAIN

President

KEITH E. CRAIN

Vice chairman

MARY KAY CRAIN

Treasurer

MERRILEE P. CRAIN

Secretary

WILLIAM A. MORROW

Senior Vp-operations

ROBERT C. ADAMS

Vice president-production

H.L. STEVENSON

Corporate editor

PENELOPE A. GEISMAR

Corporate communications mgr.

Published weekly at 740 Rush St., Chicago, Ill. 60611, Telex 6871241, Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York, N.Y. 10017, Telex 640207, Fax 212/210-0704, CRAIN COM NYK; 1 Northpark, East Suite 114, 8950 N. Central Expressway, Dallas, Texas, 75231, Fax 214/696-1936; Suite 814, National Press Building, Washington, D.C. 20045, Fax 202/638-3155; 6404 Wilshire Blvd., Los Angeles, Calif. 90048, Fax 213/655-8157; 20-22 Bedford Row, London WC1R 4EB, England, Fax 01/430-2176. \$1.75 a copy. \$70 a year in U.S. Canada and all other foreign add \$32 for surface mail. Europe and Middle East only add \$72 for air delivery. First-class mail to U.S., add \$77; to Canada add \$87. Bermuda only, \$152 per year expedited delivery. WILLIAM STRONG, vp-circulation. SHEILA GORMLEY, circulation manager. JOHN HUFFMAN, fulfillment director. Four weeks' notice required for change of address. Send subscription correspondence to Circulation Department, Business Insurance, 965 E. Jefferson Ave., Detroit, Mich. 48207, or phone 800-992-9970 or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road, Wooster, Ohio 44691. Portions of the editorial content of this issue are available for reprint or reproduction in other media. For information and rates to reproduce in general circulation media, contact: ART MERTZ, The Crain Syndicate, 740 Rush St., Chicago, Ill. 60611, 312-649-5303. For reprints or reprint permission contact: Reprint Department, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017, 212-210-0229, Fax 212/210-0704.

VBPA

Member of Business
Publications Audit of Circulation

ABP

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

The sun doesn't set at Reliance National

At Reliance National, 'sunset clauses' are yesterday's memories. Our ASBESTOS ABATEMENT program is written on a true occurrence form without a sunset clause. It is issued to contractors who have demonstrated industry expertise over several years and have a track record of successfully completed asbestos abatement projects. Rounding out our abatement insurance policies are Comprehensive General Liability, professional loss control services, and premium financing programs.

RELIANCE NATIONAL'S ASBESTOS ABATEMENT PROGRAM

Options within our program are:

- Pure Occurrence Form (no sunset clause) for the eligible contractor
- Comprehensive General Liability included
- Competitive rates, adequate limits
- \$100,000 minimum premium
- Professional liability for accredited labs & certified consultants*
- Architects and Engineers coverage available*
- Hazardous waste transportation coverage available

Come to RELIANCE NATIONAL... the choice in making 'sunsets' a thing of the past for you and your clients.



THE CHOICE
Reliance National

A Reliance Group Holdings Company

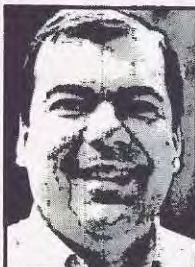
For Further Information Call: (212) 858-6354

*Available in all states except Hawaii, Alaska, Massachusetts, New Hampshire, Rhode Island, and Connecticut

Reliance Insurance Company, Planet Insurance Company, United Pacific Insurance Company, Reliance Insurance Company of Illinois, Reliance Insurance Company of New York, and General Casualty Insurance Company

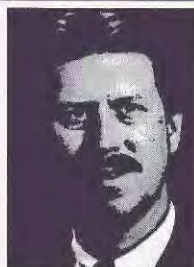
At issue

Are EAPs the most effective way to help troubled employees?



William M. Trask
manager-personnel services
James River Corp.,
Old Town, Maine

Our program has been very successful; it offers everything from drug and alcohol counseling to financial assistance and management. We've received a lot of positive feedback from the large percentage of employees who use it. But I think off-site, rather than in-house, programs are most effective because confidentiality is a key factor to a successful EAP. Compiled by Christine Woolsey



Bryce E. Farmer
vp/manager-human resources
Ranger Insurance Co.,
Houston

I consider EAPs a viable part of the human resource manager's arsenal. While other alternatives are available to minimize skyrocketing medical and long-term disability costs, EAPs will continue to have a major impact on employee welfare programs. Companies will continue to implement, focus and fine-tune their EAPs in the future because they work.



Toni L. Hengesteg
director-benefits
Ecolab Inc.,
St. Paul, Minn.

In 1989 we introduced a full-service EAP that provides short-term counseling for employees and their families. Employee feedback is positive, and usage is running at 8%. The EAP contributes to cost containment by offering managed care in the mental health and chemical dependency areas. Savings will run more than \$100,000 this year.



James P. Wayne
director-compensation and benefits
Peoples Drug Stores Inc.,
Alexandria, Va.

Employee assistance programs are an integral part of our company culture, which focuses support on employee wellness and productivity strategies. The results to date give every indication that utilization occurs at all levels of the organization with reported success. Responsiveness, confidentiality and professional assistance are key to the value added through EAPs.

GASB rules

Continued from page 3

large surpluses established to pay future losses turned into deficits, some fear.

And, municipalities with bond-issuing authority fear that the qualified opinions they say they will receive from their auditors because of the impact of the GASB proposal on their balance sheets will severely reduce their bond ratings.

But, some consultants and accountants say few self-insured public entities' bond ratings are imperiled by the proposed accounting standards.

"Large entities like San Francisco or Los Angeles won't be affected," said Allen Frazier, a consultant with The Wyatt Co. in San Francisco.

"Any good bond rater worth his salt knows the ins and outs of large city fiscal management," Mr. Frazier pointed out.

"If there is an issue here, it will be with the smaller cities, and even for them this may not be a material matter," he said.

And, Mr. Frazier predicted that bond ratings for smaller public entities would be downgraded only if rating organizations were previously totally unaware of the town's risk financing accounting practices.

Bond rating authorities look at a wide range of factors when issuing a rating, not just balance sheets, agreed Greg Berg, a principal consultant in the Simsbury, Conn., office of Tillinghast, a unit of Towers, Perrin, Forster & Crosby Inc., and a member of the GASB task force looking into the merits of the proposed accounting standards.

'To say GASB will have wholesale effects on bond ratings just isn't so,' says Mr. Ferraro.

"They look at cash flows, which are just as important as balance sheets. They also look at budgets, and GASB doesn't affect that at all," he said.

"I'd be very surprised if a municipality were downgraded based solely on unfunded loss liabilities," Mr. Berg asserted.

"A city of 500,000 people would have to have tremendous losses to have full accrual affect its bond rating. To say GASB will have wholesale effects on bond ratings just isn't so," commented Mark Ferraro, president of Ferraro & Associates, a public entity consultant in Dallas that specializes in servicing towns with fewer than 35,000 people.

Lee Robinson, director of Alexander & Alexander Inc.'s public entity consulting division in Atlanta, said accounting for claims and other liabilities on an accrual basis is nothing more than "good risk management."

"I recommend to our clients to do this not because GASB requires it, but because it's simply good risk management," Mr. Robinson said. "Large cities know they have enormous unfunded liabilities which they must address."

Mr. Robinson also pointed out that self-insured public entities can soften the blow of the GASB proposals to their balance sheets—and therefore insulate their bond ratings from the impact of the proposals—by phasing in the accounting standards before the 1993 effective date.

"Start implementing GASB practices as soon as possible," Mr. Ferraro agreed. "You know it will come into effect, and you might

Continued on next page



Listen.

It's what an employee benefits manager does. You listen to employees asking for a health plan with lower co-payments and better benefits. You listen to management asking for cost control. Then you try and please everybody.

That's when you need to start talking—to EQUICOR. EQUICOR offers a complete range of employee benefit options—all we need to formulate your benefit plan is to hear from you.

Tell us the numbers you're working with, your priorities, management's budgetary goals, and every other important factor to be considered. Then let EQUICOR design a unique, customized benefit package for your company based on good hard listening.

Next time someone gives you an earful, think of EQUICOR. And remember: whenever you need to talk about a benefits plan, you've got our ear.



The Good Listener.

For information, call (212) 618-4020

EQUICOR is a joint venture of The Equitable Life Assurance Society and Hospital Corporation of America.

EQUICOR Health Plan, Inc. is a licensed health maintenance organization in various states. Insured coverages are underwritten by The Equitable Life Assurance Society of the United States. ©EQUICOR 1989

EVERY YEAR THERE'S ANOTHER SOLUTION TO THE HEALTH CARE CRISIS. SIMPLE. EASY. WRONG.

It's a rare crisis that responds to a small fix.

Yet, year after year, that's exactly what's been offered: cost-containment programs that were effective in the areas they targeted but not broad enough to truly slow surging medical costs.

At the CIGNA companies, we believe what's needed is a whole new framework for offering health care. And so we've created one:

Integrated Managed Care.

Simply put, we form a long-term partnership with each of our client companies and with local providers of medical services.

A partnership where each member is committed to two simultaneous goals: ensuring quality medical care and containing costs.

Then, drawing from a broad array of managed care products and services, we design health care programs to meet each client's short- and long-term objectives. And we

implement them in a way that lets clients move at their own pace.

What does this mean for your company?

That at last there are health care programs that can help you contain escalating medical costs.

And what does it mean for your employees?

That they have access to quality medical care through the health care delivery system that's best suited to their needs.

To learn more about programs already benefiting companies nationwide, write the CIGNA Companies, Dept. R2, 1600 Arch Street, Philadelphia, Pennsylvania 19103.

And discover a long-term health care solution that may not be simple or easy, but does have one important thing going for it.

It's right.



GASB rules

Continued from previous page as well get used to it."

Mr. Ferraro said that self-insured public entities "do have time. They need to meet with their auditors, finance people and public officials to discuss GASB requirements."

He also suggested that as 1993 approaches, self-insured public entities should prepare a "pro forma" mock-up of their financial statements before they are certified and published to determine how the statements will be affected.

"Government entities should have been doing this (annual loss accounting and accruing) a while back," according to David Epps, executive director of the Missouri Intergovernmental Risk Management Assn., a multiline pool of 62 cities and city-owned utilities throughout Missouri.

"Without it, a lot of folks have

been living with financial statements that have given a false sense of security. So, they should take advantage of the 1993 timetable to begin accounting for losses yet unpaid," Mr. Epps said.

The reasoning behind the new accounting standards proposals is to force governmental entities to

Most public entity risk managers, consultants and accountants agree that the GASB proposals are well-intended, but some are skeptical that self-insured public entities will comply with the proposed standard.

"I've been wondering to what extent individual public entities

'If this makes entities reserve for losses far down the line, those pools of money will disappear as legislatures rob Peter to pay Paul. Anytime a legislative body sees a pot of money, it's as good as gone,' says Virginia's Mr. LaMond.

report liabilities that they know exist, GASB's Ms. Monk commented.

"You can't pass them on to taxpayers 10 years from now when the claims are settled," Ms. Monk said.

will move into compliance" said Tillinghast's Mr. Berg.

For example, Don W. LaMond, director of risk management for the state of Virginia, said that the state will not abide by the GASB proposal "unless we have to."

"Remember, government is a cash-flow business. Statutory laws don't allow governments to plan that far ahead because of changing taxes and revenues," Mr. LaMond said.

"If this makes entities reserve for losses far down the line, those pools of money will disappear as legislatures rob Peter to pay Paul. Anytime a legislative body sees a pot of money, it's as good as gone," he said.

Meanwhile, many large public entity risk-financing pools already are complying with the proposed GASB standards for pools.

"We have been reserving and keeping track of loss development for a long time," said Sue Puddington, director of the New Hampshire School Board Insurance Trust in Manchester, noting that GASB will have little effect on her pool.

"In fact, we feel this proposal will promote comparability among pools and make it easier for pools

to compare administrative and defense costs," Ms. Puddington explained.

Consultants agree with Ms. Puddington that pools will likely move into GASB without hitches.

"I just don't see pools having much trouble meeting GASB standards," Mr. Ferraro said.

Pools, for the most part, practice accrual accounting, he said.

"Pools, depending on what they've been doing, may not be affected by GASB," said Mr. Berg of Tillinghast.

"Most are already preparing their financial statements in accordance with FASB 60," he said, referring to the portion of the proposed GASB standard affecting public entity risk-financing pools that is modeled after FASB Statement No. 60.

However, the financial statements of many small pools with less sophisticated management may be hurt by the new accounting requirements, according to consultants.

"Many small pools, with say, half a dozen members, will be damaged by this," Mr. Frazier asserted. "They aren't even aware of what is required of them, and it will first hit them when their accountant tells them."

But, Mr. Frazier said he believes small pools will definitely come in line with GASB if they are not currently preparing their financial statements in accordance with the proposal.

Pools also will have a public relations problem on their hands, as the radical change in numbers will certainly prompt some pool members to question the accounting practices used in the past, Mr. Ferraro predicts.

"The negative balances that will occur will cause questions from

concerned pool members. They may finally realize that the assets and liabilities of the pool are owned by the membership," he said.

GASB is expected to meet in August to discuss comment

letters on the exposure draft issued last winter and probably will issue a final statement regarding the exposure draft in September, according to Ms. Monks.

An early analysis of the comment letters shows general support for the proposals affecting pools, especially among accountants, said Ms. Monks, noting that about 70% of the feedback received by GASB so far is positive.

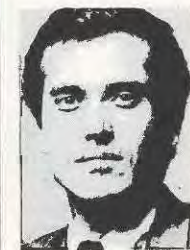
However, municipality "respondents don't like the FASB 5 part," she said.

Accountants who perform audits for public entities laud the proposed GASB standards, saying that recording and accruing for losses as they occur is a sensible accounting practice that they have advocated for quite some time.

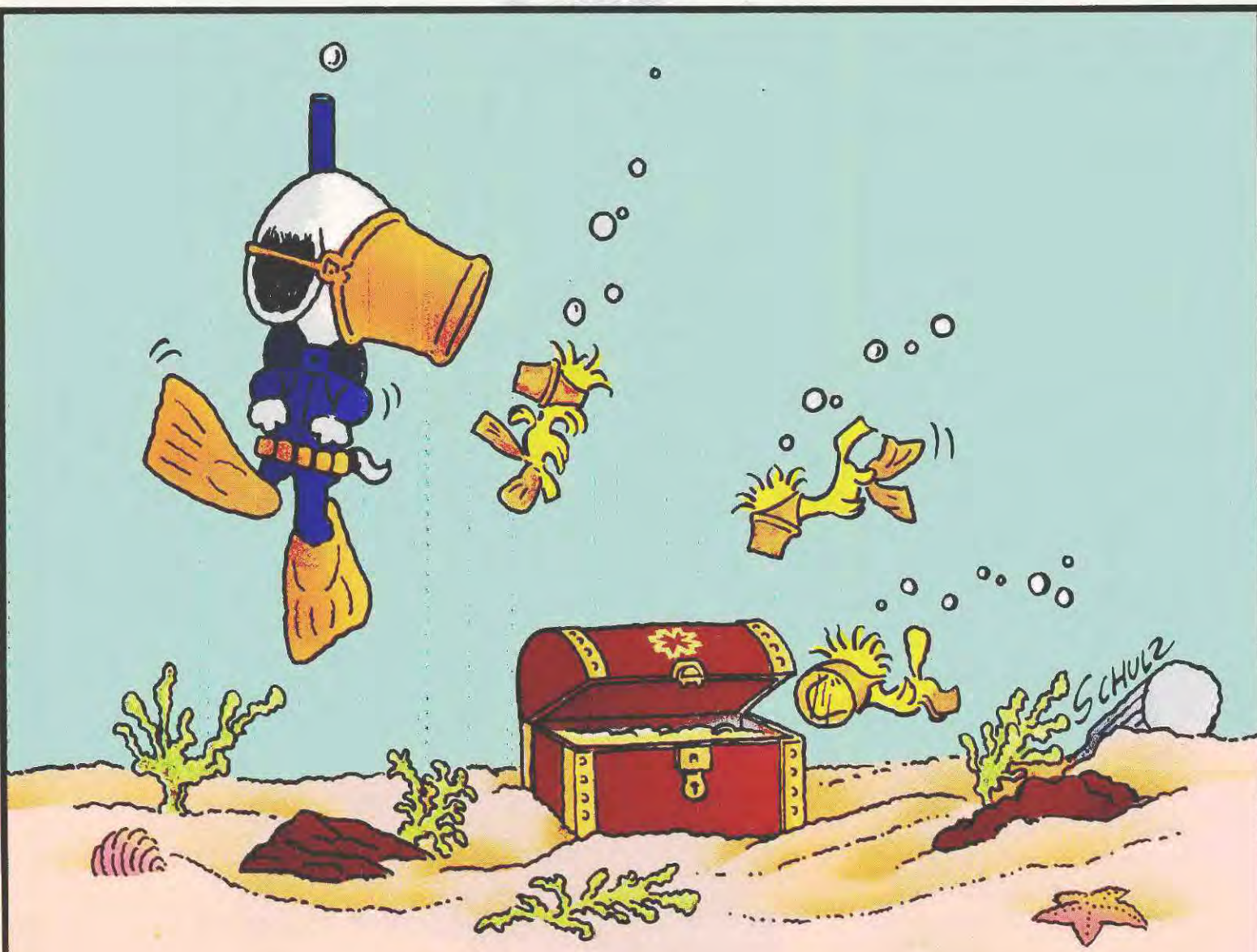
"Many of our clients have been paying as they go all along," said Frank Barfuss, a partner in the New York office of Big Eight accounting firm Deloitte, Haskins & Sells. "That's a poor accounting practice, and all we can do is issue a qualified opinion."

Mr. Barfuss said he has traditionally recommended accrual accounting for losses as they occur. "That is just part of good accounting," he said.

Jack McDonough, a GASB task force member and a specialist in technical services for insurance companies in the Hartford, Conn. office of Price Waterhouse, pointed out that he was pleased with the GASB proposal for municipal risk pools because "the draft sticks closely to generally accepted accounting procedures for insurance companies."



Mr. Ferraro



FOR GROUP LIFE AND HEALTH NEEDS, LET MET LIFE EXPLORE YOUR OPTIONS.

No matter what your company size, we have the coverage you need. We'll delve into our complete line of products, including Group Universal Life and Flexible Benefits, to find the plan that will work best for you.

Get Met and we'll follow up with helpful administrative services and prompt

payment of claims. Contact your broker/consultant, your Met Life Group Rep., or write to us at Metropolitan Life Insurance Company, Group Marketing Division, One Madison Avenue, Area 24VW, New York, New York 10010.

Discover what Met Life has to offer.

GET MET. IT PAYS.



Metropolitan Life
AND AFFILIATED COMPANIES

Guaranty fund

Continued from page 1

tutions." However, the judge said the decision is not retroactively applicable to other cases.

The plaintiff in the case, Borman's, was an 80-unit supermarket chain that had purchased primary general liability and auto liability insurance from New York-based Ideal Mutual Insurance Co., which was ordered liquidated in 1985 (BI, Feb. 11, 1985). Borman's was acquired by The Great Atlantic & Pacific Tea Co. earlier this year.

The case stemmed from an August 1981 slip-and-fall claim against Borman's. A Wayne County, Mich., Circuit Court jury in September 1985 awarded the plaintiff \$2.1 million, including interest.

Although Ideal Mutual had agreed to pay a minimum of \$950,000 toward the verdict, the insurer was put into rehabilitation before the sum could be paid.

Eventually, Borman's paid \$1 million towards settlement of the case. It then filed a claim with the Michigan guaranty fund, which denied the claim on the basis that Borman's net worth exceeded the cap included in the guaranty fund law.

Under the 1969 Michigan guaranty fund statute, policyholders cannot recover from the guaranty fund if their net worth is greater than 0.1% of the aggregate premiums written by member insurers of the guaranty fund in the preceding calendar year.

In 1987, for instance, when member insurers' written premiums totaled \$7.7 billion, companies with a net worth exceeding \$7.7 million could not recover from the fund.

The Michigan statute also set the maximum claim payable by the fund at 50% of the net worth limit—or \$3.8 million in 1987.

A company's net worth is determined by subtracting its liabilities from its assets.

Between year-end 1980 and year-end 1987, Borman's net worth ranged between \$22.8 million and \$38.8 million, while the net worth cap under the guaranty fund statute rose from \$4.3 million in 1980 to \$7.7 million in 1987.

The Michigan Property & Casualty Guaranty Assn. plans to appeal Judge Hackett's decision to the 6th U.S. Circuit Court of Appeals in Cincinnati after it obtains clarification on one aspect of the ruling from Judge Hackett, said Jeff Lipshaw, an attorney with Detroit-based Dykema & Gossett.

The appeal process could take at least one to one-and-a-half years, he said. Attorneys for the association may ask for a stay on the decision from either the federal district or appellate court pending final resolution of the case, he noted.

If the decision is ultimately upheld, it could affect the operation of other guaranty funds, observers point out.

For example, the NAIC added a provision to its model guaranty fund act in 1986 that requires any corporation with a net worth of more than \$50 million to reimburse a guaranty fund for liability claim payments made on its behalf (BI, Feb. 13). The provision has been adopted in Colorado, Connecticut, Hawaii, Illinois, Oklahoma, Rhode Island and Vermont, according to the NAIC and other observers.

In addition, Georgia raised its net worth limit, which applies to any claim against the fund, to \$3 million from \$1 million in 1985, said Percy Marchman, administrator of the Georgia Insurers Insolvency Pool.

Wisconsin subrogates against policyholders with a net worth exceeding \$10 million.

And, Missouri Gov. John Ashcroft was expected to sign legislation last week that would bar guaranty fund recoveries by a company with a net worth exceeding \$25 million, effective Aug. 14.

The Michigan ruling could affect whether California adds a net worth provision to its guaranty fund law,

said John W. Gates, executive director of the California Insurance Guaranty Assn. in Los Angeles.

While California probably would have adopted a net worth provision had the decision not been made, "I don't know what our reaction will be now," he said.

John Rodman, an attorney with the Denver-based Renner & Rodman, which represents the Colorado Insurance Guaranty Assn., noted that the Michigan ruling "creates some concern."

Colorado's net worth provision only became effective April 17, he noted. In light of the decision, "We may have some problems out here."

Thomas Jenkins, an attorney with Lord, Bissell & Brook in Los Angeles, which represents the Illinois Insurance Guaranty Fund, said that some large corporations are expected to file claims against the guaranty fund after the insolvencies of American Mutual Liability Insurance Co. and American Mutual Insurance Co. (BI, March 13).

"It's definitely going to be an issue," he said.

David Simmons, the NAIC's general counsel, said the NAIC's guaranty task force would not necessarily amend the net worth provision in its model guaranty fund law based on a

'To tax us and not indemnify us is taxation without representation,' says Jon Harkavy of RIMS.

single federal district court decision. However, he added, the task force may want to study the decision.

Observers point out that net worth provisions are an attempt to reaffirm the original intent of guaranty funds, which was to compensate individuals or companies that would be financially devastated by an insolvent in-

surer's inability to pay their claims.

Guaranty fund creators did not envision the funds serving large, wealthy companies that are not only capable of absorbing their losses, but also have the necessary resources to intelligently select an insurer, the observers say.

The financial strain caused by large policyholders' attempt to recover from guaranty funds has already led to lawsuits.

For instance, the Connecticut Guaranty Assn. is asking a state judge to reconsider his order that the state's \$300,000 cap on guaranty fund payments should be applied separately to thousands of claims involving Raymark Corp., a former asbestos producer (BI, Feb. 13).

Other observers—including risk managers—say that because large corporations indirectly finance guaranty funds through their premiums, they are entitled to guaranty fund coverage if one of their insurers becomes insolvent.

"We're gratified the court held this

way," said Jon Harkavy, vp-governmental affairs for the Risk & Insurance Management Society Inc. in New York.

"For them to tax us on the basis of our premiums, and then not indemnify us is truly taxation without representation," he said.

