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update

Illinois high court upholds bond for execs convicted of murder

SPRINGFIELD, Ill.—Three corporate officials sentenced to 25 years in prison last month for murder in the work-related death of an employee will remain free on bond pending their appeal.

The Illinois Supreme Court on July 17 upheld an appellate court's decision allowing bond to be set for the officials of Film Recovery Systems Inc., a defunct Elk Grove Village, Ill., firm.

Continued on next page

Insurers embracing claims-made form

By MICHAEL BRADFORD and ROBERT A. FINLAYSON

Most large commercial liability insurance buyers can expect insurers to force the new restrictive claims-made form on them next year, but defense costs may remain outside policy limits.

Of 19 large commercial liability insurers surveyed last week by *Business Insurance*, 17 said they definitely plan to use the Insurance Services Office's new claims-made form.

The insurers also will adopt ISO's new occurrence form, but they say its use generally will be restricted to smaller commercial accounts and those without long-tail liability exposures.

In contrast to the insurers' overwhelming acceptance of the new ISO claims-made policy form, only four of the insurers so far have decided they will include defense costs within policy limits, as proposed by ISO beginning July 1, 1986.

Ten insurers say they are undecided what they will do about defense costs and one—Aetna Life & Casualty Co.—says it will *not* include defense costs within policy limits.

The majority of the insurers expect to begin using the new ISO claims-made and occurence forms Jan. 1, 1986—the date proposed by ISO—although some say they will delay implementation six months to a year.

ISO is filing the forms with state insurance departments for a Jan. 1 implementation date. So far, the form can be used beginning Jan. 1 in 26 states and the District of Columbia (see story, page 88).

But, some insurers say data processing changes necessary to implement the new policy forms will not be completed by Jan. 1. Others admit they are waiting until more state insurance departments approve the new forms before they will implement them.

The forms will exclude all coverage for pollution liability and impose new, separate aggregate limits for specific exposures. In addition, the claims-made form will include a retroactive date. Any incidents occurring before that date—even if the claim is filed within the policy period—will be excluded from coverage.

Most of the insurers surveyed will make the retroactive date the inception of the insured's first claims-made policy, they say, rather than carrying that date forward at each renewal as had been feared by brokers and risk managers.

Insurers that will implement the ISO forms Jan. 1, 1986, include Fireman's Fund Insurance Cos.; Fremont Indemnity Co.; The Travelers Corp.; CIGNA Corp.; St. Paul Cos. Inc.; Crum & Forster Inc; CNA Financial Corp.; Royal Group and Reliance Insurance Co.

Kemper Corp. plans to adopt the new forms by mid-1986; and SAFECO Corp. will switch Jan. 1, 1987.

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Where insurers stand on ISO proposals

Insurer	Introducing claims-made policy form	Including defense costs in policy limits [1]
Aetna	Yes, no target date	No
CIGNA	Jan. 1, 1986	No comment
CNA	Jan. 1, 1986	Supports recommendation
Chubb	Yes, no target date	Undecided
Continental	July 1, 1986 [2]	Yes
Crum & Forster	Jan. 1, 1986	Yes
Fireman's Fund	Jan. 1, 1986	Yes
Fremont	Jan. 1, 1986	Undecided
Hartford	Yes, no target date	Supports recommendation
Kemper	Mid-1986	Undecided
Mission	Undecided	No comment
Ohio Casualty	Yes, no target date	Undecided
Reliance	Targeting Jan. 1, 1986	Undecided
Royal	Jan. 1, 1986	Supports recommendation
SAFECO	Jan. 1, 1987	Undecided
Sentry	Undecided	No comment
St. Paul	Jan. 1, 1986 [2]	Probably
Travelers	Jan. 1, 1986	Yes
USF&G	Yes, no target date	No comment

1 Slated for implementation July 1, 1986. 2 Adopting own policy form similar to ISO form.

Source: Business Insurance survey

Chart: Amy Palmer

Large banks exploring coverage alternatives

By STEVE TARAVELLA

LOS ANGELES—Some of the nation's leading financial institutions, frustrated by the disappearing market for directors and officers liability insurance and bankers blanket bonds, are taking matters into their own hands.

Representatives from 23 of the country's largest commercial banks have retained risk management consultants at The Wyatt Co. in Chicago and attorneys at LeBoeuf, Lamb, Leiby & MacRae in New York to study what options are available for banks to use their own money to obtain desired limits at reasonable prices.

Among the alternatives the study will consider are establishing one or more captive insurance companies, either domestic or offshore, and creating multiple pooling arrangements.

The study, which is expected to be completed Oct. 1, will address both D&O insurance and bankers blanket bonds.

"This is aimed at determining the viability of generating bank-funded capacity to relieve the pressure on the commercial market," says Edith F. Lichota, a member of the study committee who is taking a leadership role in the study. Ms. Lichota is senior vp-risk management at Irving Trust Co. in New York.

Since last fall, commercial insurers have been raising rates and limiting the amount of directors and officers liability insurance they

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NEWSPAPER

Union Indemnity won't fight New York liquidation order

By DOUGLAS McLEOD

NEW YORK—Union Indemnity Insurance Co., a unit of Frank B. Hall & Co. Inc., will not appeal a court order granting the New York Insurance Department's request to liquidate the insurer.

At a July 12 hearing, New York State Supreme Court Justice Ira Gammerman granted the Insurance Department's liquidation petition, which claims that Union Indemnity was insolvent by $138.5 million at the end of 1984.

Justice Gammerman also denied a request by Union Indemnity for more time to respond to the department's petition, but stayed his order until last Tuesday to give the insurer time to appeal.

Union had argued it should be rehabilitated rather than liquidated and submitted several proposals to the department that it said would improve its financial position.

In its 1984 annual statement, the insurer had reported a deficit of only $14.6 million and claimed in a recent court filing that the deficit may actually have been smaller.

But, Thomas G. O'Brien III, Hall's vp, secretary and general counsel, said last week Union will not appeal the liquidation order.

Although Hall claims to have sufficient grounds for an appeal, "a successful appeal is not likely to lead to the rehabilitation of Union because of the wide discrepancy as to Union's deficit between the New York Insurance Department and Union," a Hall statement read.

"Any proposed rehabilitation of Union would have required the full cooperation of the Insurance Department, but the department insisted on Union's immediate liquidation in order to trigger the operation of state security funds outside New York," the statement added.

A spokesman for the New York department denied that triggering guaranty funds had anything to do with the decision to liquidate, which he said was based on the size of Union's insolvency.

Several states where Union actively underwrote business—including New Jersey, Florida, Illinois and Michigan—were awaiting copies of the liquidation order last week to trigger their guaranty funds.

Meanwhile, Mr. O'Brien said Hall will write off its investment in Union, now carried on its books at $14.5 million. The writeoff will be taken in either the second or third quarter and will amount to about $6 million after taxes, he said.

The New York department filed its liquidation petition in state court June 5, claiming that two examinations of Union Indemnity had found the company $138.5 million insolvent at the end of 1984 and $27.9 million insolvent at the end of 1983 (*BI*, June 17).

The 1984 exam increased Union's unpaid loss and expense liabilities by $60.2 million to $96.1 million from the $35.9 million Union reported. It also boosted Union's liability for unauthorized reinsurance by $56.2 million to $75.6 million from the $19.4 million reported.

In all, the exam increased Union's total 1984 liabilities to $192.8 million from the $77.5 million Union reported, while reducing its assets to $54.3 million from the $62.9 million Union reported.

Union, which was scheduled to respond to the department's petition on June 27, was denied a 45-day extension to answer.

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update

Bond upheld for three officials

Continued from previous page

The Supreme Court also rejected a request by the Cook County State's Attorney's Office to increase the amount of the bond, which had been set at $2,500 (*BI*, June 24, July 8).

N.Y. liquidates Northumberland

TORONTO—A New York Supreme Court judge has approved the liquidation of the U.S. branch of Toronto-based Northumberland General Insurance Co.

In addition, a hearing on the liquidation of the parent company is set for July 24 in the Supreme Court of Ontario (*BI*, July 15).

An unaudited year-end financial statement showed Northumberland had assets of $123 million Canadian ($91 million U.S.) and liabilities of only $101 million Canadian ($74.7 million U.S.). The Canadian Insurance Department pursued the liquidation because much of the assets were invested in Northumberland's affiliates, said Robert M. Hammond, Canada's superintendent of insurance.

The insurer did not contest the liquidation action in New York and is not expected to contest it in Canada.

Broker saves day for Live Aid

PHILADELPHIA—B.C.A. Insurance in Ardmore, Pa., placed $10 million of liability insurance for the Live Aid concert in Philadelphia's John F. Kennedy Stadium just a few days before the concert. The city required the $10 million in coverage for the concert, a fund-raising effort for African famine victims.

As the concert date neared and insurance was still not in place, B.C.A., an entertainment specialist that places insurance for Three Rivers Stadium in Pittsburgh, The Philadelphia Flyers and the Philadelphia 76ers, was contacted by Fred S. James & Co. in Los Angeles, which had been hired to place the concert coverage.

"It was a coordinated effort with the James people," said B.C.A. President Paul Lichtman, who attended the concert. Coverage finally was placed on Wednesday preceding the Saturday concert.

B.C.A. placed the coverage with International Insurance Co., a Crum & Forster unit, and Agricultural Excess & Surplus Insurance Co., owned by Great American Insurance Co.

The premium charged to the Live Aid Foundation was "in the six-figure range," according to a spokeswoman at BCA. It was discounted by $7,000 as a contribution to the hunger-relief effort, and BCA donated about $1,000 of its commission, she said.

In addition to the coverage placed by B.C.A., the first $1 million primary layer of liability coverage was placed with Fireman's Fund Insurance Cos. through Beverly Hills, Cailf.-based Albert G. Ruben & Co. Inc. And, $5 million in excess liability coverage was placed with Scottsdale Insurance Co. of Scottsdale, Ariz., by Crouse & Associates of San Francisco.

Jewel faces class-action suit

CHICAGO—A class-action lawsuit filed last week accuses Jewel Food Stores and claims adjuster GAB Business Services Inc. of misrepresenting facts, fraud, conspiracy and deceptive business practices in settling claims after a salmonella outbreak this spring was traced to milk processed at a dairy owned by Jewel (*BI*, April 27).

The suit was filed in Cook County Circuit Court by the Daniel Nagle family of Homewood, Ill., whose four members each accepted $350 when they signed forms releasing the grocery chain from liability. They allege the claims adjuster said they could get more money if their conditions worsened. Yet, the company refused to pay additional medical bills when a daughter suffered a relapse five days after her parents signed the form, court papers say.

The lawsuit asks that claimants who signed releases be notified that they can seek additional damages. It also asks that any money already paid to victims be subtracted from any amount Jewel ultimately might have to pay in court-ordered settlements, court papers say. And, it seeks payment of attorneys' fees and court costs.

Similar releases were signed by about 5,000 people, representing more than one-third of the 16,284 confirmed salmonella cases reported in the six-state area.

The allegations are "baseless and unfounded," said Jewel attorney Tom Ryerson of the Chicago firm of Clausen, Miller, Gorman, Caffrey & Witous P.C.

More than 300 lawsuits seeking hundreds of millions of dollars in damages have been filed in Illinois in connection with the salmonella outbreak.

The Home Insurance Co. provides first-layer excess liability coverage to American Stores above a self-insured retention that insurance industry sources estimate at $100,000 to $300,000.

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Allis-Chalmers termination to cost PBGC $165 million

By JERRY GEISEL

WASHINGTON—The decision by financially troubled Allis-Chalmers Corp. to shed its huge pension liabilities will result in the largest claim ever faced by the federal government's pension insurance program.

Allis-Chalmers, a diversified West Allis, Wis.-based manufacturer, told the Pension Benefit Guaranty Corp. last week that it intends this month to terminate a 35-year-old defined benefit plan covering members of the United Auto Workers union.

According to preliminary estimates made by the PBGC, the plan's liabilities exceed plan assets by about $165 million. The PBGC will have to assume those liabilities when the plan is terminated.

The plan has just $5 million in assets, the PBGC says.

The plan's $165 million deficit is by far the biggest claim incurred by the PBGC during its 10½-year existence. Before now, the largest losses involved the 1980 and 1981 terminations of pension plans sponsored by Wisconsin Steel Co. and White Motor Corp. Each of those terminations will cost the PBGC $63.3 million, the agency estimates.

According to Allis-Chalmers officials, termination of the plan covering hourly employees is necessary for the survival of the company, which has reported $700 million in aggregate losses since 1981.

"The survival of Allis-Chalmers is at stake," said Nicholas T. Jordan, the company's director of industrial relations and benefits.

"We wish we could keep the plan in effect, but it is not in our means to do. It is terminate the plan or die," he said.

Mr. Jordan attributed the plan's financial problems to pension benefit increases sought by the union and demographic changes in the company's workforce.

Monthly pension benefits were gradually increased between 1978 and 1981 to $16 per year of service from $12 per year of service.

In addition, Allis-Chalmers has experienced a large increase in its supplemental pension benefit plan expenses in recent years as large numbers of workers have retired.

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Wellington signers may seek stays

By STEPHEN TARNOFF

Asbestos producers that recently signed the Wellington agreement said they may seek stays in some asbestos litigation while the claims-handling facility established by the agreement is set up.

However, they said they would not seek blanket stays, and they promised to consult with plaintiffs' attorneys before taking action.

According to a recent letter sent by Wellington producer members to their defense attorneys, "It is anticipated that facility members probably will be seeking stays of pending litigation designed to enable the facility to meet its goal of efficient and fair resolution of pending cases."

Members of the Wellington group have indicated that the facility will not be operational until next February.

Last week, Wellington spokesmen emphasized that rumors that members would seek blanket stays in asbestos litigation were unfounded.

"We have no intention of seeking blanket stays in all underlying cases," said Scott Gilbert of the Washington firm of Covington & Burling and an attorney for Armstrong World Industries Inc., an asbestos producer and a member of the facility.

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Lloyd's report outlines charges in Howden affair

By STACY SHAPIRO

LONDON—A group of former Alexander Howden Group P.L.C. officers misappropriated Howden underwriting funds to purchase a Swiss bank and a Panamanian company, concludes Lloyd's of London's official report on the Howden affair.

Lloyd's earlier this month expelled three former Howden officers —former Chairman Kenneth V. Grob, former director Ronald C. Comery and ex-senior underwriter Jack H. Carpenter—for their roles in the misappropriation of underwriting funds from Howden (*BI*, July 15).

In addition, Lloyd's expelled Lloyd's member Mario Benbassat for his role in the scheme. Lloyd's also recommended that famed Howden underwriter Ian R. Posgate be expelled, but that sentence was reduced at an appellate hearing to two six-month suspensions, to be served concurrently.

In the massive three-volume report, Lloyd's concludes that Messrs. Grob, Comery and Carpenter and former Howden Treasurer Alan J. Page conspired to buy the Banque du Rhone et de la Tamise, a Swiss bank, from Alexander Howden (Bermuda) Ltd. in 1979 with misappropriated Howden funds.

Disciplinary proceedings against Mr. Page have been dropped because he is in ill health.

The report, which was sent to all Lloyd's members, confirms many of the allegations that have been leveled at the Howden officials since the scandal first erupted almost three years ago and slowly unfolded (*BI*, Aug. 2, 1982).

In the report, Lloyd's says that between 1979 and 1982:

- The former Howden officers were assisted by Mr. Benbassat, who was managing director of the Banque du Rhone, in forming a secret syndicate through which the men purchased the Swiss bank.
- Each of the men owned a 10% share in the Banque du Rhone through various Panamanian and Liechtenstein trusts. The report adds they kept their ownership secret from the Howden board even after being asked at a Howden meeting if they owned shares in the bank.
- The funds used to buy the Banque du Rhone were misappropriated from Howden underwriting units by the use of various rein-

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Worker claims 'harassment'; awarded disability benefits

By CAROL CAIN

LOUISVILLE, Ky.—A recent decision by the Kentucky Workers' Compensation Board is raising the specter of racism.

In the decision, the workers compensation board awarded a former city of Louisville employee, who is white, maximum disability benefits after he suffered a nervous breakdown he claims was triggered by job-related pressure caused by harassment from other employees, who are black.

The Workers' Compensation Board declared the employee totally disabled and ordered the city of Louisville, which self-insures it workers compensation risks, to pay his medical bills.

In its decision, the work comp board also ordered the state's Special Fund to pay the former employee maximum weekly temporary total benefits of $231.47 per week.

The Kentucky Special Fund is a second-injury fund, funded through assessments on employers. The fund pays benefits to injured workers when it is determined that a current workplace injury is an aggravation of a previous injury.

In this case, the former employee had been diagnosed as a paranoid schizophrenic in 1965, seven years before he went to work for the city.

Sometimes the Special Fund pays only a percentage of disability benefits, with the employer paying the rest. However, in this case, the fund was ordered to pay 100%.

The Workers' Compensation Board also ordered that "exhaustive efforts" be made to rehabilitate

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errors & omissions

- Hartford Insurance Group's net pretax underwriting loss for the first quarter of 1985 totaled $158.2 million, compared with a pretax underwriting loss of $180.4 million in the first quarter of 1984. *BI* incorrectly reported this figure in the June 17 issue.

New horizons

Buyers forcing revolution in health care delivery

By JERRY GEISEL

Every day, Diane Lesser evaluates bids at Hughes Aircraft Co. in El Segundo, Calif.

Although competitive bidding among the aerospace manufacturer's suppliers is nothing new, the bids Ms. Lesser reviews are from hospitals seeking to be preferred health care providers for Hughes employees. And, that is new.

Ms. Lesser already has received bids from several dozen Southern California hospitals that have agreed to charge fixed rates—ranging from 10% to 20% below customary rates—for obstetrical deliveries and open-heart surgery needed by Hughes employees.

These rates, to take effect Jan. 1, 1986, will be guaranteed for at least a year.

"This is where the health care system is going: fixed amounts paid to providers," said Ms. Lesser, health care cost-containment administrator at Hughes.

"We are going more toward prepaid arrangements so an employer can predict costs," adds Dick Smith, Hughes' manager of employee benefits.

If the pilot program helps hold down the cost of maternity care and open heart surgery, the next step at Hughes will be to negotiate fixed rates for other medical procedures.

The demands Hughes is placing on health care providers, and similar demands being placed by other employers, are reshaping the nation's health care delivery system.

These employers and their group health insurers—no longer willing to pay health care costs that have increased faster than the general rate of inflation—are moving away from traditional fee-for-service health care toward alternative delivery systems they see as less costly and more efficient options for providing health care for employees.

"A revolution in the medical care delivery system is under way," declares Philip Briggs, executive vp at Metropolitan Life Insurance Co. in New York.

"We are entering a price-driven cycle," admits Bernard R. Tresnowski, who is president of Blue Cross and Blue Shield Assn. in Chicago.

The movement is just beginning, but over the next 10 years, health care experts predict the nation's traditional cost reimbursement health care delivery system will be radically transformed (see chart).

They predict that preferred provider organizations and health maintenance organizations will steal almost half the market now controlled by fee-for-service health care.

Under preferred provider arrangements, employers or their insurers negotiate rates and utilization review with hospitals and doctors. Then, the health care plan is amended to encourage employees to use the PPO providers, which sends more employees to the PPOs.

HMOs are prepaid health care plans in which employees receive all their care from the HMO's doctors and hospitals.

According to *Business Insurance* estimates based on interviews with several health care experts, about 92% of all health care today is paid for under the traditional fee-for-service system, while about 7% is paid for under the HMO system and just 1% under PPOs.

But by 1995, it is predicted the fee-for-service share of the market could slip to 55%, while PPOs will grow to 25% and HMOs to 20%.

And, the transition to alternative delivery systems will be obvious even within the next five years.

By 1990, the segment of the health care market controlled by HMOs will be 13%, while PPOs will have 11%.

"Fee-for-service is dying," asserts Dr. Paul Ellwood Jr., president of InterStudy, a health research firm in Excelsior, Minn.

"Over the next few years, few insurers will offer pure fee-for-service health plans," Dr. Ellwood says.

The health care market will change further as competitive pressures force hospitals to merge, setting the stage for a market controlled by a few powerful national networks of hospitals.

In turn, these hospitals will team up with health care insurers to offer a total health care package to a more savvy consumer (see story, below).

Dr. Ellwood predicts the future health care delivery system will be dominated by a few "Supermeds"—huge, vertically integrated companies that will both underwrite insurance and operate health care facilities across the country.

Just as competition and consolidation transformed the U.S. auto industry from an industry of dozens of small manufacturers at the turn of the century to one dominated today by three companies, by the year 2000, some eight to 20 Supermeds will control up to 75% of the health care delivery market, Dr. Ellwood predicts.

"What we may see could be various 'Sears' of health care," agrees Larry Tucker, a consultant in the Newport Beach, Calif., office of Hewitt Associates.

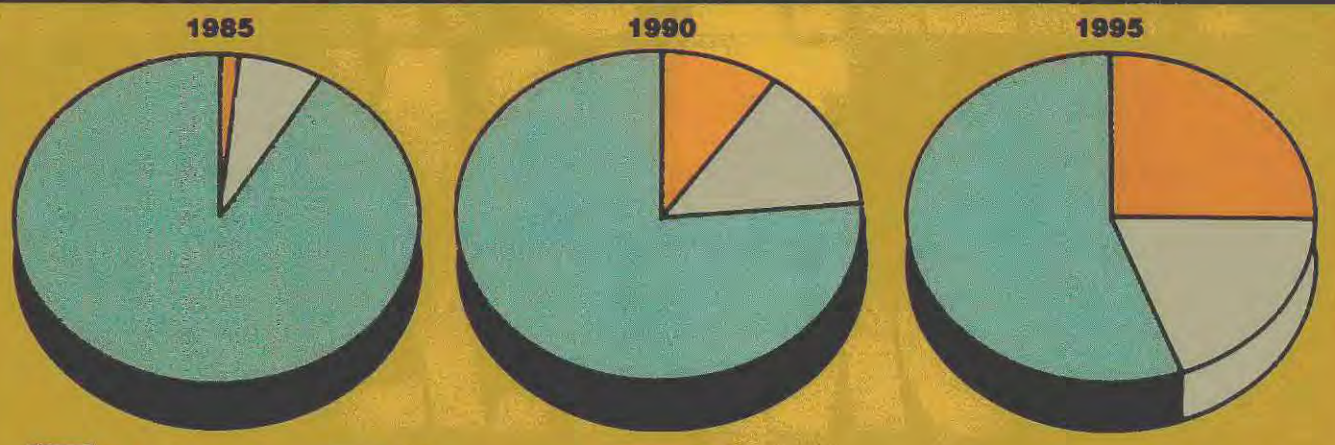
And, these Supermeds will offer a brand of "managed" health care, in which prices are agreed upon ahead of time and utilization is closely monitored.

"The key words in the future will be: Advanced fixed fees. Networks. Managed systems," predicts Sam Havens, president of Roseland, N.J.-based Prudential Health Care Plan Inc., a unit of Prudential Insurance Co. of America.

This new, managed health care system signals

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The changing health care delivery market



BI estimate based on survey of health care experts

Hospitals jumping into underwriting

By STEVE TARAVELLA

As the health care delivery system changes, hospitals—caught in the crunch of declining occupancy rates—are trying to preserve market share by underwriting group health insurance.

By selling group health products in which employees are encouraged through cost incentives to use certain hospitals, the hospitals hope to fill their empty beds and possibly make a profit from underwriting the insurance.

Several of the nation's major multihospital systems have already purchased—or plan to soon acquire—a licensed life/health underwriter through which they can offer group health insurance products to employers.

Other hospital systems are forming partnerships with insurers that give the health care institutions the marketing abilities of an insurer without having to buy one.

Among the products that are being offered to employers by hospital systems are traditional fee-for-service health plans, preferred provider organizations, health maintenance organizations and even group life insurance products.

The health care plans offered by the hospital systems often guarantee an employer's cost won't rise above a certain aggregate amount each year.

In return for the guaranteed rates, the hospital systems are betting on attracting more business to their hospitals. In fact, some say the systems don't expect to make a profit on their insurance activities alone, but are only entering the market to increase utilization at their facilities.

The guaranteed rates to employers offered by the systems give them some leverage when competing for group health business with commercial insurers, Blue Cross & Blue Shield plans and unaffiliated HMOs and PPOs, observers say, but insurers say they are not worried about the new competition.

"We don't expect to roll over and let them walk away with a large share of the market," says John D. Moynahan Jr., senior vp-group health and life at Metropolitan Life Insurance Co. in New York.

Other observers note the competition between the hospital systems and insurers may be a good thing.

"Competition breeds efficiency and productivity. It's better for everybody involved to have three choices instead of two," says Michael D. Bromberg, executive director of the Federation of American Hospitals in Washington.

At least four multihospital systems have acquired insurers since June 1984: American Medical International Inc. in Beverly Hills, Calif.; National Medical Enterprises Inc. in Los Angeles; Hospital Corp. of America in

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PPO movement attracts varied players

The tremendous spurt in the popularity of preferred provider organizations is evident in the number of players. Insurers, the traditional source of health care coverage, are a major force in the movement toward PPOs (see story, page 34). And, hospitals—sometimes in conjunction with physicians—also are forming their own PPOs in order to preserve their share of the health care market (see story, page 31). Plus, some employers, backed against the wall by endlessly increasing benefit costs, also are taking the initiative by forming their own PPOs or pressuring providers or insurers to come up with a PPO that meets their needs (see story, page 28).

Chart and page design: Amy Palmer

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update

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business insurance

Health revolution

Continued from previous page

change for everyone: employers, insurers, providers and employees.

For employers, the prospect of providers competing to provide services at fixed and discounted prices promises relief from the double-digit inflation rate that until recently has plagued the health care delivery market, and driven up group health care costs.

"The days of 20% premium hikes should be over," said Prudential's Mr. Havens, predicting that medical care costs will not increase faster than the Consumer Price Index.

For insurers, the growth of managed health care systems will compel them to set up or participate in provider networks so they can better control price. Those that can't work out such arrangements could disappear from the marketplace for lack of competitive products, experts say.

Likewise, hospitals and doctors that can promise to provide competitively priced products—without sacrificing quality—will be rewarded with more business from insurers and self-funding employers.

For employees, the growth of managed or alternative health care systems, like PPOs and HMOs, could mean enhanced benefits if they agree to see only a selected number of providers. But such a system also could reduce the traditional freedom of choice employees have enjoyed in selecting doctors and hospitals.

And, in a world where purchases are made on the basis of price, those lacking money or clout may find this new competitive world cold and cruel.

If hospitals, for example, are forced by competitive pressures to discount rates for employers and insurers, they no longer will be able to afford to treat charity cases, such as employees who are laid off and have lost their group health insurance coverage. Such costs now are passed on to private payers in the form of higher bills.

"The issue of uncompensated care is a big question that has to be answered. Who will pay for it?" asks Jack Thompson, a principal in the Chicago office of benefit consultant William M. Mercer-Meidinger Inc.

'Those who shop around will be able to get their costs down,' says Elliot Segal.

Most agree, though, that a competitive, managed health care delivery system will be largely beneficial.

"Everything indicates that the results will be positive. I'm very optimistic," said Dr. Ellwood of InterStudy.

"Those who shop around will be able to get their costs down," says Elliot Segal, a principal in the Washington office of Mercer-Meidinger.

The change in the health care delivery system is most evident in the growing prominence of PPOs and HMOs. And as the new health care system further develops, the structure of these alternative health care delivery systems could change, too.

While PPOs, as the new kid on the block, are growing at a faster pace than the more-established HMOs, health maintenance organizations are still exhibiting impressive growth.

Between December 1983 and December 1984, the number of HMO enrollees climbed to 16.7 million, a record 22.4% increase, according to InterStudy. In just the last six months of 1984, the number of HMOs swelled to 337 from 306.

"The HMO industry has never been healthier," asserts James Doherty, executive director of the Group Health Assn. of America, an HMO trade group in Washington.

Continued HMO growth seems assured. For example, CIGNA Corp. plans to spend $200 million during the next two years on HMO development, said Robert Patricelli, chairman of CIGNA Healthplan Inc., CIGNA's HMO unit.

CIGNA's plans calls for adding seven to nine HMOs during each of the next two years. CIGNA currently has a stable of 11 HMOs.

Other insurers, such as Prudential, whose HMO involvement grew from one plan in Dallas a decade ago to 17 HMOs with 450,000 enrollees today, also envision sharp HMO growth.

"We are growing at the rate of

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IN BUSINESS, THERE'S MORE THAN ONE RISK.

THAT'S WHY YOU NEED A MORE-THAN-ONE-COMPANY AGENT.

Computer Crash. Pollution Liability. Product Recall. D&O Liability. Business Interruption Losses. Product Liability. Key Person Losses. These are just some of the many risks that businesses must face every day. What's the best way to manage these risks? Many risk managers turn to their Independent Insurance Agent. They know that an Independent Agent is a true professional who can recommend creative programs that utilize traditional insurance, self-insurance, co-insurance, captives, or a combination that best suits the special needs of your business. And because Independent Agents represent several insurance companies not just one, they can help you select the best business coverages at the best price.

So no matter how big or small your business, it's a good idea to consult an Independent Insurance Agent. They're the more-than-one-company agents ...and helping you manage your business risks is their business.

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The Government stopped us from offering some of our Flexible Spending Programs.

Flexible Spending Accounts are a good idea for employers and employees.

Unfortunately, the IRS doesn't agree. In recent rulings, they eliminated some of the many advantages offered by FSAs.

But despite the changes, Flexible Spending Accounts are too important of an idea to die. Not only do they provide employers with a method for controlling benefit costs, but they help employees cover medical costs with non-taxable income.

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BI-7

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So we've reconstructed them.

Health revolution

Continued from page 4

75,000 enrollees a year," said Mr. Havens.

But, PPOs apparently also have caught the insurers' attention—and in a big way. Virtually all the major health care insurers and Blue Cross/Blue Shield plans are approaching hospitals to be part of their preferred provider organization networks, or are starting their own PPOs (see story, page 34).

For example, Metropolitan Life Insurance Co., which now has PPOs in California, Florida and Tulsa, Okla., expects to have 20 PPOs operating at the end of 1985 as part of to its MET-Elect PPO network.

And, Blue Cross and Blue Shield plans, which now have 31 PPOs, hope to add 25 more by the end of the year. Other insurers also are expanding their PPO efforts.

By the end of the year, virtually all of the 30 major insurers in California will either set up their own PPO or contract with a PPO set up by providers or by third-party claims administrators, according to Wally McCall, marketing director for the PPO Alliance, a hospital-sponsored PPO headquartered in Cypress, Calif.

"I've never seen such phenomenal activity," Mr. McCall says.

The great fear of insurers, Mr. McCall says, is that they will lose a competitive edge to others who already have worked out discount or other favorable rate conditions with PPOs.

"There is a fear that the hospitals will attempt to recoup discounts by charging others more," Mr. McCall says.

And hospitals, also afraid of losing market share, are setting up their own PPOs and wooing self-insurers and insurance companies to use them (see story, page 31).

The growth rate of some of these hospital-owned PPOs has been explosive.

For example, Florida Health Choice Plan in Delray Beach, Fla., started by several non-profit hospitals in South Florida last November, now has contracts with 18 self-funding employers and seven multiemployer plans. These employers and multiemployer plans employ 16,000 workers.

Altogether today about 330 PPOs have been established, with about 230 of those operating—or twice as many as last year.

However, that estimate, which is based on a survey completed in June by American Medical Care and Review Assn. in Bethseda, Md., already may be outdated due to the accelerated growth of new PPOs. "PPOs are being added every day," said Max Fine, executive director of the American Assn. of Preferred Provider Organizations, a Washington-based PPO trade group.

PPOs have taken off far faster than HMOs, notes William Phillips, president of Phillips & Associates, a Bethesda, Md., alternative health care delivery consultant.

"We are talking about a 100% increase in PPOs in a year," Mr. Phillips said, noting that the development of PPOs only started a few years ago.

Mr. Phillips said PPOs have developed rapidly because of their low start-up costs and because they give employees freedom to choose from what can be a long list of providers.

"They are a rational midpoint in the health care delivery system," Mr. Phillips said, adding that PPOs are a good compromise between the traditional fee-for-service system, in which employees have virtually complete freedom to choose providers, and HMOs, in which employees are locked into one group of providers for their health care needs.

In a PPO arrangement, an employee usually has an incentive—like reduced deductibles and coinsurance requirements—to use the PPO. But the employee may choose health care services outside the PPO, although benefits probably will be reduced.

'Employees see the PPO as enhanced benefits. At the same time, the company is saving money. If you can accomplish both at the same time, you've met your objectives,' says Alan Jeffery, vp of employee benefits at Security Pacific.

The first wave of employers to try PPOs like what they have tasted. For example, Security Pacific Corp., the diversified Los Angeles financial company, is receiving discounts of between 10% and 30% on charges incurred by employees treated by hospitals and physicians that are part of Med Network, a preferred provider network set up by Admar Corp., an Orange, Calif.-based third-party claims administrator.

These discounts, coupled with such utilization controls as mandatory second opinions for many surgical procedures and agreement on length of stay before surgery, led to a dramatic cost savings.

The average hospital bill for Pacific Security employees who used the FPO was $4,002 compared, with $4,999 for employees who opted for hospitals outside the PPO. In addition, doctors' bills averaged $81 for those who used the PPO's network of physicians, while the average claim for non-PPO physician care was $124.

Despite such financial incentives as free gynecological examinations and well-baby care, not every employee elected to be treated by providers in the PPO. In fact, only 11% of hospital claims were from the PPO.

Yet, Security Pacific estimates that it saved $600,000 on hospital and doctors' bills in 1984, less $240,000 in administrative charges paid to Admar.

"We saved about $2 for every $1 we spent," said Alan Jeffery, Security Pacific's vp of employee benefits.

"Employees see the PPO as enhanced benefits. At the same time,

Continued on next page



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Continued from previous page
the company is saving money. If you can accomplish both at the same time, you've met your objectives," Mr. Jeffery added.

Overall, because PPOs are so new, the savings they can achieve have not been documented yet. However, in August, Phillips & Associates will publish a study explaining how PPOs cut health care costs between 12% and 31% at six major public and private employers, said Mr. Phillips.

Not everyone is convinced that all PPOs will help buyers control costs. "Much of what is out there is garbage," a West Coast benefit manager complained. "Any two-bit TPA can say it has a special arrangement with a hospital and claim it has a PPO," the manager added.

Indeed, in sharp contrast to insurers, which are regulated by the states, and HMOs, which have to meet certain standards to be federally qualified, any entity can call itself a PPO.

Because of this lack of standards, "There could be some real duds" that will give PPOs a bad name, said Jim Stith, senior associate at Interqual, a Chicago-based health care consultant.

But others believe that the market—without the need for state or federal regulation—will weed out PPOs that can't deliver on their promises to cut costs.

'Much of what is out there is garbage. Any two-bit third-party administrator can say it has a special arrangement with a hospital and claim it has a preferred provider organization,' complains a benefit manager from the West Coast.

"There will be a shakeout period. The majority of PPOs won't make it," asserts Peter Boland, president of Boland Healthcare Consultants in Berkeley, Calif.

Few PPOs, Mr. Boland notes, have invested in health care data systems, so they cannot show buyers how their costs compare to those of non-PPOs.

"Unless PPOs can show significant cost savings, they won't make it," Mr. Boland said. "Selection of participants is the single most-important thing for a PPO. Some try to sign up all hospitals and doctors and then figure out what to do."

Geography also will be an important factor in the ability of PPOs to survive.

"A PPO must be able to say that 80% of employees are no further than five miles from a provider," said Terry Worthylake, president and chief executive officer of Preferred Health Network, a Los Angeles-based PPO with 22 hospitals and 2,200 physicians in its network.

Even if a major hospital chain comes into an area and sets up a PPO, it may not be successful if it doesn't have enough facilities in the area, Mr. Worthylake said.

Administrative factors also will reduce the number of PPOs. Multistate employers, Mr. Boland says, do not want to deal with dozens of PPOs.

"PPOs will have to band together to survive. You'll see more networks," Mr. Boland observed.

"The urge to merge will increase exponentially in the next few years," added Mr. Fine of the PPO trade association.

The marketing behavior of PPOs also is likely to change. While the earliest PPOs stressed discounts, the future buzzword will be cost-effectiveness, Mr. Boland said.

Buyers already are realizing that discounts will not cut costs if a PPO lacks strong utilization review procedures, Mr. Boland said.

Hewlett-Packard Co. did not seek discounts when it negotiated a preferred provider arrangement with El Camino Hospital in Mountain View, Calif., in July 1984.

But, the hospital did agree to such utilization controls as pre-admission certification and reviews of length of stay. With these controls installed, claims costs dropped.

For example, between June 1983 and May 1984—before it had a PPO—the average claim of a Hewlett-Packard employee treated at El Camino Hospital was $2,956. Despite a 6% rate hike in July 1984, the average claim cost dropped to $2,494 between July and December 1984, said Hewlett-Packard benefit manager Art Young.

More risk-sharing by PPOs also seems likely. Arrangements under which providers commit themselves to fixed prices, similar to the plan pushed by Hughes Aircraft, will spread.

"The willingness to take risk will be the litmus test that purchasers will begin to apply to providers," said Mr. Boland.

Some say the health benefit package of the future is here already.

For example, earlier this year, General Motors Corp. gave employees three choices of health care plans: an HMO, a PPO or a Blue Cross/Blue Shield indemnity plan with enhanced cost-control features, which the Blues call managed care (*BI*, June 3).

"The benefit design of the future will be managed care, PPOs and HMOs," said the Blues' Mr. Tresnowski.

CIGNA Corp. earlier this year began to market a new benefit package—known as Flexcare—in California that will offer employees the choice of enrolling in a CIGNA PPO, HMO or obtaining treatment by any fee-for-service provider.

And, the new products that emerge as the health care delivery system undergoes its metamorphosis clearly will bear the mark of a newly enlightened buyer.

"Five years ago, employers didn't know they had a (health care cost) problem. But CEOs have become upset over rate increases," points out Metropolitan's Mr. Briggs.

As a result, corporations are demanding changes in the health care system and, ultimately, getting what they want. "The buyer is the critical actor today," said Mr. Tresnowski. ■



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opinions

Make demands now

VICTORY IN THE FIGHT against rising health care costs is not assured, but it sure appears to be within grasp.

The health care delivery system is responding to demands for price controls and efficiency, as we report this week.

Employers that foot the bill for group health plans are no longer at the mercy of health care providers, free to administer whatever services they want at the prices they set.

Health care providers are increasingly submitting themselves to utilization review and reducing their prices to attract patients.

Employers—who have complained bitterly about rising health care costs, switched to self-insurance and shifted some of the cost to employees—can claim partial credit for the dramatic changes occurring in the health care delivery system.

If employers had continued to meekly pay whatever bills group health insurers passed along from providers, insurers would not have pushed for the change in health care use and prices.

But, lest employers, and their insurers, begin to feel too smug about their success, we hasten to recall the enormous impact of the federal government's program to reimburse hospitals for treatment of Medicare patients on a basis of diagnostic related groups. Hospital admissions fell and hospital stays were shortened since the federal government introduced prospective payment schedules for treatment of Medicare patients in October 1983 (*BI*, Dec. 24-31, 1984).

With empty beds to fill, hospitals quickly responded with more competitive products pitched to employers, whose share of the nation's health care bill is second only to the federal government's.

Now, employers can take advantage of competition in the health care market and provide their employees with health care plans whose costs can be controlled.

That doesn't mean just selecting the best of available options but also organizing an alternative health care system or convincing insurers and hospitals to do so where options do not exist.

Only those employers who fail to capitalize on the new willingness of health care providers to control their costs and prices will snatch defeat from the jaws of victory.

letters

Myriad problems to blame for insurance industry woes

To the editor: I, too, do not want to drag on ad infinitum the debate regarding the new Insurance Services Office commercial general liability policy, but I do not think Thomas D. Lewison's response (*BI*, July 8) to James A. Robertson's letter (*BI*, June 24) should go unanswered.

The insurance industry's cyclical nature has been known and commented on for years. The down portion of the current cycle is, indeed, far worse than any previously experienced. Why is this so?

Mr. Lewison alleges that it is half the result of the insurance industry's "shortsighted 'cash-flow' cyclical pricing policy, its inadequate training of underwriters and its poor actuarial work," with the United States legal system causing the other half of the problem. He seems to have ignored or is not aware of at least the following:

- Regulators who repeatedly deny rate increases while, at the same time, the selfsame insurance departments' actuaries are telling the insurers making the filings to increase their loss reserves because their products have been underpriced.
- Regulators who insist that investment income be considered in the rates but who will not allow loss reserves to be discounted, thus decreasing surplus.
- The strengthening of the dollar. This reduces the capacity of the non-U.S. insurance market, which, in turn, reduces the capacity of the U.S. insurance market because of reinsurance agreements between U.S. and non-U.S. insurers.

In addition, Mr. Lewison also has underestimated the effect the legal system in the United States has had on the insurance industry.

The average product liability award in the United States in 1984 was $1.07 million, up from $345,000 10 years ago; in 1983, 360 personal-injury cases were settled with million-dollar awards or more, 13 times the number in 1975; and last year there was one private civil lawsuit filed for every 15 Americans.

On top of the dramatic increase in the number and size of awards, legislatures and the courts have broadened coverages to include losses and expenses the policies were not intended to cover.

Actuaries are not fortunetellers. We are professionals whose training and experience is in evaluating the current financial implications of future contingent events. This does not mean we have a crystal ball that can inform us when we are pricing a product or setting reserves that the legislature and courts will redefine the intended coverages or that the courts will set new heights in awards.

These are examples of social, not economic, inflation. To expect us to know what the legislatures and courts will do is a little like expecting Noah to have built the ark without a warning from God of the imminent flood.

These social inflationary factors also catch unaware underwriters who are basing their pricing and acceptance decisions on the coverage meant to be written, not what the legislatures and courts will have in mind.

And what part did risk managers play? Never once, when prices were low and coverages readily available at high limits, did I hear of a risk manager turning down a policy because it was inadequately priced. The more knowledgeable risk managers took advantage of the situation but realized what had to come. They prepared themselves for it to the best of their ability and are not the ones now complaining.

Certainly ISO's proposed policy forms will have some language/coverage problems; any new policy form does. They are not "the solution" to the current problems the insurance industry is facing. They are an attempt to buy the industry time to marshal the forces of all concerned to work on the larger problems that require long-term solutions.

We should all help in this endeavor if we want the insurance industry to survive as a private industry. I think the current "crisis" will separate out the professional risk managers from the rest, based on their response to the insurance industry's call for help.