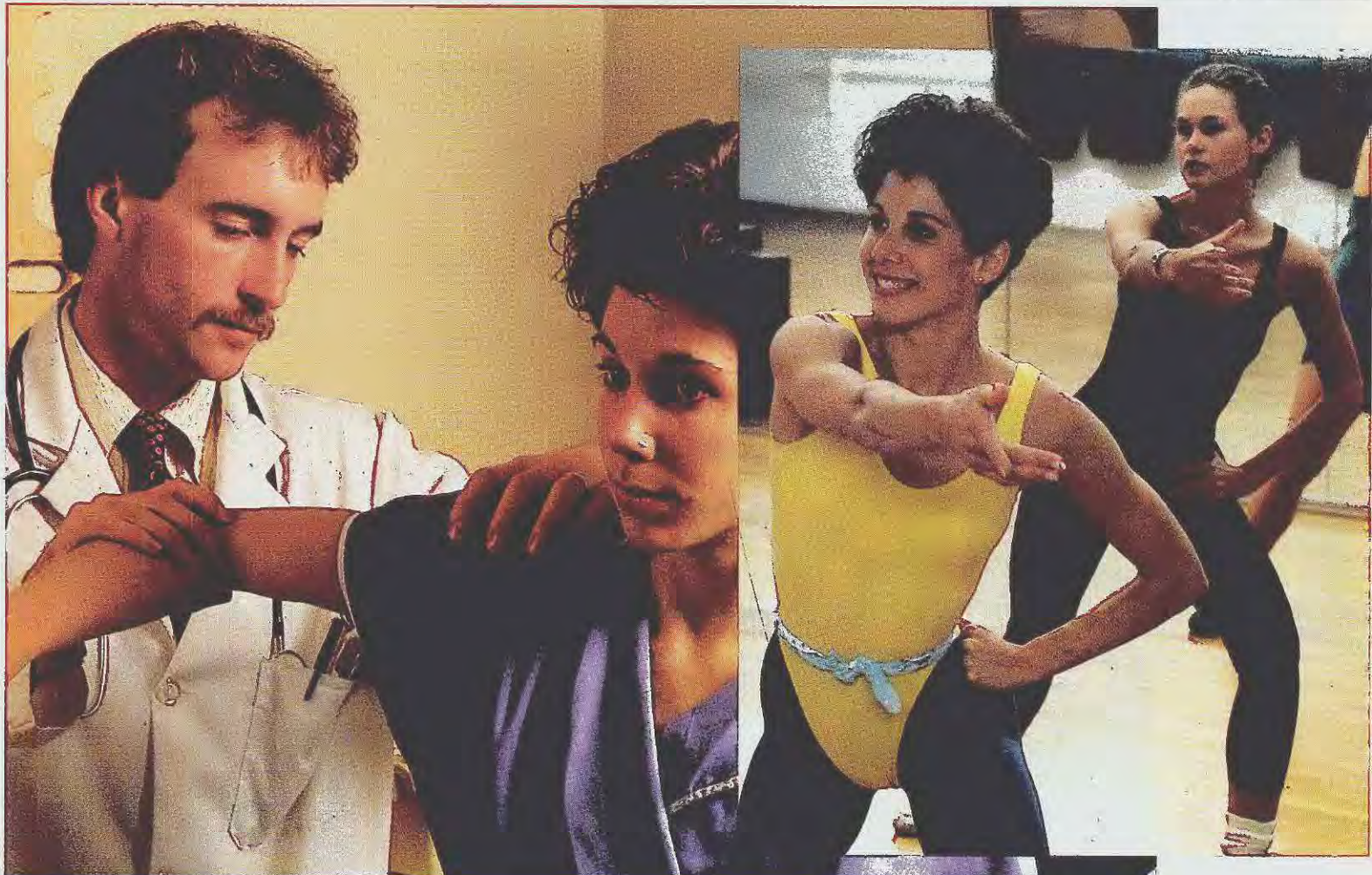
Robert Epstein, Borman's general counsel, agreed.

"It has been my feeling all along that the operation of the net worth limitation is unfair, and that the purpose of the legislature in adopting these guaranty fund acts can be accomplished in ways that are not discriminatory against insureds, and that's still the case," he said.

Placing a lower cap on covered claims, for instance, is "one very obvious way to accomplish that," said Mr. Epstein.

Net worth caps have "been one of my sore points for some time," commented Ronald W. Stasch, corporate risk manager at Federal-Mogul Corp. in Detroit and presi-

Continued on next page



FAST-TRACK RECOVERY... OF PRODUCTIVITY AND PEOPLE.

Sue Charles teaches aerobics at The Downtown Health Club. When she was injured, her physician predicted a long, costly recovery.

Who can make sure that every dollar spent on Sue's rehabilitation does, in fact, buy the speediest possible recovery?

In response to this question, a new industry was born: the medical/vocational case management industry. GRS has been a part of this industry for 12 years. Today, nobody does it any better.

WIN-WIN RECOVERY MANAGEMENT.

So before you invest in medical and/or vocational rehabilitation, make sure you have GRS recovery-management experts on your team. Because with speedy recoveries, everybody wins — employers, insurance companies and claimants.

GRS specializes in recovery-driven programs that reduce claims costs and put employees back to work faster. Find out how GRS' medical coordination and vocational rehabilitation services can put your injured workers on the fast track to a comeback.



Call me at (215) 251-9510 and I'll send you our information. Or fill out the coupon below. And please let me know if I may telephone to arrange an appointment to tell you more about GRS' special brand of fast-track recovery management.

- ☐ YES! Send me more information.
☐ YES! Call to schedule an appointment.
☐ YES! Send more information and call, too.

NAME _____ TITLE/POSITION _____
COMPANY _____
MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE (AREA CODE) _____

Mail to the address below or FAX to (215) 251-9518

**GENERAL
REHABILITATION
SERVICES INC.**
1436 LANCASTER AVENUE • BERWYN, PA 19312 • (215) 251-951C
THE FAST TRACK TO A COMEBACK

There are some very good firms that specialize in utilization review. Firms that do nothing else. So it might be interesting to compare them to an organization you may not think of for this kind of help. Ours. According to published reports,



All 1,200 of our nurse reviewers have relevant clinical experience and receive training in communication skills. We also have over 1,000 physicians in all major specialties. So complicated cases and appeals can be resolved doctor to doctor.

you're likely to find for administration, staff, medical criteria and quality

Experts say you a specialist for ut We concur.

the largest of these companies serviced 11.5 million lives last year.

We serviced over 15 million.

Of the ten leaders, the biggest staff of nurse reviewers and doctors was 600. Ours totaled 2,200.

Numbers, we realize, don't say anything about the actual service you get. Or the kind of cost containment you can expect. That depends on how well the review system operates.

On its standards. The system in our case is Custom Care-USA. And as the name implies, it's national.

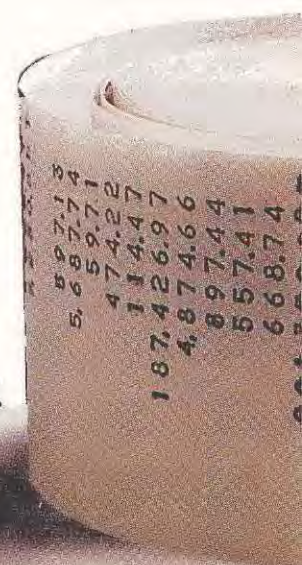
When someone calls for a review, they don't wait long for a response. We answer the phone within 30 seconds 90 percent of the time. We require reviews to be completed within one working day.

control. A case in point being the nurse reviewer.

How she does her job determines in large part how happy your employees are with the program. And how much it may save you in inappropriate medical care.

But nurses are used to communicating face to face. Not on the phone. And certainly not in the kind of complex, sensitive situations a nurse reviewer can find herself in. That takes special training. Of the firms that offer training, none has a program as large or as intensive as Custom Care-USA.

We have enough nurses to complete 100 percent of reviews within one working day. Incoming



phone calls are answered within 30 seconds 90 percent of the time even during peak periods. Written notification of review decisions is sent within two working days.

If a second opinion is required, there's a ready solution: A national

But to do that it's much better if you can manage things locally. Where you can monitor the patient, negotiate with providers and make arrangements first-hand. Not by long distance. Custom Care-USA can give you and your employees that advan-

should only use utilization review.



When Custom Care-USA reports results, they're not just estimates or projections. We pay the claims so we can tell you exactly what happened and how much you're saving.

panel of 36,000 board-certified physicians. We can quickly help your employees

locate the doctor needed anywhere in the country by specialty, sub-specialty, hospital affiliation and even special languages.

What your program consists of is up to you. Custom Care-USA is flexible. You can unbundle down to basic components. Or add more specialized services like psychiatric and substance abuse review.

One especially effective tool is something we call Individual Case Management. Managing the care of high-cost cases can provide savings of \$7 to \$10 for every dollar spent.

tage—using qualified case managers in local Plans around the country.

We're also in a much better position to evaluate results. Because we pay the claims. We don't report only what should have happened but what actually did. Which is why our Management Reports can even suggest where and how you could be saving more.

So if your company has a thousand

In the management of high-cost cases, long distance isn't as good as being there. Our Individual Case Management is done on-site. No one gives you better access to local providers or more leverage in negotiating for services.

or more employees in more than one state, and you're looking for a specialist in utilization review, call 1-800-552-2583. Utilization review may not be the only thing we do. But then again, that's why we can do it so well.



**Blue Cross.
Blue Shield.**

Registered marks Blue Cross & Blue Shield Association

AN ENLIGHTENED WAY TO MANAGE THE "GREY AREAS" OF HEALTH CARE.



Everyone knows that mental health and substance abuse present special health problems. They are more difficult to diagnose. They are more difficult to treat and monitor. And, consequently, they are far more expensive. That's why we call them the grey areas.

More and more employers and health care organizations are turning to MCC to help manage these grey areas.

The MCC approach to mental health and substance abuse care works. Studies consistently show high user satisfaction. The records show effective cost control. The reason for this success is that MCC, through its experience since 1974, is able to prescribe necessary treatment based on symptoms rather than on expediency or "customary practice."

MCC has developed a range of products that can deliver their cost-effective service according to your particular needs...including capitated "at-risk" arrangements for HMO's and PPO's, as well as employer-oriented products like Utilization Management Review, Case Management and Exclusive and Preferred Provider Programs.

We'd like to answer all your questions and discuss your specific needs. Call us at (612) 861-9500 or 1-800-433-5768 today.

It should be enlightening.



Aviation insurance

Departure-based rating more equitable than current system

By Vince Catalli

A STORM IS BREWING in the aviation insurance industry. There is growing sentiment that current aviation insurance rating practices favor the short-haul air carrier and that a more equitable system must be adopted. Resistance to altering the system is strong but the pressure for change continues to grow.

Since the 1940s, airline premiums have been based using revenue passenger miles (RPMs) and aircraft fleet values (AFVs) as a rate base for airline risks. While the RPM/AFV rating system may have worked well in the past, many airlines argue that this system produces serious inequities in the distribution of premium among the airlines that have survived deregulation and consolidation.

Today, as a result of consolidation in the industry, fewer airlines operate substantially different fleets of aircraft over different route systems. Yet, with rare exceptions, all airlines within each carrier category—majors, nationals and regionals—are charged essentially the same hull and liability rates without regard to the number of aircraft departures, the fleet composition, the number of passengers carried or the airline's loss record.

The premiums generated under the RPM/AFV rating system often bear little relation to risk.

Airline liability premiums are determined by RPMs, which is the number of passengers carried multiplied by the distance traveled, even though, according to a study conducted by American Airlines Inc., 88% of all accidents occur during takeoff, landing or associated phases of flight, not during cruising.

In a study of worldwide jet operations from 1979 to 1983, American Airlines' safety division found that: 39% of aviation accidents occurred while landing; 11% during takeoff; 9%, final approach; 8%, initial climb; 8%, initial approach; 8%, loading, taxiing, and miscellaneous other operations; 3%, climbing; and 2%, descending. The remaining 12% occurred while cruising.

A more recent study of loss data for the last 30 years by a major European air carrier established that 97% of all aviation accidents occur during takeoff and

Speaking out

landing phases.

The length of a flight, which is the distance traveled or stage length, has very little impact on loss potential. Under the RPM rating system, however, stage length directly impacts liability premium while the number of departures is disregarded.

Suppose two airlines operate the same number and type of aircraft, carry the same number of passengers and have the same number of departures.

Operator A's passengers fly an average trip of 500 miles and Operator B's passengers average 1,000 miles per trip. Operator B's liability insurance premium will be twice that of Operator A. This is not because Operator B has twice the risk but simply because Operator B generates twice as many RPMs.

Adjusting RPMs to an average industry stage length (which entails recalculating RPMs as if each air carrier's stage length were the same) illustrates the high degree of distortion in the RPM rating system. Keeping in mind that airline size has historically been measured by RPMs, it is interesting to see the changes in air carrier RPM rankings after all major airlines are adjusted to the same average stage length of 676 miles (see "Adjusted Revenue Passenger Miles").

Aircraft hull premiums are calculated as a percentage of total insured fleet value. If two airlines with different types and number of aircraft insure their aircraft for the same total value, each airline will pay the same premium. The premium will not change even if one of the carriers makes twice as many departures as the other. Once again, the premium calculation disregards the most hazardous aspects of flight—takeoff and landing—in determining premium requirements.

In addition to ignoring potential frequency of loss, the RPM/AFV rating system does not adjust for

differences in the potential magnitude of loss. If we assume that Operator A's fleet includes wide body aircraft and that Operator B uses only narrow body aircraft, the loss of a fully loaded Boeing 747 could cost insurers \$500 million while the loss of a fully loaded narrow body aircraft might only cost half that amount. But, if the total value of each carrier's fleet is the same and each produces the same number of RPMs, each will pay the same premium.

Aviation underwriting is unique in that it is probably

Adjusted revenue passenger miles

Adjusted RPM equals actual RPM divided by stage length times average stage length of 676 miles

Airline	Actual RPMs (in billions)	Stage length (in miles)	Adjusted RPMs (in billions)
A	73.1	719	68.7
American	62.0	752	55.7
B	66.8	854	52.9
C	30.7	491	51.8
D	48.7	638	51.6
E	43.2	705	41.4
F	29.7	815	24.6
G	25.0	966	17.5

Source: Alexander & Alexander Inc.'s National Aviation and Aerospace division

the only line of insurance that disregards maximum probable loss when establishing a premium for a specific risk.

Since 1984, American Airlines and its broker, Alexander & Alexander Inc., have been urging the adoption of a departure-based rating system. Departures, unlike RPMs or AFVs, measure the potential frequency of loss. Potential severity of loss may be addressed by adjusting departure rates to reflect differences in aircraft values and passenger seating capacity.

Despite the logic of this approach, only recently has there been any support for it. Many underwriters feel that the current system is unfair, but they are reluctant to support any change until the majority of the airlines endorse the concept. The underwriters fear that airlines will choose the rating system that produces the lowest premium. The result would be

Continued on next page

Changing retiree health plans not so easy

By Lynn Shapiro Snyder
and Linda Rosenzweig

THE COSTS OF providing retiree health care benefits are escalating. In addition, new initiatives by the Financial Accounting Standards Board are designed to increase the liability of employers for retiree health care benefits and will transform into a current liability what traditionally has been considered a long-term commitment.

Consequently, virtually every employer currently offering retiree health care benefits is re-examining its obligations to do so and attempting to "redesign" this benefit. However, some employers are severely restricting their ability to limit their financial exposure for such health care coverage.

Employer redesign is often really a matter of an employer's retrenchment in offering and paying for retiree health care benefits. This retrenchment already has been documented.

In a study released in February by the U.S. General Accounting Office, cost saving modifications in retiree health care plans were made by all employers

surveyed over a four-year period. More recently, in April, a survey conducted by the Washington Business Group on Health revealed that 51% of the employer respondents intend to reduce their health care coverage for current or future retirees if the FASB rules go into effect. These employers also indicated that they expect the FASB rules to increase the average retiree health care benefit costs for employers by more than 200%—from 2.5% to 7.9% of payroll costs.

There are a wide variety of ways in which an employer may redesign benefits in order to offer a more cost effective retiree health care benefit programs. For example, employers may wish to introduce cost containment mechanisms, like preadmission certification, mandatory second surgical opinions, broadened outpatient coverages and use of private utilization review of claims.

Managed care options—such as health maintenance organizations and preferred provider organizations—also may be available to help minimize a company's potential exposure to retiree health care

benefit obligations. However, until the federal government improves Medicare's interface with HMOs, PPOs, medically insured groups and competitive medical plans, it is unlikely that this alternative will make a major difference in an employer's retiree health care liabilities.

Of course, employers may wish to redesign their retiree health care benefits with increased cost sharing or a switch from entitlement plans to defined cash outlay plans. Switching to a defined cash outlay plan may be especially attractive in light of the anticipated need under the FASB rules to project future employer costs for retiree health care benefits.

However, while defined cash outlay plans may ease an employer's liability to quantify future benefits, it also places the retiree at risk to the extent that health care benefits needed exceed this allocated amount, either due to increased costs, greater utilization or both. Thus, a defined cash outlay plan is a cutback in an employer's commitment to provide retiree health care benefits and employers should be prepared to have employees and retirees perceive it as such.

Employers are discovering that their ability to redesign, and thus trim, retiree health care benefits is not only difficult to achieve but also may be severely limited under current law.

Generally, a company with a properly drafted employee benefits plan can alter any commitment it may have to current employees to provide health care benefits upon their retirement. But, when a company contemplates restricting the health care benefits payable to its current retirees, the rules of the game are far different.

Historically, courts have been hostile to employers' attempts to limit their costs at the expense of current retirees. Nevertheless, more recent cases suggest courts' willingness to provide employers with greater flexibility in plan design matters.

In *Moore vs. Metropolitan Life Insurance Co.*, the 2nd U.S. Circuit Court of Appeals held that, in the absence of fraud, an employer is not to be precluded from altering its health benefits if the employer has not bound itself in its plan documents to continue

Continued on next page

Aviation insurance

Continued from previous page
an overall reduction in the total premium pool available to pay losses.

Brokers representing short-haul carriers oppose the departure-based system, recognizing that their clients' costs would increase. These brokers are forced to argue that the only important consideration is total premium, that having agreed on price, the rate base becomes a moot issue.

Arguing that the rate base is unimportant ignores the fact that airlines in the same category are charged

a departure-based rating structure in the early 1970s, but the proposal was not widely supported at the time.

In recognition of the merits of departure rating, underwriters extended substantial concessions to American Airlines at its Nov. 1, 1987, renewal. The liability portion of American's aviation insurance was rated at \$20 per departure, the equivalent cost per departure paid by two major U.S. carriers renewing July 1, 1987. American's \$20 departure rate was equivalent to 25 cents per 1,000 RPMs and was substantially lower than the 36 cents per 1,000 RPM rate paid by the two carriers renewing earlier.

American's renewal terms were a clear deviation from the market practice of charging each of the major airlines the same rate.

Since the terms of a major placement in the London market became public knowledge, American's effective RPM rate became a target rate for future major airline renewals. Most major airlines were soon paying the same RPM rate, including the two airlines that had renewed prior to American in 1987.

But no other U.S. airlines renewed on a departure rate basis. Nevertheless, the American Airlines renewal was a significant achievement. For the first time, all underwriters participating in the

underwriters recognized that American had substantially fewer departures and actually carried fewer passengers (see "American Airlines vs. 'smaller airline'").

A sound rating system, however, must also address maximum probable loss or severity potential. To address these issues, individual rates were developed for different groups of aircraft taking into account differences in severity potential between aircraft types. These rates were applied to American Airlines' departures, in essence adjusting for American's loss severity and frequency potential by the type of aircraft.

When Federal Express Corp. of Memphis, Tenn., another A&A/Alexander Howden client renewed on March 1, 1989, it became the first cargo carrier to adopt departure rating.

Ultimately, the contest between RPM/AFV and departure rating systems must be resolved by underwriters. To avoid continuing quantum reductions in overall premium volume because of RPM/AFV rates that are translated to departure rates and are then converted to RPM/AFV rates, and so on, a single rating system must be adopted and a transition accomplished. This will be extremely difficult, especially in today's soft market. Most underwriters want to retain market share regardless of premium level.

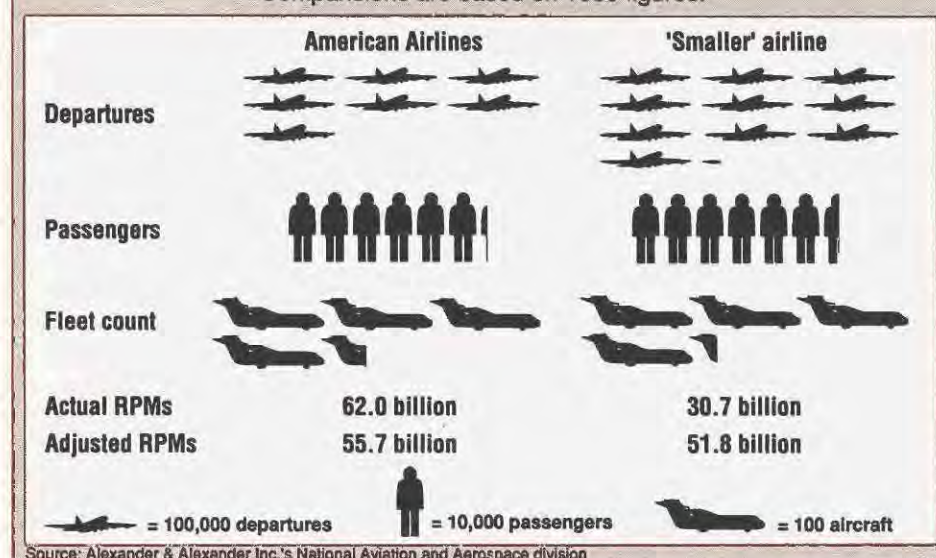
Unfortunately for insurers, airlines renewing subsequent to American Airlines were once again successful in converting American's costs to the traditional RPM/AFV rate base and using them as a benchmark for negotiating their renewal rates. This has resulted in another round of rate cuts that will stretch well into 1990.

In the end, we believe that underwriters will abandon the RPM/AFV system for a departure-based system that will logically address both frequency and severity of loss and fairly distribute premium among the world's airlines according to their true exposure to loss. This new system would reduce or eliminate the penalty paid by those carriers that rank high in RPMs but relatively low in departures or passengers carried.

Generally, long-haul carriers and airlines operating aircraft with low seating capacity will benefit. Cargo airlines will also benefit because they generally have fewer departures and a low overall maximum probable loss potential.

American Airlines vs 'smaller' airline

Comparisons are based on 1988 figures.



Source: Alexander & Alexander Inc.'s National Aviation and Aerospace division

BY HOLLY SEGUINE & JOHN HEILAND

essentially the same rate. This would suggest that rates determine premium rather than premium determining rates. None of the critical risk factors reflecting loss frequency or severity potential is evident in the hull and liability rates paid by each airline. If these risk factors were considered, the distribution of premium among the airlines would be materially different.

Despite resistance, the need for a change in the premium distribution system is gaining support. In February 1987, Jacques Gangloff of Paris-based La Reunion Aérienne, a major aviation insurer, made a presentation in London to many of the world's leading aviation underwriters, in which he criticized RPMs as a rate base. Mr. Gangloff suggested that a formula that combined the number of departures and the number of passengers carried would be a more equitable way to calculate premium.

Skandia Insurance Co. Ltd., a major international aviation insurer based in Stockholm, Sweden, proposed

American program, including many of the world's leading aviation insurers, accepted departure rating.

Later, El Al Israel Airlines, another A&A client, placed part of its aviation insurance program with a French insurer with its liability coverage written on a departure basis. And, earlier this year, Alexander Howden Group P.L.C., a London-based subsidiary of A&A, successfully placed another major air carrier on a combined hull and liability departure rate basis with different departure rates for different types of aircraft.

On Nov. 1, 1988, American Airlines renewed its aviation coverage on a departure basis, this time with different departure rates applying to different types of aircraft, hull and liability combined. American's renewal premium was the same as that recently negotiated by an airline historically viewed as presenting substantially less exposure when measured on an RPM/AFV basis. While American Airlines had significantly more RPMs and a higher fleet value,



Vince Catalli is a senior vp of Alexander & Alexander of Texas Inc. in Dallas. He manages Alexander & Alexander Inc.'s National Aviation and Aerospace Division and supervises A&A's aviation insurance business in the Southwest.

Retiree health benefits

Continued from previous page
to provide those benefits for the lifetime of retirees at the exact level of benefits as existed at the time of that employee's retirement. In reaching this result, the court refused to find that communications with employees describing the plan as providing for "lifetime" benefits "at no cost" to the employees altered the terms of the plan.

Thus, the significant legal issue in determining employer flexibility is the scope of the enforceable promise regarding post-employment benefits. This is a factually specific determination. Contrary to the decision of the court in *Moore*, some courts have looked not only to the written plan documents but have also been willing to consider any other written or oral communications with employees made prior to or at the time of retirement.

Thus, employers attempting to modify retiree health care benefits should have such action reviewed by legal counsel prior to implementation in order to attempt to avoid subsequent challenges by the retiree population.

In the meantime, the following steps

should minimize an employer's legal liabilities as the employer attempts to implement a "redesigned" retiree health care benefits program.

Employers should review all communications with employees and retirees, whether written or otherwise. Most importantly, the plan documents and the summary plan descriptions should be reviewed to assure that the employer has unambiguously reserved the right to amend or terminate the plan. This review should not be limited to plan documents but should include any other documents (e.g., application forms and collective bargaining agreements) that may describe an employee's entitlement to benefits after retirement.

If the plan documents are unambiguous regarding the employer's obligation to provide retiree health care benefits, the emerging view is that other "extrinsic evidence" that purports to modify the obligation should not be considered.

The employer should also make certain that, even if the plan documents are unambiguous, managers with responsibility for personnel and other

employee benefit matters should scrupulously avoid making any statements that would suggest that retiree medical benefits will be fixed at the level when the employee retires or that benefits will be paid for life. Similarly, all written communications or documents should be reviewed to ensure that no representations are made that might be read by retirees and other employees as expanding the employer's promise to provide health care benefits after retirement.

If an employer ascertains from a review of all the relevant evidence that it is bound—by the plan language or otherwise—not to modify the medical coverage it currently provides to its retirees, the employer may wish to attempt to modify its obligation. In attempting to achieve such an objective, the employer should proceed with caution—and the expectation that any agreement with the retirees will probably be subject to careful scrutiny by a court to ensure that the employer has not engaged in improper tactics.

For example, "take-it-or-leave-it" negotiations by one employer in order

to avoid the substantial costs of providing its retirees their promised health care benefits, was held by one court to vitiate the "accord and satisfaction" agreements signed by retirees. In addition, if a court found that such conduct violated the fiduciary rules of the Employee Retirement Income Security Act of 1974, personal liability might be imposed on all of the individuals involved in the effort to negotiate a cutback in the employer's liability for such coverage.

Lynn Shapiro Snyder and Linda Rosenzweig are attorneys in the Washington, D.C., office of Epstein Becker & Green P.C.



Ms. Snyder



Ms. Rosenzweig

InsurerTopics

A special editorial section
sent exclusively
to insurers and reinsurers

A sore subject

Insurers adjusting the claims process to be less 'painful'

By MARK A. HOFMANN

For many policyholders, filing a property/casualty insurance claim is like a trip to the dentist: It's virtually always unpleasant and can leave them with a bad taste in their mouths.

In response to such widespread resentment—which some industry observers say helped fuel the consumer dissatisfaction with the insurance industry that climaxed with California's Proposition 103—insurers are re-examining the claims-handling process and are trying to make it less painful for both personal lines and commercial lines policyholders.

"Claims are lousy; nobody likes a claim. Claims are not nice things—they immediately put people in a bad frame of mind," said Joseph P. Decaminada, executive vp, secretary and counsel for the New York-based Atlantic Mutual Cos.

"There's no doubt in my mind that claims handling is a sore subject. Claims people take the vented anger from a policyholder or a third-party claimant," said John G. Eager, claims counsel for the National Assn. of Independent Insurers in Des Plaines, Ill.

"The public is more prone to complain than it used to be," agreed Gregory M. Geil, president of Bierman-Condray Inc., a St. Louis-based independent claims adjusting firm.

Part of the reason for this negative attitude toward claims handling is the traditionally adversarial relationship that exists between policyholders and insurers, experts explain.

Policyholders resent the fact that they may not be paid the total value of their loss, even though they've faithfully paid their premiums for years, while insurers feel that policyholders have unrealistic expectations of what insurance does.

The very nature of compensation in a tort-based liability system works against insurers, points out Richard Watson, chief executive officer of Bierman-Condray and governing chairman of the claims section of The Society of Chartered Property & Casualty Underwriters in Malvern, Pa.

"The insurance industry, try as it may, is in a no-win situation," he said. As long as the tort system decides liability on an adversarial basis with a clear-cut winner and loser, the insurance industry will have a public relations problem, he said.

Adding to that problem is the widespread perception that injuries or property damage should

conditions, he said. Because insurance policies spell out conditions that may not provide for total compensation, there arises a "subtle resentment" over the claims process, Mr. Watson said.

Many policyholders don't realize that insurance is basically a group protection in which individuals pool resources, said Adrian Tocklin, executive vp-claims for Continental Insurance Co. in New York.

For example, when Ms. Tocklin recently asked a group of insurance majors at Howard University in Washington, D.C., why they thought the public's perception of claims handling was so negative, one student responded: People who have paid premiums for years without filing a claim want all they've paid back when confronted with a loss, regardless of whether the loss amounts to that total.

Another student described how her upper-middle-class family had planned to inflate the losses stemming from a stolen car because of the attitude: "I've paid my premiums all these years, and now I'm going to get them all back."

In addition, policyholders often don't realize the exact limits of their insurance policies until they file a claim, said Franklin W. Nutter, president of the Alliance of American Insurers in Schaumburg, Ill.

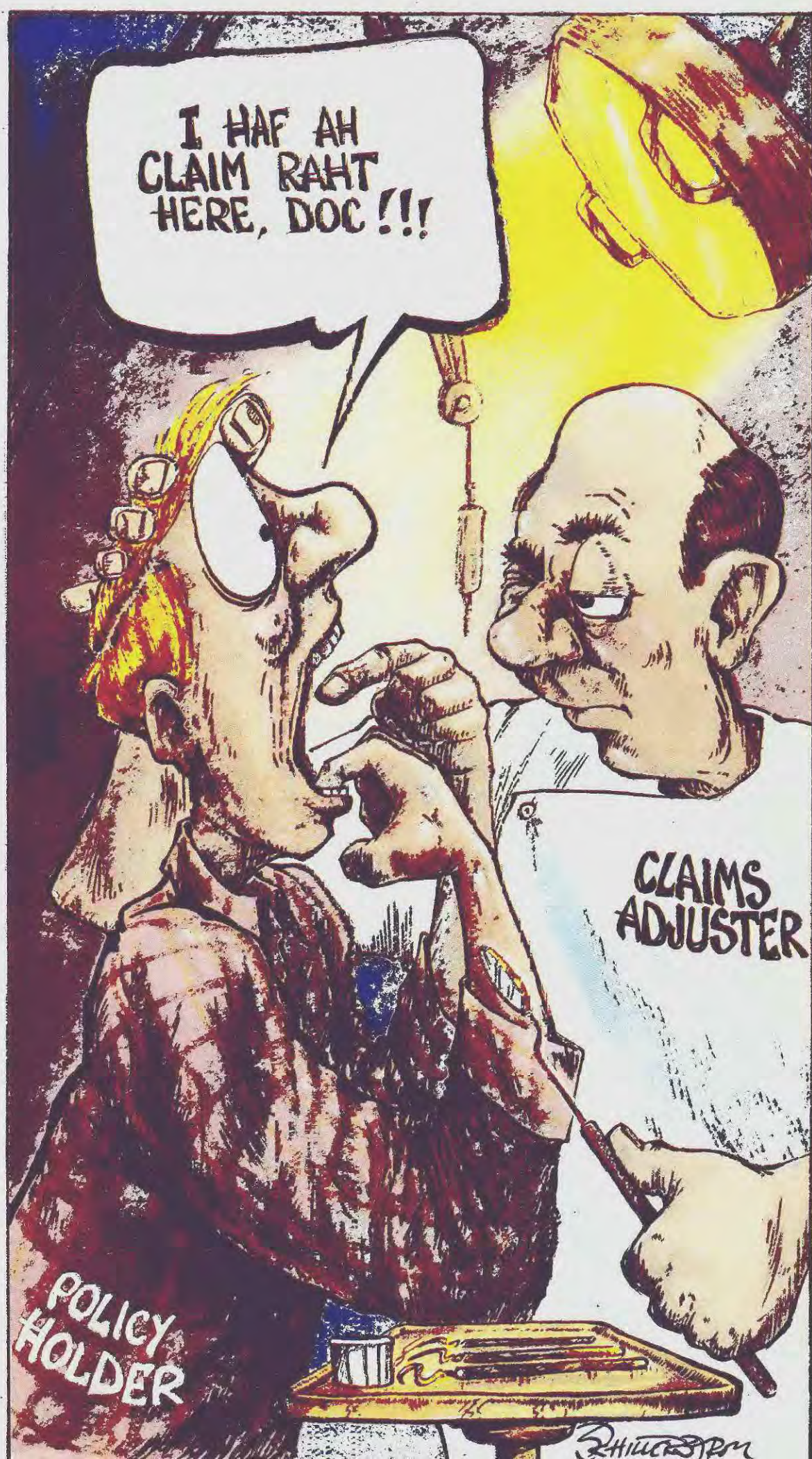
"People tend not to understand the nuances of their policy," he said.

While commercial lines policyholders tend to have a better grasp of policy language and the claims-handling process than do personal lines policyholders, risk managers still complain about claims handling, said Dennis E. Hoffmann, chairman of John Deere Insurance Co. in Moline, Ill.

He estimated that complaints are generated by an equal percentage of his company's commercial lines and personal lines claims—about 5%. However, the reason for the complaints vary.

For example, in personal lines, complaints tend to involve a feeling that the insurer is unjustly denying or underpaying a claim, while commercial lines policyholders often complain that the insurer is "too lenient" in settling third-party claims, Mr. Hoffmann explained.

Robert W. Esenberg, risk management administrator for the city of Virginia Beach, Va., and vp-governmental affairs for the New York-based Risk & Insurance Management Society Inc., agreed that the causes of friction between insurers and commercial insurance buyers vs. insurers and personal



Insurer topics

Earthquakes

Continued from previous page
ample (BI, May 29).

Fortunately, most of the international earthquake claims experts speak English, Mr. Rupp said, and those who don't speak English are fluent in the universal language of mathematics.

"I don't think the (U.S.) insurance industry has looked at all of these people," Mr. Rupp said.

Even with the addition of international experts, there still would be too few adequately trained earthquake claims adjusters to meet the demand stemming from a major California quake.

During a speech to the CPCU conference in Honolulu, Crawford & Co.'s Mr. Keary ticked off a number of specialized workers other than adjusters whose services would be in short supply after a quake. "Structural engineers will be at a premium. Experience has shown that we cannot rely on the local authorities to make the 'repair or replace' decision for us," Mr. Keary said.

"Few of the usual insurance contractors are experienced in structural quake repair options. The salvors will be deluged with opportunities but paralyzed by the logistical problems. Accountants will be swamped with the major business interruption losses," Mr. Keary continued. "Even the lawyers will be in short supply to com-

ment on the coverage issues."

And, fewer qualified claims personnel may be available than insurers or adjusters estimate, Mr. Keary noted. For example, many independent adjusters may appear simultaneously on the lists of several insurers or national claims adjustment companies.

But, even when insurers have assembled teams of claims personnel, they will face significant problems getting them on site.

First of all, insurers will have difficulty contacting claims personnel because communications will be the first thing to go during a quake, said Mr. Rupp. Even a relatively mild quake will shake telephones off their hooks, jamming the telecommunications network.

The communications system will be further strained as panicked people try to contact friends and relatives in the affected area. The telephone company might have to shut the entire system down, bringing it back on line slowly on a priority basis by returning service first to emergency service installations, Mr. Rupp said.

Earthquake Mutual would attempt to overcome the communications problem by using a mobile telephone unit, he said. The unit would work in conjunction with emergency authorities.

And, because policies will be organized on a ZIP code basis, the insurer will know how many policyholders are in the affected area and

will attempt to get in touch with them, he said.

In addition, Earthquake Mutual plans to set up its claims processing facility beyond California's borders, probably in Denver, to escape many of the communications and logistical problems that likely would beset the Golden State in the wake of an earthquake.

Aetna's Mr. Teich downplayed

'Structural engineers will be at a premium. Experience has shown that we cannot rely on the local authorities to make the 'repair or replace' decision for us,' comments Tim Keary of Atlanta-based Crawford & Co.

portable phones as the answer to the communications problem. Airwaves would be jammed, he said. Instead, Aetna would use a combination of cellular phones, ham radios and some radio broadcasts informing clients of a temporary claims center location.

Contacting claims personnel who live in the affected areas and persuading them to leave their family and property to deal with other people's losses also will be difficult for insurers, Mr. Teich said.

While Aetna has established rallying points for its catastrophe teams, employees in the quake zone would rightly place their fa-

milies' safety as their first priority, he said.

To overcome the problems associated with handling the claims from a California earthquake, Aetna has selected a temporary claims handling site in Sacramento, Calif., which is outside the earthquake-prone area.

Mr. Teich said catastrophe teams would be flown to the Sacramento

ties, fearing further injury or possible looting of damaged buildings, might seal off large areas of quake-ravaged territory to all private citizens.

Finding temporary housing for catastrophe teams also would be difficult, the experts noted.

After the initial quake, the process of rebuilding and conserving property for which claims have been filed would be complicated, the experts said.

For example, not only will insurers contend with a shortage of claims handling professionals, they will also have to deal with a shortage of contractors and building supplies.

In addition, government authorities would have first access to scarce resources and emergency equipment, said Mr. Teich.

Crawford & Co.'s Mr. Keary also noted that civil authorities might not spend too much time differentiating between structures that were damaged beyond hope of repair and those, though severely damaged, that could be saved. In the interest of time and public safety, authorities might order any building whose safety they questioned simply razed, he pointed out.

In addition, the expense of any available labor and material would likely increase considerably after an earthquake, which will increase the cost of claims for insurers, both Earthquake Mutual's Mr. Rupp and IRI's Mr. Rogers stressed. ■

LEA offers education, forum for claims execs



Insurance company officers with property claims responsibilities who are looking to sharpen their expertise and to share their experiences with their peers can find a forum in the Loss Executives Assn.

The purpose of the group, which was founded in 1921, is primarily educational, said Daniel V. Hanke, vp of New York-based Church Insurance Co. and immediate past president of the LEA.

The group helps claims executives to keep themselves "up to date on what's going on," Mr. Hanke commented.

To keep its members abreast of developments in both claims handling and the property/casualty insurance industry as a whole, the LEA holds three meetings a year and sponsors a national forum to discuss specific case studies.

The annual meeting is held every June in Absecon, N.J.

The three-day meeting combines technical workshops with social events such as banquets and award ceremonies.

At this June's meeting, panel discussions focused on the possible repeal of the McCarran-Ferguson Act, the 1945 federal law that grants insurers limited immunity from antitrust regulations; the possible spread of Proposition 103-type legislation to other states; and the future of alternative insurance mechanisms like captives, risk retention groups and self-insurance, said Herbert H. Hildebrand, LEA president.

Mr. Hildebrand is the regional manager of property claims for Philadelphia-based Colonial Penn Insurance Co.'s Tampa, Fla., office.

A one-day October meeting in New York is used as a technical workshop.

The meeting features a panel of outside experts, like attorneys, and deals with a technical claims question.

The group's two-day January meeting, which is held in a different city each year, provides for an in-depth treatment of technical claims issues.

Some of the issues examined at past January meetings included environmental claims and handling claims stemming from a large natural disaster, said Mr. Hildebrand.

ter, said Mr. Hildebrand.

The LEA also holds a national claims forum in Princeton, N.J., each November, though Mr. Hildebrand stressed that this meeting is not for novices—attendees have an average 16 years' worth of claims experience.

Attendance is limited to 125 people, who break up into small groups and work out solutions to case studies.

Then, the small-group solutions are discussed before the full group, he said.

The LEA offers two types of memberships:

- Regular membership is restricted to loss management executives of property/casualty insurance companies, whether working out of the insurer's home office or a branch or regional office.

Regular members can vote and hold office in the LEA.

- Associate members cannot vote or hold office.

This type of membership includes independent claims adjusters, engineers, defense attorneys, people

The Loss Executives Assn. helps claims executives to keep themselves 'up to date on what's going on,' says Daniel V. Hanke, immediate past president.

ple affiliated with insurance industry trade associations, salvage firms and certified public accountants.

The LEA currently is considering establishing a national claims school, possibly in conjunction with a university, for entry-level claims professionals, Mr. Hildebrand said.

The LEA has approximately 450 members, Mr. Hildebrand said.

Unlike many other insurance industry groups, LEA membership is granted on an individual basis rather than on a company basis, according to Mr. Hildebrand.

"Within the past five years, our membership has doubled," he noted, adding that he thinks the LEA "can do a lot more" to further professional education in claims.

For more information, write to the Loss Executives Assn., P.O. Box 37, Tenafly, N.J. 07670.

—By Mark A. Hofmann

1906 earthquake

Continued from previous page
well-being.

William J. Dutton, then president of Fireman's Fund, sent a letter to the company's agents describing the destruction. The letter read in part: "It is yet impossible to accurately estimate the total value of property destroyed but, while it runs well into the hundreds of millions and leads in destruction all the fires of the world's history, it is safe to say that all the more conservative companies will honorably meet our policy obligations. As far as Fireman's Fund (is) . . . concerned, of course we will."

To handle claims while protecting the company's own existence, Mr. Dutton proposed creating a new company—Fireman's Fund Insurance Corp.—to handle risks outside of San Francisco and all new business.

The original entity would have one purpose—to settle the San Francisco earthquake and fire claims as quickly as possible and then distribute whatever assets were left to stockholders. The company was to then be shut down and the new corporation was to take over its functions.

Mr. Dutton estimated that Fireman's Fund had about \$7 million of insurance in force in San Francisco. He figured that about 25% of the risks were undamaged by fire, and that claims would be further reduced by disallowing claims from the demolition of damaged structures by government cleanup crews.

But Mr. Dutton's estimate turned out to be unrealistically optimistic. Claimants were given 120 days rather than the usual 60 days to file proof of loss. By mid-July, when almost all employees had been relocated in the restored Fireman's Fund headquarters in San Francisco, losses appeared likely to reach a minimum of \$10 million. Ultimately, the insurer's earthquake losses reached slightly more than \$11 million.

While more than 90% of that total would be paid within 10 months of the quake, the insurer's foes did not wait 10 months to criticize its efforts.

On July 23, 1906, William Randolph Hearst's San Francisco Examiner heaped scorn upon the insurer for allegedly being unable to "pay its honest debts" and thereby "disgracing the State of California in the eyes of the entire world." The Examiner and other newspapers charged that

the establishment of the new corporation was a fraud designed to take the company's assets from the old company and leave the policyholders out in the cold. In addition, a group of Fireman's Fund's largest claimants—the Policy Holders' League—pressed for payment.

J.B. Levinson, the Fireman's Fund's marine secretary, outlined a plan in an Aug. 8 meeting with league leaders, whereby company stockholders would be assessed \$300 a share to help cover claims. The plan also called for claimants to be paid half in cash and half in stock, but did not set a timetable for paying claims.

The league rejected that plan, so a refined proposal was presented three days later. Under the new proposal, a policyholder would be paid 20% in cash, an additional 30% in cash within 90 days, 50% in stock and an additional dividend if the proceeds from the \$300 assessments and reinsurance exceeded forecasts.

The league's leaders said they would accept the plan if enough claimants signed an agreement.

The first cash payments were made on Sept. 12, even though fewer than half the claimants had signed the agreement. Nearly 20% of the company's 374 shareholders were unable to pay any of the assessment and other shareholders could make only partial payments. However, more than \$2 million was collected through the shareholder assessment.

Securing claimants' approval of the plan did not go as smoothly as planned because of lingering communications problems, as well as some policyholders' doubts about the value of a partial stock payment.

Nevertheless, once the initial payments had been made, greater claimant support followed, and the second 30% cash payment took place on Nov. 27. The stock issuance and an additional cash payment equaling 6.5% of claims followed in early 1907.

In a July 26, 1907, report to California Insurance Commissioner E. Myron Wolf, New York actuary named S.H. Wolfe detailed the success of the plan. After reviewing the settlement, Mr. Wolfe concluded: "It is difficult to imagine any institution being subjected to a more severe test than was the Fireman's Fund Insurance Co. It has emerged from it with its reputation untarnished. . . ." ■

Adjusters prepared for hurricane claims

By MARK A. HOFMANN

HARTFORD, Conn.—Even before a hurricane strikes, Hartford Insurance Group officials know which property claims adjusters will be on the insurer's catastrophe claims team, how they will get to the disaster site and where they will stay when they get there.

In keeping with industry practice, Hartford generally can have a catastrophe team on site within 24 hours of a hurricane's landfall, said James A. Even, senior vp-claims at Hartford Insurance Group. "We have a cadre of about 60 to 70 experienced adjusters" around the country to meet the claims handling demands in the wake of a natural disaster, he said.

"They're ready at any time to move into the area in which they are needed."

The adjusters chosen for the catastrophe team are not rookies, Mr. Even stressed. Most are college graduates with at least three to five years' experience in property claims handling, he said.

"We need adjusters who can be very productive, answer questions on the spot" and settle claims promptly and fairly, he said.

In addition to the adjusters, Hartford also uses its own pool of 30 to 40 support personnel prepared to handle the on-site clerical and data processing tasks of claims handling, he said.

They're provided with computer terminals and other automated equipment to tie into the insurer's mainframes at its home office so that catastrophe claims handling can be streamlined, he added.

The claims handling process begins before a hurricane strikes, Mr. Even explained. Hartford, like other insurers, tracks hurricanes closely and generally has a reasonable idea where they will make landfall. Armed with this information, the insurer begins by notifying the adjusters needed for the catastrophe team.

Further easing the claims handling process is Hartford's system of classifying policies by location and type. For example, the insurer would know how many homeowners policies were in force in Atlantic County, N.J., if a hurricane struck the Atlantic City area, he said. "This helps us know what our needs will be," he said.

The insurer also does not attempt to handle disaster claims from its regular office in the affected area because it does not want to hamper routine claims handling, he said.

Before a hurricane hits land, the adjusters receive airline tickets and are told where Hartford will set up its "freestanding temporary office." The insurer generally leases "one, two, three or more rooms" in a hotel or "other suitable sites" for its catastrophe team's office, Mr. Even said.

In addition, "we try to put up adjusters in the same hotel where the office will be," Mr. Even explained.

The company also rents cars in advance to make sure its catastrophe team will be mobile.

Once on site and under the leadership of a supervisor from the home office "to oversee implementation of the catastrophe operations," the adjusters contact agents who represent Hartford, Mr. Even said. "We immediately contact our agents and are in daily contact with them," he said.

"The biggest obstacles are physical ones," said Mr. Even. Both transportation and communications become problems—transportation because of fallen trees and general debris and communica-

tions because of severed wires. "There is some time delay that cannot be avoided," he said.

Because telephone service often is disrupted, the agents may have to be contacted face-to-face in their offices or homes, which means getting the adjusters into the field, he said. Agents are notified where the temporary office is, and soon the reports of losses begin pouring in, Mr. Even said.

Although Hartford has not used cellular telephones in the past, the insurer is now looking at them as a way to improve communication between the field adjusters and the agents, Mr. Even added.

According to Mr. Even, the aim of Hartford's catastrophe claims

handling process is straightforward—streamlining the claims handling process as much as possible. The insurer tries to cut through red tape and make settlements as early as possible, he said.

To accomplish this goal, adjusters work seven days a week following a catastrophe, Mr. Even said. In the case of a truly destructive hurricane, teams of 20 or so adjusters may be rotated every two or three weeks depending on the volume of claims.

While adjusters pull extra catastrophe pay for their efforts, Mr. Even does not begrudge them that extra compensation.

"They do whatever it takes to get the job done," he said. ■



Hartford Insurance Group generally can have a catastrophe team of adjusters on site within 24 hours or less of a hurricane's landfall.

We said

Ask us.

Are you getting the most from your current reinsurance protections?

And in one of the most difficult years experienced by many of our competitors U.S. RE is making its mark because we're keeping *our* promise to give *you* the right answers.

We have successfully:

Designed and placed tough reinsurance protections for companies of all sizes, both in the U.S. and abroad, where others wouldn't or couldn't perform.

Consulted on virtually every aspect of reinsurance, both creatively and confidentially.

Provided access to the best worldwide security.

And we've geared up to give you even more with the expansion of our team to keep ahead of the growing demand for our services including the creation of other innovative risk transfer mechanisms for domestic and international buyers of reinsurance and retrocessional protections. Experience that is supported by strong financial resources and state of the art systems to service every aspect of your account, now and in the future.

If you're not getting all this or would like to learn more about U.S. RE

ASK US!

We're giving the right answers.



US RE

U.S. RE Corporation
Reinsurance Brokers & Consultants
 5 Hanover Square
 New York, NY 10004
 Phone: (212) 747-1100
 Fax: (212) 747-1109
 Telex: 179037 US RE CORP

Health insurers scrutinize claims applicants

By KARI BERMAN

Life/health insurance company personnel departments are evaluating applicants for claims examiner positions with the same scrutiny that insurers expect examiners to use when reviewing claims.

In addition to screening applicants with a fine-toothed comb before hiring, health insurers are beefing up in-house training programs to make sure that new claims examiners are adequately prepared.

Insurer executives agree that improving pre-hiring procedures and raising standards for selecting claims examiners are necessary steps because of the perpetually increasing complexities of the health care system.

"The claims examiner position has changed as the health care system has grown more complex. Now we need more intelligent people who can understand managed care programs and other complicated employee benefit plans that they might face when reviewing a claim," said David Zimmerman, vp in the group life department at Metropolitan Life Insurance Co. in New York.

"The job of a claims examiner is a difficult one and no longer just involves having good keying ability. We expect a processor to have conceptual ability and be an expert judge of different situations that might come up when reviewing claims," explained Janet Kalas, manager-insurance services systems/employee benefits director at Aetna Life Insurance Co. in Hartford, Conn.

Yet, despite the complexity of the job, insurers rely on high school, rather than college, graduates to fill claims examiner openings.

"In the past, we have found that college graduates do not last long as claims examiners because the repetitive nature of the job is

numbing for them and they often decide to pursue more exciting interests," said Ms. Kalas.

Mr. Zimmerman agreed that "typically college graduates do not find the claims examining positions appealing," because they want exciting jobs with more social interaction.

"We are looking for positive attitudes and we typically find that the people we are going after are recent high school graduates who are motivated to work and view claims examining as a promising career," he said.

In addition, starting salaries for claims examiners generally range from only \$15,000 to \$23,000 annually, insurers report.

Selecting the most potentially successful entry-level claims examiners from an applicant pool generally composed of high school graduates with limited work experience can be a difficult task.

Currently, candidates for claims examiner positions likely are asked to undergo a comprehensive pre-employment screening process that may include pre-employment aptitude tests, simulated workplace testing and in-depth interviews.

"We look at the top-notch high school graduates who are bright and eager to get right into the workplace, but that can be difficult," Aetna's Ms. Kalas said.

Mutual of Omaha Insurance Co. in Omaha, Neb., is looking for the same type of candidate and experiencing similar frustrations.

"We generally hire high school and sometimes junior college graduates, but choosing claims examiners is challenging because you have to find someone who has the mental capabilities as well as a personality that is compatible with the working environment," said Clifford Lord, a second vp in the employment and development department at

Mutual of Omaha.

When considering an applicant for a health insurance claims examiner position, most insurers first administer a standard aptitude test that evaluates the candidate's analytical, mathematical and reading comprehension skills.

The most commonly used aptitude test, currently administered by 230 insurance companies, is the Job Effectiveness Prediction System aptitude test, created by the Atlanta-based Life Office Management Assn.

The JEPS test, which is composed of 11 sections, is specifically designed to help insurance companies select qualified entry-level employees.

"JEPS is very useful because it reveals specific information about the individual that you don't get to see in an interview," said Terri Bannister, a research associate in LOMA's Atlanta headquarters.

She explained that companies send LOMA a description of skills an applicant needs to fill a position, like a claims examining position. LOMA then analyzes this criteria and selects for the insurer the two to five JEPS tests most appropriate for the specified position. Twenty-five copies of each individual test cost an insurer between \$11.85 and \$19.60, depending on the length of the test.

When an applicant completes the test, the answers are scored against a chart showing that individual's chances for success in relation to the skills necessary for acceptable job performance.

"JEPS is widely used for claims examining positions and companies realize that it is best to spend the time and money gathering the most information possible in order to make the right choice," Ms. Bannister said.

Lincoln National Life Insurance Co. in Fort Wayne, Ind., is pleased with its results

since implementing the JEPS test in 1986, when it turned to the system to reduce a high turnover rate among its 800 claims examiners.

"We were hiring people who were wrong for the job. They were improperly selected and often left within six months," said Dan Lezotte, assistant vp of human resources planning and compensation development at Lincoln National.