Margaret Wilkinson Tiller
President
Tiller Consulting Group Inc.
Corona del Mar, Calif.

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State guaranty fund system on firm ground

To the editor: The Perspective article on state guaranty funds entitled "Outdated Weapons" (*BI*, June 10) may persuade the casual reader through the clever use of graphics, call-outs and catchy titles that the system of property/casualty guaranty funds in the states is on the brink of disaster.

In fact, the text of the article does not support such a contention and is largely a comparative analysis of the National Assn. of Insurance Commissioners' model guaranty fund law and the New York pre-assessment fund provisions. The authors point to some of the difficulties encountered by guaranty funds, such as designating which one pays a particular claim relating to an insured doing business in many states. However, like the NAIC and insurance industry groups currently reviewing these problems, the writers seem to suggest changes in the current system, rather than its replacement.

No state property/casualty guaranty fund has been unable to meet its obligation, as in the case of the Delaware Life and Health Insurance Guaranty Fund mentioned in the article. That situation prompted efforts currently under way to limit the scope of life and health insurance guaranty funds to the type of protection afforded by their property/casualty counterparts.

The problems of the property/casualty guaranty fund system are not insignificant, but these problems have been identified and thoughtful solutions are being discussed by regulators and the insurance industry.

However, these efforts cannot succeed if the public loses confidence in the system and the institutions supporting it as a result of rhetorical treatment of the subject, as occurred in your recent issue.

David A. Bowers
Chairman
National Committee on Insurance
Guaranty Funds
Chicago

Transcon Lines not suing Transport Indemnity

To the editor: Inclusion of my comments in your article "Policyholders Sue Transport Indemnity" (*BI*, June 3) is somewhat misleading.

While Transcon Lines experienced a great deal of frustration during the period of our cancellation by Transport Indemnity, we are *not* a participant in any class-action lawsuit against them, nor is any such participation contemplated.

Alan Schreibman
Manager-Insurance
Transcon Lines
El Segundo, Calif.

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Hospitals. . .

Continued from page 3

Nashville, Tenn. and Humana Inc. in Louisville, Ky.

Others, like Nu-Med Inc. in Encino, Calif., are scouting the market for similar insurer purchases.

At least three other multihospital systems have formed partnerships with insurers to offer health insurance products to employers: Voluntary Hospitals of America Inc. in Irving, Texas; Universal Health Service Inc. in King of Prussia, Pa.; and HealthWest Foundation in Chatsworth, Calif.

Many hospital systems are expected to follow this lead.

"My guess is they'll go more the venture route rather than acquisition," surmises the hospital federation's Mr. Bromberg. Only the largest hospital chains, he says, have the capital to acquire an insurer and absorb losses until a fledgling underwriting operation becomes profitable.

But it could be worth the cost. Hospital officials and industry analysts predict that in the next 15 years, the U.S. health care market will be dominated by a handful of corporations that have completely integrated health care delivery and financing mechanisms.

"We firmly believe we'll be the largest. We hope to be to our industry what GM is to its," says Dale L. Thomas, chairman of Voluntary Health Plans of America, the newly formed joint venture between VHA and Aetna Life & Casualty Co. of Hartford, Conn.

Others note, however, that hospital systems have entered the insurance arena so quickly that it is too early to determine what success these systems will have in the short run.

"The $64,000 question for hospital management companies is, having done all this, will it fill the beds?" says Margo Vignola, vp at L.F. Rothschild, Unterberg, Towbin, a New York-based securities firm.

Any real success won't be assessable until late 1986, she estimates.

But even if success is not guaranteed, hospital systems are jumping into the insurance business with both feet.

For instance, Hospital Corp. of America acquired 12-year-old New Century Life Insurance Co. in April and has since increased the number of states in which New Century is licensed to sell health insurance to 15 from eight.

HCA, the Nashville-based health care giant, is focusing on licensing New Century only in the states where HCA has a concentration of hospital beds, explains New Century Vp Paul Tidwell.

New Century, with assets of $6 million at the time of the sale, principally wrote reinsurance for annuity coverages written by its former parent, E.F. Hutton Life Insurance Co. of La Jolla, Calif.

HCA will use New Century to underwrite group life and health insurance plans, including traditional fee-for-service plans; separate plans that offer PPOs; and health maintenance organizations.

The acquisition of the insurer enables HCA to provide "a complete package" of health care financing, Mr. Tidwell says. "We want to be competitive to every group we can talk to."

But HCA's programs are just getting off the ground and, despite "a lot of interest," no employer has signed up yet for the group life and health insurance policies that will be available through New Century by Sept. 1.

An HMO operated by HCA is now available in Nashville and Chattanooga, Tenn., and will soon expand to South Carolina, Louisiana and New Mexico.

In addition, HCA has applications to operate HMOs pending in North Carolina, Georgia, Florida, Texas, Arizona and Virginia, and is negotiating to purchase existing HMOs in Virginia, Kansas and Oklahoma.

National Medical Enterprises is using Denver-based Assured Investors Life Co. to ease its way into the health insurance business.

Assured Investors was a small life insurer with a net worth of about $1 million when NME acquired it last month from the Woodmen of the World, a fraternal organization. Under NME's ownership, the insurer will write group health and life insurance policies and will be used to reinsure NME's HMO subsidiary, AV-MED.

"If you're going to compete in this market, you almost have to have an insurance company," says William K. Piche, president of NME's Health Plans & Systems Group.

NME, the nation's fourth-largest multihospital system, will soon increase AIL's net worth to between $12 million and $15 million, according to Mr. Piche.

NME seeks to offer employers a wide range of products including traditional fee-for-service plans, HMOs and PPOs to employers of all sizes.

By Aug. 1, NME expects 5,000 people to be covered by life and health policies written by AIL and it expects 700,000 to be covered by its health care products in five years.

Mr. Piche predicts NME's insurance products will generate annual premiums of $200 million in five years, Mr. Piche said.

The insurer, now licensed in 13 states, has an application pending in Florida and will seek licenses in three or four other states where NME has large operations, Mr. Piche explains.

NME's insurance venture will initially be a "break-even" situation, but should be profitable within one to three years, Mr. Piche predicts. The company expects to hire three or four underwriters over the next year.

Mr. Piche estimates NME's insurance products can save employers 10% to 20% on their annual health care tab, depending upon their current plan.

Another hospital system, American Medical International, acquired Los Angeles-based Fidelity Interstate Life Insurance Co. for $10 million last December. The insurer, which is licensed in 45 states and the District of Columbia, will be used to write group health products under AMI's AMICARE banner, including a PPO program, an HMO and a Medicare supplemental plan.

The three AMICARE programs, which were first offered last month in Miami, have since been offered in Denver and will be available in Tampa and Southern California by September. The company hopes to be in 20 major markets by fall 1986, estimates Charles P. Reilly, senior executive vp and chief development officer.

Since the acquisition of the insurer, AMI has worked to build "extensive insurance expertise," Mr. Reilly says. AMICARE has hired an actuary, who will supervise six underwriters to be hired by September 1987. Twenty-five additional underwriters will subsequently be hired over a three year-period.

AMICARE products will be marketed—through both national and regional insurance brokers—to employers of all sizes, Mr. Reilly explains.

AMI will also offer its PPO to self-insured clients and will offer third-party administration services to these employers, he said, adding that AMI is now expanding its existing claims processing capabilities.

Large, self-insured clients may be drawn to the AMICARE PPO as much for its claims handling and

Continued on page 12



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A FEW WORDS ABOUT OVERTREATMENT.



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Continued from page 1C

utilization review procedures as for its cost reduction potential, Mr. Reilly suggests.

Mr Reilly hesitates to predict exactly what an employer might save on his health care bill by enrolling in AMICARE, but estimates the savings would range from 15% to 30% depending on the employer's current plan.

Unlike NME and HCA, AMI does not plan to offer life insurance products.

These three hospital systems all face competition from Humana Care Plus, a hybrid HMO-PPO program that Humana Inc. started in January 1984.

Humana will have invested $10 million in Humana Care Plus for the year ending in August, according to Henry Werronen, the company's senior vp and chief operating officer of the company's Group Health Division.

Humana Care Plus is now established in 40 metropolitan areas. In some areas, Humana Care Plus operates as a health maintenance organization, while in other states the plan is a preferred provider organization.

Nationwide, 6,800 employer groups have enrolled a total of 260,000 lives in the program; about 30,000 new lives are enrolled monthly. The program is marketed both directly and through insurance brokers.

Humana Care Plus guarantees businesses with less than 50 employees that their rates for two years will not raise more than the Consumer Price Index.

Larger employers are eligible for a guaranteed rate for up to four years.

Humana acquired Commercial State Life Insurance Co. in June 1984 to write Humana Care Plus products when Humana saw how much it had spent to start insurers from scratch in Florida and Nevada.

Meanwhile, HealthWest considered acquiring an insurer—and may still do so—but found such purchases problematic "because if we're directly competing with insurers, they may not want to contract with us (for other PPO operations)," explains Senior Vp Layton Crouch.

The company sought "a working approach that doesn't alienate the big insurance companies" and is now concentrating on joint ventures, he says.

HealthWest is developing three or four joint ventures and recently submitted its first program to the Washington Insurance Department for approval. This partnership with Whatcom Medical Bureau, a Blue Shield plan in Whatcom County, Wash., hopes to offer a Medicare supplemental plan to senior citizens through a PPO arrangement.

HealthWest is also developing an HMO, called CareAmerica, that is expected to open in Southern California in September before being introduced in other markets nationwide.

Voluntary Health Plans of America, the joint venture between Voluntary Hospitals of America and Aetna Life & Casualty Co. was formed in Dallas on May 29 with $80 million, to be contributed equally by VHA and Aetna over an 18-month period.

VHPA will offer a guaranteed-premium PPO product that is designed to replace an employer's traditional fee-for-service or HMO programs.

VHPA has not yet named its PPO, but hopes to do so by early next month, says chairman Mr. Thomas. The PPO will guarantee employers a limited annual premium increase—possibly restricted to the increase in the CPI for two to four years—in exchange for a guarantee that a certain percentage of the services covered under the plan—perhaps 50% to 75%—will be performed at VHA facilities, Mr. Thomas explains.

The PPO will be available Sept. 1 in Louisville, and shortly thereafter in Phoenix and Chicago before VHPA seeks nationwide enrollment, Mr. Thomas explains. He expects it to be available in 15 cities by the end of this year and in another 15 to 20 next year.

Several Fortune 100 companies have expressed interest in the program, according to Mr. Thomas.

VHPA may have success with very large corporations because of VHA's size and geographic distribution: About 500 VHA and other hospitals and 50,000 physicians nationwide are now involved. Mr. Thomas expects 700 to 1,000 hospitals to join the program by the end of 1986.

In the next year and a half, VHPA will hire 1,500 to 2,000 employees and establish 32 regional offices and four divisional offices in addition to its Dallas headquarters. Aetna employees will temporarily serve as VHPA underwriters until permanent underwriters can be hired.

About 40 VHA employees have moved to the new company.

Mr. Thomas said he expects the venture to be profitable in 1987.

Part of the arrangement calls for VHA to form a reinsurance company, called VHA Enterprises Insurance Co., which will reinsure a portion of the coverage written under the VHPA program. Mr. Thomas said, though Aetna will provide catastrophe reinsurance coverage.

Universal Health Systems in King of Prussia, Pa., is forming a joint venture with Houston-based Philadelphia American Life Insurance Co.

The two companies are offering Universal Health-Share, a fee-for-service group health plan underwritten by PALICO with a PPO option, that was test-marketed last month to employers in Las Vegas and Reno, Nev.

The companies, offering access to five hospitals, hope to have 10,000 lives covered by the end of this year, according to Robert Duggins, vp-marketing at PALICO. They are targeting businesses with 10 to 100 lives.

The venture will likely move beyond Nevada before the end of the year, says Mr. Duggins. Illinois and Louisiana also are possible areas for expansion, he says.

Besides purchasing its own underwriter, Humana is also pursuing a joint venture with an insurer: Mutual Benefit Life Insurance Co. in Newark, N.J.

Last month, the two companies began a six-month "cross-marketing" pilot program in Denver and Louisville in which each entity would market the other's products as well as its own.

For example, Humana is pitching Mutual Benefit's life and disability insurance products to clients enrolled in Humana Care Plus, while Mutual Benefit is trying to sell Humana's group health products to its group life clients.

While the hospital systems generally expect to make a profit on their insurance business once it is established, other observers believe the products won't be profitable and will only serve to attract new patients to the hospitals.

"That's clearly what it is. Those

Continued on page 14

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PPOs facing potential antitrust worries

By STEPHEN TARNOFF

Preferred provider organizations face potentially significant antitrust problems, but the pitfalls can be avoided if the PPO is structured carefully, antitrust attorneys say.

Provider-sponsored PPOs face the greatest potential of violating federal antitrust laws that ban price fixing and other anti-competitive activities, attorneys say.

However, even PPOs organized by employers or their insurers can violate antitrust laws, and employers that merely join PPOs sponsored by others also could be prosecuted if the PPO is found to violate antitrust laws, attorneys warn.

So far, however, apparently no PPO has been found liable for antitrust violations. Furthermore, in business review letters, the Justice Department has informed two sponsors that their proposed PPOs would not be in violation of antitrust laws and in fact, aided competition (see story, page 22).

However, in addition to the federal government monitoring of the activities of PPOs, private parties—such as hospitals—have filed lawsuits alleging antitrust activities against PPOs.

For example, last September, Methodist Medical Center of Illinois filed an antitrust lawsuit against two local hospitals in U.S. District Court in Peoria seeking an injunction to block the operation of a preferred provider arrangement (*BI*, Oct. 8, 1984).

The suit, which subsequently was settled, charged that the two hospitals agreed not to compete with each other in providing hospital services to third-party payers interested in preferred provider agreements, but instead, "contracted, combined and conspired" to restrain competition and monopolize the market through preferred provider arrangements.

And in a suit brought by 30 hospitals against Blue Cross/Blue Shield of Indiana, the U.S. District Court for the Southern District of Indiana last March denied a preliminary injunction that would have enjoined operation of a BC/BS-sponsored PPO on the basis that it violated federal and state antitrust laws. That case is now on appeal before the U.S. 7th Circuit Court of Appeals.

Among the reasons cited by the court for its decision was that the PPO did not have monopoly power or the ability to exclude others from the market.

For the most part, antitrust litigation against PPOs has been limited.

"Overall, at least in the federal courts, PPOs have not been a significant bone of contention," says Steve Kramer, an attorney with the Antitrust Division of the U.S. Justice Department.

But, he notes, "there are some PPOs under investigation" for potential antitrust violations.

Attorneys say a key question in determining whether PPOs run afoul of antitrust laws is whether they hinder competition through price fixing or monopolization, or by excluding some hospitals or physicians from the PPO or preventing participating providers from joining other PPOS.

These activities are prohibited by the Sherman Antitrust Act, which prohibits contracts, combinations or conspiracies that result in restraint of trade or monopolies or attempts to monopolize markets.

In addition, PPOs can violate sections of the Clayton Antitrust Act, which prohibits mergers or acquisitions that substantially lessen competition.

Various state antitrust laws also can be invoked.

In civil actions, companies found guilty of violating federal antitrust laws can be hit with injunctions to stop doing business, triple damages and punitive damages. In criminal suits, they can be subject to substantial fines and imprisonment.

PPOs face the greatest potential of violating antitrust laws when the participating providers—physicians and/or hospitals—agree on set prices to charge insurers, employers or other payers that use the PPO.

"Price fixing is the major problem that will crop up whenever you have PPOs," says Washington attorney Peter M. Kazon, with the firm of O'Connor & Hannan.

The concern that PPOs could be accused of price fixing stems from a U.S. Supreme Court ruling involving a program similar to a PPO.

In 1982, the Supreme Court ruled in *Arizona v. Maricopa County Medical Society* that it was automatic price fixing for physician members of medical care foundations to agree on maximium prices for services to policyholders of foundation-approved insurance plans.

However, the 4-3 decision did not clearly answer how a PPO should be structured to conform with antitrust laws.

Still, attorneys say PPOs can be structured to avoid or at least lessen the likelihood of antitrust charges for price fixing.

For one thing, a PPO can be structured so that competing providers do not agree among themselves on what prices to charge, but instead individually contract with buyers or third parties that set prices, said Richard C. Warmer, an antitrust attorney with the Washington office of the firm of O'Melveny & Myers.

"In this way, the PPO could not fairly be alleged to be a mechanism for a price-setting conspiracy," explained Mr. Warmer.

Arthur N. Lerner, assistant director for health care in the Bureau of Competition of the Federal Trade Commission, agrees that illusions of price fixing can be avoided.

If the PPO is established and controlled not by providers but by an insurer, employer or entrepreneur, it can decide on reimbursement levels for providers who agree individually to participate in the program, he adds.

Competing physicians or hospitals also can form a joint venture to avoid price-fixing conflicts, attorneys say.

Since the antitrust laws are intended to prevent competitors from uniting to fix prices, the joint venture essentially creates one entity, although composed of many providers, that can negotiate prices with buyers on a one-to-one basis.

However, to establish a genuine joint venture, providers must pool their capital and share the profits and losses, attorneys say.

"There must be a real sharing of potential profit and loss to have some type of joint venture," says J. Mark Waxman, an antitrust attorney with the Los Angeles firm of

Continued on page 20

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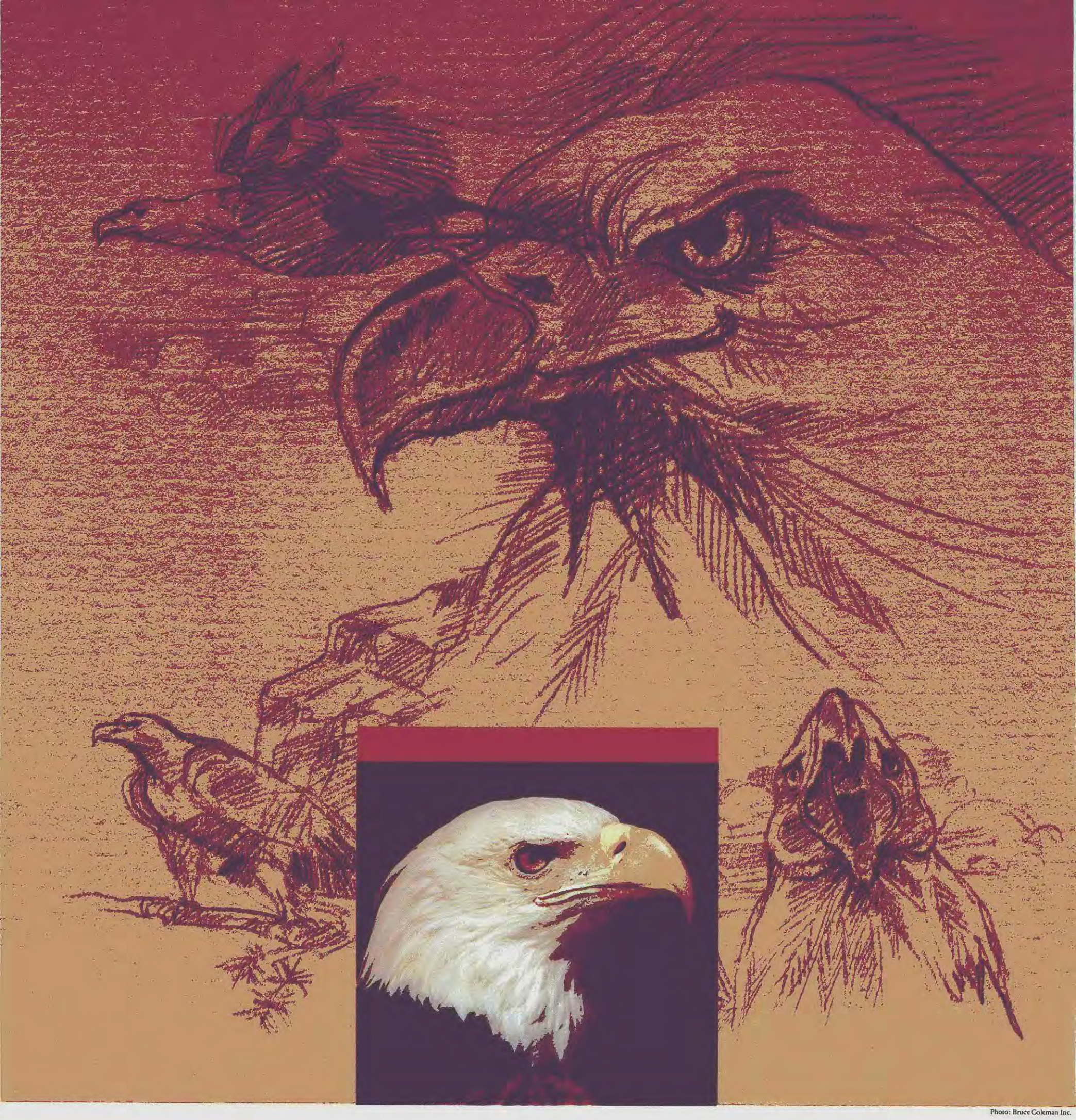


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Antitrust worries

Continued from page 16

Weissburg & Aronson.

Under the Supreme Court's opinion in the Maricopa case, "competitors who do achieve sufficient operational integration by forming some sort of partnership or 'joint arrangements in which they pool their capital and share the risk of loss' do not face per se condemnation if they jointly set prices," adds Mr. Lerner.

If a provider-sponsored PPO takes the above steps, it may not avoid all antitrust challenges, but at least it will not be found automatically liable for price fixing.

Instead, a more lenient "rule of reason" standard, which weighs the pro-competitive and anti-competitive effects of the PPO, would be used if the PPO were challenged.

And, it is possible for PPOs to set prices and not be called on the carpet for antitrust violations.

"If there is a joint venture, risk sharing, and the PPO is a new product competing in the marketplace, I think it is lawful for physicians to agree on a maximum fee schedule," says Charles D. Weller, an antitrust and health care attorney with the Cleveland firm of Jones, Day, Reavis & Pogue.

"I would say that a provider-sponsored PPO could include an agreement on maximum fees negotiated with an employer and not violate the antitrust laws if it doesn't include a substantial percentage of providers in town."

Provider-controlled PPOs definitely also can limit their antitrust liability by restricting the number of competing providers in the PPO, attorneys agree. If the providers in the PPO represent too large of a share of the market or if participating hospitals or doctors are barred from joining other PPOs, the PPO could be construed to inhibit competition under antitrust laws.

For example, when the U.S. Justice Department notified the Stanislaus Preferred Provider Organization that it was prepared to file an antitrust suit against it, the department noted the PPO enrolled about 50% of the physicians practicing in or near Modesto, Calif., and about 90% of the physicians practicing in or near Turlock, Calif.

The PPO, which subsequently disbanded, also required its physicians not to contract with other PPOs or other health care delivery organizations (*BI*, Oct. 29, 1984).

Although there is no established benchmark, attorneys say if the number of physicians in a PPO represents more than than 20% of the market, it could present antitrust problems.

Excluding a provider from a PPO or terminating its membership also can trigger antitrust charges, says Douglas L. Elden, a health care attorney with Altheimer & Gray in Chicago.

However, establishing objective criteria for the exclusion of providers, such as physical limitations of the PPO, can head off problems, adds Richard A. Hinden, an attorney with same firm as Mr. Elden.

He also recommends objective standards for the appointment of providers to the PPO and some due process protections for providers challenging exclusions or terminations from the PPO.

While the precautions cited by attorneys are geared toward provider-sponsored PPOs, some also say that employer- or insurer-sponsored PPOs can run the risk of violating the antitrust laws by fixing prices in certain instances.

"It is as much a violation for buyers to agree on the price they will pay as for sellers to agree," says Rick Pfizenmayer, a Washington attorney with the law firm of Squire, Sanders & Dempsey.

Thus, if several insurance companies, self-insureds or other purchasers band together to start a PPO and use their buying power to fix prices, it can be a violation of the antitrust laws.

However, some attorneys say this is not likely and they know of no such antitrust cases involving PPOs.

Mr. Weller points out that almost all employers sign contracts individually with PPO providers because of the differing circumstances of each employer.

Some attorneys also suggest if an employer joins a provider-sponsored PPO, it could share any antitrust liability the PPO might engender.

Based on decisions in other areas, "yes, a buyer can be both a victim and viewed as a co-conspirator," said David Narrow, an attorney with the Bureau of Competition with the FTC.

However, if a purchaser keeps an arm's-length relationship with the PPO, such liability can be avoided, says Mr. Weller. ■



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Despite antitrust threat, PPOs can foster competition: U.S.

By STEPHEN TARNOFF

Although preferred provider organizations do face some potential antitrust liability, the federal government also recognizes they can increase competition.

"In general, it seems clear that PPOs controlled by insurance companies, third-party administrators or independent contractors have real pro-competitive potential and in most cases pose little risk of anti-competitive harm," J. Paul McGrath, former assistant attorney general for the Justice Department's Antitrust Division, said in a speech this spring.

"Moreover, although PPOs created and controlled by providers present somewhat more of an antitrust risk, and thus are subject to somewhat greater scrutiny, we recognize that they too generally provide significant competitive benefits."

In at least one case, the government has threatened to sue a Modesto, Calif.-based PPO because of alleged antitrust violations. The Stanislaus Preferred Provider Organization subsequently disbanded (see story, page 22).

However, in 1983, the U.S. Justice Department issued two business review letters at the request of two PPO sponsors, approving PPOs that were structured to include many of the characteristics that attorneys say are necessary to avoid antitrust liability.

One involved a PPO established by Health Care Management Associates in three counties in southern New Jersey.

While recognizing a PPO, as an organization of competing providers, could present antitrust concerns, William F. Baxter, a former assistant attorney general for the Antitrust Division pointed out in the business review that HCMA:

- Was not affiliated with any providers or health care group.
- That contracting providers would not vote on or collectively influence fee levels.
- That the PPO would not be involved in setting fees but that fee discounts would be individually negotiated.
- That HCMA would not disseminate fee information among participating providers but only payers.

The department also noted the plan would be offered in a metropolitan area with many providers and would be limited to a maximum of 20% of all providers, and that it was unlikely the PPO would dominate the area or stifle development of competing systems.

Providers who sign with HCMA's PPO also could join other, competing organizations.

Given these facts, Mr. Baxter said, "Operation of this PPO does not appear likely to facilitate collusive behavior among providers or otherwise eliminate effective competition in any geographic area."

In another review, the department said it would not challenge a PPO marketed by Hospital Corp. of America in Nashville, Tenn.

The plan called for HCA to create a subsidiary, Medical Services Associates Inc., to develop and market a PPO in two Florida counties.

MSA was to negotiate individually the amount of the discount offered by each affiliated doctor and hospital, and the size of the discounts could vary among providers and hospitals.

Providers could affiliate with other PPOs or HMOs or serve insureds under a different type of health benefit program while participating in the MSA PPOs.

The letter noted that the Justice Department did not intend to institute enforcement proceedings to challenge the PPO because it appeared to contain enough safeguards to avoid reducing competition.

However, Mr. Baxter also said that the PPO could still present antitrust concerns in the future, particularly since HCA did not limit the number of physicians or hospitals with which MSA may eventually contract.

If a large percentage of hospitals or doctors in any geographic market became affiliated only with MSA, the antitrust division probably would further consider whether MSA impedes development of other PPOs, or reduces competition, Mr. Baxter added. ■



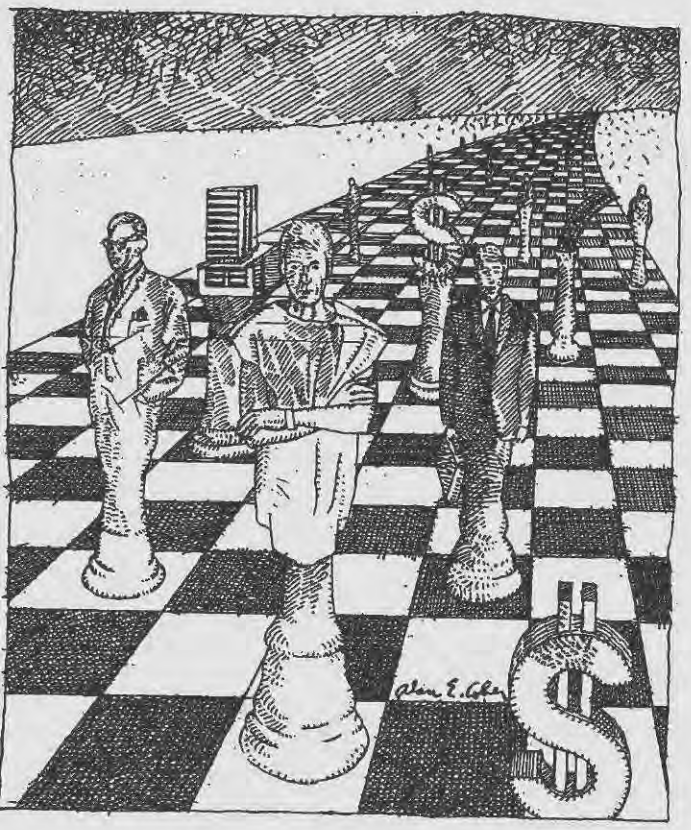
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Many states pass bills to bolster PPO growth

By JULIE TRUCK

In an attempt to control the rising costs of health care, an increasing number of states are taking steps to encourage the growth of preferred provider organizations.

During the 1985 legislative session, at least six states passed PPO legislation and nine others considered bills to further the growth of PPOs.

In addition, a bill to encourage PPO growth is pending in the U.S. Congress, and the National Assn. of Insurance Commissioners has appointed a study group that may draft a model law on PPOs.

A PPO is an arrangement between a group purchaser (either an employer or its health insurer) and a provider in which health care services are bought for a specific group at a pre-negotiated, discounted rate.

And, because health plans normally provide an economic incentive for employees to use PPO providers, participating providers are rewarded with a larger patient supply.

The movement to encourage PPOs is the result of growing employer interest in them, prompted by wildly escalating health care costs, observers say.

"Employers are beyond the point of holding the status quo. They're interested. . .in a delivery system that stimulates competition and simultaneously holds down the costs," said Bill Phillips, president of Phillips & Associates, a Bethesda, Md., consulting firm specializing in managing PPOs and health maintenance organizations.

"PPOs have been shown to do both and do it fairly efficiently," he added.

Most of the legislation considered by the states was designed to amend parts of state insurance codes that might restrict PPOs, such as regulations that guarantee an insured's freedom of choice of a provider or prohibit discrimination against providers that are not in the PPO, explained Sharon Graugnard, director of government relations for the American Assn. of PPOs in Washington, a trade association that tracks both state and federal PPO legislation.

A PPO 'stimulates competition and simultaneously holds down the cost,' said Mr. Phillips.

Many state insurance codes prohibit an insurer from restricting the providers from whom an insured may receive health care, she explained.

While a PPO does allow the insured the option to receive care from a provider not in the organization, opponents of PPOs question if the insured will do so, given the economic incentive to choose a provider in the PPO.

Allegations of discrimination arise when the rate of payment to a provider for a service depends on whether they are members of the organization, sources say.

"The PPO legislation is meant to redress those little problems. It (the legislation) is not meant to override the codes, just amend them," Ms. Graugnard added.

However, the federal bill currently pending would pre-empt state insurance codes.

The bill, H.R. 733, was introduced in January by Rep. Ron Wyden, D-Ore. It would strike down state laws that discourage the formation of PPOs, according to an aide to Rep. Wyden.

The bill would provide PPOs with protection from state insurance codes that might otherwise restrict them, the aide explained.

Currently, the bill is in a subcommittee of the House Energy and Commerce Committee.

And, the NAIC, an association of state insurance regulators, may consider developing model legislation on PPOs, said Jonathan Neipris, assistant to Pennsylvania's acting insurance commissioner, William R. Muir Jr.

Last month the NAIC's State and

Continued on page 26

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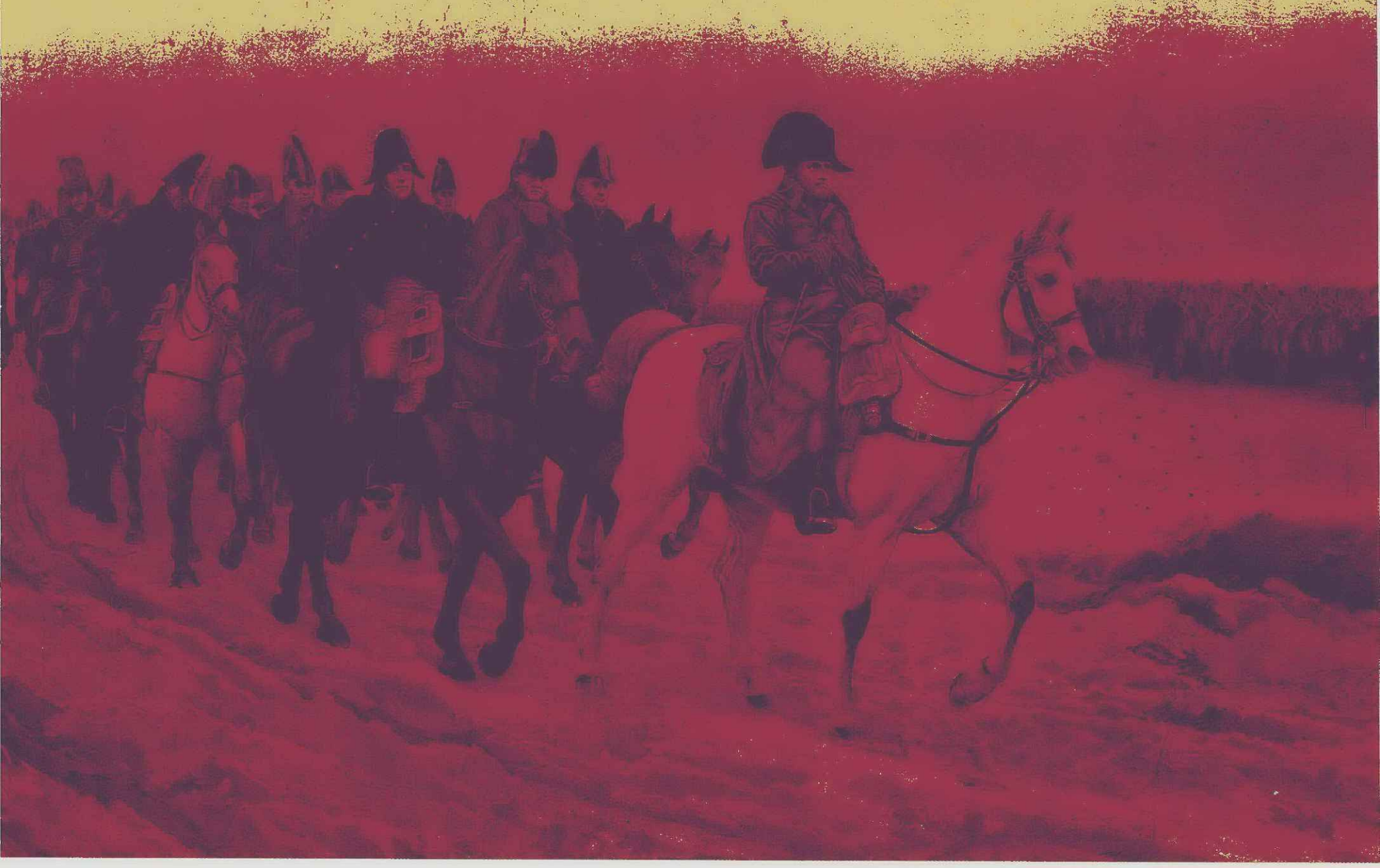
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State actions

Continued from page 24

Federal Health Insurance Legislative Policy Task Force, which Mr. Muir chairs, decided to form a subcommittee to study the issue and make recommendations to the NAIC for a possible model law (*BI*, July 8).

Mr. Neipris explained that the NAIC wants to prepare a model law because many states are looking for definitions and standards for PPOs.

"All the legislation enacted to date has more than just a sentence," allowing formation of a PPO, Mr. Neipris said.

"It often describes what a PPO is, sets standards or, in some cases, creates a regulatory framework," he added.

Prior to the 1985 state legislative sessions, about nine states had already adopted legislation expressly allowing the formation of PPOs and setting up regulations.

California, which in 1982 became the first to pass legislation, soon was followed by Indiana, Florida, Louisiana, Minnesota, Mississippi, Nebraska, Virginia and Wisconsin.

And, during 1985, at least five states—Kansas, New Hampshire, Maryland, Utah and Wyoming—enacted PPO laws.

In Illinois, two bills were passed and are awaiting the governor's signature.

In Illinois, H.B. 2089 would amend the state's insurance code to authorize insurers to offer policies that provide alternative rates of payment for preferred providers.

And, S.B. 1311 would amend a section of the insurance code that prevents doctors from participating in a PPO. Also under S.B. 1311, minimum solvency requirements for PPOs would be set by the Illinois Department of Insurance, according to Pam Mitroff, manager of health care cost management for the Illinois State Chamber of Commerce.

The bills, which were passed in late June, have 30 days to be forwarded to the governor.

In Kansas, S.B. 19, which was signed in May and is now law, allows an insurer to contract with a provider for alternate rates of payments and to pass on these lower rates to the insured, according to

'All the legislation enacted to date has more than just a sentence' on PPOs, Mr. Neipris says.

Richard Huncher, supervisor of the accident and health division of the Kansas Insurance Department.

At the insurance commissioner's request, the contract between the insurer and the providers must be submitted to the Insurance Department for scrutiny, Mr. Huncher added.

Maryland's enactment of H.B. 1070 and S.B. 298, mandates that payments to non-preferred providers may not be less than 80% of the amount that would be paid to a preferred provider.

However, Maryland's insurance commissioner can alter the 80% reimbursement requirement for institutional providers such as hospitals.

In New Hampshire, enactment of H.B. 80 requires that insurers cannot keep from joining a PPO any provider willing to meet the terms and conditions of the PPO agreement.

In addition, the new law prohibits insurance companies from limiting or denying reimbursement to an insured because the insured was referred to a non-PPO provider by a physician or hospital that belongs to the PPO.

Utah's new insurance code, which will take effect in July 1986, also requires that any health care provider willing to meet the terms of the PPO must be allowed to participate, said Peter Singer, director of the Utah Health Cost Management Foundation, a state coalition composed of business, government and labor representatives based in Salt Lake City.

The law also requires that payments to a non-preferred provider must be at least 75% of the fee a preferred provider would receive, he said.

Wyoming's H.B. 0293, which was adopted in February and took effect immediately, mandates that the PPO contract must be held by the employer or group, rather than by an insurance company. However, the insurance company is allowed to negotiate and administer the policy to provide incentives for the insureds. ■

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Anxious employers jump feet first into PPOs

By MICHAEL BRADFORD

Employers are stimulating the development of preferred provider organizations.

Faced with continually escalating health care costs, employers in some areas aren't waiting for PPOs to appear. Instead, they are pressuring their group health insurers to set them up, or they are working directly with hospital and physicians to develop PPOs.

"There is a great deal of activity and conversation about PPOs," says John D. Moynahan Jr., senior vp of group life and health operations at Metropolitan Life Insurance Co. in New York. "There has been a lot of interest among employer coalitions."

'Hardly a day goes by without a phone call from someone who wants to know how we did it,' says George Corkum, president of Fringe Benefit Consultants Inc., who helped establish the Broward County school system's PPO.

Metropolitan began a PPO in the Miami area at the urging of the Dade County School District.

"We are seeing a significant increase in requests for PPOs," reports a spokesman for The Travelers Insurance Cos.

In South Florida, where there was a noticeable lack of PPOs until last year, employers are largely responsible for getting the ball rolling.

Since two PPOs in Miami began operating in 1984—and began to produce savings—other area employers have jumped in, and PPOs have begun springing up there like bananas in the tropical sun.

The two initial PPOs, which were established for public school systems in Dade and Broward counties, are among the first employer-driven plans to take shape in the United States.

Both school systems are members of the Florida Health Action Coalition. Since the districts' pioneering PPO efforts, eight more coalition members have introduced PPOs through their insurers and others are considering instituting the plans.

John C. Erb, executive director of the 35-member Florida health coalition, pointed out that "there weren't any PPOs" in Miami until Susan Weiner, executive director of risk management for Dade County Public Schools, worked with Metropolitan to establish a program for the system (*BI*, April 15).

"She was out there on the point," Mr. Erb said. "It's prompted a lot of others to start up PPOs."

Ms. Weiner introduced the PPO concept to the coalition in 1983 and led bargaining efforts with labor unions and employee groups in the Dade County school district. After reaching an agreement with the unions and working closely for several months with the coalition and Metropolitan, Ms. Weiner's efforts were rewarded. On Jan. 1, 1984, Metropolitan had its PPO—Met-Elect—in place for the school system

If employees use the PPO, the plan covers 100% of medical costs. If an employee uses a physician or hospital that is not a preferred provider, the employee pays 20% of the medical bill.

In its first year, Met-Elect produced savings of $2.8 million in hospital costs for the school system. Metropolitan has since put the PPO into effect for employees of Metropolitan Dade County and Miami-Dade County College.

At the same time the Dade PPO went into effect, a similar program was instituted by the Broward County school system.

George Corkum, president of Fringe Benefit Consultants Inc. in Fort Lauderdale, helped officials of the Broward system design the PPO, which later was turned over to Travelers to administer. The plan is nearly identical to the Metropolitan PPO except that Broward employees must pay a $10 fee for each of the first 10 visits to a preferred provider while the Metropolitan plan pays for these visits.

In its first year, the PPO helped reduce the number of health care claims filed by 9.5%, compared with 1983's claims activity. The amount of claims paid fell $49,741 in 1984 to $11.94 million.

The plan, which stresses pre-admission certification and second surgical opinions for the 10,500 persons covered by it, helped reduce the number of surgical procedures 38.5% in 1984 to 1,728 from 2,809 the year before.

Mr. Corkum noted that the Broward County schools PPO has stirred interest among other employers who have noted its success. "Hardly a day goes by without a phone call from someone who wants to know how we did it," he said.

Other employer-driven PPOs in the Miami area that are now administered by insurance companies include Prudential Insurance Co. of America's PruNet program for Burdine's of Florida, a division of Federated Department Stores, and a Blue Cross/Blue Shield of Florida plan for the University of Miami and Florida state employees.

CIGNA and Aetna Life & Casualty Co. also have started PPOs in South Florida.

Mr. Corkum, who also is the consultant for the Dade County schools, said the Miami-area PPOs are also noteworthy because they were developed by members of the public sector.

"The public sector is not known to have such adventuresome individuals as pioneers. But it was more of necessity. These two school systems were hurt by the cost of medical care," he explained.

Mr. Corkum said that even though South Florida has seen an increase in the number of PPOs in the last 18 months, more employers should be taking the initiative to cut their health care costs.

"A lot of people should be contracting that are holding back," he said. "With the success of Dade and Broward counties, I can't follow that. They may have an erroneous perspective of PPOs."

Metropolitan's Mr. Moynahan pointed out that some employers are being frustrated in attempts to set up PPOs because they are

Continued on page 30



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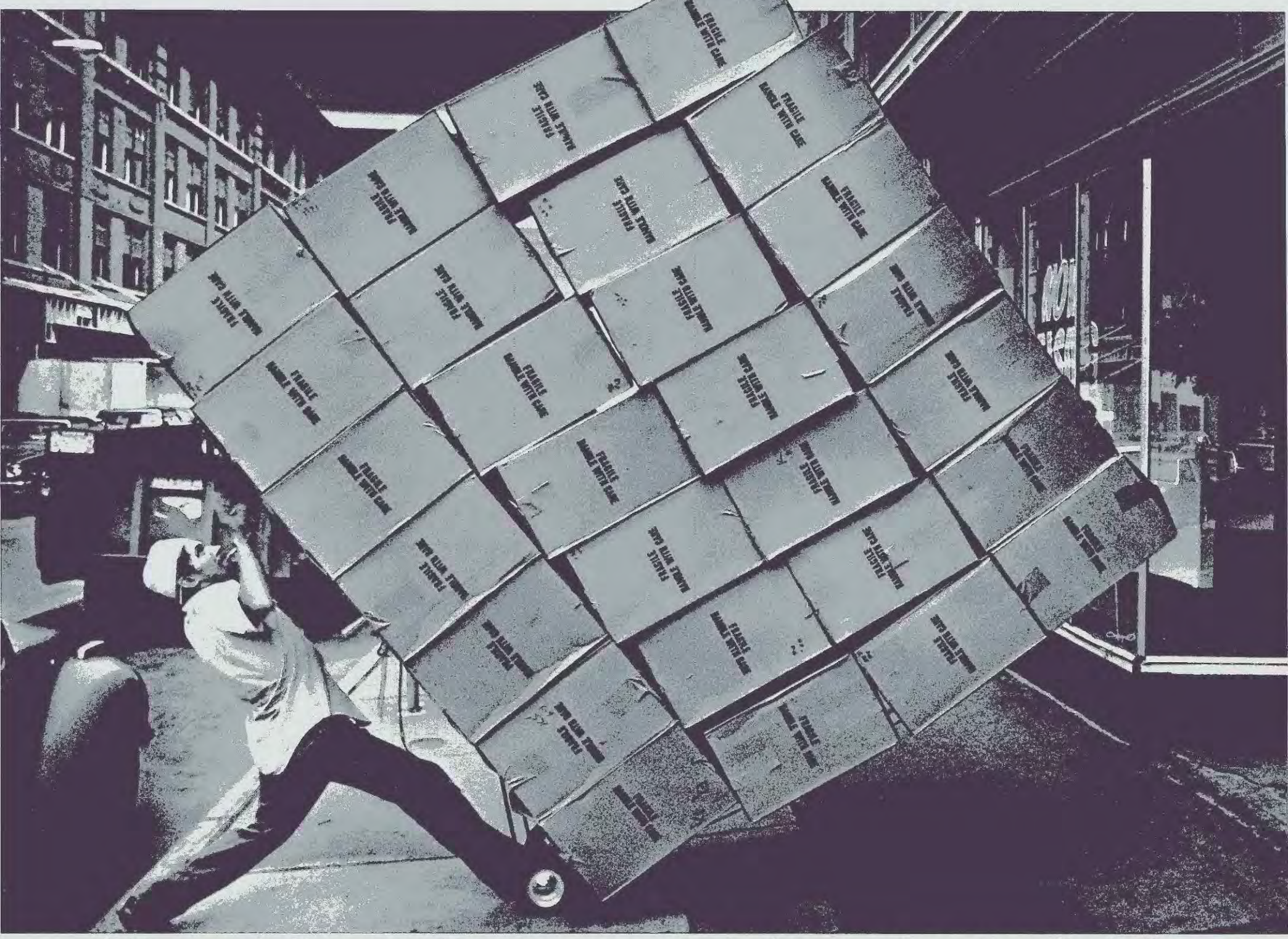
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Employer PPOs

Continued from page 28
locked into plans that were established during bargaining with unyielding unions.

"A lot of them would like to put in PPOs but they are saddled with these plans," he said.

Meanwhile, an employer-sponsored coalition in San Diego has been growing steadily since its formation about two years ago. And, Stouffer Corp. in Ohio, which established its own medical and dental PPOs in 1982 and 1983, now has broken new ground with a mental health PPO.

The Community Care Network, a PPO administered by the San Diego Community Health Care Alliance, includes 19 hospitals and 1,000 physicians and covers about 40,000 employees of 30 coalition members from San Diego County.

George Murphy, director of management development of Cubic Corp. in San Diego and a spokesman for the alliance said the PPO is providing health care at a 20% savings compared with the cost of care from providers not in the PPO.

The health care alliance formed CCN with the help of a $100,000 grant from the Robert Wood Johnson Foundation, a philanthropic health care foundation (*BI*, Oct. 31, 1983).

Stouffer, a food, restaurant and hotel company based in Solon, Ohio, began its own medical and dental PPOs in 1982 and 1983. Realizing that some health problems are not covered by those programs, Stouffer has developed a new PPO to cover expenses for mental health and chemical abuse treatment.

The health care benefit, self-funded like the others offered by Stouffer, was made available to employees July 1.

Donald Flagg, vp of human resources at Nestle Enterprises, a division of Stouffer, said the new PPO was two years in the making and "we have high hopes for it."

Mr. Flagg said the PPO was developed because "these are problem areas that are not covered under other PPOs."

The new PPO stresses evaluation, Mr. Flagg noted, and it pays for most costs connected with initial visits to a physician or psychologist that will determine if a patient has a mental health or chemical abuse problem.

Because hospitals traditionally require a 28-day stay for alcohol abuse patients, the evaluation visits can help eliminate that "automatic moneymaker" for hospitals, says Mr. Flagg, adding, "In many cases, it's totally unnecessary."

As a result of the evaluations, patients may be assigned to outpatient treatment, or "three to five days in the hospital, or even as much as 45 days," Mr. Flagg remarked. "But evaluation makes the treatment fit the problem and provides a better quality of care."

Although it's too early to tell if the mental health PPO will save money, Mr. Flagg said the medical and dental PPO programs are providing care for approximately half the cost of non-PPO care.

Currently, the PPOs are available only to Stouffer employees in the Cleveland area. But, Stouffer is considering alternative delivery systems in other locations, too, Mr. Flagg said.

He said he is aware of growing concern among employers that are becoming much more aware of the need to find ways of lowering health care costs.

"There is definitely pressure from employers to get alternative systems in place," he remarked. "We get a lot of calls from people who are interested in what we've done."

Brian Barger, president of the Morgan Bigae Institute, a health care consulting and management company in Cincinnati, said he has noticed an increase in the number of employers that are encouraging groups of physicians to set up PPOs.

"By and large, I think most employers seem to be interested in stimulating PPO development," as opposed to taking the direct route and forming the programs themselves, according to Mr. Barger.

He said more employers are approaching physicians to set up PPOs in various areas across the country.

Mr. Barger noted that a medical alliance group in Michigan that is an institute client is currently studying the feasibility of forming a PPO after being approached by a group of employers.

Mr. Barger predicts that employers will recognize PPOs as "one of the most important kinds of cost containment," as they look for alternative methods of providing health care.

According to those that have implemented PPOs, points to stress in setting up a successful PPO are:

- The program must be right for the company and its employees. Don't offer something that isn't needed or wanted by employees.
- Communications between management and employees are crucial. "You have to get a commitment from management first," said one employer that helped design a PPO. "Then it's got to filter down effectively."
- The location of the providers in the PPO must be convenient to employees' homes.
- A good data base must be established for health care statistics. Data can be obtained through employer health care coalitions to help the employer decide which providers are cost-efficient and where needed services can be found.
- Quality providers that understand that health care costs must be kept in check are a must.
- An in-house person should be designated to monitor providers and hospitals and keep track of charges. The "sentinel effect" should produce added savings. ■

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Hospitals turn to PPOs to bolster business

By STEVE TARAVELLA

'The window of opportunity for hospitals to get involved in PPOs is closing very rapidly. If they don't get involved quickly, they could find themselves locked out,' says Sharon Graugnard, AAPPO's director of government relations.

One of the most popular ways for hospitals to combat declining occupancy rates is by forming a preferred provider organization to guarantee them a share of the market.

About 60 of the PPOs operating today have been organized by hospitals. And, an additional 60 or so have been formed jointly by hospitals and physicians.

These PPOs are competing with those formed by employer coalitions, insurance companies and third-party administrators for corporate health care dollars.

The number of individual hospitals participating in PPOs will increase "dramatically" in coming months, predicts Sharon Graugnard, director of government relations for the American Assn. of Preferred Provider Organizations in Washington.

However, the total number of hospital-driven PPOs will decrease, as the individual hospital-driven PPOs merge to form state, regional and national PPO networks, Ms. Graugnard predicts.

Perhaps the best example of this consolidation is the PPO Alliance in Southern California.

The 108-hospital PPO opened its doors in April 1984, after HealthWest Foundation in Chatsworth, Calif., Adventist Health Systems-West in Roseville, Calif., and the Lutheran Hospital Society of Southern California consolidated their individual PPOs.

In some instances, however, the three systems still market their PPOs separately.

"The windows of opportunity for hospitals to get involved in PPOs is closing very rapidly. If they don't get involved quickly, they could find themselves locked out," observes Ms. Graugnard.

Hospitals that don't recognize the need to form PPOs "are kidding themselves," she says.

"If they're going to survive, they've got to be competitive."

Most of the major hospital management companies, like American Medical International Inc. in Beverly Hills, Calif.; National Medical Enterprises in Los Angeles; Hospital Corp. of America in Nashville, Tenn.; and Humana Inc. in Louisville, Ky., sponsor their own PPOs.

NME, for example, now covers about 5,500 lives through HealthPace, the PPO it started in California in April 1984. HealthPace, with 45 employer clients, plans to expand out of state later this year.

Dallas-based Republic Health Corp. also says it is considering establishing a PPO in the southeastern United States early next year.

The major hospital chains also are offering health insurance products (see story, page 3).

Hospital-driven PPOs could present more competition to the major hospital chains that are now offering group health coverage and other insurance products than would PPOs spearheaded by employer coalitions, insurers or third-party administrators, some suggest.

"As AMI, NME, HCA and Humana act aggressively in the insurance marketplace, the need for a hospital-based preferred provider organization becomes paramount for insurers," observes Wally McCall, marketing director for the PPO Alliance in Cypress, Calif.

Mr. McCall explains that, in order to compete with insurance products being offered by the major hospital chains, group health insurers will be looking for PPOs that can provide the same degree of control over delivery of care that those major chains can. And, he says, PPOs organized by other hospitals are the best alternative.

PPO Alliance, one of the largest hospital-driven enterprises, covers 520,000 lives through its network of 108 California hospitals and some 4,700 physicians statewide.

For the moment, the Alliance is concentrating on product expansion rather than geographic expansion, Mr. McCall explains.

For instance, the Alliance is marketing a new PPO, called ElderMED, designed for people covered by Medicare. The target markets are employers with many retirees or soon-to-retire employees, and insurers that sell supplemental Medicare coverage.

The Alliance also is implementing a statewide mental health PPO, including an employee assistance program, and is being considered for a workers compensation PPO by Industrial Indemnity Co., the San Francisco-based Crum & Forster unit, notes Mr. McCall.

"We have very powerful pressure on us by our clients to go out of state," says Mr. McCall. Seven national health insurers contract with the Alliance, he says: the Equitable Life Assurance Society of the United States, Northwestern National Life Insurance Co., New York Life Insurance Co., Liberty Mutual Insurance Co., Mutual of Omaha Insurance Co., Allstate Life Insurance Co. and the Hartford Insurance Group.

The Alliance began moving outside California about six months ago, and it now has PPO facilities in Chicago, Tennessee and Portland, Ore.

California employers that contract with the Alliance include: Barclays Bank of California in San Francisco; Aerospace Corp. in El Segundo; Kings County; IT Corp. in Wilmington; and Jonathan Manufacturing Corp. in Fullerton.

Competing with the Alliance is Los Angeles-based Preferred Health Network, a PPO jointly owned and operated by about 23 non-profit hospitals and about 2,800 physicians, but with affiliations at some 60 hospitals and with 6,000 doctors.

The PPO, which is also available statewide, has its strongest presence in Southern California and covers about 215,000 lives. Among its 22 clients are: unions, like Affiliated Health Funds in Pasadena, Calif.; insurers, like John Hancock Mutual Life Insurance Co. in Bos-

Continued on next page

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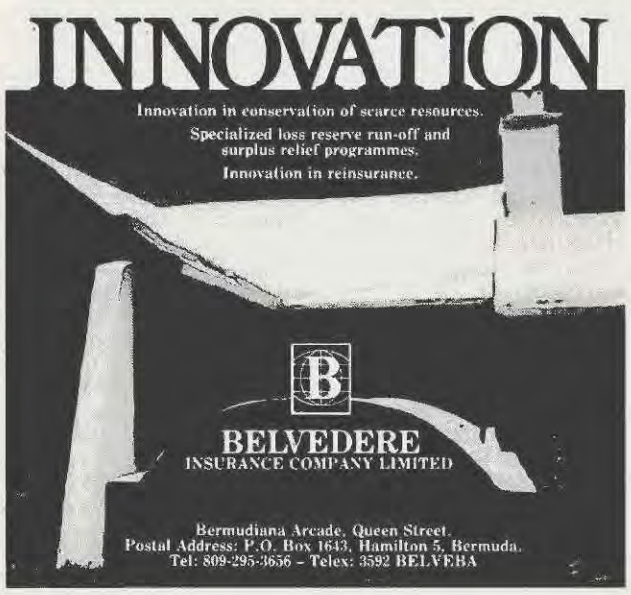
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Hospital PPOs

Continued from previous page

ton; third-party administrators, like R.L. Kautz & Co., the Irvine, Calif., subsidiary of Emett & Chandler Cos.; and individual businesses, like Global Van Lines Inc. in Anaheim.

One advantage of using PHN, according to President and Chief Executive Officer Terry L. Worthylake, is a billing clearinghouse it has in Los Angeles.

Here, all provider forms, billings and payment remittances come through one office, where they are "redefined" so the payment system can be easily understood by both provider and payer, Mr. Worthylake explains. He likens the arrangement to "a big hospital business office."

Such an arrangement is necessary, he explains, if the PPO is "to work on a large scale in a large urban market like Los Angeles."

Dallas-based Baylor Health Care System is marketing Southwest Health Network, a PPO it owns jointly with Med Southwest, a group of about 600 physicians.

Southwest Health Network is marketing itself mainly to large businesses that might offer a PPO in their self-insured group health plan. Since Texas is one of the few states that does not permit insurance companies to set up PPOs, employers whose health plans are commercially insured are not candidates for its services, explains Frank Riker, executive director.

The PPO, which began in January, offers access to 12 hospitals in north Texas. Its only enrollees so far are Baylor's own 5,500 employees, but it expects to contract with three large Dallas businesses between now and January that would bring the PPO's covered lives to about 44,000, Mr. Riker said.

But hospital PPO activity isn't limited to the big guys. Smaller community-based hospitals are also looking at PPOs to encourage use of their facilities.

A consortium of six hospitals in Washington state, for example, recently formed First Choice Health Plan Inc. to boost their occupancy rates.

Seattle's Northwest Hospital, one of the PPO members, had a respectable occupancy rate of about 79% in 1983, before the appearance of government-instituted diagnostic related groups (DRGs).

Today, only about 140 of the not-for-profit hospital's 200 beds are occupied, according to David M. Semple, director of professional services. That's only a 9 percentage-point drop—and still better than the occupancy rate experienced by many other hospitals—but Northwest still wants to fill more beds.

The PPO was incorporated last August and capitalized in February, with $1 million contributed by the six hospitals and about 620 physicians who have come aboard. And, on May 1 it took on its first client, Northwest and its 1,200 employees.

A second PPO-member hospital has since enrolled its employees, and by January the PPO expects to enroll the employees of the other member hospitals, bringing the total lives covered to almost 8,000, according to Mr. Semple. The PPO will then target Washington's employer population.

Using one of these six hospitals could help employers shave 20% off their hospital bills, estimates Mr. Semple. He predicts Northwest will save at least 10%-15% on its own employee health care costs. Before May 1, the hospital was spending $35,000 to $40,000 a month on employee health care claims under its self-insured health plan, which was administered by King County Medical/Blue Shield.

He predicts that most of the employers attracted by the PPO will be in commercially insured plans or plans covered by the Blues. Self-insured companies are "a natural" for this PPO, he says, but he estimates that only about 10% of area businesses fall into that category.

To attract new clients, the hospitals are marketing their PPO through insurance brokers and are taking out advertisements in local publications.

In addition, the hospitals have contracted with an insurance company to offer the PPO as a health care coverage option for employers.

Mr. Semple says the hospitals have contracted with Union Mutual Life Insurance Co. of Portland, Maine, to offer employers discounted health insurance if their employees are treated at the PPO's facilities. For this product, the hospital is targeting businesses with between 50 and 75 lives.

"We see ourselves working closely with commercial insurers who want to gain market share at the expense of the Blues," Mr. Semple says.

These same Washington hospitals also are vying for the business of school districts and multiple-employer trusts through an arrangement with Employee Benefit Plans Inc. EBP, a TPA based in Minneapolis, arranges excess coverage and reinsurance for the school districts and METs.

Scripps Memorial HealthCare in La Jolla, Calif. is another small PPO in which hospitals play a leading role.

The PPO, a joint venture between two non-profit Scripps Memorial Hospitals and more than 200 physicians, is just over a year old and covers about 18,000 lives in San Diego County, according to Director Tom Woldt.

The largest of Scripps' 100 clients is a consortium of Taft-Hartley trusts, but the PPO also contracts with individual employers, insurers, labor unions and TPAs. ■

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business insurance

Insurers forming PPOs to meet clients' demands

By DIANE LYNN KASTIEL

Group health insurers are rushing to organize preferred provider organizations, a move they see not only as lucrative but necessary for survival.

"We feel we have to have a PPO as part of our marketing strategy to maintain our competitive position —especially in the future," said Paul McEwan, director of group insurance for Prudential Insurance Co. of America.

Client pressure is catalyzing insurers to offer PPO options, added Jim Neely, director of provider relations for Equitable Life Assurance Society of the United States. "PPOs are the latest thing in the marketplace—and everyone wishes they had one yesterday," he said.

Insurer involvement in PPOs is relatively new: All of the PPOs established by the nation's largest group health insurers surveyed by *Business Insuance* are less than 3 years old, and some of the insurers only jumped into the marketplace earlier this year.

Some of the insurer PPOs have already attracted large numbers of employers and hundreds of thousands of employees and dependents, while some of the insurers are still trying to sign up their first PPO client.

But no matter how long they have been in the market and how successful they have been in attracting employers, many of the insurers predict they'll have national PPO networks up and running, possibly by the end of the year.

When these national networks are formed, insurers say they will offer PPOs as an option in traditional fee-for-service group health plans and some predict PPOs will eventually replace indemnity plans altogether.

"Policyholders can view this as an evolution of their standard benefit plan rather than another alternative for their employees," said Richard Maturi, director of preferred provider product development at the Blue Cross & Blue Shield Assn. in Chicago.

"As PPOs become accepted, as we have more experience with them, employers will be looking at preferred provider arrangements more as a replacement for the traditional system rather than just another alternative."

The various PPOs offered by insurers are based on a common goal: to reduce clients' health care expenditures by offering them networks of health care providers that promise cost-efficient health care through reduced fees, lower utilization or a combination of both.

But not all PPOs are the same. They vary by provider makeup, services offered, discount arrangements and the type of utilization review conducted.

For example, some insurers feel that it is vital to limit the number of providers in a PPO to a certain percentage of the total number of providers in the community. Prudential likes to limit the number of providers in its PPOs to 25% to 30% of those in the community the PPO serves.

"Basically, our intention is not to sign more hospitals or physicians than we need to set up the networks," said Mr. McEwan. "And the providers are interested in that too, because they're interested in market share. And if you go out and sign up everybody in town, it's not going to do much for their market share."

But other insurers feel limiting the number of providers participating in a PPO is unnecessary. If all providers in a community agree to offer cost-efficient services, they argue, so much the better.

"People say, 'How preferred is your network if you have all the hospitals in it,'" said Ned Peple, director of Blue Cross & Blue Shield of Virginia's PPO. "My response to that is, 'Why not have all the hospitals in it if they're all will-

Continued on page 36



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Insurer PPOs

Continued from page 34
ing to come in at the same reduced price?'"

Mr. Maturi adds that limiting the number of providers in a PPO usually only benefits the providers.

"The notion of small PPO panels was basically derived from the providers' idea of PPO," he said. "When the provider is using a PPO as a marketing tool, the less the better."

And, Mr. Peple argues, most health care providers are willing to negotiate for inclusion in PPOs—not just for the benefit of increased patient volume, but to ensure they won't lose the patients they now serve.

"We're not promising these people market share," Mr. Peple said. "We're just saying, 'If you want access to these patients, you'd better be in the program. If you don't care, you can sit out.' And the ones that sat out the first year were the ones who were most eager to get into the PPO the second year."

The range of services offered by different insurers' PPOs also varies.

All include services at a general hospital and a full range of medical doctors, including specialists. But some networks include other health care professionals, such as psychologists and physical therapists. And some insurers include special hospitals, such as teaching hospitals and children's hospitals, in their PPOs.

But, regardless of the extent of services they now offer, most insurers say that, in years to come, their PPOs will include a complete spectrum of health care providers, including such "extras" as optometrists and pharmacists.

The discount arrangements insurers require of providers also varies. Hospitals are reimbursed according to different variations on per-diem and diagnostic-related group rating plans.

Discount arrangements with individual doctors differ even further. For example, some insurers require a doctor to provide a discount based on a percentage of his or her usual fees, while some insurers reimburse all doctors in the PPO according to the same fee schedule.

And, while all the surveyed insurers said lowering health care utilization is paramount to a successful PPO, they don't all pay the same amount of attention to it. Some insist on analyzing and reviewing cases handled through their PPOs themselves, but others feel comfortable—and say they save money—by letting the providers conduct the utilization review, which the insurer monitors.

Finally, while some insurers create the PPOs they offer, many contract with existing networks rather than start up their own in states like California, where PPOs are already abundant. In these cases, the PPOs with which the insurers contract are usually sponsored by providers or entrepreneurs that are sometimes labeled "PPO marketing organizations."

Insurers say contracting with an existing PPO saves time and requires less administrative work because tasks like provider selection and utilization review are carried out by the sponsoring organization. However, the insurer may arrange separate discount arrangements with the providers in the PPO.

* * *

Several of the major group health insurers surveyed by *Business Insurance* have sponsored PPOs for several years and have attracted a sizable number of employers and employees:

Blue Cross & Blue Shield

The Blues are aggressively interested in establishing PPO networks, although individual BC/BS plans are autonomously setting up their own PPOs rather than forming one national organization.

According to Mr. Maturi, 31 of the nation's 90 Blue Cross plans have set up PPOs, together comprising about 77,000 doctors and 800 hospitals throughout the country.

In addition, various BC/BS plans have formed about five multistate preferred provider programs for multistate employers. Rockwell International Corp., General Motors Corp. and Goodyear Tire & Rubber Co. are among the companies whose employees are enrolled in these PPOs, he said.

As of April, 1.7 million people were enrolled in the Blues' PPOs, Mr. Maturi said.

The Blues' PPOs have been more successful in holding the line on health care costs than was expected, Mr. Maturi said. Employers that have used the PPOs for at least a year have seen an average premium decrease of 20% on renewal, compared with the predicted 10%-15% declines, he said.

Although each PPO is designed independently, all BC/BS plans' PPOs must adhere to strict utilization review standards, Mr. Maturi said.

For example, all must require the providers in their networks to review each hospital stay. This review must include pre-admission testing with a length-of-stay prediction, concurrent review and retrospective review.

In addition, all plans must analyze the providers in their PPOs according to cost and utilization patterns.

"We believe there will be three types of benefits plans competing in the future," said Ted Raichel, executive director of product management and research for the national BC/BS organization. "One will be an HMO, one will be a PPO." The third will be a traditional fee-for-service plan "that includes all hospitals and physicians but will have managed care and very tight utilization and cost controls," he says.

Two examples of PPOs operated by BC/BS plans are:

- Blue Cross & Blue Shield of Kansas City, Mo., which began offering its PPO, "Preferred Care," in November 1983. The network, offered in the Kansas City metropolitan area and 27 adjacent counties, includes 1,200 doctors, including specialists like psychiatrists and allergists, 12 hospitals, including teaching hospitals, and two ambulatory surgical centers.

According to a spokeswoman for Blue Cross of Kansas City, the number of doctors in the PPO was limited to about half the total number in the metropolitan area, but the percentage of hospitals was kept much smaller—12 of the area's 58 hospitals—to achieve the desired cost efficiencies.

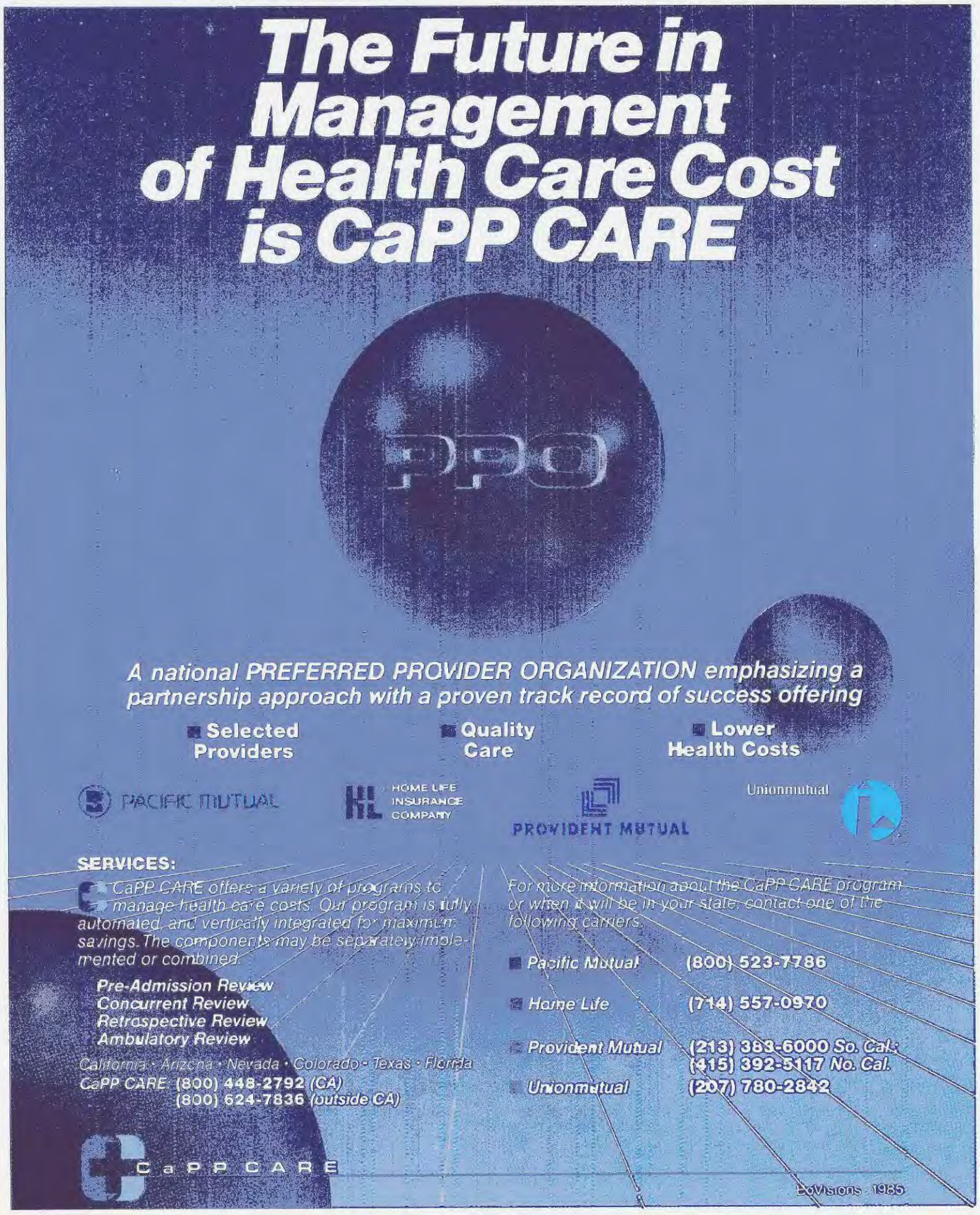
The Kansas City PPO conducts pre-certification and retrospective review of hospital admissions; hospitals are required by contract to conduct their own concurrent review, the spokeswoman said.

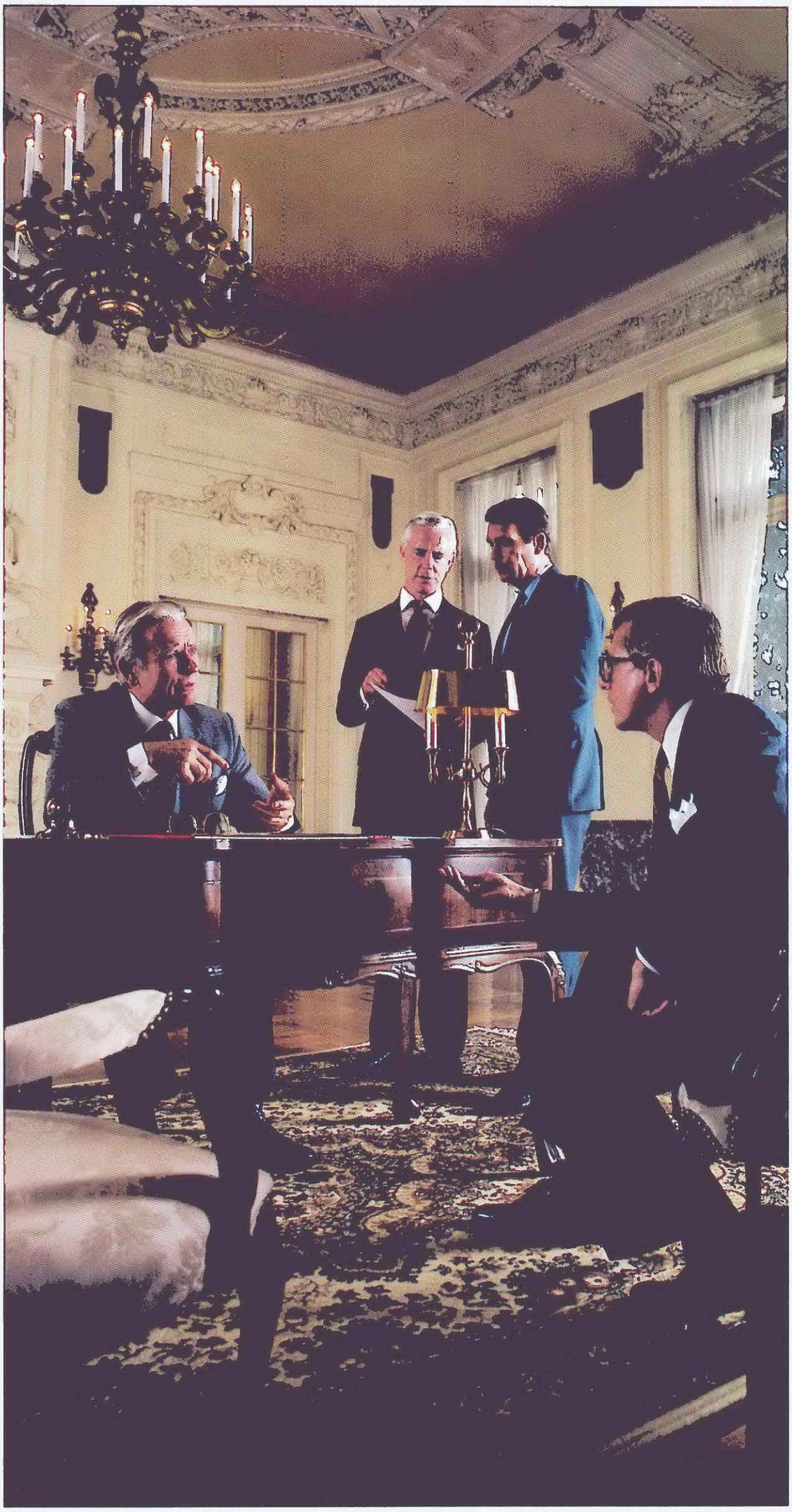
In addition, the spokeswoman said, some 450 surgical procedures must be performed on an outpatient basis in order for the provider to receive reimbursement.

Hospitals are reimbursed on a per-diem basis, while providers give PPO participants a percentage discount off their regular fees. Although the spokeswoman wouldn't say what the discount was, she did say the plan was "moving toward a fee-schedule reimbursement" to further control costs.

To date, 300 groups, with a total of 27,000 employees, have enrolled in the PPO. After the first year of operation, employers who used the PPO paid an average of 17% less premium than employers that did not use the PPO, or a difference of

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Insurer PPOs

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about $566,109, the spokeswoman said.

The average length of stay for employers using the PPO also dropped by 18%, to 5.5 days from 6.5 days the prior year. And, the average benefit paid per hospital admission for employers using the PPO was $2,372, compared with $3,074 for employers who did not use the PPO, the spokeswoman said.

• Blue Cross & Blue Shield of Virginia, whose "KeyCare" was first offered to policyholders in the summer of 1983. Unlike most insurer-sponsored PPOs, KeyCare is a free-standing product, not an option that can be added to a traditional health care plan, Mr. Peple explained.

"One of the issues we were concerned about was the tendency of (benefits plans) to make inpatient services more attractive than outpatient services," Mr. Peple said. "So we tried to modify the plan to make outpatient services more attractive. And we're trying to promote the use of primary-care physicians, as opposed to using the emergency room."

KeyCare networks are offered throughout southeast Virginia and comprise 36 hospitals, including teaching hospitals and children's hospitals, and 2,880 individual providers, including psychologists and ophthalmologists.

Blue Cross of Virginia does not limit the number of providers enrolled in its networks, and reimburses all providers according to the same fee schedule, which is set by the insurer and averages 15% lower than the schedule of reasonable and customary charges for the insurer's indemnity coverage.

Currently, the Virgina PPO has 335 groups enrolled, with about 22,000 employees and 44,000 lives, including dependents, Mr. Peple said.

The insurer monitors hospital costs and utilization by using a system known as the Appropriateness Evaluation Protocol, or AEP, the same system used by the federal Health Care Financing Administration, Mr. Peple said. The insurer also monitors outpatient services by analyzing claims data. If overutilization or inappropriate charges are found, the provider is not reimbursed; the patient is held blameless, Mr. Peple said.

To encourage low utilization, the insurer offers doctors additional reimbursement if they reach utilization goals set by the insurer.

"The (fee) schedules are not where the dollars are," Mr. Peple said. "The dollars are in hospital days and utilization of services. We're not interested in beating money out of the providers. We're interested in using services appropriately and offer financial incentives to do so."

Apparently, the program is working. In its first year of operation, hospital admissions among the groups tapping the PPO fell 11% and number of hospital days fell 14%, Mr. Peple said.

"Our first group to go on this program was at about 1,150 (hospital) days per thousand (employees)," Mr. Peple said. "They cut their utilization in half in the first year."

Prudential

Prudential began offering its "Pru-Net" PPO in October 1983 in Santa Barbara, Calif., at the request of the University of California.

Today, 140 hospitals and 13,000 doctors participate in Prudential PPOs in California, Nevada and New Mexico, said Mr. McEwan. Pru-Net was introduced in Nevada in late 1984 and in New Mexico in May.

As part of Prudential's PPO marketing program, quotes for PPO coverage are included in every bid for new and renewal business, Mr. McEwan said. Since the insurer began actively marketing its PPOs in the last quarter of 1984, about 80 group clients, with 200,000 employees and dependents, have signed up.

"The marketing is going very well," he said. "I expect those numbers to change dramatically upwards in the next few months."

In addition, the insurer cur-

Continued on facing page

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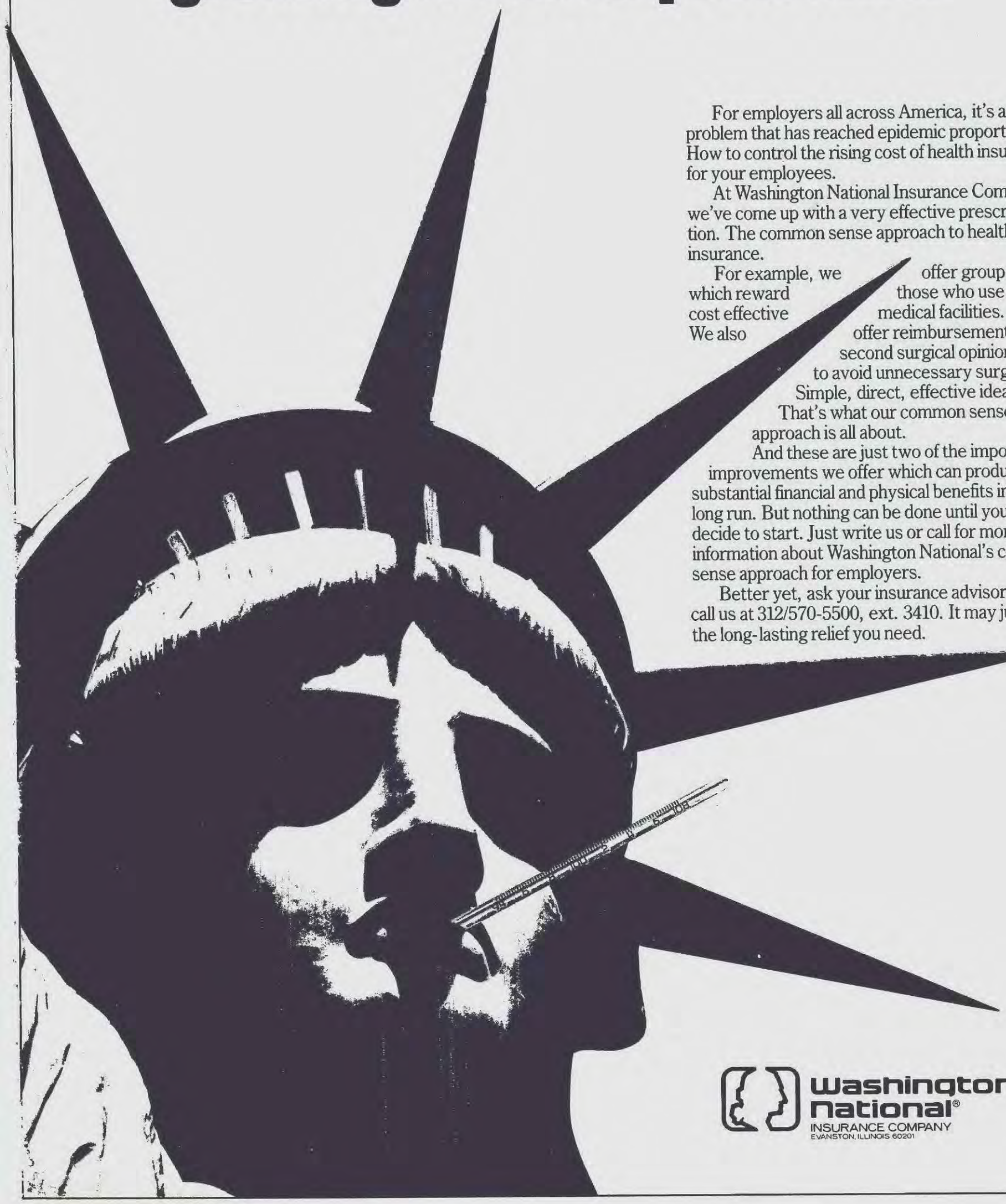
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Some insurers offering dental care PPOs

By DIANE LYNN KASTIEL

Besides establishing preferred provider organizations for medical care, a few insurers are also offering dental care PPOs to their clients.

Most of the dental PPOs are offered by insurers that have contracted with Insurance Dentists of America, a nationwide dental PPO organization based in San Jose, Calif.

However, at least one insurer is forming its own nationwide network of dental PPOs, while other insurers are contracting with independent dental practices in various cities.

About 20,000, or 22.4% of the nation's dentists, have joined IDOA, which began marketing its services to health insurers in January 1984, says James A. Vivian, IDOA's president.

To date, eight insurers have signed contracts with IDOA: John Hancock Mutual Life Insurance Co., Travelers Corp., Prudential Insurance Co. of America , Metropolitan Life Insurance Co., New England Life Insurance Co., Transamerica Occidental Life Insurance Co., The Equitable Life Assurance Society of the United States and Mutual of Omaha Insurance Co.

All of the insurers—except Equitable and Mutual of Omaha—helped finance IDOA with interest-free loans when it began operations in 1983. Equitable and Mutual of Omaha signed contracts with IDOA after the organization was up and running.

IDOA identifies dentists who are interested in joining the organization by soliciting them through advertising campaigns. It accepts interested dentists on a first-come, first-enrolled basis, until 20% of the dentists in a ZIP Code cluster have joined.

IDOA then supplies lists of participating dentists to the insurers with which it contracts.

IDOA's administrative funding comes from the insurers, which pay a monthly fee for each person that enrolls in an IDOA-affiliated PPO; Mr. Vivian would not elaborate on the cost, except to say that it decreases as more people use the network.

Each insurer can pick the IDOA dentists they want in their own plan, and each insurer negotiates its own discounted fee schedules with those dentists.

However, dentists who participate in IDOA are not mandated to participate in any insurer's PPO or accept a discount arrangement they don't like, Mr. Vivian said. However, if they do sign up with an insurer, they must submit utilization data for review and analysis conducted by IDOA to ensure dentists are not performing more procedures to balance the lower rates they must charge, Mr. Vivian said.

IDOA has both national and regional data bases with information from 139,000 dental practices, 50 million claims and 200 million procedures, he said.

Mr. Vivian said the PPO organization has been inundated with solicitations from insurers that do not yet belong to IDOA, but he is only considering accepting two more.

"We have been approached by—no exaggeration—50 (insurance) companies," Mr. Vivian said. "The six that started with us stuck their necks out and we have an obligation to these carriers to retain their competitive advantage."

But not all insurers that provide dental PPOs to clients contract with IDOA. At least one national health insurer—Aetna Life Insurance Co.—has developed its own PPO.