"We are happy with JEPS and are finding that productivity is increasing because JEPS is helping us select properly," Mr. Lezotte said.

"We use JEPS because we are looking for people who have the ability to understand and retain complicated information and the test measures cognitive skills and gives us an indication of their mental capacity," said Dennis Waypa, director of employee benefits division/claims at Travelers Life Insurance Co. of Hartford, Conn.

An applicant for a claims examining position at Travelers also is subject to a series of comprehensive interviews as part of the pre-employment screening process.

"We find JEPS very helpful in helping us choose potential claims examiners," said Mutual of Omaha's Mr. Lord.

After completing a JEPS test, a Mutual of Omaha applicant will typically be ushered into the workplace and given a first-hand look at the job site.

"We try to give the applicants a feel for the job situation by bringing them into the workplace environment so that they can see exactly what it will be like," Mr. Lord said.

He stressed the importance of controlling the high turnover rate inherent in the position by giving each candidate a clear picture of the job and its duties.

Continued on next page

Insurer Topics briefs

Institutes approve fidelity and surety designation program

MALVERN, Pa.—The board of trustees of the American Institute for Property and Liability Underwriters and the Insurance Institute of America recently approved the creation of a new designation program for those in the fidelity and surety insurance field.

The curriculum will contain one or more courses from the Chartered Property & Casualty Underwriter program as well as courses designed specifically for surety professionals.

Although details have yet to be worked out, the program will be for agents and brokers as well as commercial underwriters.

Courses are expected to begin in late 1992 or early 1993.

SIR conference

APPLETON, Wis.—The Society of Insurance Research will hold its 10th annual planning and economics conference in Baltimore Sept. 20-22. The meeting will focus on changes in the regulatory, legislative and economic arenas; strategic planning for insurance companies facing the 1990s; and new corporate techniques.

Registration is \$300 for SIR members and \$400 for non-members. For more information, contact Debbie Krueger, Administrative Director, Society of Insurance Research, P.O. Box 933, Appleton, Wis. 54912; 414-730-8858.

Investor relations

PARSIPPANY, N.J.—Firemark Consultants Inc. will hold a se-

minar on "Investor Relations for the Insurance Industry" Sept. 21 at the New York Helmsley Hotel.

Among the topics to be covered are "The Professional Investor Relations Program," "Investor Relations Vehicles: How to Most Effectively Use Media, Company Press Releases, Video," and a critique of current insurer-investor relations programs.

Registration for the seminar, which costs \$995, is due Aug. 7. For information contact Donna Galer, Vp, Firemark Consultants Inc., 1 Gatehall Drive, Parsippany, N.J. 07054; 201-538-7259.

Kemper chief feted

LONG GROVE, Ill.—The Federation of Insurance and Corporate Counsel has selected Kemper Group's Gerald L. Maatman to receive its Man of the Year award.

Mr. Maatman is president and chief insurance officer of Long Grove, Ill.-based Kemper Group's national property and casualty companies. The award will be presented at the legal group's annual meeting July 29 in Hot Springs, Va.

The award, which has been presented since 1952, is given "to a person who has rendered distinguished service to the insurance industry and is dedicated to the American ideal of free enterprise," explained Scott Conley, FICC award committee chairman and an attorney with Segwick, Detert, Moran & Arnold in San Francisco.

—By Mark A. Hofmann

Claims adjuster training gaining in popularity

By MONIQUE PARSONS

Recognizing the value of a well-trained claims adjuster, more property/casualty insurers are expanding internal education programs or referring adjusters to a variety of independent courses despite the soft market.

"Claims training classically has expanded and contracted with the business cycles, and that's not the case anymore," said William Moore, assistant vp of claims for Charlotte, N.C.-based Royal Insurance Group.

"Insurance companies, and ours in particular, have realized it's foolish to do that, and the price we paid was a loss of profit," he said.

Enrollment is up in all levels of claims education, according to instructors at the Malvern, Pa.-based Insurance Institute of America, The College of Insurance in New York and the GAB National Education Center in Denver, all of which offer special programs in claims adjusting.

Courses can be completed in a variety of settings: The IIA's correspondence courses can be taken by individual adjusters or in group sessions sponsored by an insurer.

The College of Insurance offers claims courses as part of its undergraduate curriculum, and the GAB Education Center attracts adjusters from both insurers and self-insured companies to its one- to four-week "schools" in Denver.

Many property/casualty insurance companies offer entry-level instruction for new claims adjusters, from basic on-the-job training to classes and "labs" equipped with mock-ups of fire-damaged houses or wrecked automobiles.

"Most of them have something, at least. It may not be extensive," James J. Markham, director of curriculum for the IIA, said of insurer training programs. "You can't simply hand someone a file and say, 'Here, go to it.'"

However elaborate, most insurers offer company-specific training rather than standardized instruction. But insurers also are using outside courses both to supplement their own entry-level programs and to keep experienced personnel aware of advanced methods and changes in the industry.

"With in-house training, there's no way of knowing how parochial the instruction may be," said Mr.

Markham. Insurers "candidly admit that they don't discuss the industry as a whole," he said.

The claims section of the Society of Chartered Property & Casualty Underwriters offers a workshop on commercial property forms and commercial general liability forms for experienced claims adjusters. The day-long workshop is sponsored periodically by any of The Society of CPCU's 145 chapters nationwide. The workshops cost \$85 for CPCU members and \$105 for non-members.

The Society of CPCU also sponsors annual meetings for adjusters to discuss timely, advanced topics relating to the industry, said Mari Jennings, continuing education coordinator at The Society of CPCU in Malvern, Pa.

The IIA's Associate in Claims program consists of four five-month correspondence courses that are offered in study groups sponsored by chapters of the Society of CPCU, insurance companies, adjusting firms and educational councils. Intended for experienced adjusters, the four courses emphasize professional human relations and adjusting skills.

Customer relations "are emphasized very strongly, and they are emphasized up front by deliberate design," said Mr. Markham.

The IIA claims courses are:

- "The Claims Person and the Public," which examines human behavior, communication and listening skills, bad faith, punitive damages and unfair claims settlement practices statutes.

- "Principles of Property and Liability Claims Adjusting," teaching how to investigate causes of loss, subrogation and arson, legal liability and settling injury claims.

- "Property Insurance Adjusting," which covers estimating building losses, adjusting building and personal property losses, business interruption, salvaging and condominium losses.

- "Liability Insurance Adjusting," which teaches the fundamentals of tort law, automobile and product liability, claims evaluation and workers compensation claims.

About 12,000 exams are given each year for the four courses combined, said Mr. Markham, and 1,000 to 1,500 people annually complete all four courses and receive the Associate in Claims designation awarded by

Continued on next page

Insurer topics

Continued from previous page

"They need to know what they are getting into from the start so that they are less likely to leave shortly after they are hired because they misunderstood the job description," Mr. Lord said.

Metropolitan Life's Mr. Zimmerman agreed that choosing a potential candidate can be challenging and explained that MetLife uses the JEPS test to help make the task a little easier.

"We give them the standardized JEPS test to get a better idea of each individual's analytical and comprehension capabilities," he said.

In addition to using the JEPS test to determine mental capabilities, candidates at Metropolitan Life Insurance Co. are also tested for typing skills and interviewed extensively by management.

Mr. Zimmerman noted that life/health insurers are changing their views about which skills are most important when selecting a claims examiner.

"There used to be more of an emphasis on good keying skills but now the emphasis is on analyzing and problem-solving capabilities. It just is not enough to only type in the codes," he said.

But to get an even closer look at applicants and avoid making hiring errors, Metropolitan Life is piloting a new pre-employment test that actually gives the applicant a set of basic claims to review, enabling the insurance company official to see how well the

individual performs.

"The test allows us to observe all of the skills necessary on the job because it simulates the task that they will perform daily," Mr. Zimmerman said.

While most insurance companies report practicing strict pre-employment screening procedures, there are exceptions, like Em-

Aetna's training program runs for 12 weeks, during which new hires are instructed in the basics of the insurance industry.

ployers Life Insurance Co. of Wausau in Wausau, Wis., which does not use JEPS or any other pre-employment screening test.

"Because we are the only major insurance company for miles, we always have large number of applicants from the surrounding communities," said Delores Clancey, vp-group services and claim administration.

She further explained that often management is able to evaluate a future claims examiner more thoroughly in person because many candidates begin as part-time clerks and are subsequently offered full-time positions if they are qualified.

"We have a lot of high school and junior

college students who hold clerical positions in the evenings and then, if they are good performers and we have an opening, they become full-time employees," she said.

"This is an excellent feeder source because they understand the nature of the job and we get to see them at work."

While most insurance company personnel executives agree that choosing among applicants is difficult, training those hired to be claims examiners is exponentially harder.

Because hiring a new claims examiner typically means turning an 18- to 20-year-old into a competent and insurance-literate claims examiner, new hires are required to complete rigorous internal training programs.

"Our new claims examiners take an eight-week training course that teaches them the foundations of the insurance industry and provides them with the information they will need to be ready to go at the end of the session," said Travelers' Mr. Waypa.

In addition to learning the ABCs of the insurance industry, the Travelers training course also teaches newly hired claims examiners the company's computerized claim paying system as well as important medical terminology needed when reviewing a claim.

"They need to be familiar with the human body in order to be able to identify a diagnosis and know which tests relate to specific body parts, recognizing errors if incongruities appear," Mr. Waypa said.

Newly hired claims examiners at Aetna

must go through a similar training program.

Aetna's training program runs for 12 weeks, during which new hires are instructed in the basics of the insurance industry, employee benefits and computer coding and operations.

"Our training instructors use a multimedia approach, which includes workbooks, videos, lectures and on-the-job simulations in training," Ms. Kalas said.

"We have an excellent training program for our claims examiners and have a reputation for having highly skilled people. We often see other companies placing advertisements in newspapers that say 'Attention Aetna claims processors—great opportunity at our company,'" Ms. Kalas said.

Unlike other insurers that emphasize classroom training, newly hired claims examiners at Minnesota Mutual Life Insurance Co. of St. Paul, Minn., are trained by their supervisors as they work.

"We promote learning by exposure. They start out processing easy claims and as they gain experience they graduate to more complicated work," said Jan Moser, manager of employment at Minnesota Mutual.

Ms. Moser explained that during the initial training period, which lasts two months, new claims examiners are taught about the different divisions in the company, the insurer's computer claims paying system and, most importantly, "how to translate the gray issues of a claim so that their final determinations are accurate and fair."

Claims training

Continued from previous page

the IIA.

Tuition for classes varies between \$100 to \$200 per course. Exam fee, textbooks and course guide range from \$110 to \$150.

The IIA began its Introduction to Claims course in March 1988 for entry-level claims adjusters, administrative and clerical support staff for claims departments and customer service representatives in agencies or brokerage firms. Between 1,000 and 1,500 people have passed the exam.

The Introduction to Claims course runs \$62 for course guide, text and exam fee. A separate tuition fee may be charged by local sponsors.

The College of Insurance in New York offers seven courses in claims adjusting as part of its undergraduate curriculum. Courses meet three hours per week for 15 weeks and 10 to 15 students are in each class. Tuition is \$240 per credit hour, and registration is \$12 per credit hour.

Insurance company employees with high school diplomas or college degrees, as well as the college's full-time students, may enroll in the following courses:

- "Fundamentals of Loss Adjusting," covering first- and third-party claims, responsibilities of an adjuster, coverage determination and human relations.

- "Introduction to Casualty Insurance Claims," which deals with third-party claims, purposes and procedures of casualty claims adjusting, general principles of law and writing reports.

- "Insurance Fraud Investigation," which covers automobile and property damage, as well as life and health insurance fraud.

- "Workers Compensation Claims," which teaches the application and interpretation of laws, payment of benefits and occupational disease claims.

- "Time Element Loss Adjusting," covering business interruption, accounting and problems of loss adjusting.

- "Advanced Casualty Insurance Loss Adjusting," which examines adjusting problems in auto, product liability, recent court decisions and current industry trends.

- "Ocean Marine Loss Adjusting," which covers losses of and by ships and cargoes and evaluation of losses in terms of insured losses.

"Everything is classroom instruction," said Professor Richard Holliday, who will become chairman of the college's insurance department in

appraisals" using models or on-site training, he said.

GAB Business Services Inc., a Parsippany, N.J.-based claims administration and adjusting firm, opened its National Education Center in Denver in 1965. Originally only available to GAB employees, the center's courses have been open to insurance companies and self-insurers since 1986.

GAB's four-week "Basic Adjusting School" is required for all GAB adjusters and is available to client companies for \$1,400 per student. The course offers more than seven hours of daily classroom instruction in basic adjusting principles, personal liability, marketing techniques, investigating statements and interacting with policyholders, doctors and contractors.

Students examine a half-scale model of sections of a house to learn about building materials, installation and property damage. The course also spends two days on auto damage, in which students study a crash manual and learn to write damage estimates.

Besides industrywide programs and classes, individual insurance companies are developing more intensive training programs.

United Services Automobile Assn., for example, last year launched a claims technical training center for its entry-level adjusters. The "laboratory" features a 60-foot long model of a two-story house, complete with fire and water damage, said George Allen, executive director of claims training for the San Antonio, Texas-based insurer.

Students examine the model to learn about various building materials, installation and repair techniques.

Instructors recently broadcast a laboratory demonstration of an automobile being repaired live to USAA claims departments around the country. "We're doing that so we don't have to bring everybody out here. We can make use of the claims training center in the field," said Mr. Allen.

Training directors at Transamerica Insurance Co. and Travelers Corp., as well as Royal Insurance Group, report extensive training procedures for entry-level claims adjusters.

Woodland Hills, Calif.-based Transamerica emphasizes a "decentralized training philosophy" where new adjusters study independently, spend time with a field adjuster and meet periodically with supervisors to learn communication skills and the basics of adjusting. Transamerica also en-

claims courses or to take advantage of outside programs, said Bill Hackney, claims training coordinator.

Royal requires one week of training that focuses on basic claims procedures, ethics and company expectations, followed by three weeks of on-the-job training and one week of advanced classroom study, said William Moore, assistant vp of claims.

"We have a strong training program, but we're very supportive of the IIA and CPCU courses," said Mr. Moore. "We have several hundred CPCUs. The percentage of people that take those courses has grown by leaps and bounds."

Travelers requires 12 weeks of entry-level training, beginning with four weeks of orientation in the office, where new adjusters learn the computer system and begin to interact with customers. For the remaining eight weeks, new adjusters are sent to one of 10 training centers for classroom work, where they learn to handle simple but actual files and do field work with an instructor, said Dave Walker, senior technical consultant in claims for the Hartford, Conn.-based company.

After eight months of on-the-job training, the adjusters follow up with one week of advanced instruction at the home office.

"We discourage our people from taking the CPCU course until after the first year," said Mr. Walker. "Then we encourage it."

Reinsurance Run-Off Management

*To Weather The Storm,
You Must Have Your Roots Firmly
Planted*

**GREENPINES
MANAGEMENT
COMPANY,
INC.**

**We're more than
just managers.**

900 West Valley Road,
Suite 401,
Wayne, PA 19087
Telephone: (215) 687-8956
TELEX: 881813 EVERGREEN VAFG
Facsimile: (215) 687-8979



WE CAN HELP YOU MANAGE THE MEDICAL COST CRISIS.

A Comprehensive Managed Care Approach

- Hospital Preadmission Review
- Hospital Bill Audits
- Continued Stay Review
- Medical Peer Review/Fee Review
- Presurgical Review
- Case Management
- Outpatient Review
- Long-Term Care Review

For complete information and a competitive quotation contact:



Medical Cost Management

CALL TOLL-FREE 1-800/367-9938

In Chicago 312/341-0217

Insurer topics

Work comp insurer educates consumer

By KATHRYN J. McINTYRE

SAN FRANCISCO—PMA Group Inc. is taking the mystery out of workers compensation insurance for its policyholders.

The Philadelphia-based insurer meets yearly with its larger workers compensation insurance policyholders to discuss their claims and the loss reserves established to pay them.

This is just one of PMA's efforts to communicate with its policyholders, according to W. Douglas Hager, director of marketing, who described this and other PMA communication efforts during a workshop at the Insurance Marketing Communications Assn. annual meeting June 25-28 in San Francisco.

"We believe effective communication means educating the consumer," Mr. Hager told a group of insurance marketing, communications and advertising specialists.

As a result, PMA created what it calls "PURC," for Pre-Unit Report Consultation. It takes its name from the fact that the meeting with the workers compensation policyholder occurs within five months of policy expiration, before the unit report is filed with the appropriate workers compensation bureau for calculation of the experience modifier.

During the PURC meeting, all losses are reviewed with the policyholder and the loss reserves are explained, including how the reserves were calculated.

with the account, he or she is invited to the meeting.

PMA markets insurance both directly through its own sales force and through independent agents and

retention of business because it focuses on customer service. The meetings help communicate the message that it's important to consider more than the cost of insurance when se-

about insurance and related services.

Loss prevention visits are set with policyholders. If PMA is having difficulty convincing a policyholder of the importance of recommended loss prevention techniques, PMA will show how a \$5,000 claim, for example, requires the production of 500 or 1,000 widgets to cover its cost.

"This is very effective," Mr. Hager reported.

Other efforts involve printed material.

A brochure titled "What Is the True Bottom Line?" discusses financial strength, dividend returns, premium payment plans, how claims reserves affect the price of insurance, claims control, loss control, other services and professionalism.

To help clients better understand their insurance, PMA even sent policyholders a brochure on how to read their account statements, Mr. Hager noted.

PMA also communicates with its direct policyholders and its outside sales force through quarterly newsletters, Mr. Hager said.

And, PMA has formed advisory boards of agents and brokers that meet on a local basis and also gather together for an annual meeting.

"We listen and have developed programs to meet their needs," Mr. Hager said.

IMCA unveils new logo at annual meeting

SAN FRANCISCO—The Insurance Marketing Communications Assn. has a new logo.

Unveiled at its annual meeting last month in San Francisco, the new logo includes the maple leaf in the "C" to recognize the Canadian membership of the organization and a star in the "A" for the United States.

Janet Amorello of Amorello Design in Worcester, Mass., designed the logo.

IMCA has 151 members, including about 100 insurance companies and about 50 associate members. Associate members include the media, advertising agencies and computer software companies.

About eight Canadian insurance companies are members of IMCA as well as a half dozen Canadian associate members.

IMCA holds two general meetings a year—a winter meeting in January and an annual meeting in June. It also issues publications and conducts surveys on matters of interest to insurance marketing communicators.

For additional information, contact William T. Hadley, Executive Director, IMCA, 62 Northgate Road, Wellesley, Mass. 02181.



And, PMA helps the client understand how the experience modification factor affects the workers compensation premium charges.

Other claims in other lines can be reviewed at these meetings, too.

These meetings are held with clients that annually pay at least \$100,000 in workers compensation premiums.

If an agent or broker is involved

brokers.

The 45th-largest property/casualty insurer in the United States, PMA writes only commercial insurance lines in six states: Pennsylvania, Delaware, Maryland, Virginia, North Carolina, New Jersey and the District of Columbia. Its major product is workers compensation coverage.

Mr. Hager believes that the PURC program has contributed to a higher

lecting an insurance company.

Expanding on the workers compensation communication effort, PMA recently distributed a brochure for employers to give seriously injured employees. The brochure describes rehabilitation services and has special inserts describing rehabilitation for particular injuries.

PMA also uses other communication vehicles to teach the consumer

III campaign aims to change image

By KATHRYN J. McINTYRE

SAN FRANCISCO—The property/casualty insurance industry's national advertising campaign will need to run two to three years to make a change in the public's negative attitudes, says an advertising executive.

"The industry is viewed as a profiteer," says Justin Harrington, executive vp of Hill, Holliday, Connors & Cosmopolis Inc. of Boston, the advertising agency engaged by the Insurance Information Institute to develop its new advertising campaign.

But so far, the campaign, which was launched May 29, is running at only two-thirds of what Hill, Holliday had recommended because the III lacks funding for the full program as designed, he said.

The III advertising campaign was described by Mr. Harrington during the annual meeting of the Insurance Marketing Communications Assn. June 25-28 in San Francisco.

The III is still collecting funding from insurance companies to support its program and is budgeting \$15 million for its advertising campaign this year, according to the III.

The campaign is three-tiered:

- National print advertising in consumer and business magazines.
- Television, radio and newspaper advertising in 13 states where auto insurance is an issue. Network advertising is planned to air in September.

- Additional communication efforts in those states where the auto insurance issue is particularly acute—including California, Arizona and New Jersey.

Hill, Holliday was hired in February to build a long-term campaign to change the image of the insurance business, Mr. Harrington explained.

The strategy of the advertising campaign is to surprise consumers by conveying that the insurance industry understands their position, to initiate a dialogue with consumers and to present solutions to problems, Mr. Harrington said.

"We want people to see insurers as trying to solve problems and help-

ing consumers," he said.

And that's the message of the tag line for all the III advertising: "Your Insurance Companies. We'll listen and we'll do something."

The television commercial currently being aired in 13 states depicts an accident involving an older man and a teen-age driver and is designed to show that it is not always easy to determine fault in an auto accident, Mr. Harrington said. The ad ends with a toll-free 800-number flashing on the screen inviting viewers to request more information.

The ad can be customized in states where a particular auto issue is being debated, such as no-fault auto insurance.

Among the print ads is one that picks up the television commercial theme showing how complex it is to determine who was at fault in an auto accident. Other print ads discuss such issues as no-fault insurance, drunk driving and auto theft. They include a coupon inviting the reader to request more information.

The radio spots include an announcer discussing the problems of stolen cars and drunk driving and the advantages of airbags, each ending with an invitation for the listener to request more information from the III.

The campaign's direct mail effort includes responding to requests for information and building a mailing list of 200,000 names, Mr. Harrington said.

Thousands of people responded within the first week the television commercial was aired by calling the 800-number that appears on the screen, which is that of a professional fulfillment house.

Callers with complaints or requests for advice are forwarded to III staff.

Several thousand people also have requested information based on the print ads.

In addition, Wexler Reynolds Fuller Harrison & Schule Inc. in Washington, D.C., a government affairs firm, has been engaged to help the III design strategies and build coalitions and grass roots support.



Advertiser Index

Insurer Topics

Issue of July 17

READER SERVICE #	ADVERTISER	PAGE #
—	Alliance Capital Management.....	20C
130	Green Pines Management Corp.....	20G
131	Medical Cost Management.....	20G
—	U.S. Re Corp.....	20E

Business Insurance

Issue Date: JULY 17, 1989
Card Expiration: SEPTEMBER 8, 1989

All questions must be answered in order to have your inquiry processed.

Please check one item for each category:

1. My organization is best described as:

☐ Mfg/Svcs
☐ Association
☐ Union
☐ Government
☐ Educational Inst

☐ Ins Agent
☐ Ins Broker
☐ Ins/Reins Co
☐ Actry/Consl
☐ Attorney

☐ Adj/Apprs
☐ TPA
☐ Healthcare Inst
☐ Other

2. Number of employees:

☐ 150 or less
☐ 1,000 - 4,999

☐ 151 - 499
☐ 5,000 or more

☐ 500 - 999
☐ Unknown

3. My title is best defined as:

☐ Administrative Mgt
☐ Financial Mgt
☐ Risk Mgt

☐ Benefits Mgt
☐ Loss prevention Mgt
☐ Other

4. My purchasing involvement for the requested products is to:

☐ recommend only

☐ specify

☐ approve

5. Do you now receive a personally addressed copy of Business Insurance?

☐ Yes

☐ No

Circle the numbers below that correspond to the companies listed on our Advertiser Index for the July 17, 1989 issue. Cards with more than 20 items circled will not be processed. This card expires September 8, 1989.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100	101	102	103	104	105
106	107	108	109	110	111	112	113	114	115	116	117	118	119	120
121	122	123	124	125	126	127	128	129	130	131	132	133	134	135
136	137	138	139	140	141	142	143	144	145	146	147	148	149	150

Please print clearly

Name _____

Title _____

Company _____

Address _____

City _____ State _____ Zip _____

Phone () _____

Workplace death

Continued from page 2

healthy working conditions and to preserve our human resources," as a grant of immunity to employers who are responsible for the deaths or serious injuries of their employees," wrote Associate Justice Patricia J. Boyle.

"While deterrence, and thus to some extent regulation, is one aim of general criminal laws, so too is punishment—clearly not one of OSHA's primary goals. A more important purpose, however, is the protection of employees as members of the general public," she said.

"While OSHA is concerned with protecting employees as 'workers' from specific safety and health hazards connected with their occupations, the state is concerned with protecting the employees as 'citizens' from criminal conduct. Whether that conduct occurs in public or in private, in the home or in the workplace, the state's interest in preventing it and punishing it is indeed both legitimate and substantial."

Justice Boyle also noted that "there is no argument that we may infer from OSHA's broad scope a congressional intent to occupy the entire field of safety and health regulation or to exclude the states therefrom."

Noting that OSHA allows states to set, with its approval, their own standards for workplace safety and health, the court said that the "act thus contemplates an active role by the states in all areas of regulation."

The federal Occupational Safety and Health Administration itself has never taken a position on pre-emption.

The Michigan ruling "goes hand-in-glove with the Illinois case," observed Michael J. Modelski, an Oakland County, Mich., prosecutor who has been involved with the Michigan case for several years.

The decision shows that pre-emption "really isn't a sound argument," Mr. Modelski said. "Employers won't be able to use OSHA as a protection against their workers."

In the first ruling of its kind in the nation, the Illinois Supreme Court ruled in February that officers of Elk Grove Village, Ill.-based Magnet Wire Corp. could be criminally prosecuted for allegedly exposing 42 workers to toxic substances, even though the employer's conduct was regulated by federal safety guidelines.

While attorneys in the Magnet Wire cases are seeking review by the U.S. Supreme Court, the attorney in the Michigan case does not plan similar action because he thinks there is

insufficient evidence to support the criminal charges against his client when the case is tried in lower court.