Aetna's "Prevent" program, which was first offered to clients in Philadelphia last fall, is a product of Aetna Dental Health Management Co., a subsidiary of the insurer that contracts with private dental clinics and practices.

Aetna Dental Health Management pays the salaries of dentists in its so-called "managed care facilities." In addition, it pays for administrative services and conducts utilization review.

Aetna has established managed care facilities in Baltimore, Washington, Boston, Philadelphia and Wilmington, Del.

According to William Downes, assistant vp and dental director at Aetna, Aetna is also operating a dental PPO in New York in which individual dentists that contract with Aetna are paid according to a fee schedule whose fees are usually between 5% and 15% below the average charge for a procedure.

Aetna conducts its own utilization review for this program.

Some Aetna dental PPOs that will be established in the future will also reimburse providers on a capitation system, under which dentists will be reimbursed according to the number of patients they treat, says Dr. Downes.

Aetna expects facilities to open by Oct. 1 in Toledo and Cleveland, Ohio; Los Angeles; and St. Louis. Dr. Downes said he expects the network to be nationwide within two years.

"We will be in 17 major cities by the end of this year and in another 17 major metropolitan areas by the end of 1986," he said.

Currently, four clients have signed up for Aetna's dental PPO: Strawbridge & Clothier, a department store chain in Philadelphia with 6,000 eligible employees; broker Alexander & Alexander in Baltimore, with 800 eligible employes; Suburban Hospital in Washington, with 800 eligible employees; and Union Memorial Hospital in Baltimore, with 2,500 eligible employees.

However, Dr. Downes said, Ford Motor Co., Chrysler Corp. and Owens-Corning Fiberglas Corp., have verbally committed to offering the dental PPO to their employees.

"We expect, for all practical purposes, all of our clients to get on line eventually," Dr. Downes said.

So far, the PPO includes about 500 dentists, including specialists such as orthodontists and periodontists. And, Dr. Downes said he expects to have about 10,000 dentists "in two to three years' time."

The insurers that offer dental PPO coverage through

Continued on page 56



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rently is setting up networks in Washington, Colorado and Arizona, Mr. McEwan said, adding that Prudential will probably concentrate its PPO operations in the West rather than go nationwide.

Prudential PPOs offer a variety of health care services, Mr. McEwan said, including children's hospitals, psychiatric hospitals, teaching hospitals and hospitals with special burn units and organ transplant capabilities. And specialized health care providers, like chiropractors and psychologists, will be included in as many networks as possible.

However, the insurer will limit the number of providers that can join one of its PPOs to between 25% and 30% of the total number in an area, Mr. McEwan said.

Hospitals in Pru-Net are reimbursed on a "multiple" per-diem basis. Rather than assign one flat rate per day, regardless of services used, Prudential assigns a per-diem rate by type of care, such as obstetrical care, surgery and intensive care.

Prudential reimburses individual providers according to a formula aimed at rewarding providers with cost-efficient track records and it gives all providers incentive to reduce costs.

All charges that exceed 51% of what the insurer considers "reasonable and customary" for a particular area are discounted by 15%; charges that are 50% or less of reasonable and customary charges are paid in full.

To regulate utilization and audit claims payments, Prudential reviews all claims and regularly analyzes cost and utilization data for all providers, Mr. McEwan said.

Mr. McEwan said he expects clients that participate in the PPO save between 9% and 14% the first year.

* * *

Other insurers did not start forming PPOs until last year, but have already attracted a substantial number of clients. They include:

Metropolitan Life

Metropolitan Life Insurance Co. began offering its "Met-Elect" PPO in Dade County, Fla., in January 1984. Its first client, the Dade County School Board, saved almost $11 million in 1984 by participating in the program, according to Susan Weiner, the board's risk manager.

"We're starting to see moderations in our premiums," Ms. Weiner said. "We've seen a 15% increase this year, whereas in previous years, we saw increases as high as 47%."

The school board is one of the seven employers, whose group health plans cover a total of about 100,000 employees and dependents, that have signed up for the Dade County PPO, which consists of 11 hospitals and 1,600 doctors.

Hospitals are reimbursed according to diagnostic-related groups, while doctors are reimbursed using a discounted fee-for-service system that averages 20% less than reasonable and customary charges in the area.

In addition to the Florida PPO, a Met-Elect network in Los Angeles was started in January. Sixteen companies with 200,000 employees and dependents have joined the Los Angeles plan.

Other Met-Elect PPOs were begun last month in San Francisco and Tulsa, Okla., and another dozen are scheduled to begin operations this year, including PPOs in Chicago, Dallas, St. Louis and Pittsburgh, according to William Rosenberg, manager of utilization and cost analysis for Metropolitan.

Metropolitan handles its PPO utilization review through six "medical action centers" located throughout the country and through its Corporate Health Strategies Inc. subsidiary, which specializes in health care data analysis.

Mr. Rosenberg said Met-Elect PPOs will offer, whenever possible, a variety of special services, including teaching hospitals, children's hospitals and psychiatric hospitals. Supplementary health care, like prescription drugs and vision care, can also be accessed through Metropolitan's PPOs, he added.

Transamerica

Transamerica Corp.'s life insurance subsidiaries introduced "Transamericare" PPOs throughout California beginning in January 1984. In April, Transameica began offering a PPO in Phoenix and expects to have PPOs in Ohio, Illinois, Utah and Arizona operational by the end of this year.

According to Michele Kelly, director of group special services, the insurer plans to keep expanding its PPO offerings throughout the country.

So far, 285 groups with 26,000 employees are participating in Transamerica PPOs, Ms. Kelly said, adding that participating employers have so far averaged a 22% savings on hospital expenses.

Currently, 85 hospitals and 6,000 doctors participate in Transamerica's California PPOs, while seven hospitals and 500 doctors have joined the Phoenix PPO.

"We look for hospitals that are approved by the Joint Commission of Accreditation of Hospitals," Ms.

Continued on next page

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Insurer PPOs

Continued fromp previous page
Kelly said. The doctors in the PPOs are staff members at the PPO hospitals.

The insurer performs data analysis on cost and utilization for all treatment by doctors and hospitals in the PPO, Ms. Kelly said.

Transamerica's California PPO includes two psychiatric hospitals and one rehabilitative hospital, Ms. Kelly said. And, because the insurer contracts with all providers at its PPO hospitals, its participating health care professionals include psychologists, physical therapists and oral surgeons.

Like Prudential, Transamerica reimburses providers on a modified per-diem basis, with different per-diem rates assigned to different types of care.

Doctors and other health care professionals are paid according to a fee schedule.

Great-West

Great-West Life Assurance Co.'s "STEM" PPO began operations in Denver last September and has attracted about 60 group clients, says Jim Notz, vp-group insurance.

STEM is an acronym for "Savings Through Efficient Management," which is precisely what Great-West was looking for when it selected Denver hospitals for the PPO.

"We think one of the things that distinguishes a PPO is a fairly rigid selection process for hospitals," Mr. Notz explains, "so we selected the three most cost-efficient hospitals, based on our data. These hospitals were already 15% to 20% more cost-efficient" than other area hospitals.

Unlike other insurers' PPOs, STEM only contracts with the three general hospitals; it does not contract with individual physicians. However, Mr. Notz notes that about 600 physicians have staff privileges at the three hospitals.

All types of care provided by the hospitals, including specialties like psychiatric care, are covered.

The 60 groups that have signed up with STEM are mostly smaller employers with a total of 10,000 lives, Mr. Notz says, explaining that the PPO has not been operational long enough to generate any statistics on how much the employers have saved so far.

Great-West is planning to use the Denver PPO as a base "to expand with goals of having a national network of PPOs," he says.

Great-West is putting the "finishing touches" on a partnership with other group health insurers to form PPOs across the country, though he would not name the other insurers involved in the plan. He says the system should be unveiled later this month.

"We're targeting to expand to 40 cities across the country over a three-year period through this program," Mr. Notz says.

The three participating hospitals in the Denver PPO are reimbursed by Great-West according to diagnostic-related groups, he explained. Since physicians do not directly contract with the PPO, their services are reimbursed according to reasonable and customary charges.

Great-West conducts its own utilization review of the PPO and analyzes its own data.

Aetna

Aetna Life Insurance Co. started its PPO network in early 1984 as "Aetna Preferred Care" through a contract with Hawthorne Medical Group, a multiple-specialty physician group in Los Angeles. The PPO was originally marketed as a small-business product.

The PPO, now called "Prefer," currently comprises 3,000 doctors and 30 hospitals in Los Angeles. Forty group clients use the PPO.

Aetna has also been marketing a hospital-only PPO in the Miami-Fort Lauderdale, Fla., area since February. The Florida PPO currently includes 11 hospitals and is pursuing about seven others, says John J. Harper, vp and medical director of Aetna Health Care Systems. About 25 groups have signed up.

By the end of the year, Aetna expects to have at least 20 more PPOs established.

According to Christie M. Hedahl, the insurer's director of alternative health care program development, Aetna plans to limit the number of providers in its PPOs to 40% of those in the community. The number of hospital beds will probably be limited to 20% of the community total, he said.

Aetna's has various discount arrangements with providers, including arrangements based on per-diem and diagnostic-related group changes for hospitals and discounted fee-for-service, fee schedules and maximum allowable charge schedules for doctors.

Although Aetna's PPO providers currently are limited to medical doctors and general hospitals, Ms. Hedahl expects the PPOs to include other providers in the future.

Aetna also contracts with provider-sponsored PPOs in Phoenix, Ariz., and San Diego to offer their services to Aetna policyholders. In San Diego, it contracts with the Greater San Diego HealthPlan, which includes 1,500 doctors and 30 hospitals. In Arizona, it contracts with the Maricopa Medical Foundation, which has 1,200 doctors and 11 hospitals.

Also, Aetna earlier this year entered into a joint venture with Voluntary Health Enterprises, a subsidiary of Voluntary Hospitals of America, to create Voluntary Health Plans of America, through which PPOs will be started at VHA hospitals across the country (see story, page 3).

Aetna conducts its own utilization review of the PPOs it has established using PreCert, its utilization review program, he said. Aenta uses the existing utilization review program at the PPOs with which it contracts.

* * *

Other major insurers formed their PPOs last year, but have not yet attracted a large number of employers. And some insurers' plans are just getting off the ground. Such insurers include:

Travelers

Travelers Corp. started its PPO in January 1984 in Broward County, Fla. The plan, which does not have a name, has attracted one client—the Broward County School Board, whose health plan covers 25,000 employees and dependents.

"We're planning on greatly expanding that (PPO) on Jan. 1, 1986," said Lowell Foster, a Travelers second vp. "We're planning on doing the south Florida area—Dade County, Broward County and Palm Beach County."

Currently, the Broward County PPO includes four hospitals and 800 doctors who have staff privileges at the contracted hospitals. Mr. Foster said the insurer expects to have at least 15 hospitals in the Broward County PPO by the end of this year.

The Broward County School Board reported a 3% increase in health care costs in 1984, compared with a projected increase of 12.5%, Mr. Foster said.

Travelers also contracts with a provider-sponsored PPO in San Diego and a entrepreneur-sponsored PPO in Puerto Rico. The San Diego PPO includes 26 hospitals and 2,200 doctors; the Puerto Rico PPO has 30 hospitals and 1,000 doctors, Mr. Foster said.

Travelers reimburses hospitals in its PPOs on a per-diem basis and doctors according to a discounted fee-for-service arrangement, but it

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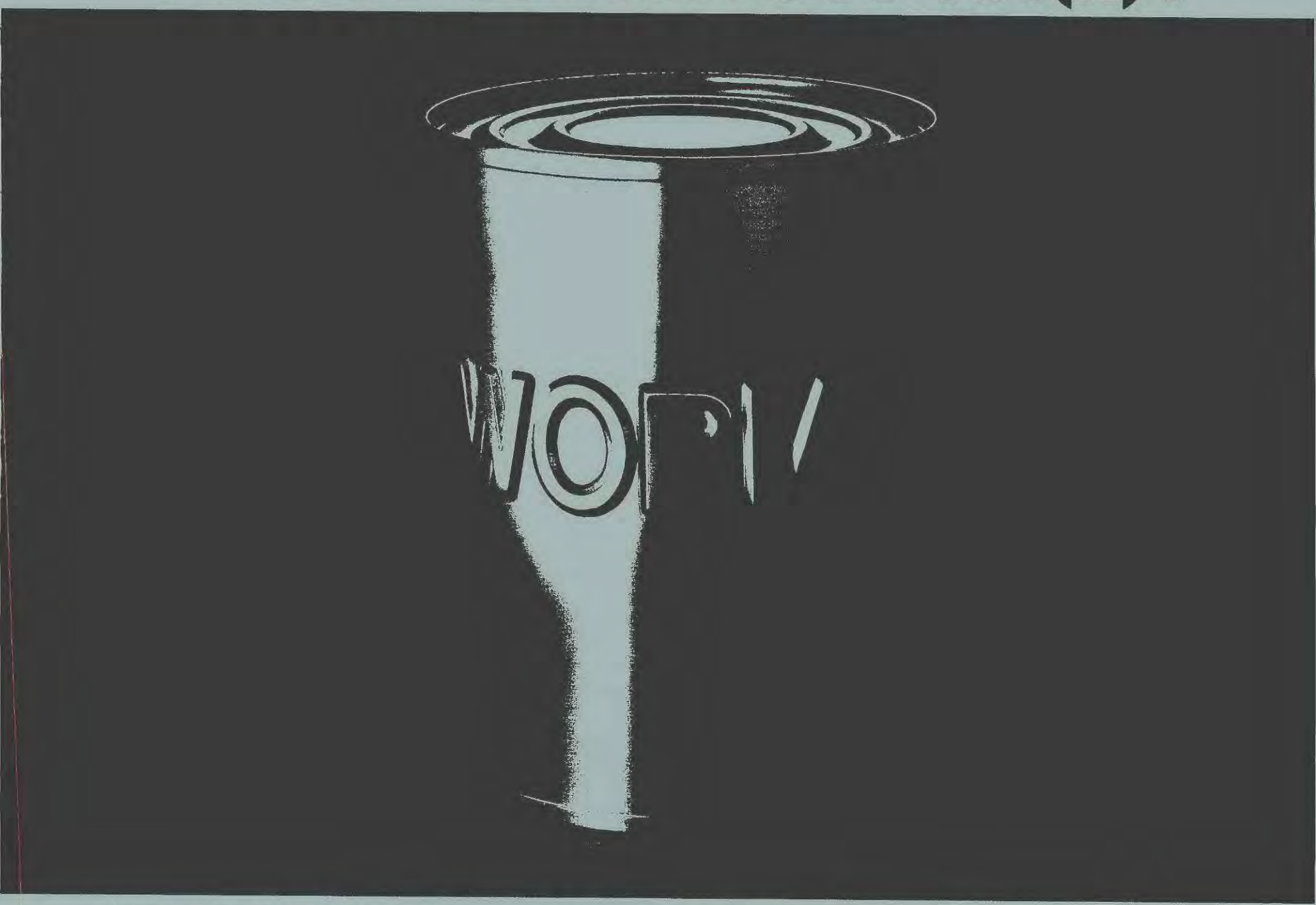
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Insurer PPOs

Continued from page 40

may switch to a schedule of fees in the future, he said. Utilization review is conducted through Medical Foundation Services Inc., a California medical foundation.

Mr. Foster said Travelers is planning to establish a nationwide PPO network, both by organizing new PPOs on its own and by contracting with existing organizations.

Although Travelers' PPOs now include only general hospitals and medical doctors, he said "it certainly makes sense to include other types of providers in the future—pharmacists are an example."

CNA

The "Cure/Preferred" PPO network has been operated in Southern California since late last year by Continental Assurance Co, a CNA Financial Corp. unit. The PPO was formed using providers in two provider-sponsored PPOs: Preferred Health Network in Los Angeles and the San Diego Foundation.

"The benefit you get in dealing with an established organization like that is that the administration is done through the network," said Ruth Garry, senior manager of systems and products development in CNA's group benefits department. "In both situations, they provide utilization review, which is critical to us."

In San Diego, Cure/Preferred is composed of 2,200 doctors and 26 hospitals, including teaching hospitals, children's hospitals and hospitals with special burn units and organ transplant units. In Los Angeles, the PPO has 400 doctors and 26 hospitals, including hospitals with special pediatric units. Specialists offered by the PPO include psychiatrists, cardiologists, allergists and plastic surgeons, Ms. Garry said.

"We insist on having all the specialties covered," she said. "We insist on having the (specialty) hospitals in addition to your primary care facilities."

Doctors are reimbursed according to a fee-for-service system with discounts for PPO enrollees. Hospitals are either reimbursed on a similar discount system or on a per-diem basis.

So far, three companies, with a total of 2,500 employees, have signed up for Cure/Preferred, Ms. Garry said.

In addition, CNA acts as an administrator for another 11 employers, with about 10,500 total employees, who contract with other PPOs. For these companies, CNA conducts administrative work, utilization review and data analysis of the providers in the PPO.

Ms. Garry said CNA will "definitely" organize additional PPOs in the future, but declined to say where they will be based.

John Hancock

John Hancock Mutual Life Insurance Co. began offering PPOs in Boston and Detroit in October 1984. A third "Hancock Preferred" network became operational July 1 in Los Angeles.

According to Jack Cross, director of alternative delivery systems development for Hancock, the insurer also expects to have a PPO up and running in southern Florida by Sept. 1 and PPOs operational in Chicago and Houston during the first quarter of 1986.

Hancock is also planning a PPO in Dallas and will eventually have a nationwide network, Mr. Cross said.

The Boston PPO includes 17 hospitals and 1,500 doctors; the Detroit network has 10 hospitals and 1,400 doctors; and the Los Angeles network includes 21 hospitals and 3,000 doctors.

The Detroit PPO should cover 30,000 lives in its first year of operation, Mr. Cross said, adding that the Boston PPO should include about 20,000 lives while the Los Angeles PPO should cover about 10,000. Since all three PPOs are fairly new, companies are still signing up, he explained.

Hancock sometimes organizes its own PPOs and sometimes contracts with existing networks, Mr. Cross said. For example, the PPO in Boston was created by Hancock, but the insurer contracted with existing provider-sponsored PPOs in Detroit and Los Angeles.

"But we go through the same evaluation (of the providers) as we do when we set up our own PPO," Mr. Cross said. "And that's important. We don't just say, 'Ah, there's a network there—let's contract with them."

Currently, Hancock Preferred providers offer basic medical services, though other types of care, like vision care, can be included in

Continued on page 44

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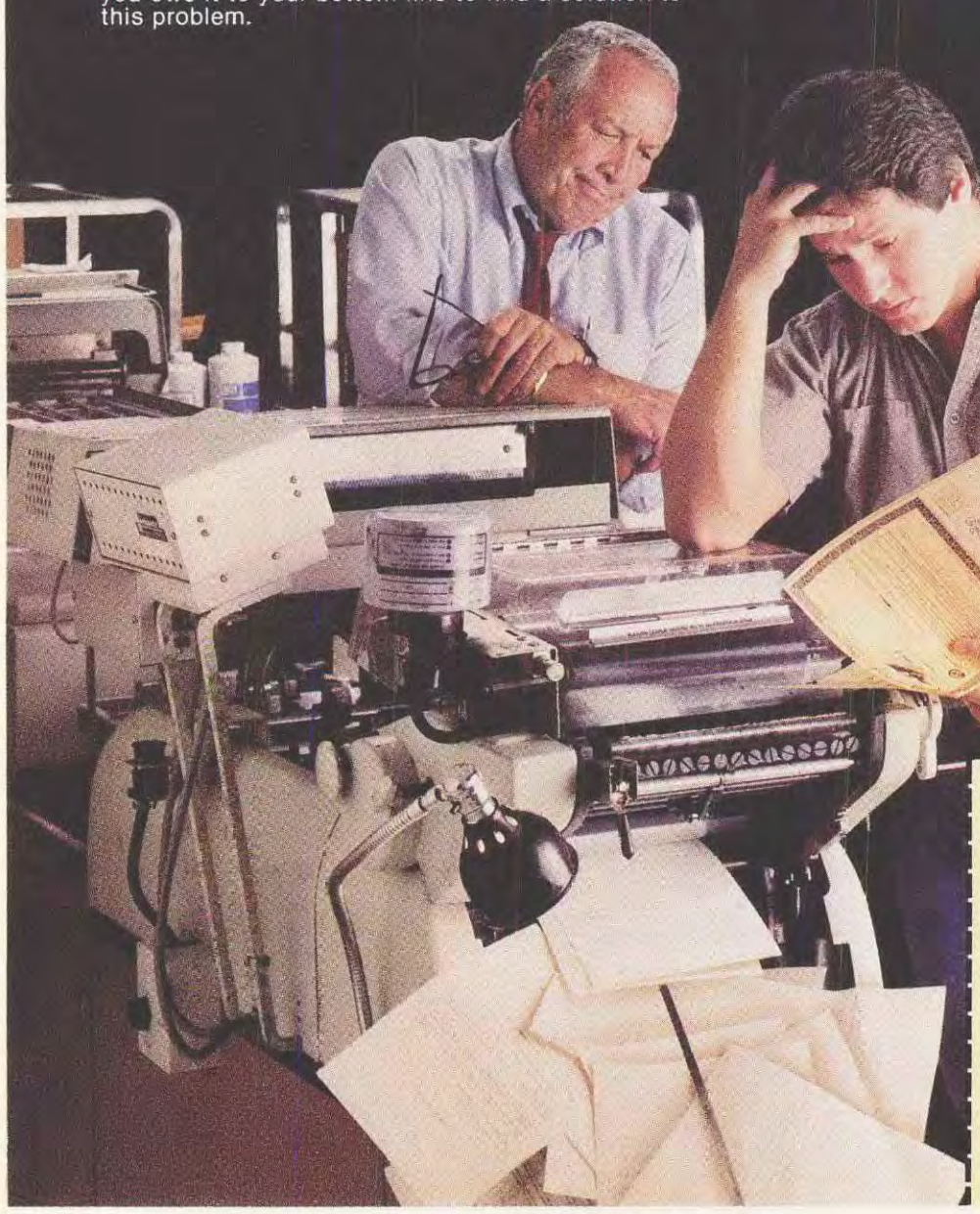
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Insurer PPOs

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an employer's health plan as separate products. "But I would say that, down the road, those programs would be folded into Hancock Preferred," Mr. Cross said.

Hancock's discount arrangements with providers in its PPOs vary.

Hancock's utilization reviews of its PPO consist of pre-certification, admission review, concurrent review and retrospective review.

Equitable

Equitable began organizing PPOs in January and is currently forming a statewide network in California, an Arizona PPO that will primarily serve Phoenix and Tucson and a PPO in the Miami metropolitan area.

So far, no groups have signed up for the PPOs, which are unnamed.

"We wish we were in more locations and we will be over time," said Mr. Neely, Equitable's director of provider relations. He said Chicago will be Equitable's next market and Pittsburgh is a possibility after that.

"Beyond that, we haven't made special plans, although there are six or eight communities where we have large customer bases and we're being pressed to start up PPOs as soon as possible."

Equitable has 2,000 physicians and 11 hospitals in the Miami PPO, including a children's hospital and a psychiatric hospital. In Miami, Equitable evaluated and chose its preferred hospitals and then selected providers who have staff privileges at those hospitals, he said.

In California, the insurer is planning to chose providers from those offered by the PPO Alliance, a hospital-sponsored PPO marketing organization based in Los Angeles, Mr. Neely said. He said he is not yet sure how many providers the California PPO will have.

Equitable is forming the Arizona PPO through a joint venture with an HMO organization, he said without further elaboration.

Mr. Neely said the hospitals in the PPOs will most likely be reimbursed by the insurer on a modified DRG schedule, while doctors will be reimbursed according to fee schedules that will vary to reflect regional medical costs.

Equitable's PPOs also will include a full spectrum of health care providers, including psychiatrists and open-heart surgeons, Mr. Neely said. He added, "if it becomes obvious in any one region that there is a lack of a particular type of service, we would have to negotiate with providers that provide that service and include them in the PPO."

Mr. Neely said the Equitable will do its own utilization monitoring, which will include pre-admission review "and all sorts of retrospective analyses."

CIGNA Corp.

CIGNA began offering policyholders PPOs under the name "Remedi Plus," in late 1984. It currently offers four PPOs in San Diego, Los Angeles, Kansas City, Kan., and Miami-Fort Lauderdale.

The Florida and Los Angeles PPOs are operated by CIGNA; in San Diego and Kansas City, the insurer contracts with existing provider-sponsored PPOs: the San Diego Foundation for Medical Care and the Mid-America Health Network in Kansas City.

Currently, 44 hospitals and 2,350 doctors participate in CIGNA-offered PPOs. Skilled nursing facilities and home health care services are also available.

Rachel Maag, the insurer's director of cost containment provider management, says CIGNA expects to add another 14 PPOs by the end of the year, preferably ones it will organize itself from the 750,000 providers already working with CIGNA Health Plan, the insurer's nationwide network of health maintenance organizations.

Because the insurer's PPO offerings are so new, Ms. Maag could not provide the number of companies enrolled in CIGNA's plans.

Ms. Maag said CIGNA will establish PPOs according to two impetuses: to penetrate markets it determines will be lucrative and to comply with the request of large accounts. "These two sources will comprise a nationwide network by year-end," she said.

CIGNA reimburses the hospitals in its PPOs on per-diem or diagnostic-related group bases; doctors are reimbursed according to discounted fee-for-service arrangements, Ms. Maag said.

The utilization review for CIGNA-sponsored PPOs is performed by its Intracorp subsidiary, headquartered in Wayne, Pa. ■

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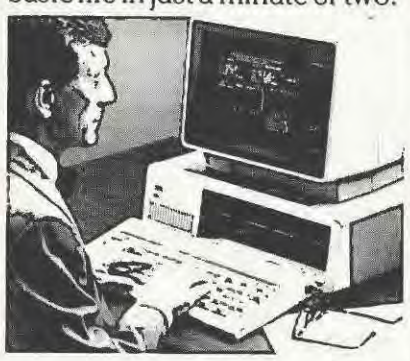


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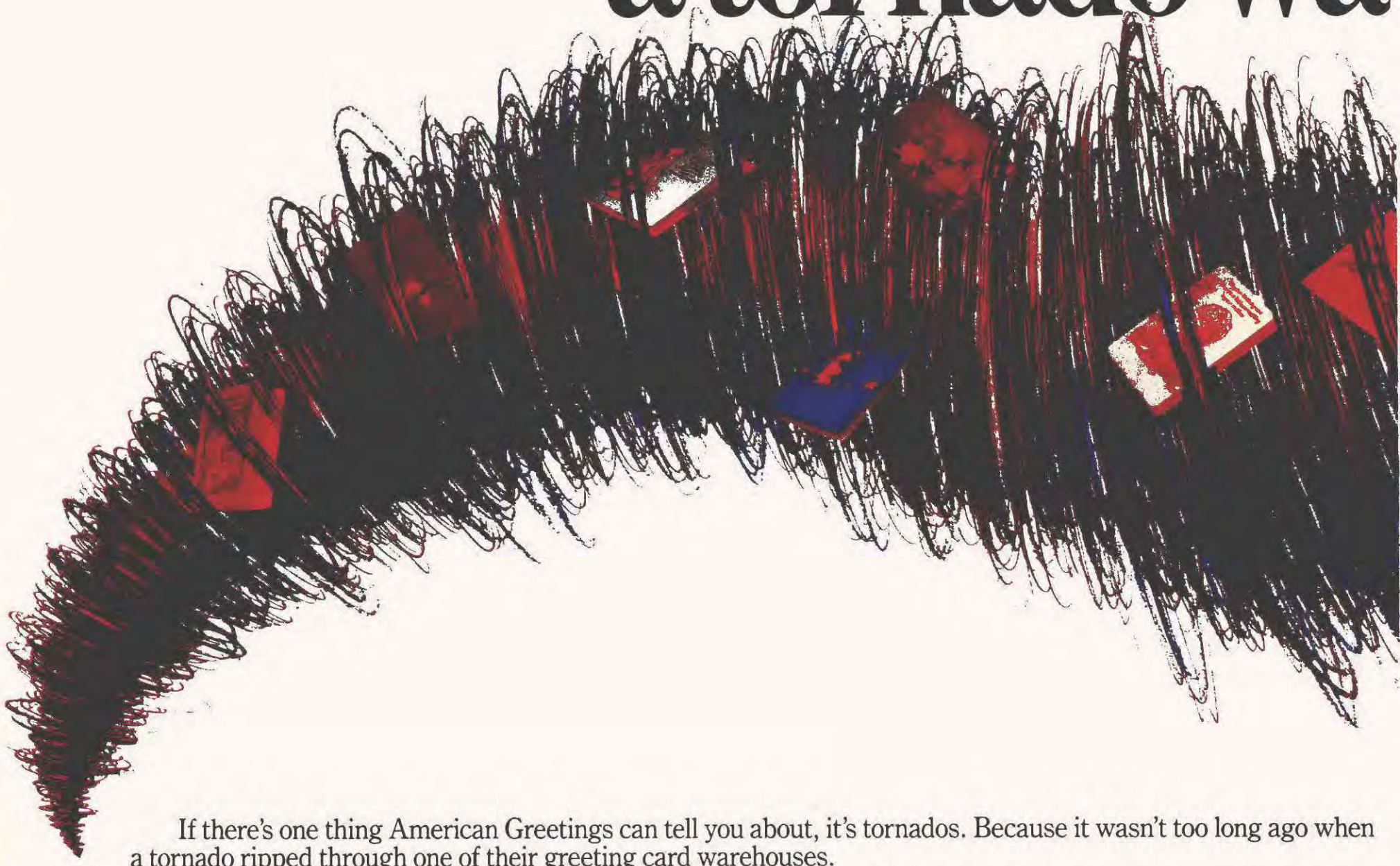
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What American Gr
a tornado wa



If there's one thing American Greetings can tell you about, it's tornados. Because it wasn't too long ago when a tornado ripped through one of their greeting card warehouses.

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This way, their cash flow remained unaffected during the recovery period. And they were able to begin cleaning up, move merchandise out and lease new warehouse space.

eetings would do if s in the cards.



To make a long story short, the recovery and repair of the plant went so well, that it was fully operational after only five months.

WE'RE TAKING THE INDUSTRY BY STORM.

To us, it's not so remarkable that the plant was back in action so soon. Because our experience has been that when you pay close attention to details before a disaster occurs, you're not in for any surprises afterwards.

Case in point. The policy for American Greetings includes fire and extended coverage for natural disasters (like tornados); boiler and machinery coverage; DIC for exposures such as floods, theft, transit; and business interruption, which proved invaluable during the plant's five month shutdown.

Another thing that proved invaluable. The Policy Workshop that we encourage all our insureds to attend. It enabled American Greetings to learn how coverages apply to a loss before it even occurs.

With thoroughness like this, it's not too hard to see why American Greetings feels secure with us. And why our other clients feel that way, too.

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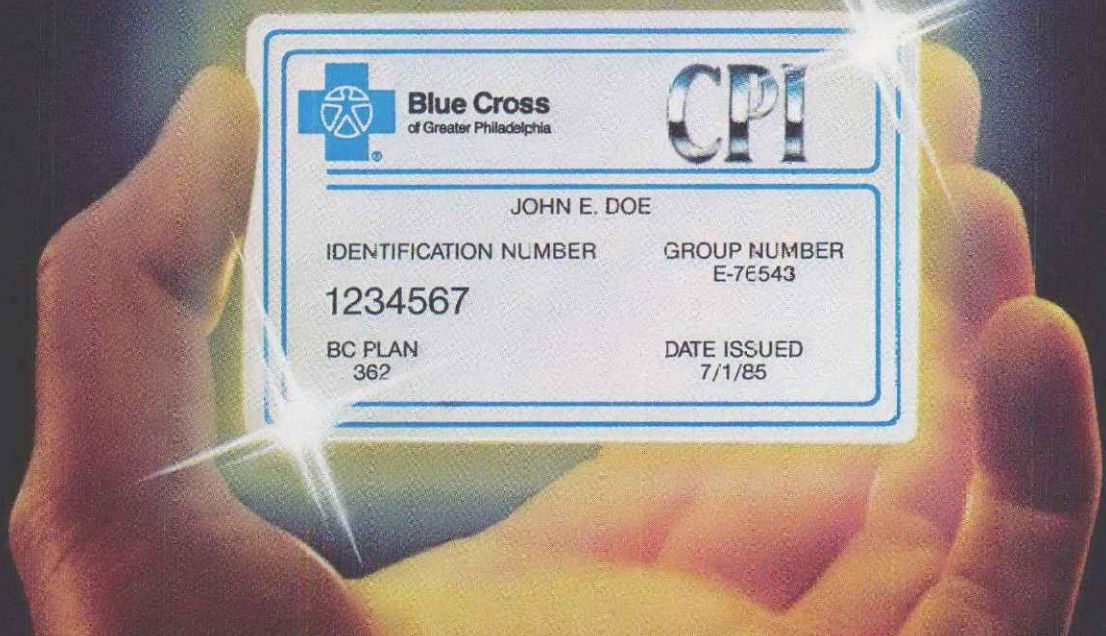
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PPO DETECTIVE WORK

Informed decisions can pay off for employers, employees

By James E. Sherman



THE RECENT PUSH to contain escalating costs of employee medical benefits has caused a rush to market a relatively new approach to health care cost containment. Preferred provider organizations represent an alternative, viable way for employers and payers of health care to provide quality health care to employees at a reduced price because of reduced utilization and an efficient delivery system.

With a nationwide enrollment in PPOs predicted to increase to 8% from 1% of the U.S. population by 1990, just five years from now, and to 18% by 1995, outstripping the growth of health maintenance organizations, PPOs are a force to reckon with in the marketplace now. In California, the nation's leader in experience and history with PPOs, approximately 25 such organizations are operational, with another 25 forming, but not yet functional.

However, this growth is fraught with hazards for the unwary. With so many types and kinds of PPOs commanding attention, the payer is hard-pressed to choose the best value for the company's money and the employees' benefit.

As brief background, a PPO is a contracting agency between the payer of health care and the providers—those hospitals and physicians that will provide an array of medical services. Because of the group purchasing power, concessions are made by the providers in the fee structure, thereby reducing the basic bills. A good PPO also will have a strong utilization review component as a further cost-cutting measure.

PPOs differ from HMOs in that with a PPO plan, the employee and his or her family have a choice of physician and hospital at the time of the medical service, not just at open enrollment, and they can choose from a much larger universe of physicians and hospitals.

PPOs differ from the traditional indemnity plan in that the financial incentives are built in to benefit design to encourage use of the preferred panel of hospitals, and physicians and charges are paid on a contract basis when incurred, not on a cost-reimbursement system.

With so many players in the marketplace, and more to come, the payers face conflicting claims as to the value of choosing one PPO over another. Further, the anticipated growth promises intense competition for a payer's—or a benefit manager's—attention.

And, there is the danger, as in any new business, of the sure-to-come washouts of weak PPOs, of those unable to deliver as promised.

For the payer, then, the task is to sort out and make sense of the chaos in order to arrive at a prudent and cost-effective selection.



James E. Sherman is president and chief executive officer of PPO Alliance in Cypress, Calif., the largest statewide network of community, non-profit hospitals and their physicians.

It is a given that you will need a PPO as a health care plan choice for employees. PPOs already are a strong benefit to attract and keep many employees. Those PPOs with good track records have proven they do control and contain health care costs significantly.

An early contract with a reputable PPO also locks in the cost of company health care for the next 12 months, or whatever is the length of the contract, thus protecting against any cost shift from a future rise in costs, sure to be charged to later payer contracts.

Payers and their representatives are advised to take a proactive stance concerning PPOs. That means becoming thoroughly familiar with and knowledgeable about the field now.

Begin the necessary research by talking to and researching existing PPOs, and invite discussions and proposals to learn as much as you can. In evaluating a PPO, look for:

- Network participation. Examine the quality, reputation and range of services offered by the PPO's providers. Are the providers well-established and acceptable to the employee community they serve? Is access to them readily available? Make sure the network can accommodate all types of medical needs, including a good complement of specialists and full-service, or tertiary care, hospitals.
- Cost-containment provisions. A stringent utilization review enhances the ultimate bottom-line benefit of a PPO. Check what these provisions are and what protections exist for cost changes, risk sharing and management accountability and reporting. Examine the policies and procedures for the utilization review, specifically in pre-admission and admission reviews, restricted day of admission, concurrent stay review, discharge planning and periodic reviews. Ask if the utilization review is available as part of the package.
- Financial stability and network basis. The last thing a payer needs is the expense, aggravation and loss of credibility involved in contracting with a PPO that folds or goes bankrupt. Therefore, carefully examine the backing, financial track record and experience of the proposed PPO. The aim here is to establish a long-term, cost-containing relationship with the PPO, one that can accommodate a company's expanding needs or a decision to shift the company's location five or 10 years down the road. Other key points to consider are the length of time the PPO has been in existence, and the expertise of its management.
- Geographic coverage. National or state coverage may be essential for the company, or it may be overkill. So, look for a PPO that can custom-tailor its services to your needs—whether they be countywide, statewide or nationwide. Wider coverage is essential to companies with multiple locations and to companies whose employees reside outside the area. A good PPO will offer total coverage and be able to structure the contract to serve all employees.
- Flexibility in employee benefit design. As one of the most crucial elements, employee benefit design is used as a financial incentive. Under most PPO plans, the employees' co-payment is 10% higher if he or she doesn't use the preferred provider, or there is a reduction or elimination of the employee deductible for using a PPO provider. Issues such as type of enrollment and inclusion of preventive care should be addressed.
- Administrative services. Examine the total fees as well as additional services, such as claims identification and processing assistance, communications and consulting help—and whether services can be unbundled.
- Risk sharing and pricing. Work with a PPO that can accomplish documented savings though pricing that places the providers at risk for what they can control. For example, a multiple per diem schedule which, when tied to a length of stay review process, will provide a very cost-effective pricing program.
- PPO ownership. You also should know that PPOs differ in their base or origin. Some are entrepreneurial, formed either by business people or consultants who have put together a network. These tend to concentrate on compiling data and have small components of physicians and hospitals, with few tertiary care hospitals. Other PPOs are physician-based, owned and operated by physicians' groups. These tend to have a large number of physicians as panel members, with a small number of hospitals enrolled.

On the other hand, hospital-based PPOs have a large number of tertiary care hospitals and a great number of staff physicians under contract. For example, PPO Alliance in California is a statewide network of more than 105 community non-profit hospitals with more than 5,000 physicians to serve the 400,000 people it currently covers.

Insurance companies can contract directly with hospitals to form their own networks or contract with an established network to provide PPO coverage.

These kinds of decisions are not easy, particularly when there is not a great deal of history and where guidelines and parameters seem to be changing constantly.

We also see the marketplace for PPOs developing, because employers and insurers are looking for ways to control health care costs.

Clearly, the ultimate aim of the payer is to get more people to use the PPO, with reduced utilization by each individual.

Although the HMO market share continues to grow, we at the PPO Alliance are beginning to work with some California employers who feel that a high HMO concentration leads to increased aggregate costs, because the heavy users of medical care stay in the indemnity plan, while the lower users join an HMO.

While individual costs in the HMO are less, some employers are finding that their aggregate health care costs continue to rise.

The PPO delivery system, along with a stringent utilization review, places a strong control on the heavy users and requires no up-front cost for the low user. Thus, the payer saves from both sides.

While many more considerations will enter into a final decision, payers are well-advised to begin the decision-making process as soon as possible. By fully informing themselves early on, payers can arrive effectively at a choice that will serve the best interests of their health care costs and the health of their employees.

With a prudent choice in the beginning, payers of health care will have an appealing product that will serve them well in years ahead.

Computers can help 'teach' benefits

By Joseph R. D'Anna
and Patrick P. Lynch

'Formerly, interaction with computers by people other than computer programmers or specialists was extremely limited because of the highly technical language required to operate computers. More recently, however, the need for specialized language has become less essential.'

EVERYWHERE we turn these days—at the office, at the bank, at home—we hear about someone's new personal computer or about new programs that make them work.

"RAM" and "ROM. . ."high-resolution graphics. . ."20-megabyte hard disks". . . All are computer terms that have become a part of our everyday language.

Although we are familiar with the features of personal computers, we may have questions about how these powerful machines can educate employees about a company and the benefits that are available to them.

Many analysts refer to the influx of personal computers—together with the more-specialized realm of television and print media—as the "Information Revolution." More and more we are a society motivated by a need to know and a need to know more quickly.

But, that is only one battle in the so-called revolution. As information needs increase, so does the complexity of the information offered. As a society, we are becoming better informed about the complex issues of the day. The information explosion is apparent in all aspects of communication, including internal communication to employees.

Traditionally, employers have relied on personnel representatives and print media to communicate information to employees. More recently, technological advancements in audiovisual capabilities have allowed employers to make video a common element in their communications programs.

But, while the traditional use of video is important and useful, it does not truly get the employees *involved* in the communications process. Instead, today's "need to know" brings with it the need to be involved.

Employees increasingly are asking to become involved in making a choice within flexible benefit programs, to decide how much to contribute toward a 401(k) salary reduction plan and to control costs by monitoring medical expenses. And, as legislation and costs force employee benefit plans to change, employee involvement in the ever-changing world of benefits will increase even further.

Personal computers now enable interaction with employees in a way that was not feasible until recently. These computers allow employees to receive information that applies to particular situations, enable them to become knowledgeable about their organization and its benefits and permit them to examine the effect of different variables.

All this can be achieved quickly, while the employee is perched before the computer. No longer is it necessary to have the employee wait a week or—in the case of a benefit statement—up to two months to receive personalized data.

Formerly, interaction with computers by people other than computer programmers or specialists was extremely limited because of the highly technical language required to operate computers. More recently, however, the need for specialized language has become less essential.

As a result, new programs can be created that are readily accessible to the average employee. Employees can be trained easily to input commands that require little or no technical orientation. After pressing a button or two, the employee can call up a specialized program that offers benefit choices from a flexible benefit plan or produces a sample statement about how a 401(k) program would affect take-home pay,.

Especially effective as a learning tool is the combination of videotape equipment and microcomputers. The computer provides a means for carefully written information to be formatted into individualized educational settings that employees can operate at their own pace. A complex benefit plan can be shown in sections that can be easily understood.

And, information that cannot clearly be demonstrated in the computer can be dramatized on the video monitor, and vice versa. Lessons can be taped and assignments or tasks built into an accompanying computer program.

In addition to the advantage of allowing for individual pacing, this method assures a consistent message while allowing for spontaneity. Moreover, computer programs can be developed to offer alternative ways of dealing with the same message.

Personal computers also can serve to train personnel in the human resources departments. A common experience at many companies is that human resources professionals often cannot provide satisfactory answers to employees' questions about their benefits.

With the microcomputer, these professionals can call up pertinent information whenever necessary. In addition to teaching about the various plans and how they are integrated, event-oriented software can pinpoint the exact area in a file where a demanding question can be answered.

The program can be organized to allow personnel managers and other employees to select topics and to provide a way of answering questions directly. Generating timely and accurate responses to employees' questions is particularly important today, when fear of lawsuits is a constant factor.

Two key features of a microcomputer are portability and size.

As personal computers become more sophisticated and begin to replace some of the functions of the huge mainframe computer, the size of the personal computer is a considerable advantage.

Microcomputers can be placed almost anywhere within an organization. Some employers choose to set up a few computers in different areas for the use of employees, while other employers prefer to keep the computers in the human resources department.

Experts predict that a microcomputer will be found in most American homes in the near future. If that happens, employees will be able to obtain information by means of a telephone hookup from their homes.

Thus, the small size and increased portability of computers will allow for a broader range of access and will promote individual interaction between user and equipment.

Nonetheless, no matter how small or portable a computer may be, or how easy it may be to operate, all is not clear sailing. The English language has gained a new term: "cyborphobia," or the fear of computers. People who dread computers should remember that they are tools only. Their greatest asset is that they can *think* more quickly than humans can.

In the area of human resources and benefit plans, one of the best things we can do is to be more helpful. And, a personal computer will help to do the job more quickly. . .and better.



Patrick P. Lynch was a senior consultant at Johnson & Higgins of California in Los Angeles, and now is with Sheppard & Associates in Los Angeles.

Joseph R. D'Anna is an assistant vp at Johnson & Higgins of California in Los Angeles.



No compensation for stress from business pressures

The alleged mental stress and anxiety brought on by business pressures was not a compensable "injury by accident," the Supreme Court of Tennessee says.

H.E. Mayes Jr. was chairman of the board, president and sole stockholder of his own construction company. Prior to 1980, his health was good.

However, after that time, his business and his health began to deteriorate. In 1980, four key employees left his business and the company experienced a cash-flow problem. And in 1981, his bonding company began to place demands on him to meet deadlines.

Further, his wife divorced him and obtained custody of their daughter, his son was arrested on drug charges and his second wife's business failed.

In 1982, he was hospitalized for treatment of acute anxiety reaction. His physician related his stress problems to his deteriorating business. Mr. Mayes applied for and was awarded workers compensation benefits.

The state Supreme Court reversed the award. The court said that the case did not justify an award for a mental or nervous disorder.

According to the court, the mental stimulus that precipitated Mr. Mayes' business experiences fell within the category of the usual stress and strain encountered in the operation of a contracting business and did not constitute an "injury by accident." *Mayes vs. U.S. Fidelity & Guaranty Co.*, Supreme Court of Tennesee, July 9, 1984 (*BI*/04/Jy.—$5)

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for $5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

legal briefs

Group policy is principal contract

A group insurance policy is the principal contract and an insured has no greater rights than are provided in that policy, a Pennsylvania appellate court says.

But, the court noted the insured's contract in the group policy here included the master policy as well as the certificate issued to a member of the group.

In January 1975, Frederick Storti was issued an insurance certificate by Minnesota Mutual Life Insurance Co. providing for disability insurance under a group policy, the master of which was held by a savings and loan association. The master policy provided for maximum benefit periods according to specific ages attained.

The certificate issued to Mr. Storti didn't state the policy's benefit periods.

Mr. Storti became disabled at age 51, which, under the master policy, entitled him to benefits for 24 months. When he was notified that his 24 months of benefits would end in December 1978, Mr. Storti claimed he was entitled to benefits for five years, or until 1981, based on a provision in the certificate terminating benefits at age 65. Minnesota Mutual rejected his claim. This suit followed, and the trial court ruled for Minnesota Mutual.

The appellate court concluded that Mr. Storti's reliance on the certificate clause was misplaced, as that language referred not to benefits but to the period of time during which the policy was to remain in force. According to the court, the benefits described in the certificate were subject in every respect to the policy, which alone constituted the agreement under which payments were to be made. *Storti vs. Minnesota Mutual Life Insurance Co.*, Superior Court of Pennsylvania, July 27, 1984 (*BI*/01/Jy.-$5)



Before choosing a flexible benefits program for your employees, first consider the demands that the plan will make of you, the employer.

At Metropolitan Life, we offer a computerized administration system specifically designed for flexible plans. From election forms and flexible credit calculations to record maintenance and employee turnover. Result: a simple, manageable plan for you and your employees.

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perspective

Weigh options when buying insurance

By The Insurance Institute of America

A.R.M. exercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. It represents the type of questions asked on, and possible answers to, the three examinations for the ARM designation.

As this month's question and answer demonstrate, the buying of insurance, even though one of the last of the sequential steps in risk management, involves several important decisions about choosing agents or brokers, policy formats and insurers that can affect directly the soundness of an organization's entire risk management program.

Q: Describe two significant potential advantages and two significant potential disadvantages of each of the following decisions that an organization may make with respect to selecting among insurers, their representatives and the coverages they offer:

- An organization decides to use just one insurance broker, rather than several, through which to purchase its insurance.
- An organization decides to obtain as much of its property/liability insurance as possible through manuscript policies rather than standard policies.
- An organization decides to obtain as much of its property/liability insurance as possible from admitted insurers rather than from non-admitted insurers.

A: For an insured organization, the potential benefits of working with only one broker (or agent), include:

- More bargaining power for the insured with the broker on the settlement of claims or on the interpretation of policy provisions favorably to the insured.
- Greater leverage, in turn, for the broker with insurers, because the broker controls all the insured's coverages with each insurer.
- Greater willingness of the broker to devote time to understanding the insured's coverage and risk management needs.
- Administrative simplicity and reduced costs for the insured to work with only one broker.

Conversely, relying upon only one broker (or agent) may have several disadvantages, including:

- Limited access to potential insurance markets, restricted to only those insurers with whom the broker does business.
- A single point of view, or limited scope of advice, available from only the single broker.
- Financial dependence upon a single broker, which may become particularly harmful if that source experiences managerial or financial difficulty.
- Broker apathy if the insured's account is not sufficiently important within the broker's overall book of business.

Possible advantages to an insured of using manuscript policies, rather than those containing only standard wording, include:

- The ability to tailor coverages to the insured's particular needs.
- Relative ease in administering policies, because several coverages that otherwise would require separate standardized insurance contracts can be integrated into one manuscript document.
- The ability to obtain broader coverages and to eliminate standard contract restrictions and conditions.

Relying on manuscript policies can also have disadvantages for the insured, including:

- Errors or oversights in the drafting of coverage or policy conditions.
- Higher premium rates charged by underwriters who rate manuscript coverages by judgment, without being confined to more tightly regulated premium rates for standard coverages.
- Access to fewer insurance markets, because some insurers will not write manuscript coverages.
- If the insured drafts the manuscript policy, loss of the advantages afforded by the rule of judicial interpretation that ambiguities are resolved against the party that wrote the policy.

An insured obtaining coverages only from admitted insurers may find they have the following advantages:

- Easier collection of claims, because insurance regulators can exercise greater influence over an admitted insurer than a non-admitted one.
- Greater assurance that an admitted insurer is financially sound, again because of generally more effective state regulation of admitted insurers.
- In any dispute between the insurer and the insured, greater ease of bringing legal action against an admitted insurer than a non-admitted one.
- In case of insurer bankruptcy, greater protection from the state insolvency or guaranty fund.

Seeking coverage from only admitted insurers also can have disadvantages for the insured, such as:

- Higher premium rates than would be charged by non-admitted insurers.
- Unavailability of some coverages that only non-admitted insurers write.
- Greater difficulty in using non-standard policy forms, which may be available only from non-admitted insurers.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Two for the benefit manager's library

Textbook could help with teaching

books & ideas

"Employee Benefits"
By Burton T. Beam Jr. and John McFadden
Published by Richard D. Irwin Inc., Homewood, Ill. 60430
$28.95 hardbound, 507 pages

By Alison Kittrell

THIS EXAMINATION OF employee benefits was designed primarily as a textbook for use by colleges and professional organizations, which is both its weakness, from a corporate viewpoint, and its strength.

It is an exhaustive look at the whole spectrum of benefits, covering history, defining terms and detailing how various programs work and how they have evolved through legislative and judicial changes as well as through practice.

In its 27 chapters, the book explains benefits ranging from Social Security and other federal plans to plans designed for the highest executives of corporations.

Since the book is essentially a textbook, working benefit managers may find some of the information simplistic.

For example, on group insurance, the authors say, "In contrast to most individual insurance contracts, the group insurance contract provides coverage to a number of persons under a single contract issued to someone other than the persons insured. The contract, referred to as a *master contract*, provides benefits to a group of individuals who have a specific relationship to the policyholder."

Obviously, it is unlikely that a person would be responsible for corporate benefits without understanding that and other underlying concepts.

However, this book, like the one in the companion review, could be a valuable resource for a benefit manager.

First, its detailed explanations and definitions might be useful in explaining to others in the company how a particular benefit program works or how a particular benefit may be implemented.

And, it is a good resource for benefit managers themselves, not necessarily to read cover-to-cover, but to refer to for specific information. Toward that end, it includes several charts and graphics.

And, benefit managers and other officials also might find the chapter on benefit planning useful. It contains sample questionnaires and other guides for use in determining a company's benefit needs and how best to meet them. And, it provides some worthwhile advice on communicating benefit information to employees.

In short, the book meets the goal set by the authors, both of the American College in Bryn Mawr, Pa.: "We have tried to write a book that can be used not only in courses given by college and professional organizations, but also as a reference resource by practitioners."

EBRI primer informs, entertains

"Fundamentals of Employee Benefit Programs," Second Edition
By the Employee Benefit Research Institute
Published by EBRI, 2121 K St. N.W., Suite 860, Washington, D.C. 20037-2121
$15 paperback, $28 hardbound; 235 pages

By Alison Kittrell

THIS PRIMER on benefits is geared mainly to employees. And, at that it is a great success.

The book, like the book in the companion review, may hold little benefit managers don't already know. But, it no doubt holds a lot of information most employees—and many senior officials—probably don't know.

And it does a clear, thorough job of explaining a wide spectrum of benefit issues. In its 28 chapters, the book covers traditional benefits like Social Security, as well as newer benefits, like flexible spending accounts and child care. All the material has been revised in this second edition, and new chapters have been added on taxation of benefits, 401(k) salary reduction plans, child care, educational assistance benefits, Keogh plans and health care cost containment.

Throughout, the prose is simple without being simplistic. For example, the book explains, "Vesting occurs when a plan participant has earned a right to his or her benefit that is not dependent on continued employment."

Charts and graphics also help to illustrate many concepts. And, the book offers interesting historical tidbits: For example, the first pension plan in the United States was established in 1759 to benefit the widows and children of Presbyterian ministers.

In fact, the book throughout is surprisingly good reading.

This primer could be extremely useful to benefit managers trying to explain benefits and benefit changes, both to employees and to company officials.

And, it is a good source for up-to-the-minute information for benefit managers themselves.

EBRI President Dallas Salisbury warns in the preface that the book is not meant to offer binding legal advice and readers always should check with lawyers or consultants on specifics. But, the book is a handy place to start looking for information, and the index and footnotes make the search easy.

It should be noted, however, that the viewpoint of the Washington-based EBRI is clear, especially in the chapter on benefit taxation: "This government policy to encourage employee benefits has been a success. It should be a matter of national pride. . . .The favorable tax treatment may not be crucial to the existence of some benefits—but it is essential to the provision of employee benefits at all income levels."



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Dental PPOs

Continued from page 54

IDOA provide a variety of programs. The insurers include:

• Travelers, which began marketing its dental PPO on Jan. 1 and has signed up more than 7,000 IDOA dentists nationwide, says Robert Neiswanger, secretary in the group insurance department.

The dentists are reimbursed according to a discounted fee schedule, which is "somewhat less than the average charge," Mr. Neiswanger said without elaboration.

So far, eight groups with a total of 150,000 employees and dependents have signed.

• Prudential, which signed up with IDOA in March 1983, currently has 9,000 dentists, including specialists, in a nationwide dental PPO.

According to Glenn Rothman, senior group consultant, the dentists are reimbursed according to schedules of maximum charges, which vary to reflect regional dental costs.

About 25 group clients insuring a total of 50,000 employees and dependents have signed up for the PPO, said Mr. Rothman.

• John Hancock, which contracted with IDOA about 1½ years ago and began marketing its PPO "Select Dental Care" to clients in May 1984. The PPO now has 6,194 dentists, including specialists, in 21 states.

Although the insurer is starting with states in which it has its largest customer bases, Hancock eventually plans to expand the network nationwide, according to Ellen Thurston, staff assistant in Hancock's dental products unit.

So far, two companies have signed up for the PPO, she said. Ford Aerospace & Communications Corp. began offering it to its 1,800 employees in Houston and College Park, Md., on March 1, and Citibank in Chicago began offering it to its 152 employees on July 1.

'IDOA has 'been approached by 50 (insurance) companies. The six that started with us stuck their necks out and we have an obligation to these carriers to retain their competitive advantage,' Mr. Vivian says.

Hancock reimburses participating dentists according to schedules of maximum allowable charges. The charges vary by region, but they usually are between 20% and 25% less than what is reasonable and customary for an area, Ms. Thurston said.

• Equitable, which contracted with IDOA in April, currently is recruiting dentists for a PPO in the New York City area. At least 250 dentists have signed up, says Jim Neely, Equitable's director of provider relations.

The company will expand the network in the future, but has not determined the cities to which it will expand, he said.

In addition to the PPO network offered through IDOA, Equitable has been offering a separate dental PPO to clients in Atlanta since September 1983. The PPO includes about 50 dentists who are members of Dental Health Services, Inc., a multiprovider practice.

The Equitable reimbursed DHS dentists according to a discounted fee schedule. DHS prepares utilization reports that are analyzed by Equitable.

So far, two clients are using the Atlanta PPO: one that signed up in September 1983 and another that joined this spring.

Mr. Neely said if DHS expands to other states, Equitable would consider offering its PPO to clients in those states.

• Transamerica, which began offering its dental PPO to its group clients in January, according to Michele Kelly, assistant vp of group special services.

Transamerica now offers the dental PPO only in California, but it will next open PPOs in Arizona and Utah and eventually plans to offer the program nationwide.

The California network has 1,300 dentists who are reimbursed according to a fee schedule that is 15% lower than reasonable and customary charges for the area. So far, three "very small" clients have signed up for the PPO, Ms. Kelly said.

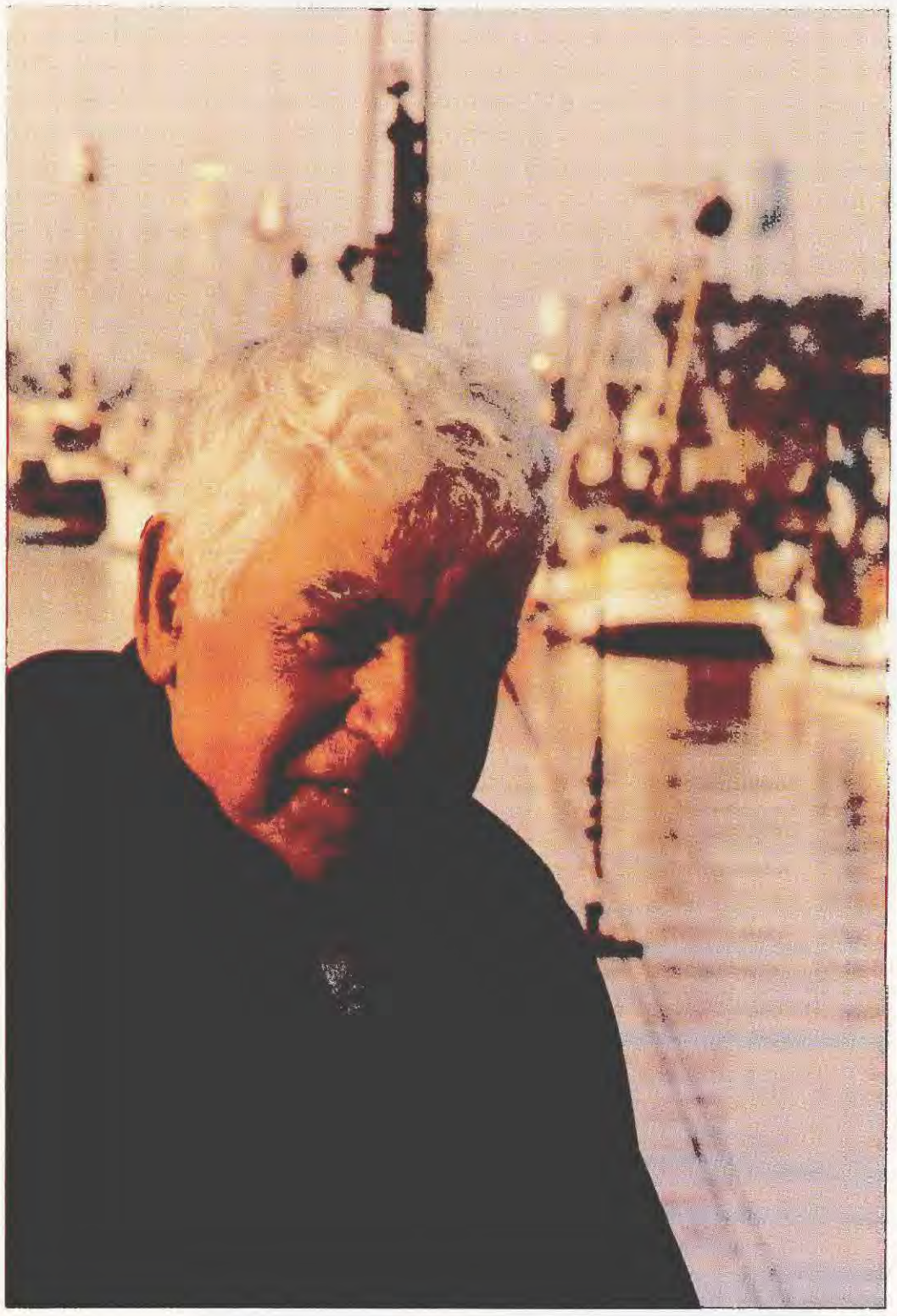
• New England Life, which began marketing its dental PPO to group clients in August 1984. It currently has 8,000 dentists, including specialists, signed up in 25 states, according to Joel Goober, assistant vp and group executive. Eventually, the insurer plans to offer the PPO nationwide, he said.

Mr. Goober would not reveal how many clients have signed up for the PPO or how providers are reimbursed.

• Metropolitan Life, which began offering its dental PPO to clients on July 1. The PPO includes 7,500 dentists, including specialists, throughout the country.

The PPO will be marketed to all large group clients, says Charles Shelley, senior consultant in group health and life operations. Dentists wil be reimbursed according to a schedule of maximum allowable charges, he said.

• Mutual of Omaha, which signed a contract with IDOA in March. According to a spokesman, the company plans to build a nationwide PPO network, but has yet not begun negotiations with dentists. ■



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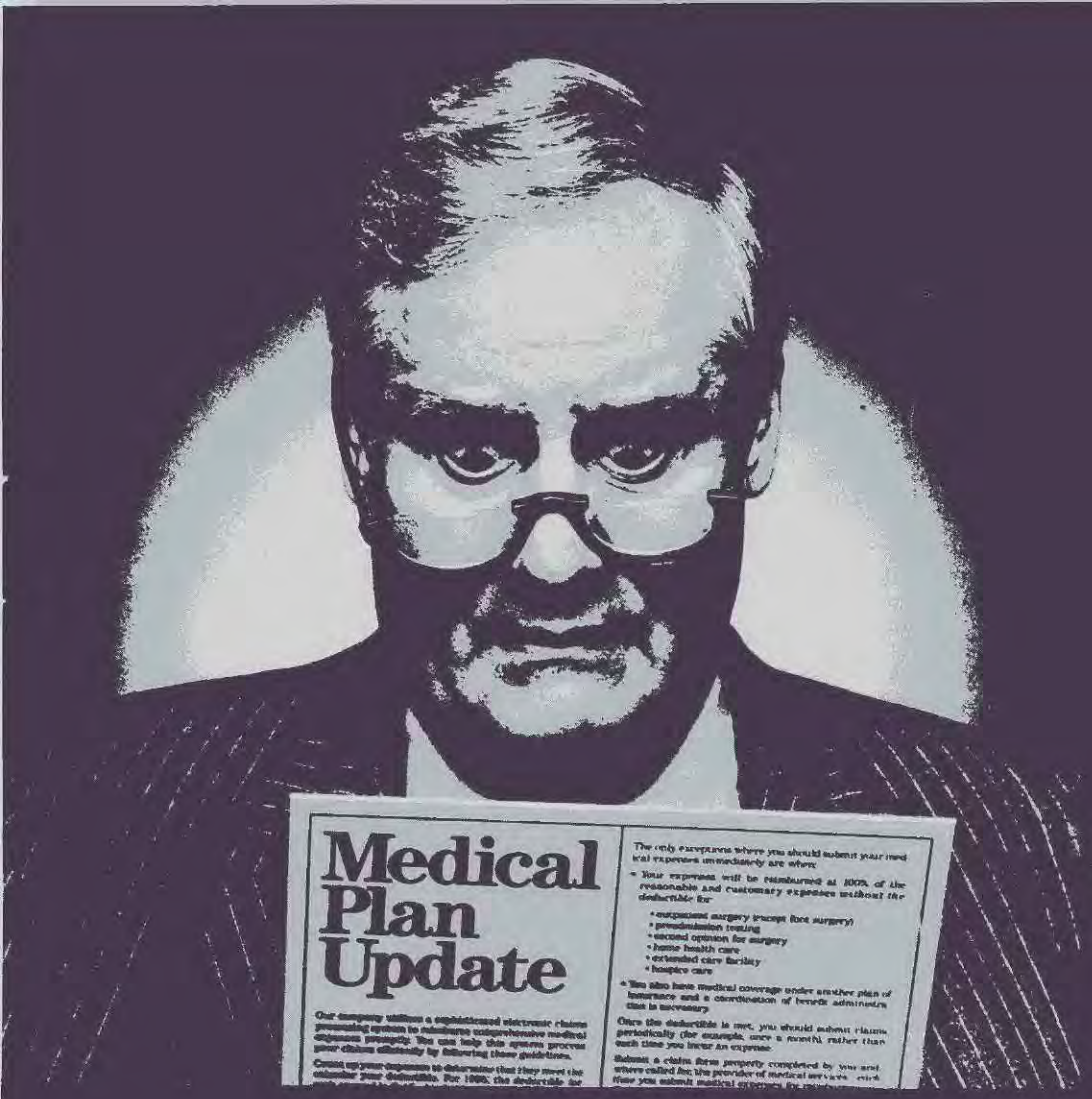
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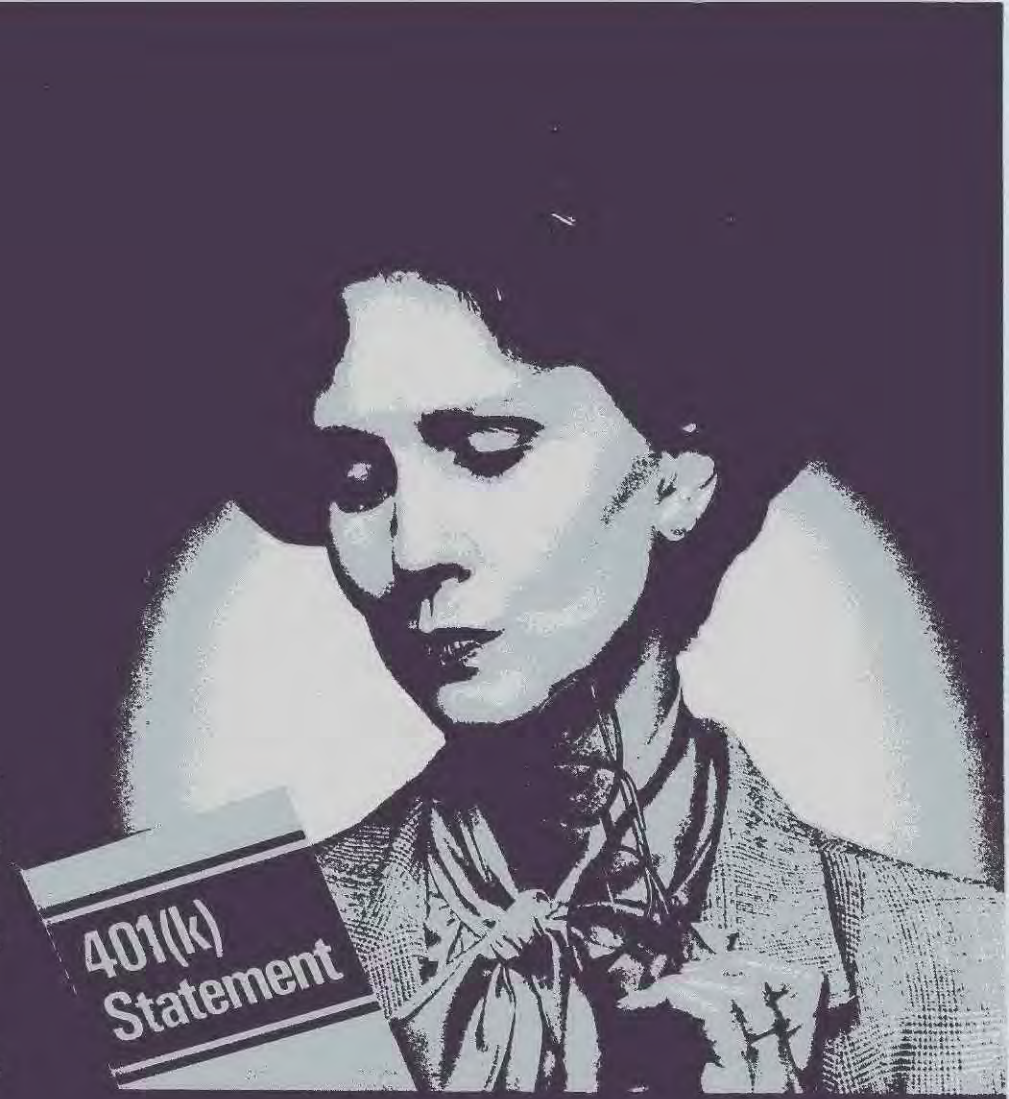
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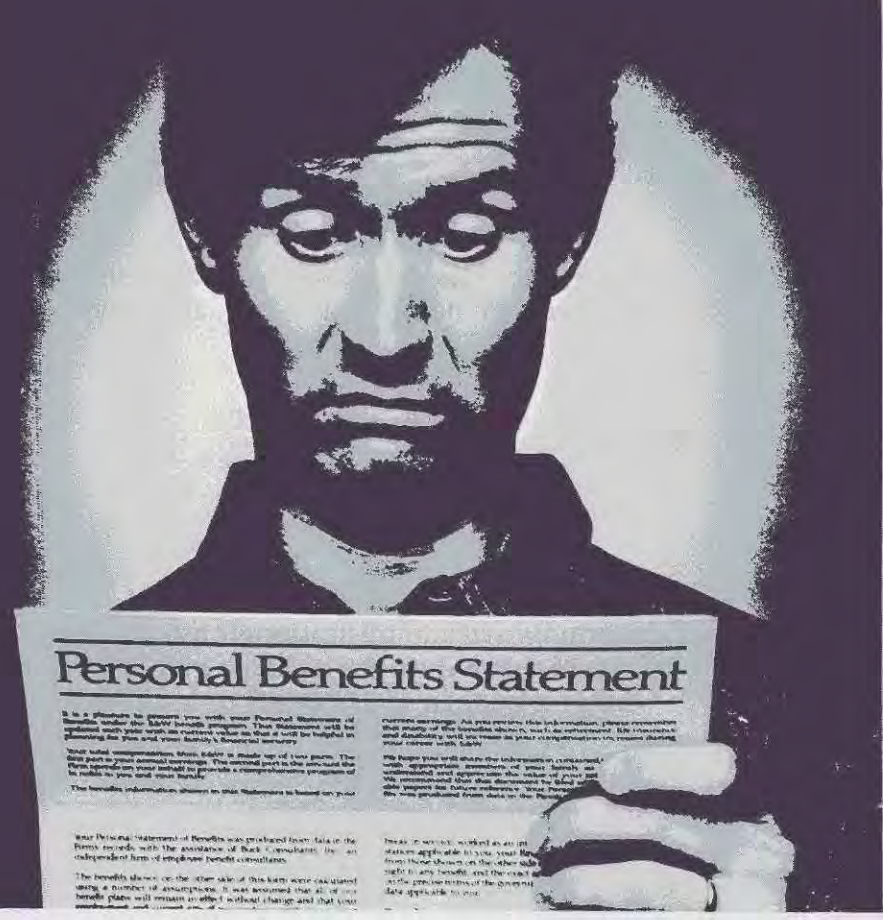
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• The AJRM Market Bulletin contains **market information** gathered from insurance experts in the United States and at Lloyd's of London. The bulletin, published in conjunction with the American Journal of Risk Management, provides vital information for brokers, agents and risk management professionals. For a free sample copy, write the AJRM, 108 Union Wharf, Boston, Mass. 02109.

• "Understanding the Cost of Post-Retirement Medical Benefits" is a new commentary published by William M. Mercer-Meidinger Inc. The eight-page report discusses how employers are currently handling **post-retirement medical benefits,** explains the accounting and legal issues involved and details employer strategies for the future. Free copies may be obtained by writing William M. Mercer-Meidinger Inc., Practice Development Group, 2600 Meidinger Tower, Louisville, Ky. 40202.

• A 1985 "Guide to **ERISA Reporting and Disclosure Requirements**" is available from the Actuarial, Benefits & Compensation Consulting Group of Coopers & Lybrand. The 18-page guide was prepared to help plan sponsors, administrators, trustees and attorneys comply with requirements of the Employee Retirement Income Security Act. For a free copy, contact Arlene Nowak, Coopers & Lybrand, 400 Renaissance Center, Detroit, Mich. 48243; 313-446-7346.

• A study of the current attitudes on causes of and possible cures for **escalating health care expenses** is now available from the International Foundation of Employee Benefit Plans. More than 1,000 responses to the survey were received from labor and management officials familiar with health plan design and administration. The cost of the study is $10 for IFEBP members and $17.50 for the non-members. For a copy, write IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005.

• Assets Protection's new magazine, **Computer Security Products Report,** is available free to individuals in the data processing, communications, computer security, security and electronic data processing auditing fields. The magazine discusses security equipment and systems as well as software and services, and it emphasizes field evalation of products and technological developments. For more information, contact Assets Protection Publishing, P.O. Box 5323, Madison, Wis. 53705.

• A sample **risk managment manual** for use in preparing your company's own corporate risk managment manual is now available from the Risk & Insurance Management Society Inc. A risk management manual supplies field personnel with up-to-date information on corporate policy regarding, for example, loss reporting, safety and security and cost allocation, and it also helps the risk manager gather information from throughout the company. To order, send $9.95 to Risk Management Society Publishing Inc., 205 E. 42nd St., New York, N.Y. 10017.

• Audio and videocassettes on **benefit issues** are available from the International Society of Certified Employee Benefit Specialists. The tapes cover such topics as trends in benefits, regulatory and legislative updates, flexible compensation, financial planning, employee stock ownership plans, health care cost management, investments, wellness, employee assistance programs, and perquisite issues. The audiocassettes cost $10 each. Videocassettes are available for $100 each. Order forms listing all available cassettes are available from the Audiovisual Services Department, ISCEBS, P.O. Box 209, Brookfield, Wis. 53008-0209, 414-786-8771.

• Single copies of "A Positive Approach To **Defending Municipalities**," a 117-page handbook written by defense attorney Jay S. Judge of the Park Ridge, Ill. law firm of Judge & Knight Ltd., are available free of charge. Multiple copies are $18.50 each. To order, write Mr. Judge at 422 N. Northwest Highway, Park Ridge, Ill., 60068. Request brochure No. 119.

• "Workers Compensation Benefits: Adequacy, Equity and Efficiency," a collection of papers reviewing **workers compensation benefit issues** presented at a seminar of the National Council on Compensation Insurance, is available. The papers cover special workers compensation funds, second injury funds and rehabilitation funds, as well as the issue of benefit levels and the question of adequacy and equity of the workers compensation system. The cost per copy is $20 for members and $26 for nonmembers. Copies may be ordered from Mr. Nau, NCCI, One Penn Plaza, New York, N.Y. 10119.

• The new, expanded second edition of the Insurance Information Institute's "Sharing the Risk," a prime source of information about the **property/casualty insurance industry**, is now available. Several areas of the book have been expanded from the first edition, including the sections on international insurance, insurance exchange operations, satellite insurance and financial guarantee funds. The 192-page book also includes a glossary of 240 insurance terms. Copies are $4.95 each; three or more copies are $3 each. Order from III, Publications Service Center, 110 William St., New York, N.Y. 10038.

• A California workers compensation insurance 12-year experience and dividend report on each **major workers compensation insurer** is now available from CHAPIN Associates. The reports, prepared on each of the 20 largest insurers in 1984, show premium written, loss ratio, dividends paid and other information from 1973 to 1984. Reports on fewer than 10 insurers are $5 per specified insurer, with lower rates available for information on 10 or 20 insurers. For more information contact CHAPIN Associates, P.O. Box 1444, Lafayette, Calif. 94549.

• The 10th edition of **"International Benefit Guidelines: 1985,"** is now available from William M. Mercer International. The publication discusses employee benefit and compensation practices in 58 countries. It looks at specific benefits issues in each country, including retirement, death, sickness and disability and other employee benefits, as well as financing methods, workers compensation and taxation. For a free copy, write to Giles C. Archibald, William M. Mercer International, 1211 Ave. of the Americas, New York, N.Y. 10036.

• A two-page summary of a survey of **health care cost management practices** currently being followed by 307 Connecticut employers to reduce their health care costs is available free from Personnel Management Services, 45 Reed St., Milford, Conn. 06460.

• **"Careers in Employee Bene-**

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Continued from previous page

fits," a booklet describing the jobs in the employee benefits field, is available from the International Foundation of Employee Benefit Plans. The booklet includes a source list for additional information and describes what a benefits career can offer, what is required and how to get started. To order the 28-page booklet, send $2 to, Publications Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069.

• The values that **pooling employee benefits in foreign countries** can reap for a U.S. multinational company and its managers at various levels are discussed in three new brochures: "Managing Benefits Abroad," "Multinational Benefit Accounting" and "Pooling for the Subsidiary." The brochures are available without charge and can be obtained from either Robert Pickrell, Multinational Benefit Associates, 980 Post Road, Darien, Conn. 06820, or Robert Johnson, Multinational Benefit Associates, Commerce Park, San Tomas, 3000 Scott Blvd, Suite 112, Santa Clara, Calif. 95050.

• "A Guide to Understanding **Corporate-Owned Life Insurance,"** is available free from Clark/Bardes Organization Inc. To order, write Clark/Bardes Organization Inc., 845 N. Michigan, Suite 815, Water Tower Place, Chicago, Ill. 60611.

• A practical guide to what ails America's health care system and **how employee benefit plans can contain rising costs** while maintaining quality care is now available from the International Foundation of Employee Benefit Plans. The 330-page "New Directions in Welfare Plan Benefits: Instituting Health Care Cost Containment Programs," discusses the dimensions of the challenge, examines existing efforts and advances new approaches. The cost of the book is $25 for IFEBP members and $40 for non-members. Order from Publications Department, IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069.

• The Hartford Steam Boiler Inspection & Insurance Co. has published a new brochure highlighting the company's approach to helping manufacturers meet the **American Society of Mechanical Engineers' code requirements.** Included in the eight-page, full-color brochure is a description of Hartford Steam Boiler's customized, cost-effective programs to help manufacturers of boilers, pressure vessels, pressure piping and nuclear components qualify for ASME code stamps. To order a free brochure, write Marketing Services, The Hartford Steam Boiler Inspection & Insurance Co., One State St., Hartford, Conn. 06102.

• A new brochure, "Ten Steps to a Successful Marine Insurance Program," is now being offered by Cook & Miller International Ltd. The guide—designed for exporters, importers, risk managers and others involved in international shipping—provides a basic outline of what steps are necessary in obtaining a comprehensive **marine insurance** program. For a free copy, write Michele Milone, Cook & Miller International Ltd, 60 E. 42nd St., Suite 724, New York, N.Y. 10165.

• Planning and evaluating a successful **employee pension plan** is the subject of a new book from the Commerce Clearing House. The 432-page "Guidebook to Pension Planning" discusses the considerations of both financial management and employee policy in formulating a plan, important pension legislative acts and the forms and procedures used in the exchange of information between the employer and outside agencies. To order a copy, send $10 to Cash-Item Department, Commerce Clearing House, 4025 W. Peterson Ave., Chicago, Ill. 60646.

• For workers nearing retirement, **the joint and survivor provision** mandated by federal law can be bewildering. A 24-page book, "Your Pension and Your Spouse—The Joint and the Survivor Dilemma," by the International Foundation of Employee Benefit Plans answers the most commonly asked questions about the provision. The book also includes financial worksheets the plan member can use to calculate anticipated retirement income and expenses. The cost is $4.95 each for IFEBP members and $7.95 each for non-members for up to 99 copies; $3.95 for members and $6.95 for non-members for 100-999 copies; $2.95 for members and $4.95 for non-members for more than 1,000 copies. Order from Publications Department, IFEPB, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069.

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MacLean, Oddy starts financial division

MacLean, Oddy & Associates, a Dallas-based wholesale brokerage unit of Sedgwick Group P.L.C., has formed a financial services division that will specialize in financially oriented and other types of coverage.

A spokeswoman for the company said the new division was created because of increased demand for a number of "reasonably complex" financial coverages.

"A lot of times clients would call us and it would be 20 questions about these coverages," said the spokeswoman. "So we decided to divisionalize and put them into one specific group."

The division will specialize in force majeure, systems performance/product guarantee and errors and omissions coverages. Other coverages handled by the new division will be directors and officers liability, political risk, kidnap and ransom/extortion, bankers blanket bond and credit enhancement. These coverages have become specialties of MacLean, Oddy, the spokeswoman said.

The spokeswoman said the brokerage could not yet predict an estimated annual premium volume that the new unit would handle.

The division will be headed by Terry Jacobson, assistant vp and manager, who will be responsible for its day-to-day management. John Hanna is president of the division, and Lafay Westbrook is assistant vp. The unit will employ three additional staff members.

Political risks

Pan Financial Insurance Co., a joint venture among three major insurers, has begun underwriting political risk, credit and war risk insurance.

The new company was formed by Skandia International Corp. of Stockholm, Sweden; The Continental Corp. of New York; and Yasuda Fire & Marine Insurance Co. Ltd. in Tokyo (*BI*, Sept. 17).

Capitalized at 9 million pounds ($11.2 million), Pan Financial has begun accepting risks and is operating from its London headquarters.

The company has also acquired a portfolio of excess-of-loss credit catastrophe insurance.

"The current level of demand for cover in these areas is extremely high and in many cases exceeds the capacity and technical expertise of the market to respond," said Alastair Malcolm, managing director of Pan Financial.

Energy department

Alexander & Alexander of New York Inc. has formed an energy department to broaden services for existing and prospective clients in the United States and overseas with energy risks.

William A. Empson, senior vp of A&A in New York, said, "The newly formed department brings together a large group of A&A specialists and effectively consolidates property, liability and marine expertise. This will allow us to concentrate on our strengths in this specialized area."

Michael K. White, president and CEO of Alexander & Alexander Services Inc.'s U.S. operations, added, "By uniting these specialists in our New York office, A&A will substantially improve its marketing strength with underwriters. This will ensure the best service for our clients in light of the hardening insurance market."

Aviation risks

National Excess Insurance Services Inc., a managing general agent in Richardson, Texas, is writing private and non-airline commercial aircraft and various airline risks on behalf of The Home Insurance Co.

National Excess is a subsidiary of Corroon & Black Corp. and was part of the broker's discontinued underwriting management group. Although the MGA has been treated as a discontinued operation since the beginning of the year, National Excess remains in business until it can be sold or is closed, said Stephen A. Crane, chief financial officer at Corroon & Black.

The MGA also has a Laguna Hills, Calif., office.

markets

HMO firms merge

United HealthCare Corp.'s acquisition of Share Development Corp. in a stock swap valued at around $59 million will create a health maintenance organization management company with 26 plans in 18 states.

United said the merger will bring its total number of plan members to 564,300 with 10,100 participating physicians in the 26 HMOs. However, the companies, both headquartered in Minnesota, will continue to operate independently.

UHC's largest-managed HMO is Physicians Health Plan of Minnesota, with 252,000 members and 2,600 physicians. Share's largest is Share-Minnesota, an HMO with 125,000 members and more than 750 physicians.

Richard T. Burke, chairman of United, said the merger "will complement our operations in the midwestern United States with the addition of Share HMOs in Nebraska, Illinois and Iowa. It will also improve our ability to compete nationally with large health insurance providers by making us one of the largest publicly held HMO companies in the country."

Continued on next page



Continued from previous page

Robert K. Ditmore, chairman of Share, said, "This combination creates one of the strongest, most experienced HMO management teams in the industry."

The merger is subject to approval by Share stockholders and the qualification of certain accounting procedures by various regulatory officials.

Pension products

CIGNA Corp. has formed a new joint venture to market, sell and service investment-oriented pension plan products.

CIGNA Asset Advisers Inc. is supported by CIGNA's Group Pension Division and the CIGNA Investment Group. The new company will provide pension investment services to corporate, government and non-profit pension plan clients, as well as foundations and endowment funds.

The new company, headquartered in Bloomfield, Conn., will have available the sales and marketing expertise of the two CIGNA groups that are supporting the venture.

"By bringing together seasoned professionals from our pension and investment areas, we are offering our pension clients a level of service unmatched in the marketplace," says John K. Armstrong, CIGNA's executive vp and chief investment officer.

Energy underwriter

The Chubb Group of Insurance Cos. in Warren, N.J. has formed an Energy Resources Group to underwrite coverage for traditional and alternative energy exposures.

"ERG is a multidisciplined group that understands the insurance, technological and financial considerations of the energy industry," says Alan Brown, national manager of the group.

"We've offered traditional energy risks for the last couple of years. However, Chubb is one of the few carriers to devote a staff exclusively to serve both sides of the energy industry," Mr. Brown explained.

Coverages to be written by the energy group are tailored to specific alternate energy projects, including hydroelectric, wind farms, methane generation, geothermal and others.