The case could not go to trial while the pre-emption question was being decided.

The "real concern," said Kenneth Mogill, a partner in the Detroit law firm of Mogill, Posner & Cohen who represented Mr. Hegedus, is that the Michigan ruling will lead to differing standards of conduct in different jurisdictions, causing problems for companies that operate in more than one state.

He also suggested the case could lead to selective, unjustified prosecutions. "It's clear that something needs to be done about preventing abusive prosecutions."

Robin Conrad, director of litigation for the U.S. Chamber of Commerce's National Chamber Litigation Center in Washington, D.C., agreed.

"This decision makes it all the more imperative for employers that the U.S. Supreme Court grant review in the Chicago Magnet Wire case," Ms. Conrad said. "Such prosecutions are a threat to uniform federal safety laws."

However, Glenn Sechen, an attorney with the Chicago law firm of Schain, Firsell & Burney, and a former prosecutor in the Chicago Magnet Wire case, disagreed. The issue is

not safety standards, but whether state authorities have the right to pursue criminal charges in workplace safety cases, he said.

"The view that you cannot prosecute is so contrary to legislative intent that its almost foolhardy," he said.

The Michigan decision "is very significant. I think you see a clear trend with other states following the lead of Illinois," Mr. Sechen said.

Joseph Kinney, founder of the National Safe Workplace Institute in Chicago, agreed.

"I've felt that once responsible courts took a look at this issue, there'd be no question where they'd

come down," he said.

Mr. Kinney also said that safety-conscious employers "should sing high praises for this decision. For a lot of employers, safety and OSHA are the remotest of issues. They recognize that safety and health are an investment in productivity, not a regulatory cost."

"You've got reputable manufacturers who are forced to compete with people who cut corners," agreed Mr. Sechen.

The People of the State of Michigan v. Patrick Hegedus, Docket No. 83601, Michigan State Supreme Court, July 3, 1989.

READER Service Advertiser Index

Issue of July 17

READER SERVICE #	ADVERTISER	PAGE #	READER SERVICE #	ADVERTISER	PAGE #
—	Aircraft Builders Council.....	22	—	General Reinsurance.....	7
1	AON Risk Consultants.....	27	10	Joseph Ivy Company.....	23
—	Arkwright Mutual.....	14	—	Larsen, Burnham & Trutner.....	21
2	Blue Cross Blue Shield Assoc....	16-17	—	Maximum Financial Group.....	14
3	CIGNA.....	11	11	MCC Companies.....	18
4	Crawford & Company.....	6	12	Metropolitan Life Ins. Co.....	12
5	Crawford & Company.....	15	13	Mutual of Omaha.....	32
6	Crawford & Company.....	25	—	Nat'l Risk Retention Assoc.....	15
7	Dorinco.....	4	—	Northwestern National Life.....	5
8	Equicor Health Plans.....	10	14	Reliance National Risk Spec.....	9
9	General Rehabilitation Serv.....	13	15	Vale National Training.....	21

READER Service

To obtain free information on the products and services advertised, turn to our post-paid Reader Service Reply Card bound in this issue, or complete the coupon below and mail to:

BUSINESS INSURANCE
P.O. BOX 1649
RIVERTON, NJ 08077-7249

Business Insurance

READER SERVICE CARD

Issue Date: JULY 17, 1989

Card Expiration: SEPTEMBER 8, 1989

All questions must be answered in order to have your inquiry processed.

Please check one item for each category:

1. My organization is best described as:

- ☐ Mfg/Svcs ☐ Ins Agent ☐ Adj/Apprs
☐ Association ☐ Ins Broker ☐ TPA
☐ Union ☐ Ins/Reins Co ☐ Healthcare Inst
☐ Government ☐ Actry/Conslt ☐ Other _____
☐ Educational Inst ☐ Attorney ☐ Other _____

2. Number of employees:

- ☐ 150 or less ☐ 151 - 499 ☐ 500 - 999
☐ 1,000 - 4,999 ☐ 5,000 or more ☐ Unknown

3. My title is best defined as:

- ☐ Administrative Mgt ☐ Benefits Mgt
☐ Financial Mgt ☐ Loss prevention Mgt
☐ Risk Mgt ☐ Other _____

4. My purchasing involvement for the requested products is to: ☐ recommend only ☐ specify ☐ approve

5. Do you now receive a personally addressed copy of Business Insurance? ☐ Yes ☐ No

Circle the numbers below that correspond to the companies listed on our Advertiser Index for the July 17, 1989 issue. Cards with more than 20 items circled will not be processed. This card expires September 8, 1989.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70	71	72	73	74	75
76	77	78	79	80	81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100	101	102	103	104	105
106	107	108	109	110	111	112	113	114	115	116	117	118	119	120
121	122	123	124	125	126	127	128	129	130	131	132	133	134	135
136	137	138	139	140	141	142	143	144	145	146	147	148	149	150

Please print clearly

Name _____

Title _____

Company _____

Address _____

City _____ State _____ Zip _____

Phone () _____

It Makes Good Cents to Know How to Estimate

Knowing how to prepare cost effective estimates does make cents and takes most of the guesswork out of estimating. That's what our courses are designed to do.

Our one, two and three week training courses in Auto Estimating™, and Residential Damage Estimating provide you a significant and quick return on every training dollar you invest with us.

Consider lower claim payments of 10-20% and then call today for schedule of classes, student reservations or free brochure.

1-800-233-7095

In PA call collect — 717-263-1805

Vale National

Vale National Training Center, Inc.

Vale West Campus
Palo Alto, California

Vale Central Campus
Arlington, Texas

Vale East Campus
Chambersburg, Pennsylvania

Key to Lloyd's is change: Chairman

By CAROLYN ALDRED

LONDON—Lloyd's of London must improve its business operations and overcome some major hurdles to remain a competitive force in the world's insurance market, Lloyd's Chairman Murray Lawrence warns.

"The Lloyd's market is involved in a period of unprecedented structural change as well as commercial challenge," he told Lloyd's members at the Society of Lloyd's annual general meeting June 28.

The market must find ways of making itself "more attractive for brokers and clients to do business here," he explained at a press conference after the meeting.

Lloyd's will announce to members in September record profits of about 600 million pounds (\$948 million at current exchange rates) for the 1986 underwriting year, Mr. Lawrence said.

For the 1985 underwriting year, Lloyd's profits totaled 193 million pounds (\$349.3 million), which reflects changes in the treatment of

members' taxes and agents' profit commissions reflected in the 1986 underwriting year, he noted (*BI*, Sept. 12, 1988).

Mr. Lawrence also noted that Lloyd's in 1987 contributed nearly 2.4 billion pounds (\$4.5 billion) to the U.K. balance of payments—more than 25% of the U.K. financial industry's total overseas earnings and nearly twice as much as the entire U.K. banking industry.

However, Lloyd's cannot be complacent, he said. "Lloyd's faces a series of crucial questions concern-

ing both its trading structure and efficiency in fast changing and increasingly competitive markets."

The Corporation of Lloyd's and market executives have been studying several ways to maintain and increase the position of Lloyd's in the market," he said.

"It will be necessary for brokers and underwriters together to examine whether the well-tried methods we have used for many years continue to be appropriate, bearing in mind not only what is now possible with modern technology, but also the vastly more competitive environment in which we find ourselves," he said.

For example, Lloyd's plans to allow direct dealing between policyholders and underwriters for small commercial property/casualty insurance and personal lines insurance. "Modern technology is allowing us to reconsider direct dealing," he said.

Even large and complex risks that likely will continue to be placed by brokers can take a more direct route to the market, he said.

For example, when trade barriers on insurance services in the European Community fall next July, corporations will be able to place their risks in Lloyd's as direct insurance rather than as facultative reinsurance.

"For the future... the successful insurers are likely to be those which get as close to the (policyholder) as possible," he said.

Meanwhile, the Corporation of Lloyd's plans to monitor the amount of business Lloyd's brokers

to try to ensure that any agent who takes this route does so truly as a course of last resort and never as an easy option," he said.

An increasing number of syndicates in the last few years have been unable to close their underwriting years because of uncertainty over U.S. liabilities, particularly environmental and asbestos claims.

Those uncertainties "are apparent in their most extreme form" in syndicates 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., Mr. Lawrence said.

Underwriter Richard Outhwaite's liabilities for his syndicates' 1982 underwriting year, which is still open, currently stand at 304 million pounds (\$480.3 million). The losses stem mainly from dozens of runoff reinsurance policies he wrote for other syndicates and London insurers to cover their liabilities from previous underwriting years.

Mr. Outhwaite has called on members of his 1982 underwriting syndicate this year to pay 64 million pounds (\$101.1 million), the largest cash call in Lloyd's history. The members also face another 76 million pounds (\$120.1 million) in losses because of the runoff policies. However, Mr. Outhwaite is disputing nearly \$200 million of claims filed by at least 10 ceding syndicates and insurers (*BI*, July 3).

"There seems to be a perception that the Council of Lloyd's and the 12th floor (the location of the chairman's and deputy chairmen's



AIRCRAFT BUILDERS COUNCIL, INC.

1989 FALL SEMINAR
September 24-26, 1989

Ritz-Carlton, Laguna Niguel
Laguna Niguel, California

TOPICS

Reflections on Apollo and Both Current and Future Space Projects

Plaintiff Lawyer's View of the Boyle Decision and the Government Contractor Defense

Update on Wind Shear Detection Technology and Other Related Subjects

Presentation on the X-29 Forward Swept Wing Aircraft Designed to Explore Advanced Technologies

Presentation on Proposed Design of the National Aerospace Supersonic Aircraft

ABC Underwriters Panel Discussion

ABC Products Liability Seminars and Claims Prevention Programs

The Aircraft Builders Council (ABC) supports an aerospace products liability insurance program and communicates its developments to aerospace manufacturers and product suppliers. The Fall Seminar is an informational forum for risk managers, brokers, and underwriters of aerospace insurance.

For additional information, please contact
Hillary Levine, Julie Taylor, or Angela Sabatino at:
Telephone—(212) 682-5110
FAX—(212) 986-9716

Aircraft Builders Council, Inc.
205 East 42nd Street, Suite 1504
New York, NY 10017



Lloyd's of London cannot be complacent, says Chairman Murray Lawrence. 'Lloyd's faces a series of crucial questions concerning both its trading structure and efficiency in fast changing and increasingly competitive markets.'

place in the market.

"Since the name and reputation of Lloyd's is an immensely valuable asset, we have a duty to monitor whether those brokers who carry it are doing everything they can to promote Lloyd's interests. We will be examining whether the amount of business every broker places in the market justifies their position as a Lloyd's broker," Mr. Lawrence said.

Lloyd's expects Lloyd's brokers to show their business in the market, even if it subsequently is placed elsewhere, he said.

Lloyd's also plans to:

- Increase its quality of service and speed of claims settlement with the use of a marketwide computer network.

- Translate policy wordings and documentations into various European languages in an effort to boost European business. Currently only 8% of Lloyd's premiums come from European countries other than the United Kingdom.

- Control costs. The Corporation of Lloyd's has not increased its budget from 1988 (*BI*, June 19).

- Promote the Lloyd's name and market products more forcefully.

Lloyd's also faces several problems that directly affect its members and therefore the market's capital base, which dictates market capacity.

"The problem of (underwriting) years left open is probably the major matter of concern to names, and we have been looking long and hard at ways to improve the situation," Mr. Lawrence said.

Although the number of syndicate underwriting years left open fell to 114 in 1988 from 120 in 1987, "more work needs to be done, and we are considering measures

offices) are passive in this matter and merely reject any proposal put to them," said Mr. Lawrence, referring to the council's rejection of a proposal to cap Outhwaite's members' liabilities.

The council "is well aware of the damage caused to the names on both the Outhwaite syndicate and the syndicates in dispute as well as to the Society as a whole by the uncertainties brought about by the lengthy and costly arbitration or litigation to resolve these differences," he told members.

As a result, the council is trying "to encourage a speedy resolution of the outstanding disputes" with the appointment of trial lawyer Mark Littman "as an independent conciliator," he explained.

Turning to another matter affecting the capacity at Lloyd's, Mr. Lawrence predicted that the market likely will see more member resignations this year after last year's record resignation of 1,750 members.

More than 500 members already this year have indicated they plan to resign their membership at the end of 1989, compared with about 400 at the same time last year, according to Mr. Lawrence.

"But I am encouraged to hear from members' agents that there are again many names in the U.K. and overseas who wish to increase their underwriting commitment to Lloyd's."

"If we also take into account a considerable number of potential new names, I am confident that the overall capacity of the market for 1990 will remain sound and well placed to benefit from an upturn in the market which we can expect to follow the present soft condition," he said.

Study finds only 31 million uninsured

By JERRY GEISEL

Washington

WASHINGTON—The number of Americans without health insurance may not be as high as commonly thought.

While some observers, such as Sen. Edward Kennedy, D-Mass., have put the number of uninsured at 37 million, an economist at the U.S. Department of Health and Human Services says there were 31.1 million uninsured people in the United States in 1987.

M. Eugene Moyer, an HHS economist, bases his findings on a recent population survey conducted by the Bureau of the Census.

The lower estimate may at least partly be explained by the fact that some coverage surveys have failed to include those covered by the Veterans Administration, according to Mr. Moyer.

Of the 31.1 million uninsured, some 9.4 million are impoverished, while 2.9 million have earnings between 100% and 124% of the poverty level, according to the survey.

In addition, more than half—or 15.6 million—of the uninsured are employed, of which 9.6 million work for companies with fewer than 100 employees, the study found.

NAIC criticized

An official of a small-employer trade association is criticizing the National Assn. of Insurance Commissioners' denouncement of the Risk Retention Act.

Last month, in a seven-page letter to the Commerce Department, the NAIC charged that the act has made it easy for "unscrupulous" individuals and entities to write coverage for risk purchasing groups without sufficient assets to protect policyholders when claims roll in (*BI*, June 26).

While the NAIC said it was "gravely concerned about the lack of protection of the public from unsound practices and financial practices" allowed by the Risk Retention Act, the NAIC said the act has had only minimal, if any, impact on the availability of liability insurance.

But in his own letter to the Commerce Department, James Anderson, senior director of government relations with the Washington, D.C.-based National Assn. of Wholesaler-Distributors, said the NAIC's "distorted view" of the Risk Retention Act deserves a response.

Contrary to the NAIC, Mr. Anderson said the Risk Retention Act has had a beneficial impact on the liability insurance market.

"Significant activity has oc-

curred regarding the formation of risk retention and purchasing groups since the act's enactment and in a soft market to boot," Mr. Anderson said. "This is a clear demonstration that the commercial insurance buying public welcomes these entities and the additional markets they provide," he commented.

Mr. Anderson also takes issue with the NAIC's concern that risk retention groups "typically" have low capitalization and inexperienced management.

Mr. Anderson, who also is chairman of the government affairs committee of the National Risk Retention Assn., a Washington, D.C.-based trade group that represents risk purchasing and risk retention groups, notes that state regulators have the authority to stop a risk retention group from operating if the group is in hazardous financial condition.

In addition, risk retention groups are subject to financial examinations and are required to file substantial financial information to the commissioner of every state in which they operate.

The NAIC letter, Mr. Anderson said, makes clear what many observers suspected: "The NAIC is institutionally committed to gutting the Risk Retention Act."

However, in an interview with *Business Insurance* last month, William Hager, commissioner of the Iowa Insurance Department, said regulators are supportive of the concept of the Risk Retention Act.

He added, though, that regulators are especially skeptical of some of those "players" involved with risk purchasing groups.

The NAIC's and Mr. Anderson's letters were sent to Edward T. Barrett II, a Commerce Department staffer who is preparing the department's second and final report on the impact of the Risk Retention Act. That report is expected to be published this fall, Mr. Barrett said.

\$2 million OSHA fine

The federal Occupational Safety and Health Administration has proposed fining a Ford Motor Co. unit \$2 million for allegedly failing to adequately report worker illnesses and injuries.

OSHA said the penalties were for reporting lapses by Ford Electronics & Refrigeration Corp., a Ford subsidiary in Lansdale, Pa., that makes electronic automobile

parts.

Ford was cited for 241 instances of alleged willful misrecording or failure to record injuries and illnesses.

These violations either occurred or were not corrected after a November 1987 agreement by Ford to correct all recordkeeping deficiencies on a corporatewide basis by June 1, 1988.

"When we make such an agreement with an employer, we intend to see that it is carried out," commented Labor Secretary Elizabeth Dole.

As part of that agreement, Ford had agreed to pay \$325,000 in fines and to review recordkeeping procedures to see that they were in compliance with OSHA and Bureau of Labor Statistics requirements (*BI*, Nov. 23, 1987).

PBGC official

Douglas Cannon, a former White House official, has been named deputy executive director of the Pension Benefit Guaranty Corp.

Mr. Cannon had been a member of President Bush's transition team with responsibility for management analysis of the Labor Department and the PBGC. Previously, he had been a senior staff member and director of administration in the White House Office of Policy Development.

Mr. Cannon, 35, also served as a special adviser to the deputy undersecretary for management at the Department of Education and was a budget analyst in the Office of Management and Budget.

Mr. Cannon earned a bachelor of science degree in economics from the University of Pennsylvania's Wharton School of Finance and Commerce in Philadelphia and a master of business administration degree from Harvard University's Graduate School of Business Administration in Cambridge, Mass.

ADEA legislation

Sen. John Heinz, R-Pa., has introduced legislation, S. 1293, that would overturn a Supreme Court decision last month allowing employers to reduce benefits for older workers without providing cost justifications.

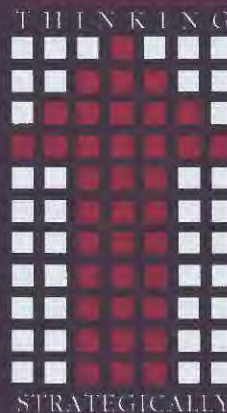
Sen. Heinz's bill would make clear that the Age Discrimination in Employment Act prohibits arbitrary age discrimination in all aspects of employment, including employee benefit programs.

Introduction of the Heinz legis-

lation comes on the heels of last month's Supreme Court ruling overturning Equal Employment Opportunity Commission regulations that prohibited age-based benefit distinctions except when justified by the higher costs of

benefits for older workers (*BI*, July 10).

"Now is the time to rebuild the wall of protection from unjustified discrimination that the court has torn down," Sen. Heinz said last week.



Aiming for Strength & Stability in the '90s

Thinking Strategically

Conference Topics

Strategic Thinking for the '90's • Environmental Analysis and Pool Growth • The Role of the Pool's Board of Directors in Developing a Strategic Vision • Linking Financial Proformas with Strategic Issues • Transferring Strategic Goals to the Budget • Attracting and Retaining Competent Pool Professional Staff • The Reality of Leadership Turnover • An Operational Strategic Management System

Conference Materials Include:

Strategic Planning Workbook • Sample Planning Worksheets • Checklist for External Threats and Opportunities • Checklist for Internal Strengths and Weaknesses • Sample Budgets • Sample Human Resources Plan including Pool Staffing and Salary Requirements

Specifically Designed For:

Pool Boards of Directors and Administrators • Organizations and Associations who Sponsor Pooling Programs • Pooling Program Participants

For More Information Contact:

The Joseph Ivy Company; 7800 North Mopac, Suite 210; Austin, Texas 78759; (512) 346-6921

Presented by:



and



Do you have to return it?

If you're racing through this issue of *Business Insurance* because you have to return it soon,

why not have your own personal subscription?

Use the card in this issue or the coupon to SUBSCRIBE TODAY.

Business Insurance

Circulation Dept. 965 E. Jefferson Detroit, MI 48207

Business Insurance gives you total news coverage of loss prevention, risk financing and benefit management. Every week. Annual subscription (52 issues) in U.S. dollars.

(Check here:)

USA

Canada

Bermuda (air only)

United Kingdom

Europe/Middle East

All other foreign

Surface Mail

☐ \$70

☐ \$102

By Air

☐ \$147

☐ \$157

☐ \$152

☐ \$150 or £83

☐ \$150

Rates on request

☐ new subscription. ☐ renewal. ☐ payment enclosed.

☐ bill me. ☐ bill company.

☐ Please send information on your special 20%-off group rate for five or more subscriptions.

Mail to: Business Insurance, Circulation Dept., 965 E. Jefferson Ave., Detroit, MI 48207

4COU9

name (please print)

title telephone

company

nature of business

☐ business or ☐ home address

city state/country zip/postal code

☐ I prefer not to receive information or advertising by mail from companies not affiliated with Crain Communications.

Benefit mandate

Continued from page 1

Chrysler Corp., support the concept of requiring employers to offer health care coverage. They point out that employers with health care plans subsidize the cost of care for the uninsured through cost-shifting by hospitals.

Unlike last year, when the committee voted so late in the session that there wasn't time for Sen. Kennedy to bring the measure to the Senate floor, last week's quick committee action means the Massachusetts Democrat will have more time to try to win full Senate approval of the bill.

Sen. Kennedy said he would like to bring the measure to the Senate floor sometime this fall.

"I am convinced we can develop sufficient support to get a bill through" the Senate, he said.

And, in an effort to win more Republican backing, Sen. Kennedy said he is prepared to work with

opponents to refine the legislation.

Some observers, though, say Senate consideration and approval of the Kennedy bill is unlikely any time soon.

"Sen. Kennedy has a long way to go before he can get a bill through the Senate. This is a very contentious issue," said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York.

"At this point, there is not a substantial groundswell of support for the legislation," added Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

Still, while the chances of enactment in the immediate future are uncertain, benefit experts say congressional interest in increasing access to health care, such as through an employer health care plan mandate, will not go away.

"The concept of mandatory health insurance will keep coming back. The issue of health insurance access is becoming a national issue

for Democrats and Republicans alike," Mr. McArdle said.

While the Kennedy legislation faces an uphill battle for approval, if enacted it would have an enormous effect on both large and small employers.

Most, if not all, large employers would have to upgrade their health care programs to meet the minimum standards laid down by the Kennedy legislation. In fact, benefit consultant Towers, Perrin, Forster & Crosby Inc. in 1987 found that not one of the 74 employers it surveyed offered a health care program that complied with all the benefit mandates of Kennedy's legislation (*BI*, Aug. 31, 1987).

And, for thousands of small employers, enactment of the proposal would require, at significant cost, health care coverage to be offered to employees for the first time.

Sen. Kennedy estimates that businesses would have to spend \$18 billion annually to upgrade or add new plans to meet the require-

ments of his legislation. Sen. Hatch has put the cost as high as \$100 billion.

Sen. Kennedy also estimates that the coverage mandate would cost employers \$1,295 per employee for indemnity plan coverage and \$1,100 per employee for health maintenance organization coverage.

While the cost to employers would be high, enactment of the Kennedy legislation would put a huge dent in the number of uninsured Americans, estimated at between 31.3 million and 37 million. Sen. Kennedy says his bill would extend health insurance to between 22 million and 24 million employees and dependents who are currently uninsured.

Under Sen. Kennedy's bill, employers would have to offer comprehensive health care plans meeting a detailed set of federal standards.

For example, coverage generally would have to be offered to all em-

ployees working at least 17.5 hours a week beginning Jan. 1 of the second year after the legislation was enacted.

Employers could pay less than 80% of the health care premium for part-time employees who work between 17.5 hours and 25 hours per week. However, the legislation does not specify the portion of these employees' health care premiums to be paid by employers.

Annual deductibles for hospital and physician services generally could not exceed \$250 per person or \$500 for family coverage. These deductibles would be indexed to match annual increases in the Consumer Price Index.

Employers, though, could charge higher deductibles if employees receive services outside of a preferred provider network.

Copayments for covered services generally could not exceed 20% with a maximum annual out-of-pocket expense of \$3,000. This catastrophic expense cap also would be indexed to increases in the CPI.

Employers, though, would be allowed to alter benefit provisions as long as the overall value of the plan was not reduced. For example, if an employer offered a prescription drug benefit, it could require employees to pay higher deductibles.

Prenatal and well-baby care coverage, though, would have to be offered without deductibles and coinsurance requirements.

Generally, employers would have to pay 80% of the health care premium for most workers. Employers, though, generally would have to pay the full premium for low-wage workers—those earning less than 125% of the federal minimum wage.

This premium requirement far exceeds the non-discrimination standards laid down by Section 89 reform legislation cleared by the Senate and the House Ways and Means Committee (see story, page 3).

For example, under the Senate-approved Section 89 measure, an "affordable" health care plan is defined as one for which employees generally pay no more than 40% of the total health care premium; under the Ways and Means Committee proposal, an affordable plan is one for which employees pay no more than 50% of the total premium.

"Clearly, Sen. Kennedy's proposed premium-sharing requirements are outside the mainstream of congressional thinking," said Hewitt's Mr. McArdle.

However, in an effort to win support or at least reduce opposition from the small business lobby, the latest version of the Kennedy legislation would reduce the impact of the health care mandates on small businesses.

For example, under one provision, the federal government would subsidize 75% of a small employer's health care costs that exceed 5% of the company's gross revenues. Under this provision, small employers are defined as those with fewer than 25 employees.

The legislation also would give employers with fewer than six employees five years to comply.

Furthermore, under the amendment offered by Sen. Harkin, the legislation would allow employers with fewer than 10 employees that have been in business for less than four years to offer a "low cost" health plan to their employees.

While the measure does not specify what a low-cost plan is, these employers, under an earlier version of the legislation, would have had to provide a plan that only covered health care expenses exceeding \$3,000 annually.

The Kennedy bill also gives states funds to start health care programs for the unemployed and those not eligible for Medicaid or Medicare.