Alternate energy coverages are available to:

- Cover losses resulting from a shortage or absence of resources vital to the economic success of a project, such as energy projects powered by water, sunlight, grain or garbage.
- Protect against losses due to the failure of an alternate energy system to perform as expected.

ERG also writes property and casualty coverages for traditional energy industries like coal, oil, gas and fossil fuel utilities.

New consultant

Tiller Consulting Group Inc. has recently opened in Corona del Mar, Calif., to provide actuarial and environmental risk consulting services.

Margaret Wilkinson Tiller, founder of the new company, said: "Tiller Consulting Group is, to our knowledge, the only firm in the country that has the in-house technical expertise to estimate the financial impact of environmental problems" like asbestos exposures.

"We also provide traditional, and some not-so-traditional, actuarial and environmental risk consulting services."

Besides separate traditional services, Tiller's offerings include combined actuarial and environmental consulting projects like occupational disease financial impact studies, product liability financial impact determination and financial evaluation of environmental liabilities with regard to mergers, acquisitions and divestitures.

Ms. Tiller was formerly principal consulting actuary and manager of the actuarial department at Warren, McVeigh & Griffin in Newport Beach, Calif.

Tiller Consulting is located at 509B Goldenrod Ave., Corona del Mar, Calif. 92625; 714-673-7089.

Mergers/acquisitions

The Crump Cos. Inc. through its Texas subsidiary, **General Insurance Managing Agency Inc.**, has acquired the insurance renewals and other assets of **Houston Mutual Agency Inc.** The operations of Houston Mutual will be added to GIMA's **Crump-Strange Agency Inc.** in Houston. The Crump Cos. is the nation's ninth-largest insurance brokerage.

The Crump Cos. has also acquired **Hanson, Winter & Orloff Insurance Brokers Inc.** of Los Angeles.

Hull & Co., an excess and surplus lines wholesale brokerage headquartered in Fort Lauderdale, Fla., has acquired the **American Eagle General Agency** of Lincoln, Neb., from **Guaranty National Insurance Co.**

Hilb, Rogal & Hamilton Co., the nation's 17th-largest insurance brokerage, has acquired **Whitley-Page Insurance Agency Inc.** of Goldsboro, N.C. Whitley-Page will be merged into **Underwood-Dawson Inc.**, another Hilb subsidiary in Goldsboro.

Emett & Chandler Cos. Inc., the nation's 13th-largest brokerage, has acquired the Kansas City office of **Reed Stenhouse Cos. Ltd.** for an undisclosed sum.

New offices

American Claims Evaluation Inc., which offers cost-containment services to corporations and insurers by reviewing hospital bills, has opened an office at 1415 W. 22 St., Oak Brook, Ill. 60521; 312-323-0710.

Tenco Services Inc., an independent insurance adjuster and surveyor headquartered in Nashville, Tenn., has opened an office at Suite 180, Stewart Building., 110 Veterans Blvd., Metairie, La. 70005; 504-831-6971.

Mutual Reinsurance Bureau has opened an office at The Executive Center, 1 Middle St., Portsmouth, N.H. 03801; 603-431-2713.

Towers, Perrin, Forster & Crosby is opening a reinsurance brokerage office at 1266 Main St., Stamford, Conn. 06902; 203-964-9990.

IDBI Managers Inc. has moved to 175 Water St., New York, N.Y. 10038; 212-344-3338.

Bayly, Martin & Fay Inc. is now located at 10 E. 40th St., New York, N.Y. 10016; 212-683-8585. ■

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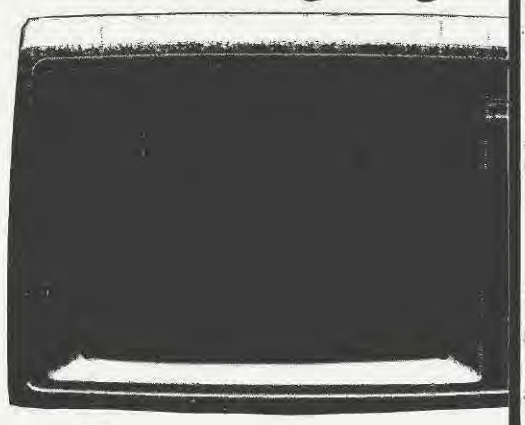
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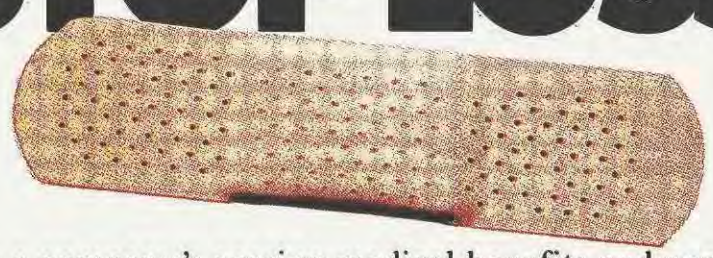
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washington

Association fights to keep 401(k) for non-profit groups

By JERRY GEISEL

WASHINGTON—The nation's largest association of trade group executives will fight to retain 401(k) salary reduction plans for non-profit organizations and state and local governments.

The 12,000-member American Society of Assn. Executives in Washington says it is developing a coalition to convince the Reagan administration to back off from its proposal—contained in the administration's recently proposed tax reform package—to wipe out 401(k) plans for tax-exempt organizations (*BI*, June 3).

The new coalition—known as the Non-profit Coalition to Perserve 401(k)—intends to make administration officials, including Treasury Department Secretary James Baker III, aware of the concerns about this "inequitable" proposal, according to Jim Albertine, the ASAE's director of government affairs.

"We want to educate policymakers," Mr. Albertine said, noting that trade associations will become less competitive with for-profit employers if they can't offer 401(k) plans.

In addition, the coalition will conduct a grass-roots campaign to alert trade groups to the impact of the administration's proposal on 401(k) plans.

"Many people don't know what has been proposed, and we want to get the word out," Mr. Albertine said.

Current law doesn't explicitly allow or forbid 401(k) plans for tax-exempt employers. However, the Internal Revenue Service, acting on a case-by-case basis, has approved 401(k) plans for non-profit employers, according to Mr. Albertine.

It isn't known how many 401(k) plans the IRS has approved for tax-exempt employers.

Non-profit employers that want more information about the 401(k) coalition or wish to join should contact the ASAE's Government Affairs Division, 1575 I St. N.W., Washington, D.C. 20005; 202-626-2713.

Tax plan 'deceiving'

The Reagan administration's proposal to tax workers on employer-paid health insurance premiums is regressive and could lead to yet higher taxes, a benefits lobbying group says.

As part of the administration's proposal to overhaul the Tax Code, employees would be taxed on employer-paid health insurance premiums of $10 a month for individual coverage and $25 a month for family coverage.

As a result, employees with individual medical coverage would have $120 in new taxable income a year, while the annual taxable income for those employees opting for family health care coverage would rise by $300.

But, such a small tax is "deceiving," according to David Hurd, chairman of the Assn. of Private Pension & Welfare Plans and executive vp of Bankers Life Co. in Des Moines, Iowa.

"We would suggest that the numbers proposed by the administration are deceiving and it is not at all unlikely that, if enacted, this floor tax will be raised over time until employees, particularly at lower income levels, will choose not to be covered by these programs rather than be taxed without an increase in salary to enable them to pay the tax," Mr. Hurd said last week in testimony submitted to the House Ways and Means Committee.

Mr. Hurd also criticized the administration's proposed anti-discrimination tests for 401(k) plans (*BI*, June 17).

He said the proposed anti-discrimination tests are "inordinately complex and will add immeasurably to the administrative costs of the plans."

PBGC sells facilities

The Pension Benefit Guaranty Corp. has earned a $625,000 profit on the sale of several meatpacking facilities formerly owned by a company that left the PBGC with a big pension debt.

However, the profit will not come close to offsetting the company's pension liabilities that have been assumed by the PBGC.

In March, the PBGC paid $2.175 million at a court-ordered auction for the Columbus Junction, Iowa, facilities and four hog-holding stations in the surrounding area that were formerly owned by Rath Packing Co. Rath has been operating under Chapter 11 of the Federal Bankruptcy Code since November 1983.

The agency says it has accepted a bid of more than $2.8 million for the facilities. The offer was made by Iowa Beef Corp. of Dakota City, Neb.

The profit, though, is small compared with the benefits the PBGC will have to pay to participants of several underfunded Rath pension plans that the company terminated in 1982 and the PBGC then took over (*BI*, Oct 11, 1982).

The agency estimates that the plans' liabilities are about $60 million.

OSHA inspections

The Occupational Safety and Health Administration expects to conduct about 71,000 worksite inspections in fiscal 1985, about the same number it conducted in fiscal 1984.

An OSHA analysis of the 35,336 inspections during the first six months of fiscal 1985 found that 31,332, or 89%, were walk-around checks of working conditions. An additional 4,004 checks were records inspections that ended after compliance officers determined that a manufacturer had a better accident record than the national average.

Some 54% of the checks were in the construction industry and 35% were of manufacturing sites. The rest were in other types of businesses.

OSHA inspectors reported 59,550 safety and health violations and proposed more than $4.6 million in fines in the first six months of fiscal 1985.

Meanwhile, Patrick Tyson, deputy assistant secretary of labor for occupational safety and health, has been named acting OSHA chief.

Mr. Tyson replaces former OSHA chief Robert Rowland, who resigned last month.

NAIB gets new home

The National Assn. of Insurance Brokers has moved to new quarters in Washington.

The broker association now is located at 1401 New York Ave., N.W., Suite 720, Washington, D.C. 20005. The new telephone number is 202-628-6700. ■

Pressley named risk manager at Gold Kist

Paul Pressley has been promoted to director of risk management and insurance at Gold Kist Inc. in Atlanta. In his new position, Mr. Pressley will be responsible for property and casualty insurance and the workers compensation self-insurance program for the diversified agricultural cooperative. Mr. Pressley replaces **Dennis McGovern**, who left the company, and he reports to Peter Gibbons, vp-finance. Mr. Pressley had been manager of protection services in Gold Kist's corporate protection department. He has a bachelor's degree in engineering from North Carolina State University in Raleigh and a master's of business administration degree from Georgia State University in Atlanta. He holds the Chartered Property & Casualty Underwriter designation.



Mr. Pressley

* * *

Diana P. Walker has been named director of risk management at Thousand Trails Inc., a membership campground company in Bellvue, Wash. In this newly created position, Ms. Walker is responsible for insured, self-insured and loss-control programs covering more than 2,500 employees, 43 resort properties and more than 73,000 member families. Before joining Thousand Trails, Ms. Walker was an account executive with Marsh & McLennan Inc. in Seattle, and prior to that, she was an assisant vp with Johnson & Higgins in Los Angeles and San Francisco. Ms. Walker reports to Mel Kays, executive vp. She attended University of Redlands in Redlands, Calif., and holds the Associate in Risk Management designation.



Ms. Walker

* * *

Arnold Davenport, has been named vp-risk management for Marriott Corp. in Washington. In this newly created position, Mr. Davenport will be responsible for the insurance and loss-prevention functions at the hotel and restaurant firm. Previously, he was vp-loss prevention at the company. He reports to William J. Shaw, vp-finance and corporate controller. Mr. Davenport has a bachelor's degree in business from the University of Rochester in Rochester, N.Y., and he is a graduate of the Management Development Program at Harvard University Graduate School of Business Adminstration.

* * *

William Szykula, 42, will become director of workers compensation at K mart Corp. in Troy, Mich. Mr. Szykula, an attorney, is currently an assistant director at K mart. Mr. Szykula has an undergraduate degree in economics and psychology from Michigan State University in East Lansing and a law degree from the University of Detroit Law School. Mr. Szykula replaces **John J. Molloy**, who is leaving this month to join Associated Risk Services, a third-party administrator in Atlanta. Mr. Molloy, 64, will be a senior vp at 1-year-old ARS, in charge of operations. Mr. Molloy is on the executive committee of the National Council of Self-Insurers, is a consultant to the International Assn. of Industrial Accident Boards and Commissions and serves on the executive board of several state self-insurance associations.

* * *

Karyn M. Roach, 34, has been appointed corporate risk manager of Newpark Resources Inc. in Metairie, La. In this newly created position, Ms. Roach will be responsible for administration of the property, casualty and group insurance programs at the oil and gas service company. Previously, Ms. Roach was corporate insurance administrator of Newpark. She reports to James C. Farrell, vp-insurance.

•

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comings & goings: buyers

N.Y. must pay $2 million award

NEW YORK—The city of New York has been ordered to pay $2 million to a 15-year-old girl whom police failed to protect from an attack by her father.

The city self-insures its liability risks and will bear the cost of the award, a spokesman said.

The state Court of Appeals recently affirmed two lower court rulings that New York police did not protect Dina Sorichetti—age 6 at the time of the attack—when her father tried to kill her after picking her up for a visit at a police station.

The child's mother, who was separated from her husband, said Frank Sorichetti—who was convicted for attempted murder and is in prison—threatened her and the child as he left the station.

The attack left Dina physically and emotionally handicapped, the suit says. ■



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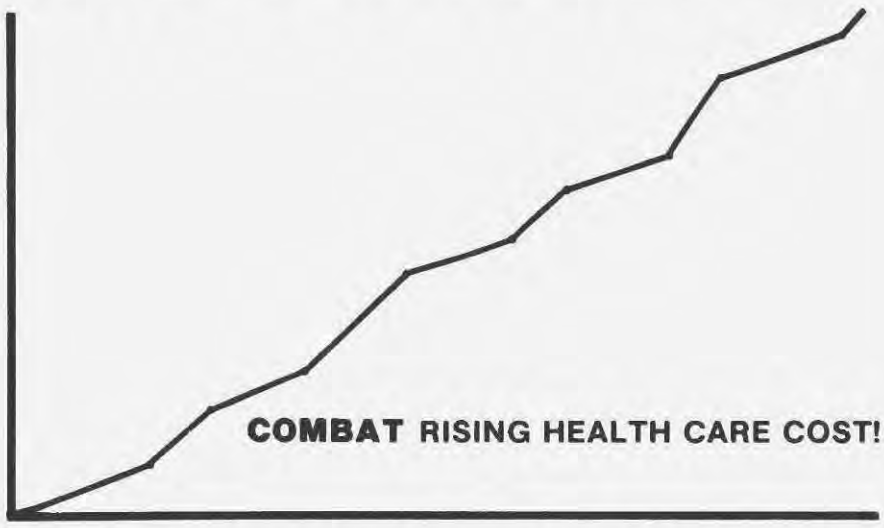
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Many companies still offer full hospital reimbursement

By MARLA ANTELIS

Many companies still provide their salaried employees with full reimbursement for hospital charges, despite the emphasis on health care cost containment, a new study indicates.

Also, few large companies offer coverage for ancillary health care services like vision and hearing care as part of their salaried employees' medical plans, according to "Salaried Employee Benefits Provided by Major U.S. Employers in 1984," conducted by Hewitt Associates in Lincolnshire, Ill.

Hewitt recently compiled its annual "factbook" of current practices in benefits for salaried employees from data collected in early 1984. The survey identifies trends in companies' employee practices in the areas of health care, retirement, long-term disability and group life insurance benefits.

The surveyed companies include 90% of the Fortune 100 and about 60% of the Fortune 500.

All 762 employers surveyed provided medical coverage to salaried employees. In addition, slightly more than half—53%—of employers surveyed reimbursed 100% of reasonable and customary hospital room and board expenses.

Twenty percent of the total companies provided full reimbursement for 365 days of hospitalization per year. Eight percent limited the reimbursement to 120 days; 4% to less than 120 days; and 2% to 180 days.

Six percent of plans had no reimbursement limit, and 12% provided 100% reimbursement up to a specified dollar amount, at which point a lesser percentage would be reimbursed.

Coinsurance, whereby the employee pays a portion of medical expenses, was applied on hospital room and board charges by 47% of surveyed companies.

Six percent reimbursed 90% of reasonable and customary charges. Three percent of plans reimbursed employees at the 85% level; and 28% reimbursed 80% of these charges.

One percent based reimbursement of employees' hospital costs at a per-day flat dollar rate, and 8% said reimbursement depended on the type of health plan option chosen by the employee.

Some 24% of surveyed plans provided full reimbursement of surgical charges, while an additional 3% provided full reimbursement up to a specified limit and then reimbursed at a reduced rate.

Some 44% of surveyed companies provided 80% reimbursement of surgical procedures. Six percent reimbursed at the 90% level; 4% at the 85% level; less than 1% at the 80% level and less than 1% at the 95% level.

Of the remaining companies, 11% percent reimbursed surgery costs according to a schedule, and 6% reported that reimbursement varied according to the health plan option selected by the employee.

Forty-nine percent of the plans provided first-dollar hospitalization coverage, while 45% of the salaried employee plans surveyed required a deductible.

Forty percent of plans that required a deductible set the deductible at $100 per year; 12% required $150; and 16% required more than $150. Nine percent required a $50 deductible; 1% required less than $50; 3% required $51-$99; and 2% required $101-$149.

An additional 7% of surveyed companies whose plans had a deductible said they based the deductible on salary, and 9% reported other criteria upon which they based deductibles.

In addition, 87% of these plans specify a maximum deductible per family.

Most surveyed companies also reported that their plan contained a stop-loss cap to limit the employee's exposure to health care-related expenses.

In 67% of plans, employees were responsible for paying up to $1,000 —excluding any deductible—of covered health care expenses annually.

The majority of plans—76%—placed a lifetime maximum on the amount of benefits an employee can receive. The next-largest group —17%—set no maximum limits on an employee's medical benefits. Two percent based benefit limits on the cause of the illness; 2% imposed both lifetime and annual maximum benefits; less than 1% imposed an annual maximum benefit; and 2% said the overall plan maximum depended on the option selected by the employee.

Of those plans having a lifetime maximum, 36% provided between $500,001-$1 million in coverage. The next largest group—29%—offered between $250,001-$500,000. And, 23% had maximums ranging from $200,001-$500,000 in coverage.

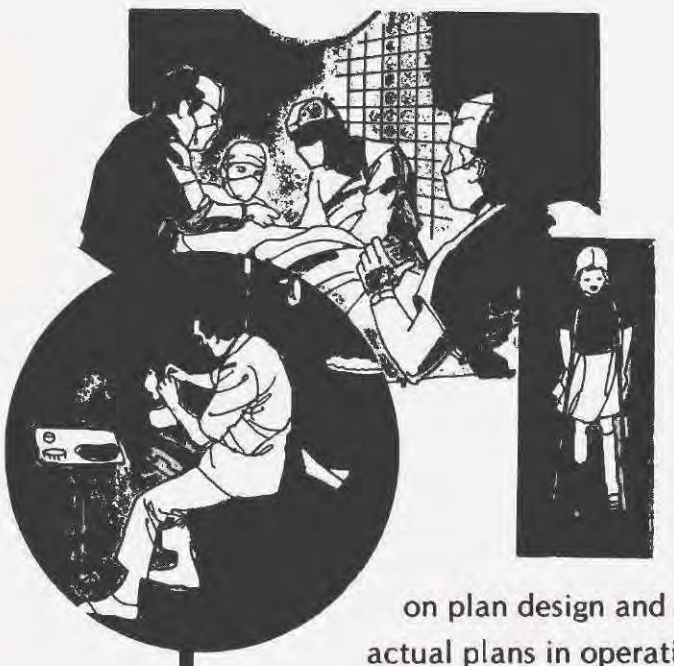
The survey also showed that many companies' medical plans cover retirees as well.

Medical benefits for retirees under the age of 65 were provided by 91% of plans surveyed. Medical benefits for retirees over the age of 65, coordinated with Medicare benefits, were provided by 86% of companies.

Group long-term disability benefits were offered to salaried employees by 84% of surveyed companies.

Thirteen percent said they offered a group LTD plan as well as a disability benefit under their pension plans; and 3% offered pension disability benefits only.

Continued on next page



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The pay-replacement formula used by half the surveyed LTD plans provided benefits equal to 60%-64% of pay. The next-largest group—17%—provided benefits equal to 50%-59% of pay. Eleven percent of the surveyed LTD provided benefits equaling 65%-69% of pay; 4% offered benefits equal to 70% or more; and less than 1% offered benefits equal to less than 50% of pay.

Three percent of the companies said the benefit formula depended on the option selected by the employee, and 14% reported that other formulas were used.

Thirty-three percent of companies surveyed offered a maximum monthly LTD benefit of $4,001 or more. Fourteen percent offered a maximum monthly benefit of between $3,001-$4,000; 11%, between $2,501-$3,000; 6%, between $2,001-$2,500; and 6%, $2,000 or less.

No dollar maximum was stated in 29% of LTD plans. One percent said the maximum depended on the option chosen by the employee.

Duration of LTD benefits varied somewhat. Some 88% of the companies' plans paid LTD benefits until age 65 in cases where the disability occurred before age 60. If the disability occurred before age 60, 3% paid benefits until age 70; 1% reported benefits were payable until age 62; and 4% paid benefits for life.

Four percent of companies based duration of LTD benefits on years of service, and 1% based duration on the employee's age at the time disability occurred.

In addition, 58% of the surveyed companies reported that their LTD plans did not require an employee contribution. Forty-two percent required an employee contribution, and less than 1% said it depended on the plan option chosen.

In the area of ancillary health care benefits, dental care was the most common benefit offered by surveyed companies. The majority of employers—89%—offered the benefit to their salaried employees.

Fifty-two percent of the surveyed dental plans required a deductible for certain services only. Deductibles often are waived for specific services, such as preventive care.

Twenty-eight percent of surveyed plans required a deductible for all dental care, and 19% of plans did not require any deductible.

Of the dental plans surveyed, 79% covered orthodontia benefits, although this percentage excluded those employers with flexible spending or reimbursement accounts that could be used to cover orthodontia benefits.

A large number of surveyed dental plans—44%—did not require employee contributions toward dental coverage. However, 34% required employee contributions for employee and dependent coverage.

Twenty-one percent required contributions for dependent coverage only.

Vision and hearing care benefits were not offered by most companies in 1984. Only 19% of companies had a plan providing vision care benefits. Six percent offered the benefit through a reimbursement account only, and less than 1% said the benefit was dependent on which option the employee chose.

Even fewer companies—5%—reported that they offered a hearing care plan, though 6% offered the benefit through a flexible spending or reimbursement account, and 1% said provision of the benefit depended on the option selected by the employee.

The study also examined the prevalence of group life insurance coverage.

Some 73% of surveyed employers offered both non-contributory group life plans and plans in which employee could contribute to increase their benefits.

Fourteen percent offered company-paid plans only, while the remaining 13% offered a contributory plan only.

At companies with non-contributory plans only, 26% offered a benefit of 200% of annual pay. An additional 25% offered a benefit equal to an employee's annual pay, while 11% provided a benefit between 101%-1.999% of annual pay. Two percent provided a benefit less than 100% of annual pay, while 10% provided a flat-dollar amount. The other 17% used some other type of benefit formula.

Of those offering non-contributory group life plans, 35% of companies said no dollar maximum was placed on the amount of coverage provided; 14% offered a maximum benefit of more than $400,000; 6% offered a maximum benefit of $300,000-$399,999; 7% offered a maxiumum benefit of between $200,000-$299,000; 8% offered a maximum benefit of between $100,000-$199,000; 6% offered a maximum benefit of between $50,000-$99,000; and 11% offered a maximum benefit of less than $50,000.

At companies where employees could contribute to the cost of group life coverage, 34% offered maximum coverage that exceeded 400% of an employee's annual pay. Some 28% offered maximum coverage of 300%-399% of pay; 29% offered 200%-299% of pay; and 4% offered less than 200% of pay. Five percent offered maximum coverage according to some other formula.

Of those plans in which both the company and the employee contributed to the cost of the coverage, 41% placed no cap on the amount of life insurance benefits.

Eleven percent limited benefits to $1 million or more, 9% offered a maximum benefit of $600,000-$999,999; 9% offered a maximum benefit of $500,000-$599,999; 4% offered a maximum benefit of $400,000-$499,999; 8% offered a maximum benefit of $300,000-$399,999; 9% offered a maximum benefit of $200,000-$299,999; 6% offered a maximum benefit of $100,000-$199,999; and 3% limited group life benefits to less than $100,000.

Employee contributions to group life insurance plans were based on a flat rate for all ages by 46% of the plans. A variable rate based on age was used to calculate employee contributions in 45% of the plans; and a rate varying with sex and age was used by 1% of plans.

A flat percentage of pay was used to determine employee contributions in 2% of plans, and a variable rate based on amount of coverage was used in 4% of plans.

Most companies surveyed offered one or more capital accumulation benefits to their salaried employees.

Continued on next page



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Hewitt survey

Continued from previous page

The vast majority—91%—offered one or more defined contribution capital accumulation plans, usually as a supplement to a defined benefit pension plan.

The most common capital accumulation plan offered was a savings/thrift plan, offered by 76% of surveyed companies. For purposes of the survey, profit-sharing plans that require employee contributions were characterized as savings plans.

Fifty percent of these plans featured employer contributions and a 401(k) salary reduction.

Five percent offered savings plans with a 401(k) salary reduction feature that did not include employer contributions.

The next most popular capital accumulation option, offered by 46% of surveyed companies, was some kind of employee stock ownership plan.

Seventeen percent of the companies surveyed offered profit-sharing plans to salaried employees. Fourteen percent offered the plan without a 401(k) feature, while 3% offered some type of 401(k) feature to their profit-sharing plans.

Nine percent offered no capital accumulation plans to employees.

The Hewitt study included principal benefit plans for salaried employees of 762 major U.S. employers, comprising 90% of the Fortune 100 companies and about three-fifths of the Fortune 500 companies.

Participating companies by industry group included: industrial, 63%; commerical banking and diversified financial, 11%; insurance, 8%; utilities, 6%; diversified services, 5%; retailing, 5%; and transportation, 2%.

Twenty-one percent of the industrial companies surveyed reported less than $500 million in annual sales; 21% reported $500 million to $1 billion; 18% reported $1 billion to $2 billion; 8% reported $2 billion to $3 billion; 8% reported $3 billion to $4 billion; 7% reported $4 billion to $5 billion; and 9% reported $5 billion to $10 billion. No sales figures were reported by 3% of the industrial companies, and the revenues of the other types of companies participating in the survey were not reported.

•

Copies of the 25-page factbook, "Salaried Employee Benefits Provided by Major U.S. Employers in 1984," are available for $25 each from Hewitt Associates, Julie Stastny, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

Nearly all companies offer defined benefit plan: Survey

Some 93% of the companies in the Hewitt Associates survey on employee benefit practices report they offer salaried employees a defined benefit pension plan.

A highest average pay formula was used by 87% of companies. Of the total, 76% used highest average pay over five years; 10% used a three-year average; and 3% used another time frame.

Of the remaining companies, 13% used career average pay as a basis for calculating pension benefits, and less than 1% offered fixed dollar benefits.

Slightly more than half the surveyed companies—51%—recognized bonuses in their formulas for determining pension benefits. Forty-six percent excluded bonuses, and 3% recognized a portion of employee bonuses.

In 82% of the surveyed plans, employees were 100% vested after 10 years' service, while at 1% of the employers, workers were 100% vested after five years' service. One percent also indicated employees became 100% vested after a different length of time.

Of the remaining plans, 12% had a graded vesting schedule, while 4% used the so-called "rule of 45" vesting schedule, which takes into account both years of service and the employee's age.

Ninety percent of surveyed plans defined benefit plans did not require employee contributions.

Companies also were surveyed on their early retirement eligibility requirements. Not quite half of the companies—46%—made employees eligible for early retirement at age 55 after 10 years of service with the company. The next largest number—17%—had two or more alternatives that could be chosen by employees wishing to take early retirement, such as allowing retirees with a certain number of years of service or those at a certain age and a lesser number of years of service to opt for early retirement.

Eleven percent gave employees the option of early retirement with no regard to years of service; 8% provided the option at age 55 with 15 years of service; 5% at age 55 with five years of service; 3% at age 50 with 10 years of service; 2% at age 55 with 20 years of service; 2% at age 60 with 10 years of service.

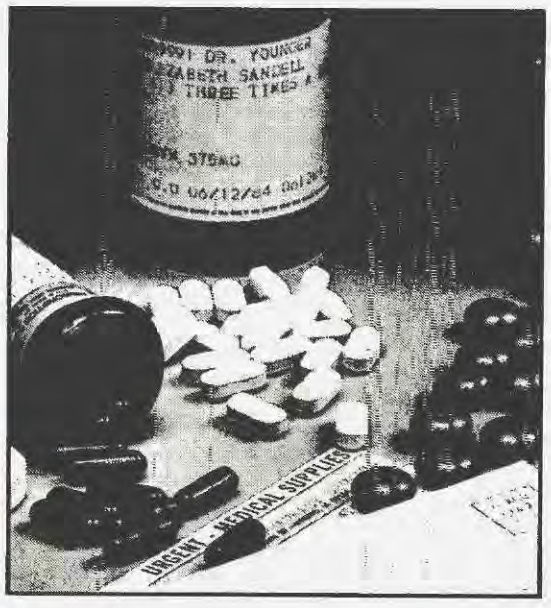
Six percent reported they had other eligibility requirements for early retirement.

Forty percent of companies said employees that retired before age 65 received reduced benefits. The age at which employees could retire and receive full benefits was set at 62 by 34% of companies; age 60 by 14%; and age 55 by 8%.

Four percent reported other minimum ages at which unreduced benefits were granted.

Most plans—64%—did not provide pension benefit increases for employees still on the job after they reached what was considered "normal" retirement age. Twenty-four percent provided a credit for years of service and recognized subsequent pay increases; 6% provided an actuarial increase only; 3% provided pay recognition only; 2% had service credit only; and 1% offered an actuarial increase, service credit and pay recognition. ■

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American International Group makes common stock offering

American International Group Inc. has announced the public offering of 3.45 million shares of common stock at a price of $84.75 per share.

The offering includes an option granted to the underwriters, Goldman, Sachs & Co. and Salamon Brothers, to purchase up to $450,000 in additional shares to cover over-allowances. This option was exercised in full.

AIG intends to add the net proceeds of the offering for general corporate purposes, including possible investments in or extensions of credit to subsidiaries.

Frank B. Hall

Frank B. Hall & Co. Inc. has agreed to sell 1 million shares of its common stock through a private placement in Europe through Fox-Pitt, Kelton N.V.

After the sale, Hall will have 15.8 million shares issued and outstanding.

Hall has agreed to file a registration statement with the Securities and Exchange Commission covering the shares. Fox-Pitt intends to resell the shares to institutional investors outside the United States at $28.375 per share. Fox-Pitt says it has indications the issue will be fully subscribed.

Hartford

Hartford Fire Insurance Co., principal company of the Hartford Insurance Group, has filed a registration statement with the Securities and Exchange Commission for a series of public offerings of up to $200 million of preferred stock.

Net proceeds will be added to The Hartford's general funds to increase both its surplus and premium-writing capacity.

The First Boston Corp. is expected to underwrite the offering.

Old Republic

Old Republic International Corp. has sold 740,000 shares of $4 Series F Convertible Exchangeable Preferred Stock with a stated value of $50 per share. In addition, it has sold a $30 million principal amount of 11.5% Sinking Fund Debentures due in 2015.

Each share of the convertible stock is initially convertible into 1.156 of Old Republic common stock, equivalent to a conversion price of $43.25 per share.

Merrill Lynch Capital Markets, E.F. Hutton & Co. Inc., Kidder, Peabody & Co. Inc. and Paine Webber Inc. are the co-managers of the offerings.

Old Republic says it will use the proceeds to repay notes due to banks, add to the capital of its insurance units and for general corporate purposes.

General Re

General Re Corp. has authorized the offering of 3 million shares of common stock.

The company has granted the underwriters an option to purchase up to 450,000 additional shares in order to cover over-allotments.

Net proceeds from the sale will be contributed principally to General Re's property/casualty reinsurance subsidiaries as needed to support anticipated premium growth in those subsidiaries. The balance of net proceeds, if any, will be used for general corporate purposes.

Morgan Stanley & Co. Inc., Goldman Sachs & Co., The First Boston Corp. and Salomon Brothers Inc. will manage the offering.

Travelers

The Travelers Corp. has arranged for a $400 million five-year Euronote purchase facility.

If The Travelers chooses to borrow under this facility, notes will be issued and bid upon at a maximum rate of 10 basis points over the London Interbank Offered Rate (LIBOR).

The facility was arranged by Credit Suisses First Boston Ltd. and will be managed by a group of 16 international banks. ■

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Harlow named chairman of J&H benefits unit

James G. Harlow, senior vp at Johnson & Higgins in New York, has been named chairman of the broker's National Benefits Office, responsible for the firm's nationwide employee benefits consulting and actuarial services.

Mr. Harlow succeeds **John H. McGowan,** who plans to retire at year-end. Mr. Harlow joined J&H's employee benefit plan department in 1960 as a consultant.

Sam W. Aiena, a J&H senior vp, will succeed Mr. Harlow as managing director of J&H's New York office. He had been Mr. Harlow's deputy. **Richard E. Meyer,** senior vp-property department, becomes deputy managing director of the New York office.

In addition, J&H has made several other personnel changes in its employee benefit division. **Edward J. Emering** joins J&H's Chicago office as senior vp. He had been a partner and regional director of actuarial services at Touche Ross & Co. **Robert H. Shannon** joins the New York office as vp. He had been director of marketing at Buck Consultants Inc. **Thomas J. Cavanaugh** joins the New York office as vp. He had been a consulting actuary at Buck. **Robert North Jr.** joins the New York office as a vp in the National Benefits Office. He had been with Towers, Perrin, Forster & Crosby. **Richard P. Jensen** joins the Cleveland office as vp. He had been a vp at Connecticut General Life Insurance Co. Also, **Richard P. Miller** transfers to J&H's Chicago office as vp and manager of the employee benefit department. He most recently served as employee benefits manager in the New Orleans office.

Other agent/broker changes:

Peter S. Pilgrim rejoins Marsh & McLennan Inc. in Cincinnati as vp and manager of insurance services. He formerly had been executive vp of K&K Insurance Agency, and president of its subsidiary, K&K All-Risk Insurance Agency, both in Fort Wayne, Ind.



Mr. Pilgrim

Carey M. Brickell Jr. appointed chairman at Bayly, Martin & Fay Inc. of Jacksonville, Fla. Also, **L.J. Clary** named president and manager of the Jacksonville office.

Michael A. Borges promoted to director of risk management at Emett & Chandler Northern California Inc. Mr. Borges most recently served as vp.

William S. Pontius named senior vp of Public Entities National Co., a Nashville, Tenn.-based subsidiary of Corroon & Black Corp. specializing in property/casualty programs for public entities and associations. Mr. Pontius most recently was president of Enterprise Insurance Co., a division of Mission Insurance Group. Also at Corroon & Black, **James M. Corroon** promoted to eastern region director for brokerage services and **Edward A. Sweeney** named chief executive officer of Corroon & Black Co. of New York Inc. Mr. Corroon, nephew of Corroon & Black Corp. Chief Executive Officer Robert Corroon, joined Corroon & Black Co. of New York in 1967 and has served as chairman and chief executive officer of that company since 1982. Mr. Sweeney also joined Corroon & Black of New York in 1967 and has served since president and chief operating officer since 1982.

Jeffrey M. Scales named executive vp of Heffernan Kiler & Doble Inc. in San Francisco. He is responsible for the company's property and casualty operations.

Jean-Marie Bioul, managing director of Marsh & McLennan Inc., named chairman and chief executive officer of Henrijean & Cie S.A. in Brussels, Belgium, a Marsh & McLennan affiliate. He succeeds **Baron Philippe Snoy**, a managing director at Marsh & McLennan and chairman of Henrijean, who retired. Mr. Bioul, a managing director at Marsh & McLennan, served as operating officer since 1980 and joined the company in 1944.

Raymond B. Vaughn Jr. named president of Meeker Sharkey & Moffatt in Cranford, N.J. Mr. Vaughn most recently was vp of Amalgamated General Agencies in Union, N.J.

Three appointments have been announced at Rollins Burdick Hunter of Michigan Inc. in Detroit. They include: **Francis W. McMillan II** named president; **John W. Chaney** named executive vp; and **Thomas E. O'Meara** promoted to vp from assistant vp. Mr. McMillan most recently served as group vp-insurance and trucking for Ralph C. Wilson Industries. Mr. Chaney was executive vp with Commercial Underwriters Inc.

George W. Ferguson named president of Republic Hogg Robinson of New England Inc. Mr. Ferguson previously was senior vp at the Boston office of Frank B. Hall & Co. Inc.

comings & goings: industry

Excess/surplus

Glenn Herbst has been named president of of Pine Top Insurance Co. in Phoenix, Ariz., which was recently acquired by Whitney Financial Group from Greyhound Corp. (*BI*, April 8). Mr. Herbst, who is also chief operating officer, joined Pine Top in December 1981 and became executive vp in 1984. Other executive changes at Pine Top include **George Powers,** named chairman; **H. Loren Hawley**, named vice chairman; **E. James Noren**, named vp; and **Gerald Olney**, named vp-treaty reinsurance.



Mr. Herbst

John Mairs named president of New York-based Glanville Special Risk Insurance Brokers Inc., a unit of Jardine Insurance Brokers Group. He most recently was senior vp in charge of the New York office of Cameron & Colby Inc.

Allen F. Brown joins Nebel & Clark Inc., an excess/surplus line marketer in Inverness, Ill., as senior vp.

Walter L. Mueller joined Chicago-based L.W. Biegler Inc. and International Surplus Lines Insurance Co. as senior vp/chief administrative officer. Mr. Mueller previous was vp-Chicago operations at Argonaut Insurance Co.

Terry J. Dowty joined Stewart Smith Mid America Inc. in Chicago

Continued on next page

To All Concerned:

THIS IS FOR YOU TO SEND OUT

Our company is currently evaluating various utilization review firms prior to selection of the one we feel will most effectively contribute to our continuing efforts in health care cost management. If you would like to be considered, kindly complete and return this questionnaire to us.

1. Firm Name _____

   Address _____

   Contact/Title _____ Tele. _____

2. Check those Health Care Cost Management services provided by your firm:

   ☐ Pre-Admission Review
   ☐ Length of Stay Management
   ☐ Concurrent Utilization Review
   ☐ Retrospective Utilization Review
   ☐ Case Management
   ☐ Second Surgical Opinion
   ☐ Hospital Bill Audit
   ☐ Others (Specify): _____

3. Geographical area serviced: ☐ Nationwide ☐ Other (Specify)

4. Any group size restrictions? ☐ Yes ☐ No

5. Size range of groups currently servicing: From _____ to _____

6. Type of clients currently servicing: _____

7. Year firm founded _____. Total years executive staff actively involved in utilization review _____.

8. Does your firm provide:

A.	Employee Education Programs	☐ Yes	☐ No	
B.	Employee Education Materials	☐ Yes	☐ No	
C.	Employee Information Line	☐ Yes	☐ No	
D.	COST BENEFIT GUARANTEE	☐ Yes	☐ No	
E.	Utilization Reports and Analysis	☐ Yes	☐ No	
	Any Extra Charge?	☐ Yes	☐ No	

9. If your firm is selected, how long between execution of contract and implementation. _____.

Continued from previous page
as vp in charge of the property and casualty brokerage operation. Mr. Dowty most recently was president of Floyd West & Co., a Dallas-based excess/surplus lines marketer.

Insurers

W. Craig Heston and **Wallace H. Watkins** named executive vps, and **Albert A. Ritchie** named vp of Utica Mutual Insurance Co., principal member of the Utica National Insurance Group in New Hartford, N.Y. Mr. Heston joined Utica National in 1963, and most recently served as assistant to the president. Mr. Watkins joined Utica National in 1984 as senior vp and senior underwriting officer.

H. Michael Tannert elected vp of NWNL Reinsurance Co., a unit of Northwestern National Life Insurance Co. in Minneapolis. Mr. Tannert joined NWNL Re in 1984 as assistant vp.

Jack B. Helitzer appointed vp in the group staff operations department of Metropolitan Life Insurance Co. in New York. Mr. Helitzer, who joined Metropolitan in 1959 as an attorney, most recently served as assistant vp. Also, **Gail Fitzpatrick Praslick** appointed vp in Metropolitan's pensions department in New York. Ms. Praslick, who joined Metropolitan in 1981, most recently served as assistant vp.

Stephen R. Smith named executive vp of Westchester Fire Insurance Co. in Basking Ridge, N.J., a unit of U.S. Insurance Group. Mr. Smith, who joined USIG in 1983, most recently served as senior vp.

Wausau Insurance Cos. in Wausau, Wis., has named three executives to new positions. **Thomas Murphy** named senior vp-field operations; **James O'Halloran** named vp-audit; and **Ronald Goetzke** named vp-credit. Mr. Murphy, who joined Wausau in 1957, most recently served as vp-risk management services. Mr. O'Halloran joined Wausau in 1955 and most recently served as assistant vp-audit and credit. Mr. Goetzke, who joined Wausau in 1959, continues as director of corporate credit operations.

Ronald J. Anderson named president of the Asia-Pacific Divisions of New York-based American International Underwriters, an affiliate of American International Group Inc. He will be based in New York. Mr. Anderson, who joined the company in 1983, most recently served as president of AIU's Southeast Asia Division in Hong Kong. Also, **David M. Hupp** named regional vp-Southeast Asia. Mr. Hupp, who joined AIU in 1970, also will continue as president of AIU Hong Kong.


Mr. Heath

Gene R. Heath named president of HealthCare Network, a St. Louis-based health maintenance organization. He succeeds **Ralph D. Alexander**, who was named president and chief executive officer of MetLife HealthCare Management Corp., which operates HealthCare Network. Mr. Heath previously was the HMO's chief marketing officer.

Michael A. Coutu and **Kenneth M. Fujino** named senior vps of Fireman's Fund Insurance Co. in Novato, Calif. Mr. Coutu, who previously was with American Express International Banking Corp., works in the financial insurance department in the company's New York office. Mr. Fujino, who joined Fireman's Fund in 1964 and most recently served as vp, is responsible for commercial insurance operations.

L. Richard Hudson joins Fremont Insurance Services in Los Angeles as senior vp. He most recently served as president and chief executive officer at Financial Indemnity Co.

Thomas M. Finholm named managing partner at Thomas McGee & Sons in Kansas City, replacing **Edward J. Reardon**, who retired July 1. Mr. Finholm, who joined the company 33 years ago, has been a partner since 1964.

Reinsurers

Frank Conly named senior vp and director of the bond department at North American Reinsurance Corp. in New York. Mr. Conly, who joined North American Re in 1979, most recently served as assistant vp/surety product line manager.