AWARDS

The best... the brightest... the most innovative communication programs

Employee Benefits Communication Awards Luncheon

On August 7th Business Insurance salutes the winners of the 17th annual EBC Competition at an Awards Luncheon at the Helmsley Hotel in New York. Recognizing outstanding communication programs, Alfred Malecki, Publisher of Business Insurance, will present awards in six categories:

- booklets
- personalized correspondence
- audio-visual presentations
- multi-media programs
- special projects
- total benefits programs

Meet the people behind these award winning programs and see first hand how other employee benefits executives are tackling their communication programs.

After lunch you'll have an opportunity to view winning entries from this year's EBC Competition.

Make your reservation today for the EBC Awards Luncheon ... then you be the judge ... take a look at how other industry professionals are communicating their employee benefits.

Monday, August 7, 1989
The Helmsley Hotel, New York City
Awards Luncheon: 12:15pm - 2:00pm*
EBC Program Viewing: 2:00pm - 3:30pm*

Tickets are \$70.00 per person; reserved tables of 10 are \$625.00. A \$25 per ticket service charge applies to cancellations received after July 20. No refunds after August 1st.

Reserve your Luncheon tickets by contacting Barbara Dalton at 212-210-0780; or fill out the coupon below. Tickets are available on a first-come first-serve basis. Seating is limited.

*Confirmation along with hotel room details will be sent upon receipt of paid reservations.

**Business
Insurance**

EBC Awards—Monday, August 7, New York City

- ☐ Luncheon only
☐ Luncheon and program viewing (immediately following lunch)

name _____

title _____

organization _____

address _____

city/state/zip _____

phone _____

For additional luncheon tickets attach a separate list — include name, title and company affiliation — along with this reservation card.

Please reserve _____ seats \$70.00 each
Please reserve _____ tables of 10 \$625.00 each
Total \$ _____

- ☐ payment enclosed
make checks payable to Business Insurance
☐ Visa ☐ Mastercard ☐ American Express ☐ Optima card

account # _____ expiration date: _____

cardholder name: _____

signature: _____

Mail this card to Barbara Dalton, EBC Awards Registrar,
Business Insurance, 220 East 42nd Street, NYC 10017-5806
OR CALL (212) 210-0780

AMA seeks plan for employer-paid health insurance

By MICHAEL BRADFORD

CHICAGO—The American Medical Assn. is drafting a legislative proposal it hopes will lead to a federal law requiring employers to provide medical insurance to all workers.

The AMA proposal calls for businesses with more than 100 employees to be the first to provide coverage for their full-time workers, an AMA spokesman said.

The group is still discussing how the mandatory insurance law could be structured to avoid financially harming small businesses, the spokesman said. An AMA report says the organization plans to build in safeguards "against excessive hardship for marginal employers that might cause business failures and employee layoffs."

The AMA suggests that businesses receive tax credits to help offset the cost of the provisions. Details of the tax credits will be part of the legislative proposals.

The spokesman said the AMA's proposals are ones the group "has been discussing for years."

The AMA's House of Delegates, which sets policy for the organization, endorsed the concept at its annual meeting last month.

The AMA also will seek changes to the Medicaid program in an effort to extend health insurance to all people with incomes below the national poverty level.

"Eligibility would be determined by the poverty level," the spokesman noted. "If they are at it or below it," they would be eligible.

Currently states have varying Medicaid eligibility rules.

And, the AMA is pushing for states to establish "risk pools" that would provide individual coverage for the "near poor"—those whose incomes are just above the poverty level. The AMA is proposing that states set up the pools to write coverage at rates of between 110% and 125% of "the average premium for comparable group coverage."

Under the proposal, people with incomes at the poverty level or as much as 150% of that figure would be eligible for vouchers from the state to offset part of the premium for coverage in a pool. Individuals with income between 150% of the poverty level and twice the amount of the poverty level could buy coverage from the pool, but would be ineligible for a state subsidy.

The proposals are drawing some fire.

Dr. Quentin Young, president of the Health & Medicine Policy Research Group in Chicago, said the AMA's approach is "costly and the least effective."

The AMA plan merely calls for large cash expenditures without providing comprehensive solutions, Dr. Young said, noting that Canada's government-operated national health care system is a better method for providing health care coverage for the uninsured.

"From a health care viewpoint, no country more closely resembles us than Canada," Dr. Young said. Canada's system has provided coverage for a fraction of the cost of the U.S. system for 15 years, he added (BI, Feb. 20).

He noted that Canadian provinces are allowed to charge either a tax or premium for coverage. In either case, the price is around \$30 per month for individual coverage and \$60 for family coverage.

However, the AMA is adamant about avoiding adoption of such a national health care plan.

In a report prepared by AMA staffers, the AMA says part of its strategy in gaining acceptance for its health care proposals will be to air television commercials and run print advertisements that tout the advantages of its system while keying on "disadvantages of foreign systems such as Canada's."

The AMA says that calling for the private sector to provide coverage to the uninsured "would alleviate some of the perceived need for a radical overhaul of U.S. health care along the lines of the Canadian model."

Editorial Index Service

The Business Insurance Editorial Index Service directs you to all news reports and feature articles published by Business Insurance newsmagazine.

The annual service includes 3 quarterly reports and a cumulative annual volume. In addition, article citations between publication of quarterly reports are available from BI's Information Centers in New York and Chicago. Complete alphabetical and chronological listings by company, person, subject and geographic location enables you to access data quickly and accurately.

Take advantage of this cost effective tool and fill out the coupon today or call 212/210-0137

Business Insurance

Business Insurance Editorial Index
220 East 42nd Street, New York, NY 10017

Please send me the following index(es):

Full Index Service at \$100* ☐ 1989

Softcover edition at \$100* each ☐ 1986 ☐ 1987 ☐ 1988

Hardcover edition at \$150* each ☐ 1981 ☐ 1982 ☐ 1983

☐ 1984 ☐ 1985

TOTAL ENCLOSED \$

PAYMENT MUST ACCOMPANY ORDER —

☐ Visa ☐ Mastercard ☐ Optima

☐ American Express ☐ Check Enclosed

(make check payable to Business Insurance)

* foreign postage additional

Account # Exp. Date

Signature

Name

Title

Phone

Company

Address

City

State

Zip

Top Quality, Promptly



*When time and quality really count,
call Crawford & Company*

Claims Services

Casualty

Property

Vehicle Services

HealthCare Management

Health and Rehabilitation

Health Management Services

Sentinel Audit Systems™

Risk Control Services

Risk Management Services

Risk Sciences Group

Crawford
CRAWFORD & COMPANY

5620 Glenridge Drive, N.E. • P.O. Box 5047 • Atlanta, Georgia 30302 • (404) 256-0830

The professional marketplace

RATES AND CLOSING TIME:

Rates: Display classified is \$101.50 per column inch, minimum of one inch. Straight classified is \$8.25 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional \$17.50 charge for all blind box ads. Only those responses which fit into a business size envelope will be forwarded. Responses are forwarded daily.

Closing: Published every Monday. Copy must be in typewritten form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required for straight advertisements. Mail ads to Margaret Hikido, Classified Advertising, 740 N. Rush St. Chicago, IL 60611. For more information call 312-649-5340. FAX 312-280-3189.

RETAILERS WANTED

Large Missouri Association needs Life & Health Insurance Company to write group coverages. Should be able to accommodate 10,000 certificate holders, have a varied portfolio and have strong underwriting and claims adjudication. This 10 year old association has never before had group life and health coverages. Members are primarily small business owners, no agent or broker calls, please.

For additional information telephone:
Association Groups of America, Inc.

1-800-272-7230 or (314) 997-3666

or write to:

10420 Old Olive Street Road, Suite 103
St. Louis, MO 63166

INSURANCE AGENCY PRODUCER

Unique opportunity for the individual seeking a career and ownership potential with a professional insurance agency.

The individual must have a college degree, a proven record in marketing and underwriting, innovative talents, a thorough knowledge of property and casualty insurance, and determination for self improvement including CPCU designation.

Please submit a resume to:

John R. MacLennan, CPCU
MACLENNAN & BAIN
INSURANCE

8585 Broadway
Merrillville, IN 46410

COMMERCIAL SALES

Third quarter expansion by two major P&C brokerages. Similar situations in ARIZONA and OHIO requiring exp. in production of medium-to-large commercial accounts. Production/servicing split 75/25. Direct writing exp. acceptable. Salary OPEN plus bonus incentives.

GILBERT-HAFNER & COMPANY
Insurance Staffing Consultants
6060 N. Central, Dallas, TX 75206
AC214 361-9341

ACCOUNT EXECUTIVE - SALES REP.

PROPERTY/CASUALTY INSURANCE

Substantial Merrillville, Indiana based Insurance Agency offers unique opportunity for right person. Should have extensive knowledge of the business as well as proven record in marketing. Must be aggressive, a self starter, detail oriented and possess communication skills. In addition to excellent career opportunity, we offer excellent compensation and benefits package. Send resume to:

William G. Braman, CPCU
Braman Agency, Inc.
8601 Connecticut St.
Merrillville, IN 46410

Healthcare

MARKETING REPRESENTATIVE

COMMUNITY CARE NETWORK, a large California PPO, seeks a Marketing Representative for its San Diego office. Background should include 2 or more years' experience in marketing/administering group health insurance, PPO's, HMO's, or cost containment programs. Individual should be a self starter, a professional comfortable with telemarketing, direct sales & statewide travel. Competitive compensation package, auto allowance & strong benefit package are included. Send resume with salary history to:

Community Care Network
11755 Wilshire Blvd., #870
Los Angeles, CA 90025
EOE

HELP WANTED

RISK MANAGEMENT ANALYST

Multinational consulting firm seeks an analyst for its risk management consulting practice in Chicago. Analyst will assist in a wide variety of assignments, including risk financing studies, policy analysis, captive formation and bid management. The ideal candidate will have the capacity and desire to grow into a consulting role. The candidate must have three to five years of hands-on property and casualty experience, have or be working toward the CPCU designation, have an excellent academic record with good research and writing skills, be able to work independently or with a team, and be a self-starter. Send resumes to Box 2540, Business Insurance, 740 Rush St., Chicago, IL 60611-2590

CLAIM CONSULTANT

Major reinsurance company seeks a claim consultant for its San Francisco Branch. To qualify, you must have extensive commercial liability experience with a history of increasing responsibility in supervisory/management positions. Travel required. Exceptional compensation package. Interested parties should forward a resume with complete work history and salary requirements to Box 2538, Business Insurance, 740 Rush St., Chicago, IL 60611-2590

BUSINESS OPPORTUNITIES

AVIATION INSURANCE FRANCHISES
Join a national network of producers insuring aircraft owners in their region. Prime, exclusive territories still available. For owners list, Aviation expertise and placement service write: AIMCO Network, PO Box 20388, NY, NY 10023, FAX: (212) 874-6018.

Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's, Presidents and Owners 2,431
Vice-Presidents, General Managers and Other Administrative Personnel ... 3,650

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,745
Secretaries, Treasurers, controllers and other Financial Personnel 4,446

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, pension, safety, security, industrial relations, human resources and employee/labor relations 10,687
Sub-total 23,959

Associations 548
Government, Unions and Educational Institutions 1,299
Commercial Consumers Sub-total 25,806

Insurance Agents and Brokers 10,745
Insurance Companies 7,557
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,580
Others Allied to the Field 2,688
TOTAL 50,376

* Source Business/Occupational breakdown of qualified circulation, November 28, 1988 issue, as submitted to BPA for December 1988 BPA Publisher's Statement.

FOR SALE Denver Agency

Sizeable and well established insurance consulting firm in the Denver, Colorado area, specializing in group marketing benefits with expertise in self-insurance, cash flow management, premium earnings, deductible and co-insurance; also an administrator of medical reimbursement plans and multiple employer trusts. Only qualified buyers will be considered.

CONTACT: H. B. Ingebreetsen
303 E. 17th Ave. Suite 700
Denver, CO 80203
(303) 832-3978

BROKERS

Exclusive Territories Available

Refuse Haulers - Short Term Auto Rental Agencies - Artisan Contractors Entire Books or Individual Accounts

Write or Call

American Business Owners
PO Box 8588
5000 Cedar Plaza Pkwy.
St. Louis, MO 63126

1-800-553-5680 1-314-842-3200

HELP WANTED

EXECUTIVE OFFICER/REINSURANCE
Large Philadelphia-based, multiple-line property and casualty insurance company, involved in both assumed reinsurance and commercial lines, is seeking an experienced Reinsurance Officer to assume responsibility as its top executive responsible for all aspects of its reinsurance operations except marketing. The candidate must have a minimum of 10 to 15 years' experience managing operations of this type. Retirees are welcome to apply. This unequalled position offers a highly competitive salary, bonus and other benefits. Interested individuals, please submit resume with salary requirements, to: Box 105-367, 1530 Locust St., Phila., PA 19102 Equal Opportunity Employer

RETAIL PRODUCERS WANTED SPECIALTY PROGRAMS ARE NOW AVAILABLE

Target States
AL. IN. MS. TX. DE. KS. NE. WA. GA. LA.
OH. WI. ID. MI. OK. WV. IL. MO. SD. WY.

Target classes for Liability Coverage

Campgrounds	Mini Golf Courses	Short Term Rental Car
Day Care Centers	Real Estate Agents	Special Events
Go Kart Tracks	Restaurants & Bars	Strategy Games
Insurance Agents	Riding Academies & Stables	Taxi Cabs
Limousines	Service Stations	Water Parks & Water Slides

Protected Territories are available to qualified Producers for most Classes

For more information regarding these Programs call:

Toll Free 1-800-272-7230; In Missouri 1-314-997-3666

Or Write To: A. B. Carter Inc.

10420 Old Olive Rd., P.O. Box 66842
St. Louis, MO 63166

VICE PRESIDENT - SALES

Paragon Life Insurance Company has a highly visible opening for a proven sales performer to direct national sales activities. In addition to developing sales relationships with alphabet houses and other employee benefit specialists, duties will include development of strategic marketing plans.

Qualified candidates will have a minimum of a Bachelor's degree along with a strong, successful sales record. MBA and other credentials are considered a plus. Excellent oral and written communication skills are required. Candidates must also be creative, analytical, and have the ability to develop a detailed understanding of product and marketing issues. Refined presentation skills and excellent interpersonal skills, along with a highly professional demeanor are essential.

Paragon — a national provider of consumer-oriented payroll deduction products including Group Universal Life, Group Variable Universal Life, and the new Executive Group Carve Out plan — offers a challenging career opportunity and growth potential with a rapidly growing company. An excellent benefits and compensation package is provided.

Qualified candidates please submit a resume including salary history to:



Personnel Department
Paragon Life Insurance Company
101 South Hanley
St. Louis, MO 63105

RISK MANAGEMENT INSURANCE ADMINISTRATOR

Heitman Properties Ltd., is a leading national real estate investment firm. Due to continued growth, our Risk Management Dept. is seeking an Insurance Administrator.

Responsibilities will include maintenance of all aspects of our Property/Casualty Insurance program, allocation of premiums, and handling Property & Casualty claims and lawsuits.

We require a bachelor's degree and at least two years commercial property and casualty insurance experience. Prefer knowledge of Lotus 1-2-3.

Heitman offers a highly competitive starting salary and excellent benefits. Please send resume, in confidence, to:

HEITMAN PROPERTIES LTD.
180 N. LaSalle #3600
Chicago, IL 60601
ATTN: ELIZABETH Z. FRY

THE GREYHOUND CORPORATION RISK MANAGER

Greyhound Airport Services Companies, a Miami based group of Greyhound subsidiaries, is seeking an individual to fill the position of Risk Manager.

Requires a degree in Risk Management, 4-6 years field experience & excellent references are needed.

Interested applicants should send resume including salary history to:

Human Resources
Director
P.O. Box 026071
Miami, FL 33102

Equal Opportunity Employer

DIRECTOR OF RISK MANAGEMENT

Univision Holdings is seeking a Risk Management Director to manage the development and implementation of its corporate-wide risk management function. Univision Holdings is a Spanish language television/broadcasting network, of which Hallmark Cards is the majority owner. The position is located in the New York City area. Responsibilities include the identification and evaluation of inherent risks and their proper treatment, thorough loss prevention/control activities and risk financing programs. The ideal candidate will be fluent in English and Spanish, have a B.S. degree in loss control related field and have 5 years experience in loss control activities. Experience/knowledge of the broadcast industry is helpful. The position requires travel to Univision's facilities throughout the USA.

We offer a competitive salary and benefits package. Please submit resume and salary history to:

Vice President of Finance
Univision Holdings, Risk Management Dept.

330 Madison Avenue
26th Floor
New York, NY 10017-5002

or Twinbridge Plaza
24 Meadowland Parkway
Secaucus, NJ 07094

Alexander & Alexander, a leading international insurance brokerage firm, has an exceptional opportunity for an Account Executive in our growing Financial Services Department.

ACCOUNT EXECUTIVE

Financial Services

Experience working with Financial Services clients is necessary.

We offer a competitive compensation and benefits package, excellent working conditions and an opportunity for growth. Please send resume including salary requirements to:

Personnel - Dept. C

Alexander & Alexander Inc.

225 N. Michigan Avenue • Chicago, IL 60601
Equal Opportunity Employer M/F/H/V

Alexander & Alexander

Antitrust case

Continued from page 1

Minnesota's workers compensation rating system was evolving toward a system of open competition from prior approval of rates recommended by the rating organization, which created uncertainties for insurers.

The insurers also face the possibility of far more extensive litigation if a motion by the employers that their case be certified as a class action is approved.

If the class is approved, "thousands" more employers would be eligible to join the case and their actual damages—in the form of excessive work comp premium payments—could exceed \$100 million, the employers' complaint says.

And, actual damages could be trebled if the insurers are found guilty of federal antitrust violations, noted Vance Opperman, an attorney with Opperman & Paquin in Minneapolis, who is co-lead counsel for the group of six employers.

U.S. District Court Judge James Rosenbaum will hear arguments on the motion to certify the class on Aug. 24.

Meanwhile, five of the 14 insurer defendants are expected to submit to Judge Rosenbaum offers to settle their portion of the litigation for a total of \$8.7 million.

The Minnesota antitrust case reflects insurance industry critics' "growing awareness" of the industry's abusive practices and antitrust violations, Mr. Opperman said.

"I believe plaintiffs' lawyers will be looking at this more and more," said Oklahoma City attorney James

based Continental Insurance Co., a unit of Continental Corp.; Employers Insurance of Wausau, a Wausau, Wis.-based unit of Nationwide Mutual Insurance Co.; Excalibur Insurance Co. of Minneapolis, which is now in liquidation; Federated Mutual Insurance Co. of Owatonna, Minn.; Novato, Calif.-based Fireman's Fund Insurance Co.; New York-based The Home Insurance Co., a unit of Am-Base Corp.; Boston-based Liberty Mutual Insurance Co.; Detroit-based Michigan Mutual Insurance Co.; St. Paul Fire & Marine Insurance Co., a unit of The St. Paul Cos. Inc. of St. Paul, Minn.; Stevens Point, Wis.-based Sentry Insurance; Transport Insurance Co. of Dallas, a unit of American Financial Corp.; The Travelers Insurance Co. of Hartford, Conn.; and Minneapolis-based Twin City Fire Insurance Co., a unit of the Hartford Insurance Group.

The employers also named the Workers' Compensation Insurers' Rating Assn. of Minnesota, which the state established in 1921 as a rate setting and classification bureau.

Until 1979, Minnesota workers comp insurers in WCIRAM were required to classify workers comp risks and determine appropriate rates through the use of pooled data, subject to approval by the state's insurance regulator. The classifications and rates were binding on all work comp insurers.

However, Minnesota changed this law in 1979 as part of a two-step move toward deregulation of the work comp insurance market.

In the first phase, beginning in June 1979, Minnesota law allowed workers comp insurers to charge lower rates than those approved by the regulator, as long as the rates were not discriminatory. However, insurers were prohibited from charging rates that exceeded the bureau rates.

That portion of the law remained in effect through 1983. Since 1984, the state has required only that worker compensation insurance rates not be excessive, inadequate or unfairly discriminatory.

In addition, the legislation providing for WCIRAM's existence was repealed. Its successor, the Minnesota Workers' Compensation Insurers Assn., pools data and issues only advisory rates to workers comp insurers.

In the employers' original consolidated complaint, they allege that the insurers violated federal and state antitrust laws by engaging in price fixing. The employers charged that the insurers entered into an agreement not to use rates lower than the maximum set by WCIRAM and allowed by the state insurance commissioner, even though state law beginning in 1979 allowed the flexibility to charge lower rates.

For example, employers subsequently alleged that despite revisions in the WCIRAM's bylaws during this period, insurers still were required to abide by WCIRAM rates.

In subsequent court filings, the employers argued that the insurers' alleged price fixing activities constituted a boycott, which was prohibited by the "boycott exception" contained in the federal McCarran-Ferguson Act.

The 1945 statute grants insurers limited exemption from federal antitrust law, but the exemption does not apply "to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation."

McCarran-Ferguson also gives states primary authority for regulating insurers.

According to the employers' suit, the insurers' alleged price-fixing and boycott agreement deprived employers of "the benefit of free and open competition."

As a result, employers' work comp rates were "raised, fixed, maintained and stabilized at artificial and non-competitive levels," and employers paid more in premiums than they would have had to otherwise, said Mr. Opperman, the plaintiffs' attorney.

However, the insurers deny that they fixed prices and that the rating organization threatened to boycott insurers that did not charge the maximum rate.

Until 1984, when rate setting was completely deregulated, the rating organization performed "the important function" of recommended maximum rate levels for the insurance commissioner's approval based on data collected from numerous insurers, an insurer attorney emphasized.

In addition, the revisions in the rating organization's bylaws only reflected the changes in the state's workers comp rating laws, the insurers argued.

In any event, the insurers' conduct was exempt from the application of the federal antitrust law under the McCarran-Ferguson Act, they argued.

In November 1983, Judge Paul Magnuson in U.S. District Court in St. Paul, Minn., found that the court does not have jurisdiction in cases alleging insurer price fixing. Judge Magnuson said price fixing is an insurance business activity regulated by the states.

However, he refused to dismiss the case, saying the plaintiffs presented enough evidence of possible violations of federal antitrust law provisions prohibiting boycott.

Judge Magnuson's decision is noteworthy because of his effort to define the relationship between price fixing and boycott, an insurer attorney said.

The judge said that "there appears to be an undesignated point, on the line between 'mere price fixing' and an absolute refusal to deal, where enforcement activity in support of a conspiracy to fix prices gives rise to a

'boycott' for purposes of the McCarran exemption."

Judge Magnuson certified the case for appeal to the 8th U.S. Circuit Court of Appeals in St. Louis but it was returned unheard for further proceedings, Mr. Opperman said.

Discovery on the boycott issue concluded in July 1987, and Judge Rosenbaum, who by this time was hearing the case, granted the insurers' motion for summary judgment.

Among other things, Judge Rosenbaum found that WCIRAM's articles and bylaws "were not passed to enforce an alleged price fixing agreement among workers compensation insurers."

While 1979 and 1981 articles and bylaws made provisions for rates and required members to adhere to them, those revisions appear to be "vestiges

Continued on next page

'The issues (boycott and price fixing) are difficult to separate,' says an insurer attorney.

M. Little, who has filed an antitrust lawsuit against work comp insurers in Oklahoma (see story, page 28).

Mr. Opperman expects one or two similar suits may be filed elsewhere.

Insurer attorneys also believe the case is significant.

"It is of significant concern to have uncertainty as to when collective activity is lawful and when it suddenly crosses the line and becomes unlawful," said an insurer attorney.

And, the case highlights the risk an insurer faces in doing business if it is required to participate in cooperative rate setting, said the attorney, who asked not to be identified.

In addition, an insurer can find itself facing allegations of illegal price fixing when a state changes from a prior approval system to a file and use system, insurer attorneys emphasized.

"An insurer can be sued and hung up for long periods of time" in costly litigation, another insurer attorney said.

"The case appears to point up how tough it is to wean the industry from a utility-rating approach to a free-market approach," observed Jon Harkavy, director of governmental affairs and general counsel of the New York-based Risk & Insurance Management Society Inc.

The Minnesota employers involved in the litigation are: Austin Products Co. of Farmington; A&M Moving & Storage Co. of St. Paul; Briggs Transportation Co. of St. Paul; Butterfield Foods of Butterfield; the Catholic Diocese of Winona; and Tony Downs Foods Co. of St. James.

The employers consolidated their individual lawsuits filed in the early 1980s before a U.S. District Court in September 1985.

The consolidated lawsuit named many of the leading workers compensation insurers writing the coverage in Minnesota between 1979 and 1983: Hartford, Conn.-based Aetna Casualty & Surety Co.; New York-

Set your dates with Business Insurance

JULY

ISSUE	AD CLOSING	FULL-RUN SECTION	DEMOGRAPHIC SECTION
17	JUL 5		INSURER TOPICS: Claims Adjusting
24	JUL 11*	RISK MANAGEMENT: SYSTEMS & ANALYSIS Directory: Risk Management Info Systems	
31	JUL 19		

AUGUST

7	JUL 25*	EBC AWARD PROFILES Directory: 401(k) Plan Administrators	AGENT/BROKER TOPICS: Errors & Omissions — Prevention & Funding
14	AUG 2	SURPLUS LINES Directory: Surplus Lines	

New York: 212 210-0228

Chicago: 312 649-5276

Los Angeles: 213 651-3710



Reinsurance and Claims Services

REINSURANCE AND CLAIMS CONSULTANTS

123 North Wacker • Chicago, Illinois • 60606
312 • 701 • 3440

756 Public Ledger Building • Philadelphia, Pennsylvania • 19106
215 • 925 • 6157

CLAIMS MANAGEMENT

100 Metro Park South • Old Bridge, New Jersey • 08857
201 • 290 • 8000

A Subsidiary of the AON Corporation

Antitrust case

Continued from previous page
of the pre-1979 law which required all insurers to charge rates set by the commissioner. It is clear the 1982 articles and bylaws did not compel such a rate adherence and, in fact, allowed members to depart from any of WCIRAM's mandates to accommodate the law," the judge ruled.