Mr. Conly

Jerrold H. Paskins named vp-claims at First Horizon Insurance Co. in Minneapolis. Mr. Paskins, who joined First Horizon as claims manager in 1983, will continue in that role. First Horizon is a Cargill Inc. subsidiary specializing in treaty reinsurance. **John Engestrom** appointed senior vp-treaty operations of Skandia America Reinsurance Corp., a wholly owned affiliate of New York-based Skandia America Group. He previously was chief executive-treaty division Europe of Skandia International Insurance Corp. Also at Skandia America Group, **Michael D. Covney** joins the company as vp and actuary, and **Glen B. Slay**, who joined the company in 1973 as property/faculty underwriter, promoted to vp. In addition, **Richard L. White** named senior vp and chief financial officer of Skandia America Group, and **Fred K. Ellis** named senior vp and chief investment officer.

Joseph W. Sampias named vp in the claims department at National Reinsurance Corp. in Stamford, Conn. Mr. Sampias joined the company in 1980.

James P. Snedeker joins G&R Intermediaries Inc. in New York, a unit of Gill & Roeser Inc., as senior vp. Mr. Snedeker previously was with Holborn Agency Corp and Marsh & McLennan Inc. in New York.

George H. Roberts named president of Reliance Reinsurance Management Inc., in Philadelphia, a subsidiary of Reliance Insurance Co. Mr. Roberts most recently served as a vp at American Re-Insurance Co.

Stephen L. Lunsford named president of Herbert Clough Inc. in Stamford, Conn., a reinsurance intermediary subsidiary of General Re Corp. Mr. Lunsford joined General Re in 1972 and most recently served as vp.

Clark R. Hontz, **Robert K. Whalen** and **Frank A. Deon** promoted to senior vps at Baltica-Skandinavia Reinsurance Co. Inc. in Morristown, N.J.

Other suppliers

Richard B. Carpenter named president and chief operating officer of Nashville, Tenn.-based Corroon & Black Benefits Inc., a subsidiary of Corroon & Black Corp. Mr. Carpenter will continue as executive vp of the company's Benefits & Specialty Sales Group, also based in Nashville. He joined Blair, Follin, Allen & Walker, a CBBI subsidiary, in 1968. Also at CBBI, **Donald R. King** named chairman. Mr. King, who is a senior vp at Corroon & Black Corp., will continue as chief executive officer at CBBI and president of BSSG. He joined one of the corporation's predecessor firms in 1966.

John L. Quaadman named president and chief operating officer of Benefit Cost Management Inc. in Atlanta. ■

For evaluation of utilization review firms.

HERE'S YOUR FIRST RESPONSE

1. Firm Name Medical Review Corporation
   Address 40 Maple Avenue, Morristown, NJ 07960
   Contact/Title Marc Allen, President Tele. (201) 267-2233

2. Check those Health Care Cost Management services provided by your firm:
   - ☑ Pre-Admission Review
   - ☑ Length of Stay Management
   - ☑ Concurrent Utilization Review
   - ☑ Retrospective Utilization Review
   - ☑ Case Management
   - ☑ Second Surgical Opinion
   - ☑ Hospital Bill Audit
   - ☑ Others (Specify): Dental Second Opinion; Case Mix Analysis

3. Geographical area serviced: ☑ Nationwide ☐ Other (Specify)

4. Any group size restrictions? ☐ Yes ☑ No

5. Size range of groups currently servicing: From 200 to 100,000

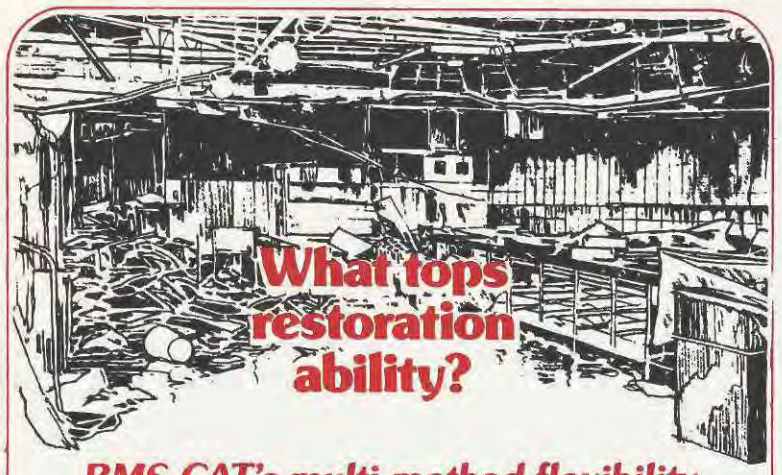
6. Type of clients currently servicing: Fortune 500 Corps, TPAs, PPOs, Insurance Companies, Unions, Small Employers, Trade Associations.

7. Year firm founded 1982. Total years executive staff actively involved in utilization review Over 40 years.

8. Does your firm provide:

A.	Employee Education Programs	☑ Yes	☐ No
B.	Employee Education Materials	☑ Yes	☐ No
C.	Employee Information Line	☑ Yes	☐ No
D.	COST BENEFIT GUARANTEE	☑ Yes	☐ No
E.	Utilization Reports and Analysis	☑ Yes	☐ No
	Any Extra Charge?	☐ Yes	☑ No

9. If your firm is selected, how long between execution of contract and implementation. 30 days.



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3. Consultation — We organize priorities, prepare a plan of action and deal with government agencies.

4. Retained Job Management — BMS CAT provides specialized equipment and chemicals and supervises the insured's employees to provide the most efficient work force.

5. Total-Service Restoration — We organize every aspect of each job including furnishing all equipment, chemicals and labor. You can rely on our guarantee that the proposed work will solve specified problems for the projected cost. Taking advantage of all of BMS CAT's services simplifies coordination, prevents duplication of effort and minimizes time and expenses.

BMS CAT's patented equipment, specialized chemicals and proven techniques are vital to restoration. But we're known for more than just cleaning ability. It's our flexible approach to treat each job with uniquer ess, urgency and discretion that will put you back in business fast.

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Blackmon Mooring Steamatic Catastrophe, Inc.

Consultants help employers cut work-related back injuries

By STEVE SHERWOOD

DALLAS—Employee back injuries are a real pain in the neck for employers.

Responsible for an estimated $10 billion in workers compensation claims annually, back injuries are rapidly becoming a big-ticket item for many companies. To help control these costs, risk managers are turning to back injury consultants to help reduce the frequency and severity of back injuries.

The diverse selection of products used to reduce or prevent back injury claims ranges from a simple back brace that forces employees to properly bend their knees while lifting to complex ergonomic engineering. Ergonomics is the science that seeks to adapt work or working conditions to the employee.

One Dallas consulting firm even offers computerized analysis of back-injury data and a follow-up case management service.

Which method a company ultimately uses will depend on its needs and budget.

"There is no doubt our back-injury rate was increasing dramatically until we called in Back Systems Inc.," said Sam Coniglio, safety engineer for the Pantex nuclear weapons plant operated by Silas Mason/Mason & Hanger Co. Inc. in Amarillo, Texas. "We have every conceivable type of work going on at our 10,000-acre facility and every conceivable exposure to back injuries."

Pantex, which employs 2,750 workers, saw the number of lost-time back injuries peak at 60 a year, Mr. Coniglio said. In 1983-84, the first full year its Back Systems program was in place, Pantex's injury rate was cut in half, he said, adding the company has since cut its lost-time injuries to one or two a year.

If Dallas-based Back Systems' estimate of the average cost of a lost-time back injury—$6,000—is applied, Pantex saved about $180,000 the first year. "At a cost (to the company) of $6 to $10 per employee, the program brought a fantastic return," Mr. Coniglio says.

Founded in 1983, Back Systems was a spin-off of the North Texas Back Institute, a medical clinic that treated back injuries exclusively, said Terry Broxson, the firm's president. Back Systems now has Exxon Corp., GTE Corp. and the Texas Utilities Generating Division of Texas Utilities Electric Co. among its clients.

In addition to training and ergonomic engineering assessments, Back Systems offers:

- Data analysis of individual companies' back-injury rates based on incidents, severity, time lost, average cost by location and average claims by location.
- A case-management reporting system allowing risk managers to follow the progress of each injury to be sure the employee is receiving proper, cost-effective care.
- A hot-line phone system through which risk or safety managers can get immediate advice from Back Systems specialists.

The firm is also starting a joint venture with Corporate Systems Inc., a risk management information systems vendor, to take a more systematic approach to data analysis, Mr. Broxson said. An analysis of three years of back-injury data will cost about $1,000 per company for Corporate Systems clients.

"One company we deal with has a range in cost of $22,000 per injury in the East and $3,000 in the West, due to the variance of medical care costs and other factors," Mr. Broxson says. "Data analysis helps them identify which units produce the most injuries and why."

Four hundred members of the Texas Assn. of Business will have their back-claims data analyzed by Back Systems and Corporate Systems, according to M. Glen Jackson, associate partner of Self-Insurance Resource Inc. SIR is the program manager for the business association's workers compensation pool, which has 5,000 members.

"Back injuries account for 35% to 40% of the members' (workers) compensation costs," said Mr. Jackson. "There is a possibility that through this (data analysis), our members will be able to reduce their back-injury costs by as much as 10%."

To follow up data analysis, Back Systems offers a computerized case-management reporting system, Mr. Broxson says. "Based on medical algorithms (step-by-step standards for treatment) we've developed, we will review each case, telling the employer how we think his employee should be treated, whether the actual treatment is appropriate and what it should cost."

As for Back Systems' effectiveness, Larry Edwards, manager of medical services for TEIA, says, "The jury is still out, but they have a lot of plans that are unique and conceptually exciting. Now we get to the nitty-gritty by putting it to work and seeing how it holds up against all the variables. If they do nothing else than provide concrete statistics, they will help."

A program designed by the Dallas-based Spine Education Center for Anderson, Clayton & Co. in Dallas, maker of Seven Seas products, was extremely effective, said Bill Thompson, the company's loss-prevention manager. "At one of our plants we had $120,000 worth of back injuries in one year. The year following the program's use, they were reduced to $6,000."

Back injuries that occur at the company's plants account for 50% of Anderson, Clayton's workers compensation costs, he said. "As a rule of thumb, you could tack on four times that cost because of hidden production losses."

Two-thirds of Anderson, Clayton's program focuses on routine back care, which is very important, Mr. Thompson says. "It helps make people more conscious of how the back works and how it can be hurt gradually. It effectively concentrated on body mechanics—how you sit, stand, reach, bend over. It definitely worked for us.

"The program, which is still in use, has been a large contributor in Anderson, Clayton's 60% to 70% reduction in accident losses over the last three years, he maintains. "Overall, three years ago we averaged 500 actual injuries a year in all our plants. Now we average about 150."

Nancy Selby, president of Spine Education Center, founded the company in 1979. Among its clients now are Frito-Lay Inc., Texas Instruments Inc. and Hartford Life Insurance Co.

"I think a company can realistically expect a 25% reduction in back injuries and a 50% reduction in lost time if they use our customized programs," Ms. Selby says. "Our thrust is to give people enough education on body mechanics so they can avoid being injured either at home or at work."

Each of its programs, for which the Spine Education Center charges an average of about $6,000, includes on-site inspections, an hour-long slide show, lifting guides and booklets on body mechanics and first-aid techniques.

"If someone is lifting 100-pound sacks day in and day out, you can give him all the training in the world. But, in the end, it won't help," she says. "Sometimes the job simply needs to be changed—maybe it is a two-person job."

For those whose jobs involve continual lifting, some companies have opted out of back-injury prevention training in favor of special preventive equipment, such as Comp Equipment Corp.'s CompVest.

This fabric vest, worn over the clothing, prevents employees from bending in ways that might lead to lower-back injuries.

Introduced in 1984 by St. Paul, Minn.-based Comp Equipment, the CompVest has brought "fantastic" savings to Northern States Power Co., said Robert Ehlers, safety coordinator for the utility's Lakelands District in Dallas. Northern States helped test the CompVest in a pilot program last year.

Although cost-savings figures were unavailable, Mr. Ehlers said that by having employees use the vest, back injuries in his district during 1984 were reduced to four from nine the year before. Only one of the 1984 injuries was a lost-time injury, compared with five lost-time injuries the year before.

Northern States purchased 600 of the vests, at $100 each, for its linemen, mechanics, construction and other heavy laborers, he says, adding the savings more than offset the cost of the vests.

"Before the pilot program, we had guys going to the chiropractor every other day," Mr. Ehlers points out. "They started wearing the vests and they haven't been back since. It keeps them on the job, and that alone means unbelievable savings." ■



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Health care employers stress wellness

Employers in the health care industry are more inclined to offer wellness programs than non-health care companies, according to a recent survey.

On the other hand, employers in the health care industry are less likely to offer enrollment in health maintenance organizations as an option to employees, the survey reveals.

In addition, they're less likely to include cost-containment provisions in their plans, like mandatory second surgical opinions or incentives for using outpatient treatment.

The survey, "Company Practices in Health Care Cost Management," was conducted by Hewitt Associates in Lincolnshire, Ill.

The data provided by 118 hospitals, medical centers, health services foundations and other health care providers—describing healthcare cost management practices for nonunion employees from 1982 through 1984—was broken out from a broader survey of 1,185 industrial and non-industrial companies nationwide conducted throughout January, February and March 1984.

In comparing health care providers' and non-health care employers' approach to employee health care, the survey showed that 64% of the surveyed hospitals and health care associations offered smoking cessation programs, compared with 31% of the non-health care companies.

The overwhelming majority of health care companies—85%—offered first-aid programs and/or cardiopulmonary resuscitation training, compared with 70% of non-health care companies.

While 78% of the surveyed health care employers offered physical fitness classes, such classes were offered by only 37% of the non-health care companies.

Sixty-five percent of health care employers offered stress management seminars or hypertension screening, compared with 36% of non-hospital employers.

In addition, 74% of health care employers offered nutrition education or weight-loss assistance, compared with 29% of non-hospital employers.

However, despite the willingness of employers in the health care industry to offer these types of wellness programs, these employers were less likely to offer cost-containment options or provisions in the health care plans.

For instance, 35% of the health care companies surveyed indicated that they offered their employees an HMO option, compared with 60% of non-hospital employers that originally were surveyed.

Moreover, 10% of the health care employers covered home health care under their plans, compared with 63% of the other employers.

Only 6% of health care organizations surveyed require employees to seek a second opinion prior to certain surgical procedures, compared wth 28% of non-health care employers.

Moreover, full coverage for the cost of obtaining a second surgical opinion was offered by only 28% of the health care employers' plans, compared with 53% of non-health care employers' plans.

Only 30% of the surveyed health care employers offered incentives for workers to use outpatient surgery, compared with 39% of the non-health care employers.

Non-health care employers also were slightly more likely to offer financial incentives to workers that reduce their health care utilization.

Of the 118 health care companies surveyed, only 1% gave financial rewards like a year-end bonus if the individual employee kept medical plan utilization to a minimum, compared with 2% of the non-health care companies.

Only 3% gave rewards—like a year-end bonus or automatic adjustment of employee contributions—to the employee group if the medical plan had favorable experience overall, compared with 4% of non-health companies.

Also, fewer than 10% of the health care employers offered financial incentives in the form of higher reimbursement levels or cash awards for use of extended care facilities, hospice care or shortened hospital stays, compared with 12% of non-health companies.

Trends also indicated in the survey include:

- A large number of health care employers' plans are moving from first-dollar coverage for hospital and surgical charges to the use of deductibles.
- An increasing number of health care employers are reporting they've increased health plan deductibles.
- Hospital and health care organizations surveyed are shifting more hospital and surgical costs to employees by increasing the employee's coinsurance payment. More plans now reimburse hospital and surgical expenses at 80% rather than 100% coverage levels.
- The number of medical plans requiring employees to contribute toward the cost of health benefits is rising.
- Plan financing is moving away from fully insured arrangements toward self-funding methods.

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"Company Practices in Health Care Management: A Special Study of Hospital/Health Care Employers" is available for $50 from Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000; attention: Lorrie Cuda.

Tennessee, Utah get safety plans

WASHINGTON—Tennessee and Utah each have job safety and health plans scheduled for final approval this month by the Occupational Safety and Health Administration.

Utah's program was scheduled for approval last week, and Tennessee's program is scheduled for approval today. Upon final approval, OSHA officially will relinquish its standards and enforcement authority for areas covered by the state programs.

The Tennessee and Utah programs cover workplace safety and health in private industry and in state and local government. OSHA covers maritime employment in the private sector, railroad employment (where not regulated by another federal agency), employment at the Tennessee Valley Authority, and employment on military bases and among U.S. government workers.

With the approval of the Tennessee and Utah programs, job safety and health plans have been approved in 10 jurisdictions. The other jurisdictions are the Virgin Islands, Hawaii, Alaska, Kentucky, Arizona, Wyoming, Iowa and Maryland. ■

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AUG. 4-6. *Business Insurance* Employee Benefits Communications conference in New York, sponsored by *Business Insurance*; $575. Registrar, Business Insurance Communications Services Department, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

AUG. 4-9. The Basic Course in Reinsurance in Princeton, N.J., sponsored by The College of Insurance; $825 for college sponsors; $950 for others. Laura McKeor., The College of Insurance, One Insurance Plaza-101 Murray St., New York, N.Y. 10007; 212-962-4111.

AUG. 5-7. Recognition of Accident Potential in the Workplace Due to Human Factors course in Los Angeles, sponsored by the University of Southern California; $425. Registrar, Office of Extension and In-Service Programs, Institute of Safety and Systems Management, University of Southern California, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

AUG. 5-7. Fundamentals of Employee Benefits conference in New York, sponsored by the American Management Assns.; $695 for members; $800 for non-members. Karen Marquardt, AMA, 135 W. 50th St., New York, N.Y. 10020; 212-586-8100.

AUG. 6. Chemical Exposures in the Workplace seminar in Burbank, Calif., sponsored by St. Joseph Medical Center; free. James Eppink, 818-843-5111.

AUG. 6-8. Industrial Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Also **Sept. 17-19 and Oct. 7-9**, all in Marinette. Sara Lambrecht, Ansul Fire Protection., Stanton St., Marinette, Wis. 54143.

AUG. 7. Coping With Wrongful Discharge Claims seminar in Los Angeles, sponsored by the Claims Committee and Legal Committee of the California Workers' Compensation Institute; $50. Registrar California Workers' Compensation Institute, 120 Montgomery St., Suite 715 San Francisco, Calif. 94104.

AUG. 8-9. Legal Aspects of Occupational Safety and Health course in Los Angeles, sponsored by the University of Southern California; $375. Registrar, Office of Extension and In-Service Programs, Institute of Safety and Systems Management, University of Southern California, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

AUG. 11-14. Communications Institute in Monterey, Calif., sponsored by the International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. International Foundation of Employee Benefit Plans, Registration Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005-0069; 414-786-6700.

AUG. 11-16. International Assn. of Auto Theft Investigators annual seminar in Des Moines, Iowa; $80. Lt. Jerry Lewis, Iowa State Patrol, 5328 N.W. Second Ave., Des Moines, Iowa 50313; 515-281-8388.

AUG. 12. Plan Administration conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $90 for members; $135 for non-members. Registrar, ISSC, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

AUG. 12. Cost Effective Administration conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $90 for members; $135 for non-members. Registrar, ISSC, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606.

AUG. 18-21. 1985 Corporate Benefits Management conference in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. Registrar, IFEBP, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis., 53005-0069; 414-786-6700.

AUG. 18-22. 71st Annual Convention of the International Assn. of Industrial Accident Boards and Commissions in Sun Valley, Idaho; $175 for members; $240 for non-members. Larry Spjute, IAIABC, P.O. Box 1252, Boise, Idaho 83701; 208-334-2193.

AUG. 19-20. Fourth Annual Governmental Insurance Conference in Austin, Texas, sponsored by the Professional Development Institute; $245. Joanne Paulman, PDI Conference Manager, PDI, P.O. Box 13288, NTSU, Denton, Texas 76203-3288; 817-565-2483.

AUG. 19-21. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; $445; $415 for three or more registrants from the same organization. Also **Sept. 10-12** in Los Angeles; **Nov. 5-7** in Boston; and **Dec. 2-4** in Houston. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

AUG. 19-23. Developing and Managing a Basic Safety and Health Program course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $650. Also **Oct. 28-Nov. 1** in Long Grove. Tommy Thomas, NATLSCO, Route 22 and Kemper Drive, Long Grove, Ill. 60049; 312-540-2400, 800-323-9585.

AUG. 19-23. Recognition of Occupational Health Hazards course in Los Angeles, sponsored by the University of Southern California; $675. Registrar, Office of Extension and In-Service Programs, Institute of Safety and Systems Management, University of Southern California, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

AUG. 20-22. Petroleum/Chemical Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Also **Sept. 10-12** and **Oct. 1-3**, all in Marinette. Sara Lambrecht, Ansul Fire Protection, 1 Stanton St., Marinette, Wis. 54143.

AUG. 22. Fundamentals of Environmental Health seminar in Houston, sponsored by the International Safety Academy; $185. Also **Nov. 8** in Boston; **Dec. 5** in Houston. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

AUG. 27-29. Utilities Fire School in Marinette, Wis., sponsored by Ansul Fire Protection; $650. Sara Lambrecht, Ansul Fire Protection, 1 Stanton St., Marinette, Wis. 54143.

SEPT. 3-6. Reinsurance Accounting & Finance for Cedants & Assumers seminar in Crotonville, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,245. Registrar, Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 914-832-9384.

SEPT. 6-7. Workers Compensation: Your Safety & Health Balance Sheet course in Los Angeles, sponsored by the University of Southern California; $250. Registrar, Office of Extension and In-Service Programs, Institute of Safety and Systems Management, University of Southern California, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

SEPT. 7-11. 18th Annual Canadian Conference in Jasper, Alberta, sponsored by the International Foundation of Employee Benefit Plans; $555 (Canadian) for IFEBP members; $645 (Canadian) for non-members. Pre-conference institutes will be held **Sept. 7 and 8**; $185 (Canadian) additional for members; $215 (Canadian) additional for non-members for each pre-conference institute. IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

SEPT. 9-11. Risk Management Information Systems course in San Francisco, sponsored by the Risk & Insurance Management Society's Continuing Education Program; $545 for members; $645 for non-members. Also **Oct. 7-9** in Arlington, Va. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 9-13. Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $500; 10% discount for two or more registrants from the same company. Also **Nov. 11-15** in Long Grove. John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

SEPT. 9-13. Fundamentals of Money Management workshops in Philadelphia, sponsored by the International Foundation of Employee Benefit Plans; $700 for members; $825 for non-members. Registrar, IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005-0069; 414-786-6701.

SEPT. 9-13. Hazardous Materials: Handling and Disposal course in Los Angeles, sponsored by the University of Southern California; $675. Registrar, USC, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 900899-0021; 213-743-6523/6524.

SEPT. 9-14. Fifth Annual Educational Conference of the Self-Insurance Institute of America in San Francisco; before Aug. 15, for the full week: $495 for members, $470 for additional registrants from the same company, $595 for non-members; for the property/casualty sessions Sept. 10 and 11: $325 for members, $300 for additional registrants from same company, $395 for non-members; for the employee benefit sessions Sept. 11-14: $375 for members, $325 for additional registrants from same company, $445 for non-members. All fees increase $30 after Aug. 15. Registrar, SIIA, P.O. Box 15466, Santa Ana, Calif. 92705; 714-261-2553.

SEPT. 10-12. Establishing and Auditing an Effective Product Safety Management Program course in Chicago, sponsored by the National Safety Council; $375 for members; $470 for non-members. Russell Marhefka, Director-Product Safety Programs, National Safety Council, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

SEPT. 11-12. Washington, D.C.: The Arena for Congressional Impact on our National Retirement System meeting in Washington, sponsored by the National Employee Benefits Institute; free for members; $395 for non-members. Thomas G. Schendt, National Employee Benefits Institute, 2550 M St. N.W., Suite 785, Washington, D.C. 20037; 800-558-7258.

SEPT. 11-12. Controlling the Pipeline, the fourth annual Banking and Insurance Forum sponsored by Tillinghast, Nelson & Warren Inc., in Washington; $650; $600 for subsequent registrants from the same company. Eileen B. Callahan, Conference Coordinator, Tillinghast, Nelson & Warren Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

SEPT. 11-13. Fundamentals of Insurance conference in Chicago, sponsored by the Risk & Insurance Management Society's Continuing Education Program; $445 for members; $545 for non-members. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 12-13. Financial Analysis for Risk Management Decisions seminar in New York, sponsored by The College of Insurance; $750. Also **Oct. 17-18** in St. Louis. Registrar, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-962-4111, Ext. 303.

SEPT. 12-15. Annual Convention of the National Assn. of Professional Surplus Lines Offices Ltd., in Boston; $325; $350 after Aug. 12. Registrar, NAPSLO, P.O. Box 1507, Roswell, Ga. 30077; 404-998-9075.

SEPT. 18. Back Injury Prevention Using NIOSH Guidelines seminar in Houston, sponsored by the International Safety Academy; $185. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

SEPT. 18-20. Soaring to New Heights in Safety conference in Lanham, Md., sponsored by Maryland National Capital Park & Planning Commission in cooperation with the National Capital Region of the National Park Service and the Mid-Atlantic Regional Council of the National Recreation & Park Assn.; $100. Patricia Deavers, M-NCPPC, 9915 Moreland St., Fort Washington, Md. 20744; 301-699-2502.

SEPT. 18-20. Techniques of Risk Management course in Chicago, sponsored by the Risk & Insurance Management Society's Continuing Education Program; $445 for members; $545 for non-members. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 19. Redesigning the Work Environment to Avoid Carpal Tunnel Syndrome seminar in Houston, sponsored by the International Safety Academy; $185. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

SEPT. 19-20. Casualty/Loss Reserve seminar in Kansas City, Mo., sponsored by the American Academy of Actuaries and the Casualty Actuarial Society; $270 before Aug. 12; $300 after Aug. 12. Registrar, AAA, 1835 K St. N.W., Suite 515, Washington, D.C. 20006; 202-2233-8319.

SEPT. 19-20. PPOs: Meeting the Competitive Challenge conference in Scottsdale, Ariz., sponsored by The American Assn. of Preferred Provider Organizations; $445 for members before Aug. 2, $495 after Aug. 2; $500 for non-members before Aug. 2, $550 after Aug. 2. Registrar, AAPPO, 4301 Connecticut Ave., N.W., Suite 139, Washington, D.C. 20008; 202-362-4298.

SEPT. 20. Employee Education conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $90 for members; $135 for non-members. Registrar, ISCC, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

SEPT. 22-24. International Benefits seminar in

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Continued from previous page

St. Thomas, Virgin Islands, sponsored by the International Foundation of Employee Benefit Plans; $500 for members; $575 for non-members. Registrar, International Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005-0069; 414-786-6701.

SEPT. 22-25. 1985 Canadian Risk Management conference in Ottawa, Ontario, Canada, sponsored by the Canadian Capital Region Risk & Insurance Management Society; $225; $250 after Aug. 22. John Harris, City of Nepean, 3825 Richmond Road, Nepean, Ontario K2H 5C2; 613-829-1510.

SEPT. 23-25. 1985 Trustees and Administrators Institutes in Banff, Alberta, sponsored by The International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. Registration Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069.

SEPT. 26-27. Construction Safety and Health seminar in Chicago, sponsored by Lakeside Management Services; $90; $25 for students. James Opoka, Lakeside Management Services, Saint Joseph Hospital, 2900 N. Lake Shore Drive, Chicago, Ill. 60657; 312-975-3388.

SEPT. 30-OCT. 1. Perinatal Risk Management: Understanding and Preventing the Multimillion Dollar Claim seminar in San Francisco, sponsored by the American Society for Hospital Risk Management and The Structured Settlements Co.; $175 for ASHRM members; $235 for non-members. Registrar, American Hospital Assn., Division of Education, 840 N. Lake Shore Drive, Chicago, Ill. 60611; 312-280-6083.

SEPT. 30-OCT 2. Techniques of Loss Control course in Denver, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Fran Jordan, Administrator-Continuing Education Program, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 1-3. Effective Training Skills workshop in Norwood, Mass., sponsored by Factory Mutual Engineering Corp.; $485. Registrar, Training Department, Factory Mutual Engineering, 1151 Boston-Providence Turnpike, P.O. Box 9102, Norwood, Mass. 02062.

OCT. 2-4. West Coast Regional Conference sponsored by the Los Angeles chapter of the Risk & Insurance Management Society in Palm Springs, Calif.; $270 for members before July 29; $250 for additional registrants from the same company before July 29; $290 for members after July 29; $270 for additional registrants after July 29; $80 for spouses. Greg Breed, Director of the Corporate Insurance Campus Crusade for Christ Inc., Dept. 76-20 Arrowhead Springs, San Bernardino, Calif. 92414; 714-886-9711 Ext. 1439.

OCT. 2. Accident Investigation and Analysis seminar in Houston, sponsored by the International Safety Academy; $185. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

OCT. 3-4. Quantitative Techniques for Risk Management seminar in New York, sponsored by The College of Insurance; $495 for sponsoring participants; $535 for all others. Registrar, Professional Development Programs Division, The College of Insurance, One Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

OCT. 3-6. The Fitness Providers Challenge: Marketing and Managing Employee Health Programs conference in Fort Worth, Texas, sponsored by the Assn. for Fitness in Business; price not yet set. Susan Hagerty, AFB, 1312 Washington Blvd., Stamford, Conn. 06902.

OCT. 6-10. Washington Insight on Employee Benefits conference in Washington, sponsored by the U.S. Chamber of Commerce; $1,175. Suzanne Lulewicz or Deborah Murphy, U.S. Chamber of Commerce, 1615 H St., N.W., Washington, D.C. 20062; 202-463-5575.

OCT.7-9. 1985 Health Care Cost Management seminar in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; $420 for members; $495 for non-members. Registrar, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069, 414-786-6700.

OCT. 7-10. Highly Protected Risk Property Conservation course in Long Grove, Ill., sponsored by the Kemper Group; $400; free for Kemper HPR-insured property owners. W.P. Thomas Jr., Manager, Engineering Research & Staff Development, HPR Department, A-1, Long Grove, Ill. 60049; 312-540-3380.

OCT. 7-11. Total Loss Control Management seminar in Philadelphia, sponsored by the International Safety Academy; $655; $625 for three or more registrants from the same company. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

OCT. 16. Health Promotion conference in Chicago, sponsored by the Illinois State Chamber of Commerce; $90 for members; $135 for non-members. Registrar, ISCC, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

OCT. 16-18. Successful Retirement Planning Programs workshop in Kansas City, Kan., sponsored by Retirement Advisors Inc.; $450. Also **Nov. 6-8** in New York. Registrar, 919 Third Ave., New York, N.Y.; 212-421-2400.

OCT. 23-26. Techniques of Finance and Accounting course in Minneapolis, sponsored by the Risk & Insurance Management Society's Continuing Education Program; $445 for members; $545 for non-members. Also **Nov. 4-6** in Montreal. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 24-25. Intergovernmental Pool Directors and Trustees seminar in San Francisco, sponsored by the Public Risk & Insurance Management Assn.; $150. PRIMA Pooling Seminar, 1120 G St., N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

OCT. 28. Commercial General Liability Program in New Orleans, sponsored by the International Risk Management Institute Inc.; $235. Conference Coordinator, International Risk Management Institute Inc., 10300 North Central Expressway, Building III, Suite 208, Dallas, Texas 75231; 214-363-9656.

OCT. 28-31. Fifth Annual Construction Insurance conference in New Orleans, sponsored by the International Risk Management Institute Inc.; $585. Conference Coordinator, International Risk Management Institute Inc., 10300 N. Central Expressway, Building 3, Suite 208, Dallas, Texas 75231; 214-363-9656.

OCT. 28-31. National Safety Council Congress and Exposition conference in New Orleans, sponsored by the National Safety Council; $90 for members; $125 after Sept. 27; $125 for non-members; $175 after Sept. 27. Registrar, NSC, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800.

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

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*"Derivation of Major Medical Offset Factors for Prescription Drug Plans"—Sieben & Associates, Inc., available upon request from PCS.

Minet sells its Lloyd's managing agency

By STACY SHAPIRO

london line

LONDON—Minet Holdings P.L.C. is the latest Lloyd's of London brokerage to sell its Lloyd's managing agency.

Under the Lloyd's Act of 1982, all Lloyd's brokers must divest their managing agencies by July 1987. However, most brokers are selling their agencies now to ensure no problems will crop up when Lloyd's re-registers all managing agencies in July 1986.

Minet announced recently that it was selling its managing agency, J.H. Minet Agencies Ltd., in various blocks to the underwriters and directors of the agency for an undisclosed amount. The transactions will be completed by January.

Minet Holdings has already announced it will close its other underwriting agency, Richard Beckett Underwriting Agencies Ltd., whose members must prove to Lloyd's by July 31 that they can pay 62 million pounds ($85.5 million) in losses to satisfy Lloyd's solvency requirement (*BI*, June 3).

J.H. Minet Agencies currently manages four syndicates with a combined premium capacity of 70.1 million pounds ($96.7 million). Minet Agencies also manages a Lloyd's members agency that handles the activities of 400 members.

The management of non-marine syndicate 322—the largest of the Minet syndicates—will be sold to R.D. Robertson Underwriting Agencies Ltd., a company owned by the syndicate's current underwriter, David Robertson.

The other three syndicates, motor syndicate 887, non-marine syndicate 919 and marine syndicate 920, are also being sold to their respective underwriters: Graham Butts, Donald Carey and Graham Palmer.

The members agency is being sold to a newly formed company whose major shareholders are Mr. Butts, Mr. Palmer, Mr. Carey and C.L. "Peter" Jackson, currently managing director of Minet Agencies. Minet will have a small shareholding in the new company, the company announced.

In another transaction involving a Lloyd's underwriting agency, one of the two groups of underwriters purchasing the management of their syndicates from Alexander Howden Underwriting Ltd., a unit of Alexander Howden Group P.L.C., has formed a new company that will manage syndicates (*BI*, July 1).

The new managing agency will be called Devonshire Underwriting Agencies Ltd. Malcolm Rumsey, former chairman of Lloyd's Underwriters' Assn., will serve as independent, non-executive chairman of the agency. Brian Peters, former secretary to the Lloyd's Underwriting Agents Assn., will be the agency's managing director. Other directors include Peter Nickels, former manager of Alexander Howden Underwriting; Tom Hignett, a partner at the accounting firm of Reed Taylor & Co.; and the underwriters who are purchasing the syndicate management from Howden: Peter Suttle, former chairman of Lloyd's Motor Underwriters' Assn.; Christopher Bohling; Ronald Ford; Alan Gioes; Geoffrey Knight; and Roger Lister.

Baby syndicates

Lloyd's of London is proposing a code of practice on "preferred underwriting" to eliminate any so-called baby syndicates remaining in the market, says Lloyd's Chief Executive Ian Davison.

Baby syndicates are organized alongside larger syndicates. Only selected members belong to the smaller baby syndicates, which accept risks that the underwriter believes are likely to produce few losses, thus increasing the profits of the baby syndicate members.

The code of practice will remind underwriters that preferring one syndicate over another is "wrong" and "forbidden by the law of agency," said Mr. Davison.

"There is no need for a bylaw" outlawing baby syndicates, he said. "We are reminding people that the practice is a breach of the law of agency."

Lloyd's is exected to approve the proposal this fall.

Mr. Davison admits "there are still some baby syndicates around," but he says they will be eliminated when underwriting agencies re-register with Lloyd's next July.

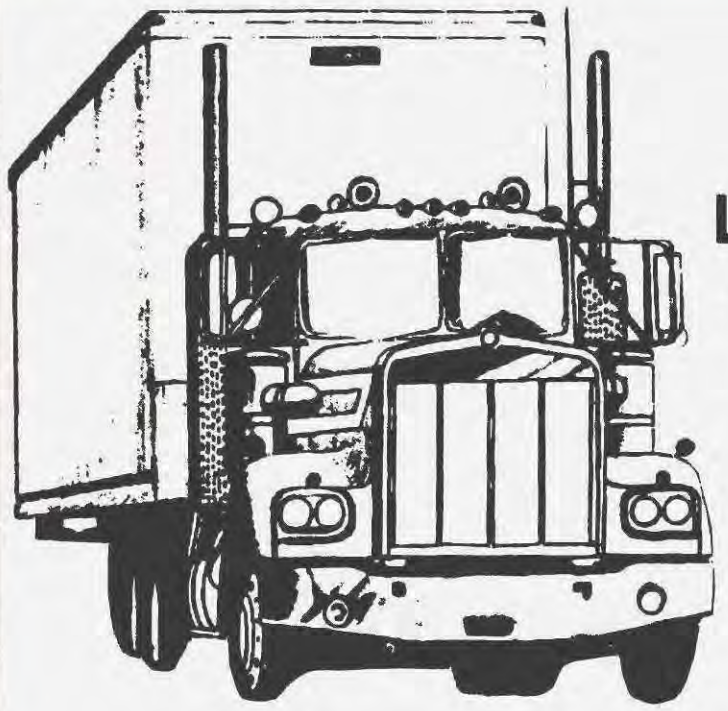
Architect coverage

The Royal Institute of British Architects may start its own professional liability insurance program because many members have not been able to purchase adequate coverage at a reasonable price.

The RIBA has hired broker Bowring U.K. Ltd. to consult on the plan and had considered buying ABS Insurance Agency, a specialist in architects' coverage, to manage the program. However, the acquisition has run into problems and may not be completed, said a RIBA spokeswoman, who would not elaborate.

The spokeswoman noted that in order to attract insurers to underwrite the program, RIBA may have to mandate that all RIBA members purchase their professional liability coverage through the program, the spokeswoman said. RIBA will meet this week to discuss whether the coverage should be mandatory for

Continued on next page



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Continued from previous page
all members.

British architectural firms currently purchase professional liability insurance limits ranging from 250,000 pounds ($345,000) to 50 million pounds ($69 million), but "some architects are finding it difficult to get any coverage, let alone 40 to 50 million pounds," said John Kemp, chief executive of Bowring Professional Indemnity Ltd, a Bowring unit. "A number of architects are going without cover."

According to the RIBA spokeswoman, "Premiums are going up steeply and the markets in some cases are not there."

For instance, one architect, whose professional liability premium doubled upon renewal for the same amount of coverage, now pays an amount equal to 12% of the company's annual revenue, the spokeswoman said.

Two others reported rate increases of 528% and 350% for slightly increased limits, she added.

Any kind of professional indemnity plan implemented by RIBA "will bring some kind of stability to the market, we hope," she said.

AIDS coverage

A group of U.S. embalmers is seeking coverage from a Lloyd's of London underwriter that would indemnify them if they contract Acquired Immune Deficiency Syndrome because they embalmed an AIDS victim.

"It's on my desk," says Burt Stratton, underwriter for syndicates managed by Haynes & Clack Underwriting Agencies Ltd.

The embalmers' group, which Mr. Stratton would not name, embalmed 156 AIDS victims in the past year, and no embalmer is known to have contracted the disease by embalming a victim.

Mr. Stratton said the association is requesting coverage limits of either $100,000 or three times an embalmer's salary. The policy would pay when the embalmer is diagnosed as having AIDS.

Mr. Stratton says he probably will attempt to write the risk, although he has not yet offered a quote. But, he said, "First, I'll get some medical evidence for it."

Mr. Stratton also says he would need to know "how many homosexuals are there among the embalmers." AIDS is most common among homosexuals, and Mr. Stratton says a homosexual embalmer could get AIDS without embalming a victim.

Merrett forecast

Lloyd's of London underwriting agency Merrett Syndicates Ltd. is forecasting two years of profits for Lloyd's marine syndicate 418, Lloyd's largest marine syndicate, and its sister incidental non-marine syndicate 422 following record losses during Lloyd's most recent accounting year.

According to Merrett's annual report, the company expects that syndicates 418 and 422 will show an as-yet-undetermined profit for the 1982 accounting year, which closes in 1985 under Lloyd's three-year accounting system. Merrett attributes the likely profits to an absence of marine catastrophes and a profitable portfolio of aviation business.

Merrett also expects a profit in the 1984 accounting year, which closes at the end of 1986, although after one year the account is "a pretty mixed bag," the report says.

"The satellite account is awful, but will be much improved by the disposal of recovered satellites," according to Merrett Chairman Stephen Merrett's message to syndicate members in the annual report.

Mr. Merrett, who was a lead underwriter for two satellites lost early in 1984 that were subsequently recovered on a space shuttle mission, is still trying to sell the probes (*BI* Nov. 19, 1984).

Earlier this year, Merrett announced that the two syndicates had posted losses of 6.4 million pounds ($8.8 million) for the 1982 accounting year, the first time in 25 years the syndicates have posted a loss (*BI*, May 20). Together with Merrett-managed non-marine syndicate 417, Merrett Syndicates reported total losses of about 11 million pounds ($15.2 million) for the 1982 accounting year.

Mr. Merrett also noted in the annual report that Merrett Syndicates has no intention of becoming a "mega-underwriter" at Lloyd's by purchasing managing agencies that Lloyd's brokers must sell to conform with the Lloyd's Act of 1982.

Merrett-managed syndicates now account for less than 10% of Lloyd's total market capacity, he said. "It is self-evidently not in the interests of a free and healthy marketplace for this group to seek to control too large a share of the overall premium capacity of Lloyd's."

Mr. Merrett also reported syndicates 417, 418 and 422 are among those that will be reviewed by Britain's Inland Revenue Service in connection with "rollover" reinsurance policies (*BI*, May 27).

Rollovers, according to Lloyd's are catastrophe reinsurance programs. The Inland Revenue, however, believes that rollovers are transfers of syndicate reserves to offshore funds for which improper tax deductions were taken.

Although the Merrett syndicates case will not be heard until 1986, "it is in the interest of our names for the position to be determined because the Revenue is seeking to restrict the repayment to names of legitimate tax losses," said Mr. Merrett. "The overall result in the Lloyd's market for 1982 can only serve to magnify this problem." ■

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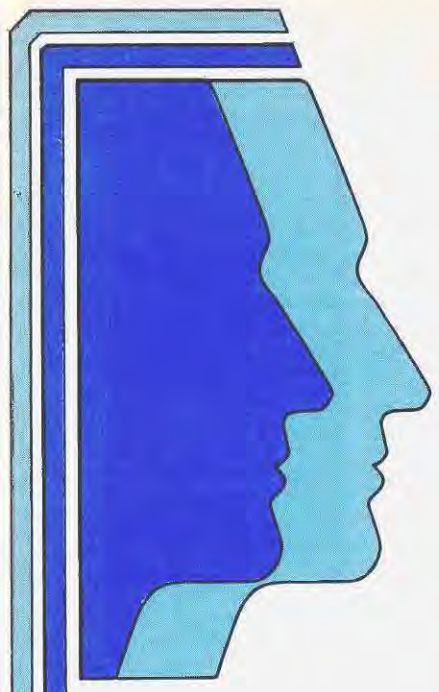
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THE DOLLARS & SENSE OF COMM

AGENDA

GENERAL SESSIONS focus on the foundation of effective communication.