Judge Rosenbaum also said that "no evidence was presented to the court to show that any insurer was expelled from WCIRAM or prevented from selling workers compensation insurance in Minnesota because of deviation or attempts at deviation from the rates set by the commissioner."

The employers appealed Judge Rosenbaum's decision to the 8th Circuit, which in February affirmed Judge Rosenbaum's judgment that federal antitrust law does not apply to the insurers' rate setting activities.

However, the appeals court reversed and vacated the portion of Judge Rosenbaum's summary judgment that the insurers did not engage in a boycott, coercion or intimidation or agreements to engage in such conduct.

The appeals court said "we find sufficient evidence, if un rebutted or if believed, that would clearly justify a jury finding that during the relevant time period an illegal boycott agreement existed between WCIRAM and its members in violation of the federal antitrust laws."

That evidence included "an express agreement" to exclude insurers from WCIRAM membership if the prescribed rates were not utilized, as well as "acts of intimidation and coercion to maintain uniform rates by all workers compensation carriers," the appeals court said.

The appeals court also reversed and vacated another portion of Judge Rosenbaum's decision so that a fed-

eral trial court also could hear an allegation of state antitrust law violations—for which insurers have no McCarran exemption—and sent the case back for further proceedings.

While the courts have "technically" resolved the price fixing issue, Judge Rosenbaum almost certainly will have to look at the issue of price fixing to determine if a boycott occurred, insurer attorneys say.

"There is no question that the trial will be on both issues—price fixing as well as boycott," said an attorney.

"The issues (boycott and price fixing) are difficult to separate," another insurer attorney said.

"The judge will consider the whole case, not just the boycott issue," said an attorney familiar with the case.

"The 8th Circuit opinion makes it very difficult for insurance companies to do business and participate in cooperative rate setting," an insurer attorney said.

Most of the insurers responded to the appeals court ruling by asking the U.S. Supreme Court to review whether the appeals court used the correct standard of review in reversing Judge Rosenbaum's summary judgment for the insurers.

Referring to the Supreme Court's refusal to review the case, insurer attorney Richard Liebeskind Jr. said he was "disappointed but not surprised" because the court rejects nearly all petitions it receives.

Mr. Liebeskind, who is with Cravath, Swaine & Moore in New York, represents The Home Insurance Co.

Mr. Opperman, the plaintiffs' attorney, said: "It's a favorable result. We can go to trial more quickly."

A jury trial in U.S. District Court for Minnesota in Minneapolis is scheduled for May 1990, he said.

Meanwhile, five insurers—Aetna, Continental, Employers Insurance of Wausau, Sentry and St. Paul—have negotiated settlements totaling about \$8.7 million with the plaintiffs, Mr.

Oklahoma employer's suit alleges pricing conspiracy

OKLAHOMA CITY—An Oklahoma company is charging that workers compensation insurers writing in Oklahoma engaged in a conspiracy to violate federal antitrust laws by charging excessive premiums.

Cimarron Pipeline Construction Co. of Drumright, Okla., filed a lawsuit May 10 in U.S. District Court for the Western District of Oklahoma on behalf of all employers that bought workers compensation insurance in Oklahoma from mid-1985 to mid-1988, according to James Little, an attorney with Conner & Little in Oklahoma City, who represents Cimarron.

The suit, which seeks class-action status, alleges that more than 100 insurers inappropriately "required and coerced" employers to "involuntarily" sign consent-to-rate forms, which allow insurers to charge rates that exceed those approved by the state.

Insurers typically require that only employers with poor safety records sign such forms, under which employers agree to pay rates that exceeded those established by the Oklahoma State Board for Property Casualty Rates, Mr. Little said.

The insurers allegedly "conspired and agreed" that they would not offer workers compensation insurance in the state unless all policyholders agreed to pay a rate of at least 25.9% more than the manual rates established by the state board, Cimarron contends.

The company contends that workers comp insurers have illegally collected more than \$42 million from Oklahoma employers in each of the years in question.

The suit seeks treble damages of \$126 million based on one year's losses, and an additional \$130 million in punitive damages.

Federated Mutual Insurance Co. of Owatonna, Minn., the only insurer to respond to the lawsuit, denied using any unlawful consent-to-rate forms and denied any "illegal combination, conspiracy or boycott," court papers say.

The litigation stems, in part, from an earlier controversy over Oklahoma workers compensation insurance rates.

In 1985, the National Council on Compensation Insurance, which represents workers compensation insurers in Oklahoma, had sought approval from the state board for a 42% rate increase, according to Richard Race, assistant commissioner of the Oklahoma Insurance Department's property/casualty division.

The board approved a 25.9% increase that went into effect Nov. 1, 1985.

The state's attorney general successfully appealed the board's rate decision, and in July 1986 the state Supreme Court vacated the ordered increase, sent the issue back to the board for rehearing and ordered insurers to refund any excess premiums paid by employers based on the rate hike (BI, Feb. 23, 1987).

Coverage written under consent-to-rate agreements was not affected by the ruling or subject to the refund, Mr. Little said.

In May 1988, the board granted an average 23.8% rate increase for insurers writing workers comp coverage in the state.

—By Meg Fletcher

Opperman said.

There is a "high probability" that such settlements, which are subject to Judge Rosenbaum's approval, will absolve the insurers from any liability in the case, Mr. Opperman said.

However, attorneys for some of the

insurers say it is uncertain whether the settlements will eliminate all liability possibly faced by the insurers.

"Settlement may eliminate liability as far as plaintiffs, but not necessarily among insurers," said Eugene Warlich, an attorney with Doherty,

Rumble & Butler, who represents Liberty Mutual.

"Everyone is aware there might be some rights of contribution, reimbursement and indemnity bouncing around here," another insurer attorney explained.

COMMUNICATIONS

EMPLOYEE BENEFITS COMMUNICATION COMING AUGUST 7

Putting together a corporate employee benefits program takes planning, knowledge of available resources and options, and hard work. If the results of those efforts are not communicated effectively to employees ... then the benefits are not beneficial ... to anyone.

Recognizing the importance of clear, concise, and effective communication of benefits, Business Insurance reinforces its commitment to this area by acknowledging those companies that excel in communicating benefits to their employees.

BI PROFILES EBC WINNERS

In the August 7th issue of BI editors will announce the winners of the 17th annual Employee Benefits Communication competition and profile the award winning programs in six categories: booklets, personalized correspondence, audio-visual presentations, multi-media programs, special projects and total benefits programs.

From flex to healthcare programs, 401(k), ESOP, wellness and retirement programs — the emphasis on effective utilization of benefits and compensation continues. BI's readers will turn to this feature for ideas and information on communicating benefit packages to their employees.

AD CLOSING: JULY 25

Introducing

401(k)

DIRECTORY OF PLAN ADMINISTRATORS

As interest in 401(k) plans continues to peak and as more employers offer 401(k) plans to their employees, executives responsible for their company's employee benefits need information about firms that provide 401(k) plan administration services. In response to industry need, BI will publish its first Directory of 401(k) Plan Administrators in the August 7th EBC Profiles feature.

When it comes to covering all aspects of employee benefits, only one publication is committed to effectively communicating information needed by corporate decision makers: Business Insurance.

Reserve space today in the issue that will inspire and motivate thousands of executives responsible for their corporation's employee benefits programs.

Business Insurance

New York: (212)210-0228
Chicago: (312)649-5276
Los Angeles: (213)651-3710

35mm

Dupont Plaza

Continued from page 3

tion (BI, May 22; May 15).

The fire, which occurred on New Year's Eve 1986, killed 97 people and injured more than 100 others (BI, Jan. 12, 1987; Jan. 5, 1987).

Several attorneys for companies participating in the latest round of settlements said they were happy to put the litigation behind them.

"Our client (AAA Packaging & Shipping) was very pleased to have resolved the case," said defense attorney Maria I. Hoelle, an associate with Corlett, Killian, Ober, Hardeman, McIntosh & Levi in Miami. She also would not discuss the terms of the settlement.

"The cost factor of continuing to defend the case," combined with her client's unwillingness to re-

to the litigation said they include:

- \$2.1 million from Bally Manufacturing Corp., which supplied the slot machines used in the casino of the hotel, where 84 of the fire's 97 fatalities occurred.

- \$1 million from Falcon Products, which supplied stack chairs containing polyurethane foam with vinyl upholstery to the hotel.

- \$500,000 from Mitchell-Mann Inc. and 2M Design, which provided wall covering to the hotel.

- \$500,000 from David P. Goodman d/b/a Acme Feltworks, which manufactured, distributed and/or supplied furniture used in the hotel.

However, defense attorney Amy M. Friedman with Sedgwick, Dertert, Moran & Arnold in Los Angeles, said her client's settlement negotiations are not finalized.

- \$500,000 from Firth Carpets

- \$350,000 from Superior Paint, which manufactured paint used in the hotel.

- \$250,000 from G.A. Marse Associates Inc., which supplied fabrics or materials used in some of the hotel's carpeting.

- \$250,000 from Carpets From London Inc. and Carpets From London Ltd., which manufactured carpeting used in the hotel.

- \$250,000 from J. & W. Wholesale Supply Co., which supplied wood laminate used in the ballroom and bar.

- \$250,000 from S.C. Johnson & Sons Inc., which manufactured and/or supplied floor wax the hotel used.

- \$250,000 each from Carol Cable Co. Inc. and Reynolds Metal Co., both of which manufactured wire coated with polyvinyl chloride used in the hotel.

- \$225,000 from Vasallo Industries Inc., which manufactured, distributed and/or supplied conduit used in the hotel.

- \$150,000 from Cosentini & Associates, which designed the hotel's heating, ventilation and air-conditioning system.

- \$75,000 from Sara Lee Corp. (Electrolux), which manufactured floor wax used in the hotel.

- \$25,000 from Columbus Blinds Corp., which manufactured blinds used in the hotel.

In addition, the source said settlements with product and service suppliers (BI, March 27) that were finalized earlier this year include:

- \$300,000 from Warner Burns Toan Lunde, the hotel's primary architects.

- \$250,000 each from cable manufacturers Cerro Wire & Cable Corp., Reynolds Metal Co. and Phelps Dodge Corp.

- \$250,000 from Mobay Corp., which manufactured polyurethane foam used in furniture supplied to the hotel.

- \$250,000 from Tarkett Inc., which manufactured adhesives used in wall coverings in the hotel.

Ltd., which manufactured carpets used in the hotel.

- \$500,000 from AAA Packaging & Shipping, which had packaged sofa beds stored in the south ballroom where the fire originated.

- \$400,000 from Buck Creek Industries Inc., which manufactured yarn used in carpeting in the hotel.

- \$400,000 from Nevamar Corp., which supplied laminate used on dressers stored in the ballroom where the fire originated.

- \$375,000 from Lerch, Bates & Associates Inc., the hotel's elevator inspector. Fire reports noted that elevators failed to function properly at the time of the fire.

- \$375,000 from Central Chair Co., which manufactured stools used in the casino.

'Our client (AAA Packaging & Shipping) was very pleased to have resolved the case,' says defense attorney Maria Hoelle, adding that 'the cost factor of continuing to defend the case' was instrumental in the decision to settle.

main in San Juan during the trial, were instrumental in the decision to settle, she said, adding that AAA Packaging & Shipping did not admit liability.

And while Peter Herzog, an associate with Bryan, Cave, McPheeters & McRoberts in St. Louis, declined to discuss the settlement terms of Falcon Products Inc., he stressed that his client was "happy to be out" of litigation.

Plaintiffs have alleged that the flammability of many products supplied to the hotel or the materials used in those products contributed to the rapid spread of the fire and subsequent loss of life.

While terms of the recent settlements are covered under a court confidentiality order, a source close

Mead Re

Continued from page 2

of assumed reinsurance risks.

Gross written premiums in 1986—its last full year of underwriting—amounted to \$51.2 million, while net premiums totaled \$39.3 million. Mead Re's combined ratio for 1986 hit 291.7% while policyholder surplus fell to \$2.2 million from \$23.4 million at the end of 1985.

In reviewing Mead Re's plans to run off its business, the Illinois Insurance Department permitted the reinsurer to discount its loss reserves because it was no longer underwriting and because Mead Re and its parent had demonstrated an intention to honor the reinsurer's obligations, according to Norman Koefoed, manager of financial surveillance for the Illinois Department.

Mead Corp. has contributed roughly \$40 million to its subsidiary's surplus in the last few years, Mr. Koefoed noted.

"We feel that they are being honorable with us, and they are not going to be going out and writing more business," he said.

Mr. Koefoed added that as long as the runoff is going smoothly, Mead Re policyholders benefit more than they would if the Illinois department were forced to take the company over.

"If we put it into liquidation, it would do no good to anyone, and might harm other companies that would be paid in the normal course" of the runoff, he said.

While confirming that Mead Corp. has bolstered the reinsurer's surplus with roughly \$40 million, however, Mead Re's Mr. Richards sounded a cautious note about further contributions.

"We are an independent company, and any funding that Mead has done for us up until now does not indi-

cate what they are liable to do in the future," Mr. Richards said.

The parent company's efforts to bolster Mead Re's surplus occurred "pretty well in the past," and "since that time we have been trying to fund ourselves," he added.

The California department's action, however, questions Mead Re's financial stability.

Mead Re last year discounted its loss reserves by \$54.6 million, the cease and desist order says. If the effect of this discounting were reversed, Mead Re's surplus would drop from the \$7.2 million the rein-

ceedings."

In addition to noting that the Illinois department specifically permitted Mead Re's reserve discounting, Mr. Richards questioned the California department's other findings.

"I have no way of knowing where they got that number from," Mr. Richards said of the Insurance Department's projection of a potential \$50 million to \$100 million reserve deficiency. "I don't know what analysis the California department did."

"I don't see the deficiency they

'If we put (Mead Re) into liquidation, it would do no good to anyone, and might harm other companies that would be paid in the normal course' of the runoff, says Norman Koefoed of the Illinois Insurance Department.

surer reported at the end of 1988 to a surplus deficit of \$47.4 million, the California department charges.

In addition, California regulators say a review of Mead Re's 1988 financial statement shows that the reinsurer faces potential reserve shortages of another \$50 million to \$100 million.

The financial statement also showed \$20.9 million in unsecured reinsurance recoverables from companies that are either in receivership, known to be in financial trouble or that are unauthorized in California, the cease and desist order says.

Taken together, these findings represent "grounds which threaten to render (Mead Re) insolvent or in hazardous condition" and which could make the reinsurer "subject to conservation or liquidation pro-

are talking about," he added.

Noting that Mead Re has just started an actuarial review of its incurred-but-not-reported loss reserves, Mr. Richards said, "We don't anticipate anything like what they're talking about."

He added that he is unsure about the accuracy of the California department's figure on unsecured reinsurance balances.

Mr. Richards declined to comment for the record on whether the California department's action has affected Mead Re's runoff, including its ability to collect from retrocessionaires, commute retrocessional contracts or negotiate a possible sale of the company.

"We're getting a lot more questions" from regulators and others, Mr. Richards said. "It caused quite a flurry for about three weeks." ■

Update

Satellite damage insured

Continued from page 2

Insat 1-D, commissioned by India, was hit by a crane hook after being mated with a launch vehicle. However, initial damage estimates from the June 19 incident have not yet been released, underwriters in London say.

Ford Aerospace has prelaunch insurance coverage limits for the satellite of \$58 million. Willis Faber P.L.C. placed \$53 million of the coverage in the London market. The coverage is led in the London company market by Excess Insurance Co. and at Lloyd's of London by syndicate 448, managed by Wellington Underwriting Agencies Ltd.

The remaining \$5 million is underwritten by Trieste, Italy-based Assicurazioni Generali SpA.

Meanwhile, the Indian government has \$20 million insurance excess of a \$5 million retention to cover any additional expenses incurred prior to a successful satellite launch.

Cadillac put in conservatorship

FARMINGTON HILLS, Mich.—The Michigan Insurance Department has taken over operations of Cadillac Insurance Co., which specializes in non-standard automobile liability and physical damage and surety coverages.

Deputy Insurance Commissioner Dominic Bannunzio said Cadillac, which was put into conservatorship July 7, is insolvent by an estimated \$15 million. It reported \$40.7 million in net premiums written in 1988, according to A.M. Best Co.

The department will decide within 60 days whether to rehabilitate or liquidate Cadillac, Mr. Bannunzio said. "We're hopeful that the company can be turned around."

Cadillac is owned and operated by Ernest Solomon, whose son, Shelby, is the state's budget director. Mr. Bannunzio stressed, however, that this has had no impact on the department's treatment of Cadillac.

RBH delays restructuring

CHICAGO—Chicago-based Rollins Burdick Hunter Co. has not yet determined how it will restructure operations following its July 3 purchase of Fort Worth, Texas-based Bayly, Martin & Fay International Inc. (BI, May 29).

Any restructuring or management changes "will probably be announced later in the year," said Joan E. Steel, vp of financial relations for RBH's parent, Aon Corp.

RBH's acquisition of BMF, the 10th-ranked U.S. broker based on 1988 gross revenues, makes seventh-ranked RBH a contender for the No. 6 spot of Frank B. Hall & Co. Inc. (BI, June 26). Combined, RBH and BMF reported \$341.6 million in gross revenues in 1988, while Hall reported \$366.9 million in gross revenues.

No verdict for Howden exec

LONDON—Due to his ill-health, a verdict will not be brought against Jack Carpenter, one of the former Alexander Howden Group Ltd. executives now on trial for charges of conspiring to defraud Howden and Lloyd's of London syndicates of millions of dollars.

However, former Howden Chairman Kenneth V. Grob and former Lloyd's underwriter Ian R. Posgate will continue to be tried in London's Southwark Crown Court.

Mr. Carpenter had open-heart surgery several years ago, and his lawyers argued that he was unfit to give evidence, and that the strain of the court case could cause a cardiovascular attack.

Meanwhile, counsel for Mr. Grob began his defense last week.

Briefly noted

The Florida Insurance Department is suing Coopers & Lybrand in state court in Miami, charging the accounting firm with malpractice in its audits of the defunct **Insurance Exchange of the Americas**. . . The House Ways and Means Committee rejected a proposal by Rep. Bill Archer, R-Texas, to delay for one year the newly expanded Medicare program as well as the new surtax that many beneficiaries must pay (BI, July 10). . . The District of Columbia City Council last week shelved controversial **handgun legislation** that would have held gun manufacturers, distributors and importers strictly liable for deaths and injuries caused by shooting incidents. The bill was preliminarily approved last month on an 8-4 vote (BI, July 3). . . Holmes Harden, executive vp at **Frank B. Hall & Co. Inc.**, has left the New York-based broker. Mr. Harden, who was responsible for Hall's U.S. retail brokerage operations, was chief financial officer until last October (BI, June 26). While industry sources say Mr. Harden was dismissed, a Hall spokesman said he "left the company for personal reasons". . . **Tropical storm Allison** caused an estimated \$45 million in insured damages when it struck portions of Texas and Louisiana June 25-27, according to the American Insurance Services Group. Allison, assigned Catastrophe No. 12, was followed by another series of storms assigned Catastrophe No. 13 that caused an additional \$45 million in insured damages from hail, winds, tornadoes and flooding in Texas, Oklahoma and Louisiana July 2 and 3. . . Companies controlled by Sir James Goldsmith have asked the California Insurance Department to approve an acquisition of **Farmers Group Inc.** as part of Sir James' bid to take over Farmers' parent, B.A.T. Industries P.L.C. The filing was not complete, however, and the California department has asked for additional information about how takeover-related debt will be retired. . . The **National Assn. of Insurance Brokers** is hiring Edward K. Hamilton, a New York-based management consultant, to prepare a study of three insurance industry problems: insurer regulation, insolvency and market volatility. The study was discussed at the NAIB meeting at Sea Island, Ga., last month (BI, June 12). Mr. Hamilton is with the firm of Hamilton, Rabinovitz & Alschuler Inc. . . Trial began last week in U.S. District Court in Cincinnati in a lawsuit brought by Chubb Corp. and 8,800 farmers against a former Chubb managing general agent—**Good Weather International Corp.**—that allegedly oversold drought insurance in 1988 (BI, Jan. 2; July 18, 1988).

Section 89 reform

Continued from page 3

Jan. 1, 1991, whichever is earlier.

By contrast, under the new Rostenkowski proposal, most employers would have to comply with Section 89(k) on Jan. 1, 1990.

For public employers, like state and local governments, the new Rostenkowski proposal, though, delays compliance with all aspects of Section 89 until Jan. 1, 1992. The Bentsen bill does not contain a delayed compliance date for public employers.

However, the Bentsen proposal would delay Section 89 compliance for small employers—those with 20 or fewer employees—until Jan. 1, 1991; the Rostenkowski measure lacks a comparable provision.

"There seems to be a congressional consensus there should be some kind of delay for Section 89. That is very encouraging news for employers," said Wyatt's Mr. Grossman.

In addition, both the Bentsen and the new Rostenkowski proposals now contain identical provisions that only part-time employees working 30 or more hours a

week must be included when running Section 89 non-discrimination tests.

The original Rostenkowski proposal called for employers to include employees working at least 25 hours when running the non-discrimination tests, while the current Section 89 statute requires that employees working at least 17.5 hours a week be included for Section 89 testing purposes.

"A 30-hour-a-week requirement is a much more realistic number. It is much closer to practices in the business world," said Hewitt's Ms. Georgemiller.

The two measures also now take somewhat similar approaches to determining whether a sufficient percentage of employees are eligible for "affordable" health care coverage. If a plan fails this "eligibility" test, highly compensated employees are taxed on the full cost of their health care coverage.

Under the Bentsen bill, "core" health care coverage would have to be available to 90% of all employees.

In addition, employee premium contributions could not exceed 40% of the total premium. How-

ever, if an employer limits employee contributions for individual coverage to less than 40% of the total cost, it could require employees to pay more than 40% of the total premium for family coverage (BI, June 12).

Under the new Rostenkowski measure, core medical coverage also would have to be offered to 90% of all employees, while generally the employee premium contribution for either individual or family coverage could not exceed 50% of the total premium.

However, premium contributions for employees earning less than \$20,000 annually could not exceed \$1,000 for individual coverage or \$2,000 for family coverage. These premium contribution limits and the \$20,000 salary ceiling would not be indexed.

However, small employers that were not professional service organizations and had 20 or fewer employees could use an alternative affordability test. If a small employer opted for this alternative, it would not have to meet the 50% limit on employee premium contributions or the \$1,000/\$2,000 limit on premium contributions for lower-income employees.

Under this alternative test:

- A small employer would have to offer a single health care program available on the same terms and conditions to all of its employees who are subject to Section 89.

- The same employer subsidy or contribution would have to be made for all employees.

For example, if an employer paid 80% of the premium for highly compensated employees, it also would have to pay 80% of the premium for non-highly compensated employees.

The affordability test provisions in the new Rostenkowski bill represent a dramatic departure from his original proposal.

Under the affordability approach in the first Rostenkowski proposal, core medical coverage would have had to be available to 90% of non-highly compensated—rather than 90% of all employees. In addition, employee premium contributions could not have exceeded \$520 a year for individual coverage and \$1,300 for family coverage. These maximum contribution limits would have been indexed to the annual increase in the average national wage.

This affordability test was sharply criticized by benefit experts. They noted that if employers increased employee premium contributions to keep up with medical inflation, which is rising faster than wages, eventually their health care plans would flunk the eligibility test and highly compensated employees would be taxed on their health care benefits.

On the other hand, if employers didn't raise employee contributions to match medical care inflation, employers would have had to absorb a greater percentage of health care costs.

The Bentsen and Rostenkowski measures both include a second non-discrimination test, known as the benefits test.

Under this test in both bills, a plan that is only available to a limited class of employees would be considered non-discriminatory if the cost of that coverage is no greater than 133% of the cost of a core health plan available to 90% of all employees.

The cost of coverage that exceeds this 133% threshold would be included as taxable income to highly compensated employees.

Under the original Rostenkowski bill, employees' pretax contributions toward premiums, such as under a flexible benefits plan, would have been treated as employer contributions for highly compensated employees, but as employee contributions for non-highly compensated employees.

This would have increased the

"cost" or "value" of coverage provided to highly compensated employees and, thus, would have increased the chances that highly compensated employees would be taxed on a portion of their health care benefits.

However, the new Rostenkowski proposal provides a new alternative test—a so-called 150% test—that employers with flexible benefit plans could use in lieu of the 133% test.

Under the alternative test, the value of the health care plan actually received by highly compensated employees could not be 150% greater than those received by non-highly compensated employees. For this test, pretax contributions would be included as an employer contribution for both highly and non-highly compensated employees.

For example, assume an employer offers employees an individual and family health care plan, valued respectively at \$1,500 and \$3,500 annually. To obtain coverage, employees must make a pretax contribution of \$500 to the individual plan and \$1,200 to the family plan.

The company has 100 non-highly compensated employees. Thirty of those employees choose the individual plan, 60 employees select the family plan, while 10 non-highly compensated employees decline coverage.

To determine the average value of a health care benefit provided to non-highly compensated employees, the employer would multiply the value of each health care option by the number of non-highly compensated employees who select that option.

In this example, the \$1,500 value of the individual plan would be multiplied by the 30 non-highly compensated participants, which equals \$45,000, while the \$3,500 value of the family plan would be multiplied by its 60 participants, which equals \$210,000. These two figures—\$45,000 and \$210,000—then would be added. This total, \$255,000, would be divided by all of the employer's non-highly compensated employees—in this case 100—regardless of whether they actually select health care coverage. In this case, the average value of a benefit provided to a non-highly compensated employee would be \$2,550.

Under this example, as long as the average benefit provided to highly compensated employees did not exceed \$3,825 (150% of \$2,550), highly compensated employees would not be taxed on their health care benefits; the same steps would be taken to determine the average value of health care benefits to highly compensated employees.

This testing procedure for pretax contributions is much more favorable to highly compensated employees than the formula used in the 133% test, which is the same in both the original and new Rostenkowski proposals.

Using the same example in running the 133% test, the "net" value of the \$1,500 individual plan for non-highly compensated employees would be \$1,000 (\$1,500 minus the \$500 pretax contribution). This \$1,000 net value would be multiplied by 133% to determine how much an employer could contribute toward the health care benefit for highly compensated employees—in this case \$1,330.

However, since the employer contribution for highly compensated employees equaled \$1,500 under the proposal (\$1,000 in direct employer contributions plus

\$500 in pretax contributions), highly compensated employees selecting single coverage would be taxed on \$170.

Similarly, highly compensated employees selecting family coverage would be taxed under the 133% test.

The "net" value of family coverage for non-highly compensated employees would be \$2,300 (\$3,500 minus \$1,200 in pretax contributions). Under the 133% test, highly compensated employees selecting family coverage could receive as much as \$3,059 in employer-provided benefits without being taxed.

However, in this example, highly compensated employees actually receive \$3,500 in benefits (\$2,300 in direct employer contributions and \$1,200 in pretax contributions) and thus would be taxed on \$441.

"Clearly, you end up—with the new 150% test for flex plans—with much more favorable results for highly compensated employees than under the first Rostenkowski proposal," said Wyatt's Mr. Grossman.

"A utilization test, such as the 150% alternative test, can require more data, but it also can lead to better results," said Ms. Georgemiller.

The Bentsen bill also treats pretax contributions made by highly compensated employees more favorably than the original Rostenkowski bill.

Under that measure, as long as certain conditions are met, pretax contributions are treated as employer contributions for both highly and non-highly compensated employees.

That equal treatment increases



the chances that highly compensated employees will not be taxed on their health care benefits.

While the bridging of the differences between the Bentsen and Rostenkowski proposals increases chances Congress will overhaul Section 89 this year, it does not guarantee approval.

Indeed, several hurdles in the legislative process still must be cleared before the current—and vastly unpopular—Section 89 statute is stripped from the Internal Revenue Code and a new law is put in its place.

While the Rostenkowski Section 89 reform proposal is part of budget reconciliation legislation in the House, the Senate-approved Section 89 reform package is included in child care legislation.

As soon as the Ways and Means Committee and the full House give final approval to budget reconciliation legislation, the Senate Finance Committee will begin to draft its version of budget reconciliation legislation.

At that point, the Finance Committee is expected to tack the Bentsen Section 89 reforms, or something similar, onto its budget reconciliation bill.

Once the Finance Committee and full Senate approve budget reconciliation legislation, the differences in the House and Senate bills—including the Section 89 reform provisions—will have to be ironed out by a congressional conference committee.

After conferees can work out a compromise bill, the full House and Senate will have to vote on the measure. If approved, the budget reconciliation bill would go to President Bush for signature. ■

Insurance services guide

PLASTIC CARDS

Designing, Manufacturing, Embossing, and Mailing

MORGAN MIDWEST PHONE (313) 553-6660 FAX (313) 553-3488

InPhoto Surveillance



USA

800-822-8220

CLAIMS PROCESSOR PRODUCTION AND ERROR TRACKING SOFTWARE

INCREASE PRODUCTIVITY * REDUCE ERRORS

Design your own reports in any format

DataVisions
10761 Pebble Hills Ste 239
El Paso, Tx 79935
(915) 592-9801

FREE INFO

\$425.00
for Personal Computers



Software of Florida, Inc.

Insurance Software Specialists

- SOPHISTICATED SOFTWARE
- QUALITY SERVICE
- AFFORDABLE PRICING

- HEALTH CLAIMS ADMINISTRATION AND BILLING
- WORKERS' COMPENSATION CLAIMS ADMINISTRATION
- FLEXIBLE BENEFITS ADMINISTRATION
- COBRA ADMINISTRATION

MINI, MICRO AND NETWORK BASED SOFTWARE
CALL FOR MORE INFORMATION OR A FREE DEMONSTRATION
(813) 797-7814

2087 U.S. 19 NORTH / SUITE D, CLEARWATER, FLORIDA 34623



INSURANCE SOFTWARE PACKAGES, INC.
Value Leaders In Risk Management Software

Workers' Compensation Claims Management System

Ideal For Self Insureds, TPA's, Associations & Carriers

- Prepares State Regulatory Reports & Forms
- Handles Multiple Employers
- Calculates Benefit Amounts
- Adjusts Bills Against Medical Fee Schedules
- Provides Safety And OSHA Reports
- Loss Forecasting Module
- Tracks Reserves
- Processes Claim Payments & Checks
- Performs On-Line Inquiries
- Management & Ad Hoc Reports
- Monitors Claims Due Review
- Reinsurance Reporting

Installations Coast To Coast - Call For A Free Demo Diskette



INSURANCE SOFTWARE PACKAGES, INC.
5118 N. 56th Street, Tampa, FL 33610
US (800) 237-8133 FL (813) 621-6069



For advertising information in the INSURANCE SERVICES GUIDE
Contact: Margaret Hikido, 740 Rush Street, Chicago, Illinois 60611
Telephone (312) 649-5340

Health care data needed by self-insurers: Expert

By GLENN HUNTLEY

LOS ANGELES—Managers and third-party administrators of self-insured health care plans must arm themselves with more detailed utilization data to combat inevitable cost increases, an expert says.

Wholesale slashing of benefits can cut some costs, but that type of action also may embitter plan enrollees, warned Stephen F. Coady, president and chief executive officer of third-party administrator Health Economics Corp. in Dallas.

"I'm not sure that we aren't pushing ourselves closer to mandated benefits" by cutting back health care plans, Mr. Coady said during the "Back to Basics" seminar sponsored by the Self-Insurance Institute of America last month in Los Angeles.

As health care costs have soared in recent years, employees' out-of-pocket limits have been increased and some benefits have been eliminated—to little avail, he said. Despite the best of efforts, the benefit plans are still stung by rising costs.

For example, savings from higher deductibles and copayments often are overestimated because plan managers fail to consider that typically 5% of covered individuals account for 50% or more of health care costs.

Plan managers may miss the fact that much of the health care dollar is spent on individuals who pay the deductibles and copayments early and are receiving large amounts of health care services at 100% reimbursement rates, Mr. Coady said.

In addition, self-insured employers are still left facing the key factor pushing up health care costs—"the doom and gloom curve," Mr. Coady said.

"The doom-and-gloom curve" represents the compounding increase in health care utilization as more people get older. The U.S. workforce is moving steadily up the age curve, and there is nothing a benefit manager can do to change those demographics.

Because of the aging population, annual health care cost increases in the 15% to 20% range are not a cyclical phenomenon, but an indefinite condition, Mr. Coady said.

"I think we will do a good job if we can

moderate that rate of increase," he said.

Most forecasts indicate that health care as a percentage of gross national product will grow to 15% in the year 2000 from about 12% now, Mr. Coady pointed out. "The bottom line is health care is expensive and getting much more expensive."

However, if employee benefit managers and third-party administrators of self-funded benefit plans obtain detailed health care utilization and population data, utilization review techniques can help hold cost increases down, Mr. Coady advised.

If an employer finds an unusually high number of psychiatric cases, data broken down by

Wholesale slashing of benefits can cut some costs, but that type of action also may embitter plan enrollees, warns Stephen F. Coady.

age and sex may indicate, for instance, the claims are for adolescent girls seeking help for eating disorders, he said.

In that case, population data could be used to identify families with adolescent girls. Letters directing the targeted group to preferred providers could be sent to them to help minimize the costs of future cases, Mr. Coady explained.

Other effective cost containment measures include:

- Limiting the number of providers in managed care plans.

Too many providers in a preferred provider network tends to defeat the purpose, Mr. Coady said. "It doesn't make much sense when every provider is part of the plan. You are back to ground zero."

- Granting utilization review nurses authority to waive second surgical opinions when appropriate.

Since most second opinions agree with the first opinion, it may be more cost effective to allow the nurse to decide when a second opinion

may be beneficial, he said.

- Instituting aggressive case management in cases of serious illness and expensive treatments.

At least 5% of current cases should be under active case management, he said. If not, all files should be evaluated to determine where major case management may be needed.

- Contracting with a general practitioner to provide in-house medical care.

For groups of more than 2,000 employees and dependents, an in-house physician can more than pay for himself by providing on-site care and appropriate referrals.

- Paying for some screening tests, particularly mammograms.

Mammograms can result in higher costs for preventive care, but the costs of treating the disease are reduced because early detection leads to more cost-effective treatment, Mr. Coady said.

- Identifying "centers of excellence," medical facilities designated for major procedures such as organ transplants.

The costs of travel and lodging are more than offset by the discounted fees available if all cases are sent to a single facility, Mr. Coady said.

Lastly, benefit changes in self-insured plans also can result in discounts on stop-loss coverage, but underwriters tend to judge the potential savings on the conservative side, pointed out Sandra L. Ruder, second vp for Employers Reinsurance Corp. in Overland Park, Kan.

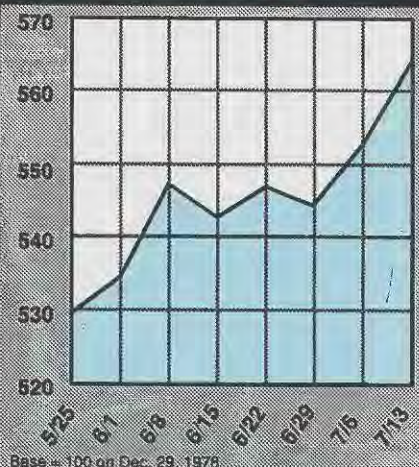
For example, increasing the annual deductible per individual to \$500 from \$200 could result in a stop-loss rate cut of 3% to 7%, she said. Reducing the same deductible to \$100 would increase the rate by 2% to 5%.

Likewise, increasing an out-of-pocket limit to \$5,000 annually from \$2,500 could earn a 2% rate discount, Ms. Ruder said.

Although any one benefit change may net only small reductions, a variety of modifications and use of managed care theoretically could bring down stop-loss rates by as much as 17%, she said.

Ernest A. Clevenger, president and chief executive officer of American Progressive Benefits Corp. in Brentwood, Tenn., moderated the seminar.

BI Insurance Index



Insurance industry stocks shot up 11.6 points last week, as the *Business Insurance Index* rose to 564.7 on July 13, from 553.1 on July 6. Advancing issues were led by Sierra Health Services, up 20%; Hilb, Rogal & Hamilton Co., up 11.3%; and Chandler Insurance Co., 9.5%. Decliners followed Western Health Plan Inc., down 20.6%; Belvedere Corp., down 4.9%; and Durham Corp., down 3.7%. The most active issue during the period was Sears, Roebuck & Co. (Allstate Insurance Group), 2.4 million shares traded. The *Business Insurance Index* gained 2.1% for the period; the Dow Jones 30 Industrials rose 3.1%; the Standard & Poor's 500 gained 2.8%; and the New York Stock Exchange Composite was up 2.5%.

British Issues

July 13 Companies	Price	P/E	Div. %	Yield	1 Week High-Low	
					pence	pence
Comm Union	407	15.4	29.3	7.2	407-384	
Genl Accident	987	9.2	70.7	7.2	987-925	
Gdn Royal Exch	216	11.4	15.7	7.3	216-210	
Royal	418	12.8	34.0	8.1	418-394	
Sun Alliance	298	8.6	17.0	5.7	298-275	

Brokers		Price	P/E	Div. %	Yield	1 Week High-Low	
						pence	pence
Bradstock	200	13.7	10.0	5.0	205-200		
CE Heath	466	13.3	34.5	7.4	466-465		
Hogg Robinson	138	11.5	9.3	6.8	138-138		
Lloyd Thompson	220	16.9	8.0	3.6	221-220		
PWS Holdings	45	11.3	3.3	7.4	45-45		
Sedgwick Grp	250	17.6	16.7	6.7	250-245		
Steel Brl Jones	239	15.9	15.3	6.4	239-238		
Willis Faber	231	17.1	15.3	6.6	231-229		

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

BI Industry Stock Report

JULY 13, 1989

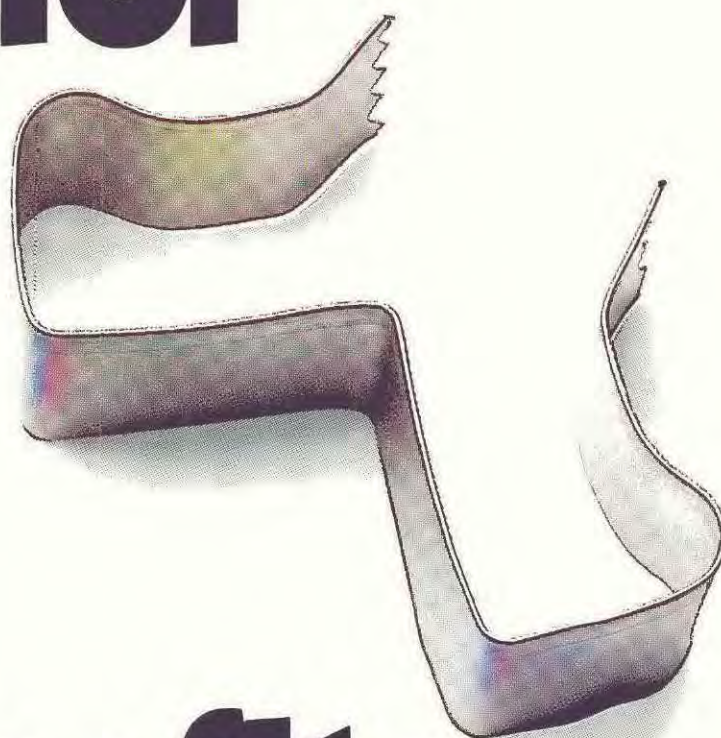
7/7/89 THRU 7/13/89

		Weekly Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	26.38	4.5	12.3	26.88	22.63	370	1.00	3.8	17.8	2.90	9.10
Corroon & Black Corp.	NYSE	35.38	4.4	13.7	35.75	30.75	181	1.24	3.5	13.8	7.62	4.64
Gallagher Arthur J. & Co.	NYSE	20.00	0.0	19.4	20.38	16.13	24	0.52	2.6	14.2	5.33	3.75
Hill Frank B. & Co.	NYSE	4.25	-3.0	47.6	4.63	2.50	72	0.00	0.0	-2.1	0.00	N/A
Hilb, Rogal & Hamilton	OTC	17.25	11.3	13.1	17.25	13.75	105	0.20	1.2	15.5	4.60	3.75
Marsh & McLennan Cos. Inc.	NYSE	66.88	3.5	18.9	67.63	55.13	270	2.50	3.7	16.6	6.48	10.32
Poe & Assoc Inc.	OTC	8.75	0.0	6.1	8.75	8.25	1	0.40	4.6	9.5	1.43	6.12
BROKERS AVERAGE												
			3.0	18.7					2.8	12.1		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	33.25	3.1	12.7	34.00	29.25	214	0.40	1.2	7.0	21.28	1.56
Berkshire Hathaway Inc. DE	NYSE	6915.00	2.8	47.1	7000.00	5948.00	76	0.00	0.0	24.5	2468.63	7.96
ITT (Hartford Group)	NYSE	59.00	1.1	17.7	60.75	49.75	1041	1.48	2.5	10.1	56.33	1.05
Sears Roebuck & Co. (Allstate)	NYSE	44.88	0.6	9.8	48.00	40.13	2391	2.00	4.5	16.8	36.09	1.24
CONGLOMERATES AVERAGE												
			1.9	21.6					2.1	14.6		
INSURERS/REINSURERS												
Aetna Life & Cas Co.	NYSE	57.38	0.7	21.4	58.88	46.75	967	2.76	4.8	8.8	58.11	0.99
AmBase Corp.	NYSE	13.88	0.0	26.2	14.50	11.00	202	0.20	1.4	5.2	18.66	0.74
American General Corp.	NYSE	37.25	3.5	24.7	38.00	29.50	516	1.50	4.0	11.3	28.04	1.33
Amer Heritage Life Inv	NYSE	26.38	0.0	2.4	27.88	25.00	2	1.20	4.5	10.3	22.47	1.17
Amer Indty Fin'l Corp.	OTC	12.25	0.0	16.7	13.00	9.50	18	0.56	4.6	7.9	17.38	0.70
American Int'l Group	NYSE	86.00	2.1	26.9	88.00	66.25	1110	0.48	0.6	12.0	33.55	2.56
Aon Corp.	NYSE	36.88	3.9	31.7	37.13	27.00	379	1.40	3.8	12.8	16.67	2.21
Argonaut Group	OTC	58.50	1.3	33.7	59.25	43.50	42	0.00	0.0	7.6	36.83	1.59
AVEMCO Corp.	NYSE	23.75	2.2	-8.2	26.13	22.63	13	0.40	1.7	12.6	9.20	2.58
Baldwin & Lyons Inc.	OTC	19.25	6.2	29.4	19.00	14.50	23	0.20	1.0	6.8	17.57	1.10
Belvedere Corp.	AMEX	4.88	-4.9	8.4	5.50	4.50	4	0.04	0.8	7.4	8.43	0.58
Chandler Insurance	OTC	10.00	9.5	44.1	10.88	7.00	159	0.00	0.0	5.8	9.53	1.05
Chubb Corp.	NYSE	70.88	3.3	22.2	73.50	57.63	346	2.32	3.3	8.2	53.50	1.32
CIGNA Corp.	NYSE	58.50	3.8	24.1	59.88	45.88	597	2.96	5.1	10.2	53.08	1.10
CNA Fin'l Corp.	NYSE	75.25	2.4	24.4	79.25	57.63	149	0.00	0.0	11.7	54.52	1.38
Continental Corp.	NYSE	35.13	2.2	8.5	36.00	31.50	676	2.60	7.4	23.9	42.10	0.83
Durham Corp.	OTC	32.75	-3.7	-0.8	34.00	30.00	1	0.92	2.8	18.9	26.32	-1.24
Fireman's Fund Corp.	NYSE	34.88	0.7	19.2	36.00	29.00	274	0.60	1.7	8.7	32.74	1.07
Fireman's Gen Corp.	OTC	17.25	9.5	28.9	18.25	12.13	271	0.60	3.5	13.3	17.61	0.98
Frontier Insurance Group	OTC	18.25	-2.7	46.0	18.38	11.13	41	0.00	0.0	9.7	7.53	2.42
General Re Corp.	NYSE	68.00	2.6	22.5	69.38	54.38	847	1.36	2.0	12.8	29.04	2.34
Hanover Ins Co.	OTC	28.13	4.2	5.2	30.25	25.75	90	0.44	1.6	5.8	31.47	0.89
Harleysville Group Inc.	OTC	20.38	3.2	13.2	22.50	17.75	25	0.48	2.4	7.1	18.94	1.08
Hartford Steam Boiler	OTC	43.25	2.4	17.7	44.00	34.75	467	1.60	3.7	11.9	13.04	3.32
Kans City Life Ins	OTC	35.50	0.7	2.9	36.00	32.75	4	0.00	0.0	12.7	39.22	0.91
Kemper Corp.	NYSE	39.75	1.3	65.6	40.50	35.63	487	0.84	2.1	10.5	28.91	1.37

		Price	Weekly % change	Year to Date % change	Annual High Low		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Lawrence Ins. Group	AMEX	7.13	1.9	-9.5	8.50	6.63	3	0.24	3.4	15.2	3.19	2.24
Liberty Corp. S.C.	NYSE	36.38	3.9	1.1	38.00	32.50	6	0.80	2.2	20.7	21.17	1.72
Lincoln Nat'l Corp.	NYSE	52.75	2.7	19.9	53.38	42.75	138	2.48	4.7	13.1	39.21	1.35
NAC Re Corp.	OTC	27.75	4.1	31.1	28.25	20.63	556	0.20	0.7	14.9	15.21	1.82
Navigators Group	OTC	26.75	-0.9	33.8	27.25	20.50	13	0.00	0.0	11.4	15.22	1.76
Nobel Ins Ltd.	OTC	2.31	-2.9	-51.4	2.50	0.75	52	0.42	8.2	-8.9	7.76	0.30
Northwestern Nat'l Life	OTC	38.38	6.2	23.3	39.13	26.88	460	1.20	3.1	13.9	37.50	1.02
Ohio Cas Corp.	OTC	46.00	1.1	28.7	46.00	35.50	217	2.08	4.5	6.7	33.30	1.38
Old Rep Int'l Corp.	OTC	26.13	2.0	8.9	26.88	23.38	173	0.74	2.8	13.3	26.50	0.99
Orion Cap Corp.	NYSE	22.25	1.7	44.7	23.00	15.38	57	0.84	3.8	7.2	12.93	1.72
Phoenix Re Corp.	OTC	10.13	1.3	6.6	11.00	8.75	57	0.00	0.0	5.6	12.99	0.78
Protective Life Corp.	OTC	15.38	0.9	16.1	16.25	12.88	28	0.70	4.6	76.9	14.54	1.06
Re Capital Corp.	AMEX	11.63	1.1	27.4	12.50	9.13	52	0.00	0.0	11.6	12.60	0.92
RLI Corp.	NYSE	8.38	8.1	9.8	9.25	7.13	29	0.36	4.3	8.2	10.71	0.78
Provident Life & Acc Ins Co.	OTC	24.38	6.0	26.6	24.75	19.13	718	0.68	2.8	10.3	23.24	1.05
St. Paul Cos. Inc.	OTC	54.75	2.6	25.9	55.50	43.00	638	2.20	4.0	7.4	32.00	1.71
SAFECO Corp.	OTC	30.63	3.0	29.6	32.00	23.13	816	1.20	3.9	7.6	24.88	1.23
SCOR U.S. Corp.	NYSE	8.63	0.0	-5.5	9.50	7.50	47	0.20	2.3	6.5	10.35	0.83
Seibels Bruce Group Inc.	OTC	13.50	0.0	18.6	13.63	10.25	83	0.80	5.9	11.3	13.42	1.01
Selective Ins Group Inc.	OTC	25.50	6.3	10.9	26.00	21.75	81	1.40	5.5	5.5	22.33	1.14
Statesman Group Inc.	OTC	3.63	0.0	-16.0	4.00	2.38	128	0.05	1.4	90.8	3.48	1.04
Tokio Marine & Fire Ins	OTC	73.63	3.0	-19.4	95.50	66.00	2	0.24	0.3	44.6	0.00	N/A
Torchmark Corp.	NYSE	40.88	5.5	34.0	41.25	30.00	204	1.20	2.9	12.9	12.24	3.34
Transamerica Corp.	NYSE	38.25	2.3	12.9	38.63	32.75	1146	1.88	4.9	8.6	30.70	1.25
Travelers Corp.	NYSE	42.50	2.7	22.3	43.13	34.50	936	2.40	5.6	33.2	44.85	0.95
Trenwick Group Inc.	OTC	17.25	5.3	19.0	17.75	13.75	383	0.24	1.4	9.7	16.91	1.02
United Fire & Cas Co	OTC	32.75	1.1	7.4	32.75	29.00	1	1.20	3.7	6.0	22.56	1.45
United States Fid & Gty	NYSE	33.00	2.3	15.8	34.00	28.50	657	2.80	8.5	12.3	22.57	1.46
UNUM Corp.	NYSE	34.25	1.5	26.9	34.88	26.63	276	0.60	1.8	11.3	30.64	1.12
USLIFE Corp.	NYSE	46.25	5.1	32.6	46.88	34.13	220	1.40	3.0	11.3	54.27	0.85
Washington Nat'l Corp.	NYSE	27.00	0.9	0.0	27.63	24.00	23	1.08	4.0	-19.3	32.33	0.84
Zenith Nat'l Ins Corp.	NYSE	19.50	-0.7	11.4	19.88	16.75	35	0.84	4.3	9.1	13.61	1.43
INSURERS/REINSURERS		AVERAGE	2.3	17.8					3.1	13.1		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp.	OTC	33.50	8.9	176.2	33.00	11.75	668	0.00	0.0	17.1	3.54	9.46
HMO America Inc.	OTC	8.75	2.9	14.7	4.69	0.44	513	0.00	0.0	-7.7	1.12	7.81
Pacificare Health Systems	OTC	26.75	0.0	118.4	32.50	12.25	0	0.97	3.6	21.4	6.35	4.21
Safeguard Health Ent.	OTC	7.88	3.3	43.3	8.13	4.75	187	0.00	0.0	13.4	2.99	2.64
Sierra Health Services	AMEX	6.00	20.0	268.1	6.00	1.50	204	0.00	0.0	-4.9	1.59	3.77
United HealthCare Corp.	OTC	10.38	5.1	137.0	10.63	4.13	1890	0.00	0.0	-4.7	0.31	33.48
United Medical Corp.	AMEX	5.88	0.0	12.0	6.75	5.13	5	0.00	0.0	1.8	4.11	1.43
U.S. Healthcare	OTC	12.13	0.0	108.8	13.13	5.25	1385	0.20	1.6	173.3	2.87	4.23
Western Health Plans Inc.	AMEX	0.50	-20.6	-27.5	1.13	0.44	12	0.00	0.0	-0.2	0.82	0.61
HMOs	AVERAGE		2.2	94.6					0.6	23.2		
ALL COMPANIES	AVERAGE		2.3	26.9					2.7	14.3		



The break-the-mold, something for everyone, dollar stretching flexible benefits plan.



Our ChoiceFlex® flexible benefit plans can add benefits, defer taxes and control costs for you and your employees, and take the cookie-cutter rigidity out of your group benefit coverages.

**Mutual
of Omaha®**
Companies
Group Operation

The Managed-Cost Professionals.™

For more information on expanding benefits while controlling costs with Mutual of Omaha's ChoiceFlex program, send your business card to Tom McKellar, Director of National Accounts, Dept. C, Mutual of Omaha Group Operation, Mutual of Omaha Plaza, Omaha, NE 68175.