Listening To Employees
Suzanne Kenney, Manager, Employee Listening Services, HEWITT ASSOCIATES

After interviewing more than 29,000 employees and examining written survey responses from 85,000 others, Ms. Kenney will present fascinating data on how employees feel about their benefits. What are employees saying, what questions are they asking, and what choices are they making about benefits?

Working With Consultants: The Consultant Side
George Heiring, Managing Partner, HEWITT ASSOCIATES

In the first of a two part series, Mr. Heiring offers a practical approach, injected with gentle humor, to the ever-changing relationship between consultant and client. He addresses such issues as what should the client expect, what is unreasonable for the client to expect, and how clients can get the most results from their consultant.

Working With Consultants: The Company Side
Steve Wasserman, Director, Benefit Communication & Training, DART & KRAFT, INC.

In part two, Mr. Wasserman addresses the client side of the consultant-client relationship. He will make pratical suggestions on when, where, why and how you should use consultants. Further, Mr. Wasserman will recommend what groundwork should be done prior to and while working with a consultant — groundwork that will save you time and money.

You Be The Judge
Herbert Zeltner, HERBERT ZELTNER CONSULTANT INC.

A dynamic speaker who sparks controversy and leads you in an energetic session, Mr. Zeltner returns once again to the BI Conference. He will introduce selected audio-visual programs submitted to the EBC Competition and will offer you a glimpse of what other industry professionals are doing.

CASE STUDIES encourage group interaction.

Your Retirees: An Untapped Health Care Cost Containment Weapon
Jeffrey M. Ostroff, President, JEFFREY M. OSTROFF ASSOCIATES
Vivian Anderson, Corporate Personnel, ALLSTATE INSURANCE COMPANY

Providing medical benefits to retirees can be very costly; and expenditures will continue to rise as the retiree population grows. Mr. Ostroff will present a brief overview of the post-retirement health benefits issue. In addition, Ms. Anderson will walk you through a communications program Allstate used to effectively deal with this problem. Attendees will be given strategies which offer companies the opportunity to contain health care costs for both retirees and active workers.

Benefits Overhaul
Steve Wasserman, Director, Benefit Communication & Training, DART & KRAFT, INC.

While producing communication materials for benefit changes may have to be done in a tight time frame, good plan and communications design takes months. The communicator must keep all lines of communication open during the design and production process, and have suppliers ready to go when the job begins. In an informative presentation, Mr. Wasserman discusses effective communications planning, what communication approach was taken in a benefits package redesign, and how production was achieved in a short time frame.

Computers Can Talk Benefits
Pam Keeler, Director, Advanced Benefit Communications,
METROPOLITAN LIFE INSURANCE COMPANY

In an effort to increase employee understanding and perception of their benefits program, Met Life took a new look at the employee communications field. After a careful study of benefit communications needs, Metropolitan designed an innovative program. Now, Met employees can directly access their benefit and savings plan information through interactive computer terminals stationed throughout Met Life headquarters. Ms. Keeler will explain the intricacies of this unique communications vehicle and what it takes to make it succeed.

PRINT WORKSHOPS address specific communications needs.

The Power of Personalizing Print
Deborah K. Huffman, Senior Vice President,
FRANK B. HALL CONSULTING COMPANY

Ms. Huffman will address the pros and cons of personalizing print communications. How technology is distancing the workforce from management, the pressure that "personalizing" can place on your data base, and current applications for personalized benefits communications, are just some of the issues she will discuss. Additionally, Ms. Huffman will compare the strengths and weaknesses of traditional vs. laser print materials, and will provide good and bad examples of personalized communications using both techniques.

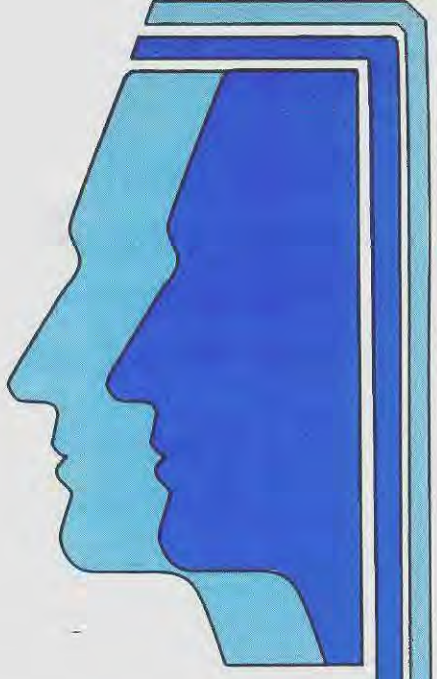
Standard Print Communications & Print Enhancement
Martin Lapidus, Consultant,
TOWERS, PERRIN, FORSTER & CROSBY

To effectively communicate benefits to employees you must have a precise understanding of the issue at hand. You must also anticipate what reaction management expects from employees. Mr. Lapidus suggests that it is the nature of the benefits program (positive change, negative change, update, etc.) that helps determine the elements of effective communication. Further, he offers a practical approach to what management's goals should be in communicating benefits to employees.

TASK FORCE is a challenging professional forum.

Designed to encourage idea-sharing among attendees, the task force is perhaps the most intriguing component of the Business Insurance Conference. At the time of registration we invite you to submit questions, problems, or issues on benefits communications (see registration form). During this session the group will be divided into small task force units. Within this unique "give and take" framework you will discuss and evaluate the proposed communications problems with your professional counterparts. Each task force will then have the opportunity to state the problem and present their findings to all attendees. The task force is a stimulating forum where your input is an integral part of the BI Conference learning experience.

August 5 and 6
The Grand Hyatt Hotel, New York City



This year our Conference format covers four major areas. While meeting as a large group, the general sessions focus on the foundation of effective communication. Small case study meetings encourage group interaction, and rotating schedules afford you the opportunity to attend all three sessions. Print workshops will center on two techniques — standard and laser printing — and you can select the one which best suits your needs. The task force, a new component of the *BI Conference*, is a challenging forum where you actively partake in evaluating the "real life" problems confronting communicators. We encourage you to submit your problems, questions or postulates of benefits communications on the attached registration form.

Highlighting the *1985 BI conference* is the 13th annual EBC Competition Awards Presentation. Print programs submitted to this year's Competition will be available for review in the EBC Gallery. Another feature, the Benefits Literature Gallery, is where you can collect some of the latest information available from consultants, insurance companies and service organizations.

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EBC AWARDS LUNCHEON

Alfred Malecki, Publisher, BUSINESS INSURANCE

At a luncheon honoring the winners of the 13th annual EBC Competition, awards will be presented to those companies who have excelled in communicating their employee benefits programs. One of the winning audio visual programs will be shown.

A limited number of additional seats are available for the EBC Awards Presentation luncheon. Tickets are $50.00 each, available on a first come-first serve basis; advance reservation is required. Please contact the Registrar.

REGISTRATION

The Business Insurance Conference opens Sunday evening, August 4, with advance registration and cocktail reception. Sessions begin Monday, August 5, at 8:45 am and adjourn Tuesday, August 6, at 4:15 pm.
The cost is **$575.** A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook and educational materials, breakfast, coffee breaks, luncheons and cocktail reception.

Payment required with registration.

All cancellations must be received in writing. A full refund will be made on cancellations received prior to July 5. A $100 service charge will apply to cancellations received after July 5. No refund will be made on cancellations received less than 5 business days prior to the conference.

However, if your plans change at any time, you may substitute the name of another person from your company without penalty.

All registrations will be confirmed in writing.

To register, simply complete the form and send it along with your payment to:
Business Insurance, Communication Services Department
220 E. 42nd St., Suite 930, New York City, NY 10017
For additional information call: Ann Vazquez, Registrar, at 212/210-0137

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We have set aside a block of rooms at a special rate at the Grand Hyatt Hotel in New York City. Rates available to Conference Registrants only: $100 single; $125 double.

You must mention the *Business Insurance Benefits Conference* when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call the Grand Hyatt Hotel at 212/883-1234; or toll free at (800)228-9000. These rates will be honored only until July 22.

BI 7/22

REGISTRATION FORM

Please register me for the 1985 BI Conference
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Kentucky case

Continued from page 2

and return the employee to work in "an all-white setting, if necessary."

The city of Louisville and the Kentucky Special Fund are appealing the board's ruling in Jefferson County Circuit Court on two grounds.

First, they say the injury is not work-related, and therefore it is not compensable under the state's workers compensation law.

And second, both are arguing in briefs filed with the court that the Workers' Compensation Board's order is in violation of state and federal civil rights laws.

Stress-related workers compensation cases are on the increase throughout the country, but this is believed to be the first case in which a workers compensation board has awarded benefits because of an employee's claim that he could not work in an integrated environment.

The case involves Gary Pearl, a 40-year-old Louisville resident who, according to his attorney, was diagnosed as a paranoid schizophrenic in 1965, while serving with the U.S. Army in West Germany.

"Prior to Mr. Pearl's employment with the city, he had a spotty job history and bouts of paranoid schizophrenia, for which he was hospitalized," said his Louisville attorney, Fred Radolovich.

But, Mr. Pearl was able to "bounce back" after each bout, according to Mr. Radolovich, and the illness had been under control for several years.

The Workers' Compensation Board 'ordered rehabilitation and directed exhaustive methods be made to return (Mr. Pearl) to gainful employment, in an all-white setting, if necessary,' says Ms. Shively, acting director of the board.

In 1972, Mr. Pearl took a job as a laborer in the city's park department and worked his way up to a supervisor's position, Mr. Radolovich said.

However, in 1979, the city cut back manpower in various departments, and Mr. Pearl was reassigned to the sanitation department. There, according to his attorney, he ultimately wound up working at the city incinerator, where he was the only white employee.

An opening occurred in the sanitation department for a supervisor and, because Mr. Pearl already had been a supervisor in the park department, he got the position. This disappointed other workers in the sanitation department, Mr. Radolovich said.

"They found out that Mr. Pearl was a no-nonsense supervisor...who enforced the rules," Mr. Radolovich said, explaining that as time went on, the workers under Mr. Pearl's supervision began physically threatening him.

Mr. Radolovich said Mr. Pearl went to his supervisor for guidance, but was told to go back to work and try to get along with his co-workers.

The harassment and threats allegedly increased. Finally, in March 1983, Mr. Pearl, instead of going to the job site, went to the director of the Department of Sanitation, Evelyn Waldrop, to seek help, Mr. Radolovich said.

Then, according to Mr. Radolovich, Ms. Waldrop and a psychiatrist persuaded Mr. Pearl to be admitted to a hospital, where he again was diagnosed as being a paranoid schizophrenic.

Ms. Waldrop, who now is executive director of the state Public Works and Services Cabinet, declined to comment on the case since it is still in litigation.

Mr. Pearl ultimately resigned from his job and was promised retirement pay, which Mr. Radolovich said Mr. Pearl never received. When his group health insurance benefits and other sources of income ran out, Mr. Pearl contacted Mr. Radolovich.

In September 1983, the city was informed that a claim had been filed with the Workers' Compensation Board, citing Mr. Pearl's recurring depression due to job stress and racial pressures on the job, said Kevin O'Donnell, Louisville's risk and insurance manager.

During the hearing of the case before the Workers' Compensation Board, physicians' affidavits presented as testimony said it would be impossible for Mr. Pearl to return to work unless it was in an all-white setting, Mr. Radolovich said.

The Workers' Compensation Board, in a unanimous decision issued April 29, ruled in favor of Mr. Pearl. The city of Louisville and the Special Fund subsequently filed appeals with the Circuit Court.

Last month, Mr. Radolovich also petitioned the Circuit Court, asking that benefits be paid to Mr. Pearl, pending appeal.

That request was granted, but the Special Fund subsequently petitioned for—and was granted—a temporary restraining order by the state's Court of Appeals. A decision on a permanent restraining order is pending, said Gemma M. Harding, staff attorney with the Special Fund.

"We feel that (Mr. Pearl's) condition falls outside the statute...and that the paranoid schizophrenia did not result from employment," said Aubrey Williams, director of the Special Fund.

The city also maintains that Mr. Pearl's condition is not related to his job.

And, the city further argues that the Workers' Compensation Board's order to return Mr. Pearl to an "all-white" job setting is against civil rights laws, said Frank Quickert, director of law for the city of Louisville.

"We will exhaust every legal avenue to fight this case," Mr. Quickert said.

He said the city also interprets the board's decision to mean it must rehire Mr. Pearl for a job in an all-white setting. However, Workers' Compensation Board members say the city has misinterpreted its decision.

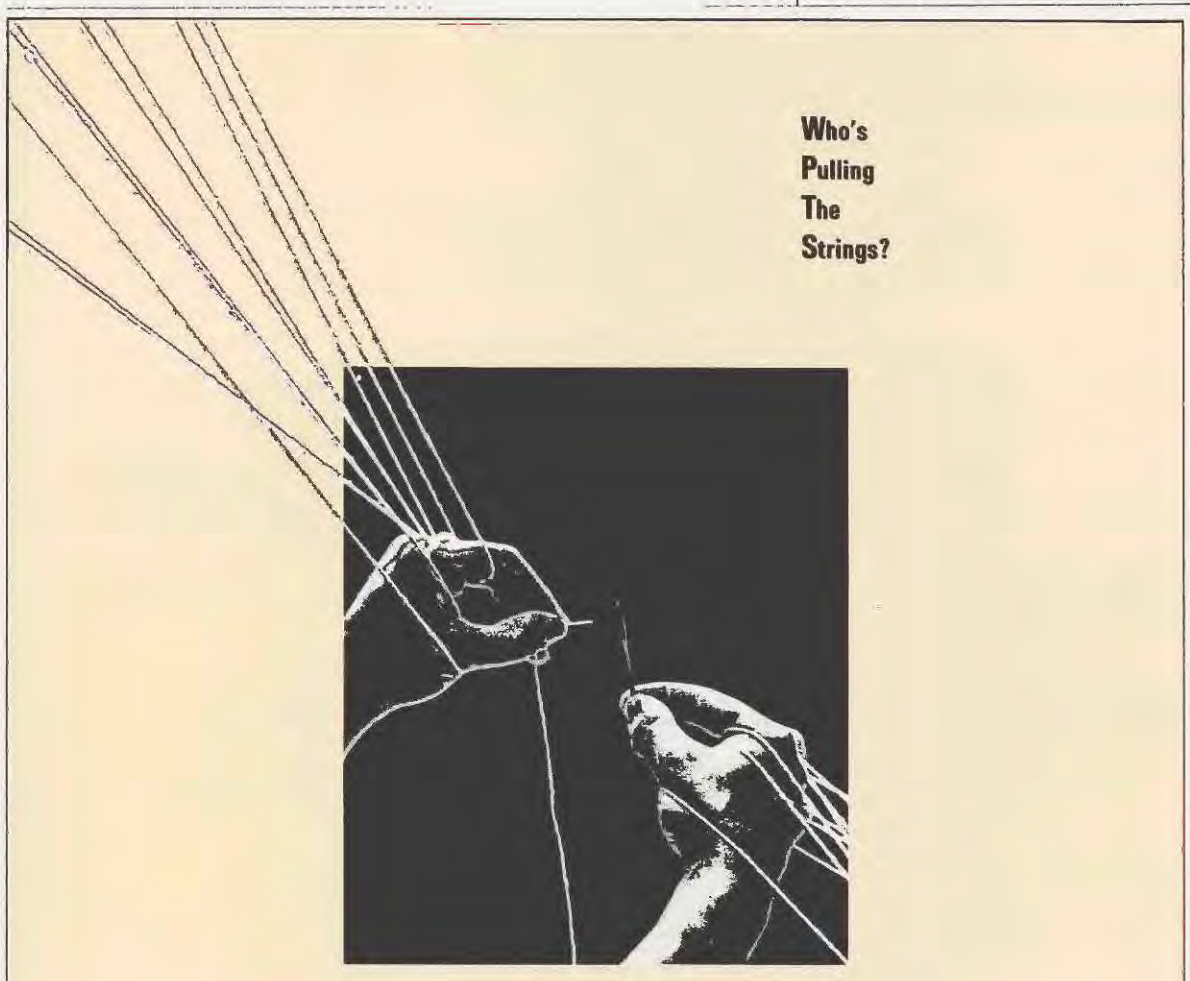
"The board's opinion strongly urged that every effort be made at vocational rehabilitation. It ordered rehabilitation and directed exhaustive methods be made to return (Mr. Pearl) to gainful employment, in an all-white setting, if necessary," explained Suzanne Shively, deputy secretary of the state's Labor Cabinet and acting director of the Workers' Compensation Board.

But, she said it will be up to the rehabilitation staff of the board, and not the city of Louisville, to carry out that directive.

"Rehab is within the board's domain," said Lanny Holbrook, a Fort Mitchell, Ky., attorney and chairman of the Workers' Compensation Board.

Like Ms. Shively, Mr. Holbrook said that the city is misinterpreting the order regarding Mr. Pearl's return to work.

Briefs in the Circuit Court case are scheduled to be filed by next month, after which Jefferson County Circuit Court Judge Jack E. Mudd may request oral arguments. ■



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FASB sets hearings on pension changes

STAMFORD, Conn.—The Financial Accounting Standards Board will hold public hearings Monday through Wednesday in New York and Aug. 1-2 in Stamford on proposed accounting changes for terminations of defined benefit pension plans.

The subject of the hearings is a proposal, "Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits," based on two exposure drafts issued by the FASB.

The proposal generally would require recognition of gains or losses in some circumstances in which current requirements either are ambiguous or do not permit recognition, said Timothy S. Lucas, FASB project manager.

"Situations covered by the exposure draft include asset reversions, in which annuities are purchased to cover vested benefits and excess assets are withdrawn from the plan, as well as plan curtailments," Mr. Lucas said.

"Curtailments would include reductions in the size of a workforce, terminations of benefit accruals and plant closings."

Comments are due on the proposal by Aug. 31.

If it is adopted, the provisions of the draft would be required for financial statements starting in calendar year 1987, but earlier compliance would be encouraged. ■

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Texas insurance commissioner resigning post to join law firm

AUSTIN, Texas—Tom Bond, who has served as Texas insurance commissioner since October 1982, will resign effective Aug. 1.

Mr. Bond, 38, will join the Austin office of the law firm of Akin, Grump, Strauss, Hauer & Field.

"I sincerely regret the departure of Tom Bond, said Lyndon J. Olson Jr., chairman of the Texas Board of Insurance.

"His contributions to the sound administration of this agency, as anticipated, have been outstanding. He is a leader and an innovator, and he has handled some difficult problems with great effectiveness and sensitivity," according to Mr. Olson.

Mr. Bond began his government service in 1973 as a legislative assistant after working as a newspaper and magazine reporter.

He joined the staff of the state Board of Insurance in 1979 and served two years as director of information services and assistant deputy commissioner.

He returned to the state agency as commissioner in 1982 after receiving a law degree from the University of Texas School of Law and working for a law firm.

The board is expected to name a new commissioner within a few weeks.

around the states

Municipal coverage

DALLAS—The city of Dallas' quest for liability insurance may be aided by a new state law that goes into effect Sept. 1.

The law voids the former statute that required that competitive bids be taken for excess insurance coverages for cities with populations of more than 50,000.

The new law may help Dallas because insurers spurn competitive bidding, claiming that preparing the bids is too time-consuming and is a barrier to a long-term relationship between an insurer and a policyholder, industry sources say.

Dallas, with about 1 million residents, has been operating without liability insurance since May 1, when its coverage expired. It decided to go bare when bids for replacement coverage included premium increases ranging from 600% to 1,000% (*BI*, July 8).

Until the new law takes effect, city officials are reviewing Dallas' "excellent" loss history during the past five years, in order to provide more detail to the city's 323-page bid solicitation, said Dallas Risk Manager Mark Ferraro.

The city also is reminding department heads about the lack of liability coverage, and it is stepping up efforts to charge liability claims to the department that has incurred the claim, Mr. Ferraro added.

Attorneys' pools

TALLAHASSEE, Fla.—The Florida Department of Insurance earlier this month adopted rules for groups of attorneys seeking to self-insure their professional liability exposures.

The tightening property/casualty insurance market and rising rates are causing attorneys to explore alternatives to conventional insurance, according to an Insurance Department spokeswoman.

The rules require that:

- An attorneys' group wishing to self-insure must seek departmental approval to establish a trust fund. The application must outline plans for loss prevention and claims handling.
- Once approved, an attorneys' group must meet unspecified capital and surplus requirements, which could vary according to the number of attorneys covered in the plan and the coverage limits offered, the spokeswoman said.

Capital and surplus requirements may be less than those required of a commercial insurer. But, group members may be assessed extra costs if premiums do not cover claims, the spokeswoman said.

- A group must submit annual audit reports.

Florida-based groups of attorneys and physicians have been allowed to self-insure since 1975. However, so far only groups of doctors have done so.

Interest among attorneys in self-insuring began last year, as the result of rate increases and capacity problems, said the spokeswoman.

The spokeswoman added that the Florida Bar Assn. and The Academy of Florida Trial Lawyers currently are exploring the feasibility of establishing a trust fund for self-insurance.

"By insuring themselves, they will have greater control over premiums and policy renewal, although premium costs are likely to be similar to rates for conventionl insurance," said state Insurance Commissioner Bill Gunter.

Work comp group

WESTWOOD, Mass.—The Massachusetts Self-Insurers Assn. is reactivating after an 18-year hiatus.

Originally formed in 1940 as the Massachusetts Industrial Council Inc., the group changed its name to the Massachusetts Self-Insurers Assn. in 1943, when state law allowed employers to self-insure their workers compensation programs.

Over the years, members lost interest in the group, and its final meeting was held in 1967, according to A.L. Lawrence, one of the founders who now is retired.

However, last fall, some of the 170 self-insurers in the state decided to regroup, and a state charter was approved last month, said John J. Barston, legal counsel pro tem. Mr. Barston also is the house counsel for Trans-Lease Group, based in Westwood, Mass.

Trans-Lease's Vp Paul C. Meleedy is the president and chairman of the new group.

"Self-insurers believe they ought to be banded together to protect self-insurance in Massachusetts," Mr. Barston said.

About 30 to 40 employers already have joined the group, which met for the first time this month.

Other officers are: William E. Axford, claims manager with Star Market Co. in Cambridge, vp; Richard Fink, treasurer of H.B. Smith Co. Inc. in Westfield, treasurer; and Alfred S. McIntyre, director of employee benefits at New England Telephone Co. in Boston, secretary.

Also on the board of directors are Bruce F. Buckler, a principal with Buckler, Irvin & Graf Inc. in Winchester; Ellen M. Dyer, employee benefits administrator with AT&T Technologies Inc. in North Andover; and Thomas P. Welgoss, manager of corporate insurance at The Gillette Co. in Boston.

Additional information about the association is available from Mr. Meleedy at 617-329-4400.

Comp litigation costs

SAN FRANCISCO—The direct, out-of-pocket cost of litigating a workers compensation claim in California was $3,521 per case in 1984, up 45% from the costs reported three years earlier, according to a study by the California Workers' Compensation Institute in San Francisco.

The average litigation expense for both the claimant and the defendent—including attorneys' fees, the cost of forensic medical reports or testimony and related ancillary expenses—was 43% of the average payment of $8,137 for disputed claims, the institute said.

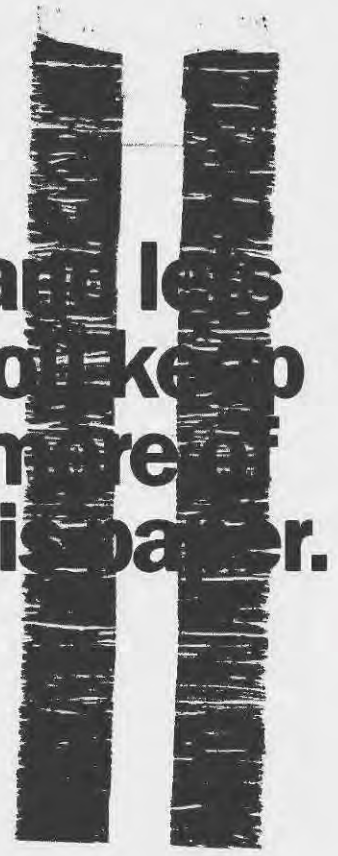
By comparison, in 1977, average litigation expenses were $1,681 per workers compensation claim, or 28% of the average award of $5,990 in disputed claims.

In 1979, litigation expenses of $2,025 per claim were 33% of the average award of $6,120. And, in 1981, litigation expenses of $2,436 were 41% of the average award of $5,879.

The Institute points out that, based on its studies, the total cost of litigation in California's workers compensation system is at least $600 million a year.

The study results were based on data collected on 1,681 claims resolved by decisions of the Workers' Compensation Appeals Board during the six-week period ending Aug. 24, 1984. ■





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Book gives experts' views of how PPOs affect costs

A new book takes an in-depth look at preferred provider organizations and their effect on health care costs.

"The New Health Care Market: A Guide to PPOs for Purchasers, Payers and Providers" contains the perspectives of 107 experts, including corporate benefit managers, labor union representatives, insurers, physicians, attorneys and hospital administrators.

The contributors evaluate the benefits and disadvantages of PPOs and analyze their significance to employers, health care providers and third-party payers.

The book was edited by Peter Boland, president of Boland Healthcare Consultants in Berkeley, Calif.

The book costs $65, plus $2 shipping for the first copy and 50 cents for each additional copy.

To order, write the American Assn. of PPOs, Suite 139, 4301 Connecticut Ave. N.W., Washington, D.C. 20008; 202-362-4298.

DRG software

Health Systems International in New Haven, Conn., has developed a software package for employers, insurers and third-party administrators that is designed to cut health care costs by evaluating hospital claims before payment is made.

HSI, which developed the diagnostic related group prospective payment system for the U.S. Health Care Financing Administration, is offering a computer program that groups patients into DRGs exactly as Medicare does to pay claims.

The software, called Medical Claims Monitoring System, checks claims for inconsistencies and tells users if charges exceed reasonable prices for the treatment.

A spokesman for HSI said, "Unless corporations and payers are prepared to say, 'This is all I will pay for this service,' there will be no effective cost containment."

For information on pricing and other details, contact HSI, 100 Broadway, New Haven, Conn. 06511; 203-562-2101.

Comp statistics

The National Council on Compensation Insurance has released its 1985 edition of the Annual Statistical Bulletin, a comprehensive source of workers compensation insurance statistics.

This year's edition includes information on workers compensation premiums, benefits, expenses, statewide average wages and weekly benefits by injury types.

The bulletin is available to all NCCI members for $100 and to non-members for $150. Copies can be obtained by calling James Nau, the NCCI's manager of products and services, at 212-560-1975.

Labor law digest

The 25th edition of the Digest of California Labor Laws, published by the California Chamber of Commerce, attempts to unravel the maze of California laws and court decisions affecting employers.

The 137-page digest explains and summarizes the general principles and rules under the state laws and judicial decisions.

Workers compensation, the California Occupational Safety and Health Act and disability insurance are among the book's topics.

The chapter on workers compensation covers the employer's obligations and liabilities, benefits, self-insurance and the Workers' Compensation Appeals Board. It also explains the Asbestos Workers' Account and longshoremen and harbor workers' insurance.

Each section of the digest contains footnotes, citing the specific chapter and code in the law, or the court decision.

Other areas of the book explain employers' role in such labor issues as wages and hours, fair employment regulation, child labor laws and collective bargaining.

The 1985 Digest of California Labor Laws costs $40. Copies may be obtained from the California Chamber of Commerce, Attention: Digest, P.O. Box 1736, Sacramento, Calif. 95808. ■

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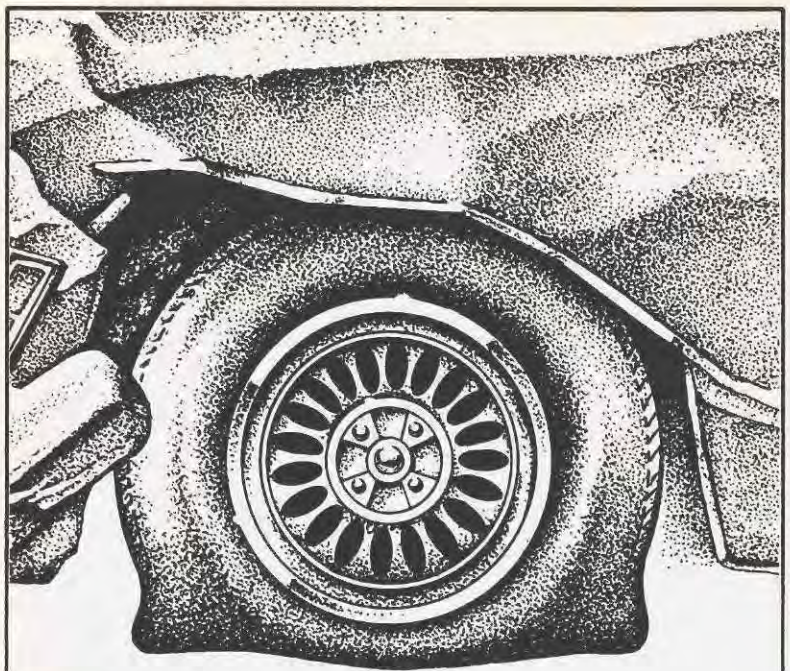
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BC/BS plans to refund surplus to federal government, workers

The Blue Cross & Blue Shield Assn. in Washington, D.C., plans to refund $754 million in surplus funds to the federal government, the U.S. Postal Service and 1.5 million federal employees and retirees insured under group health care plans.

A BC/BS spokeswoman said the surplus reflects a dramatic drop in health care utilization for the plan in 1984 and so far in 1985.

According to the spokeswoman, hospital admissions dropped 14.1% to 292 per 1,000 subscribers in 1984 from 340 per 1,000 in 1983. Average length of stay dropped 8.9% to 7.2 days in 1984 from 7.9 days in 1983. And, the number of inpatient days per 1,000 subscribers dropped 22.3% to 2,044 per 1,000 in 1984 from 2,632 per 1,000 in 1983.

Utilization continues to decline in 1985, the spokeswoman added.

The Blues attribute the decreases to cost-containment programs like outpatient surgery and diagnostic testing; pre-admission, second surgical opinion and utilization review; plan redesign, including more deductibles and co-payments; and increased competition among providers.

Of the $754 million to be returned by BC/BS, about $421 million will go to the federal government, $44 million to the U.S. Postal Service and $289 million to federal employees.

The refund amounts are prorated according to each group's contribution to the plan's premium. The government contributes an average of 61% of the cost of emplpoyees' group health care premiums; its employees contribute the remaining 39%. The Postal Service contributes an average of 75% to its employees' premiums; the employees pay the balance.

Under the proposed refund distribution, employees and retirees of the federal government will receive a refund of $73 for standard-option individual coverage; $179 for standard-option family coverage; $173 for high-option individual coverage; and $374 for high-option family coverage.

Postal workers and retirees will receive $18 for standard-option individual coverage; $51 for standard-option family coverage; $140 for high-option individual coverage; and $300 for high-option family coverage.

The refund program is pending approval by the U.S. Office of Personnel Management, which administers the federal government's group health care program.

Transit contracts

The Southern California Rapid Transit District has new contracts with three of its unions that call for greater employer contributions to health care.

The settlements with the United Transportation Union, the Amalgamated Transit Union and the Brotherhood of Railway, Airline and Steamship Clerks mark the first time since 1969 that contracts have been reached with all three unions without a walkout.

The ATU contract, ratified June 6, is retroactive to April 1 and expires June 30, 1988. It covers 1,800 workers.

Under the ATU's previous contract, the transit district contributed $242 a month for each employee to the union-administered health and welfare fund. Under the new agreement, that contribution increases to $266 a month, retroactive to April 1, and increases again to $292 a month on April 1, 1986; to $321 a month on April 1, 1987; and to $333 a month on April 1, 1988.

benefit beat

The new contract also increases employer contributions to the pension fund to $30.70 a month per retiree, retroactive to April 1, up from $21.17 a month under the old contract. On April 1, 1986, the company's contribution increases to $44.52, and on April 1, 1987, it increases to $64.55. Also, the contract mandates that all retirees receive a minimum pension of $350 a month.

The ATU's health insurance is underwritten by Union Labor Life Insurance Co. of Washington.

The BRAC contract, ratified May 2, also is retroactive to April 1 and expires June 30, 1988. It covers 750 workers.

The contract increases the company's contribution to the BRAC health and welfare fund, which is administered by the union, to $243 a month for each employee, up from $203 under the old contract, retroactive to April 1. The company's contribution will increase to $268 on April 1, 1986, and to $293 on April 1, 1987.

In addition, the company will provide $14,000 in life insurance to each union member with at least two years of service, up from $7,500 under the previous contract.

CIGNA Corp. and Transamerica Assurance Co. underwrite BRAC's health care coverage; Transamerica also underwrites its life insurance coverage.

The contract with the UTU, ratified April 25, is retroactive to Feb. 1 and expires June 30, 1988. It covers 5,300 employees.

Like the other two contracts, the contract increases the transit district's contribution to the union's health care fund to $272 a month per union member, retroactive to Feb. 1, from $257 a month under the previous contract.

That will increase to $295 a month on Feb. 1, 1986; to $318 a month on Feb. 1, 1987; and to $332 a month on Feb. 1, 1988.

In addition, the contract requires that the transit district make contributions to the health and welfare fund for part-time workers, who work no more than 30 hours a week. Approximately 600 of the 5,300 UTU members employed by the transit district work part-time and did not receive any benefits under the previous contract.

Retroactive to Feb. 1, the district will contribute to the fund $75 a month per part-time employee. That will increase to $85 a month on Feb. 1, 1986, to $95 a month on Feb. 1, 1987; and to $100 a month on Feb. 1, 1988.

Under the new contract, the transit district also will contribute $2 a month per employee to the UTU's life insurance fund, up from $1.375 under the old contract.

In addition, the contract allows union members to retire after 25 years of service, regardless of their age. Under the previous agreement, employees had to have 30 years of service to retire before age 55. Normal retirement with full benefits is at age 55 with 10 years of service.

Blue Cross of California underwrites the UTU's health care coverage; Standard Life Insurance Co. of Jackson, Miss., underwrites the life insurance coverage.

Oscar Mayer pact

A new contract for hourly workers at the Oscar Mayer & Co. meat processing plant in Madison, Wis., includes an incentive for employees to retire.

The contract, with Local 538 of the United Food & Commercial Workers International union/AFL-CIO, covers the more than 1,600 workers at the Madison plant, the largest of Oscar Mayer's nine processing plants. It was ratified in May and will expire Sept. 1, 1986, said a company spokesman.

Under the former contract, monthly pension benefits were $15.50 per year of service. Under the new contract, workers who retire between June 1 and Oct. 1, 1985, will receive monthly retirement benefits of $17.50 per year of service. Workers retiring after Oct. 1 but before the end of the contract next September will receive monthly benefits of $15.50 per year of service.

Workers that retire after Sept. 1, 1986, will receive monthly benefits of $15.50 per year of service prior to May 1985, and $11.25 per year of service thereafter.

Oscar Mayer employees can retire with full benefits at age 60 or at any age after 30 years of service.

Employees with less than 30 years of service can opt for early retirement at age 55 with a 30% reduction in their benefits. The early retirement reduction is phased out gradually until an employee reaches age 60.

Chrysler health costs

Chrysler Corp.'s 1984 health care bill of $402 million was $58 million less than the company expected.

Chrysler says most of the savings come from cost-containment measures like second surgical opinion programs, pre-certification, utilization review, outpatient surgery and a generic drug program.

The automaker expected its health care bill to be about $460 million in 1984 with the cost-containment measures in place, a company spokeswoman said.

However, the actual bill was $58 million less, and Chrysler credits the following cost-containment efforts with the savings:

- Pre-certification of all non-emergency hospital admissions for salaried employees.
- Utilization review of all hospital stays of salaried and hourly employees.
- A second surgical opinion program for salaried and hourly employees that requires a second opinion in all non-emergencies. If the employee does not get a second opinion when applicable, he or she must pay 20% of the surgeon's fee.
- Outpatient surgery incentives offered to physicians. Doctors are paid 25% more than what is considered reasonable and customary for certain surgical procedures if they are performed on an outpatient basis. If they are performed on an inpatient basis, the doctor is only paid 75% of the reasonable and customary charge. But, the employee pays the same copayment regardless of how the surgery is performed.
- A generic drug program that provides low-cost, generic prescription drugs to both salaried and hourly employees.

Various Blue Cross & Blue Shield plans are the major underwriters of Chrysler's group health insurance program.

•

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing in the employee benefit field. We'd like to know if you've made any changes. Write Diane Kastiel, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.

Banks' D&O

Continued from page 1

will write for financial institutions, citing huge losses and fears of more to come (*BI*, Sept. 3, 1984; Jan. 21).

The Wyatt-LeBoeuf study is only one of several moves by financial institutions to combat high prices and limited coverage.

Many mid sized U.S. banks have been discussing formation of an association captive with broker Johnson & Higgins. These banks met with J&H in Chicago June 27.

And, about 2,200 banks in the Midwest recently formed their own insurer, BankInsure, in Oklahoma City.

The joint Wyatt-LeBoeuf study began after each realized the other had begun work separately on a similar study, commissioned by different banks.

Some banks had approached Sidney R. Pine of LeBoeuf, Lamb in April and others approached Warren G. Brockmeier, vp-risk management services at Wyatt, in May. The two enterprises joined forces soon thereafter and invited representatives of the Fortune 100 banks to a June 7 meeting in Chicago.

About 70 people attended, representing about 50 banks, Mr. Pine estimates.

A seven-member executive committee was selected at that meeting. The members have spoken two or three times since then and will meet again in Chicago the first week in August, according to committe member Ms. Lichota.

Wyatt and LeBoeuf project the study will cost $175,000, to be borne equally by the banks that decide to participate. As of late last week, 23 banks had committed themselves, at a cost of $7,500 each, and several others were still reviewing the proposal. If others join, the cost will be less for each bank.

Additional participation was being sought by telephone last week.

Besides Ms. Lichota, insurance professionals spearheading the study are: Walter Cahill, vp and director at Chase Manhattan Corp.; J. Robert James, vp at Chemical New York Corp.; Paul McConnell, vp-compensation and benefits at Barnett Banks of Florida; Arthur Bilek, vp-security and risk management at First Chicago Corp.; Harry Campbell, insurance manager at Texas Commerce Bancshares in Houston; and Richard Klovstad, president of insurance and risk management at Norwest Corp. in Minneapolis.

Albert Howard, vp-insurance at First Interstate Bancorp. in Los Angeles, is serving as an advisor.

Among the 15 other banks now contributing to the study are: Wells-Fargo in San Francisco; Security Pacific in Los Angeles, Republic Bank Corp. in Dallas and North Carolina National Bank in Charlotte. Others who were considering joining late last week were Crocker National Corp. in San Francisco and Manufacturers Hanover Corp. in New York.

"Everyone's hopeful this effort comes up with a viable alternative for financial institution D&O. We need a means to provide upper limits," says Claudia R. Mastrapasqua, vp at Security Pacific.

It is too early to predict what the final proposal might be or even what excess limits of coverage the banks hope to obtain.

The permissible involvement of banks in the U.S. insurance market is an issue that will be addressed.

"An important preliminary question is whether or not the Federal Reserve System approves of such an insurance group," Mr. Pine says. The various antitrust, tax and incorporation issues that must be decided if the banks set up their own insurance mechanism will be addressed by a team at LeBoeuf.

In addition to answering legal and fiscal questions, the study will address how banks could be rated so that both small and large banks could benefit from any solution Ms. Lichota points out.

"We recognize that among the largest 100, there are banks of significantly different kinds of exposures," she says.

An underwriting rating schedule might be based on a bank's size, profitability, loss and claims experience and merger and acquisition activity, Ms. Lichota explains. Banks smaller than the largest 100 could later join.

The absence of such a rating system has already discouraged some banks from joining. Wachovia Corp. in Winston-Salem, N.C., for example, declined to join the Wyatt-LeBoeuf study.

The bank, which Fortune ranked 42nd, suspected that its premiums would be raised if it joined the venture because it would be rated with larger banks whose risks "are disproportionate to our risks," said Senior Vp Thomas Sanders.

Seattle-based Rainier Bancorp., ranked 50th, has not yet decided if it will join the Wyatt-LeBoeuf study, according to Barbara McDaniel, vp and corporate insurance manager, but it is participating in the J&H study.

J&H is looking into forming an offshore association captive through which mid sized banks could obtain D&O coverage and has hired Covington & Burling, a Washington law firm, to help.

The New York-based broker hopes to attract 30 interested banks to a July 30 meeting in Chicago.

The institutions J&H is targeting are regional, mid size and conservatively managed banks with assets of between $2 billion to $15 billion "who consider themselves a preferred risk," explains Richard Rice, a J&H senior vp and director.

About 125 U.S. banks are potential candidates for the facility, estimates J&H Vp Alan Page.

J&H proposes that its risk management services division conduct a feasibility study at a cost of $125,000 to be paid equally by the study participants.

J&H hopes to have commitments from the banks by Aug. 15, and to complete the study by Oct. 15, Mr. Page said.

Oklahoma broker C.L. Frates & Co. also responded to the tightening market for D&O insurance and bankers blanket bonds by bringing together bank associations in five states to found BankInsure in Oklahoma in May.

The insurer, capitalized at $3 million, will underwrite D&O, bankers blanket bonds and workers compensation, multiperil and commercial auto policies for about 2,200 banks in five states.

The $3 million was contributed equally by the bank associations in Minnesota, Wisconsin, Oklahoma and North and South Dakota.

About 725 banks have already expressed interest, said Timothy O'Tolle, a Frates account executive.

He expects BankInsure to write its first policies later this year.

Banks have been forced to seek alternative sources of insurance because the commercial market for D&O and bankers blanket bonds is so difficult right now.

One financial institution risk manager calls the situation "financial rape" and says, "I think we should go see 'Rambo' to get even."

Almost all banks, regardless of loss record, are being asked to take larger deductibles and lower limits, but at higher premiums.

"I don't think there's a deductible out there less than $1 million, and many are headed for 10," says Security Pacific's Ms. Mastrapasqua.

At July renewals, First National Bank & Trust Co. in Oklahoma City saw its D&O coverage limits reduced to $10 million from $15 million, its deductible increase to $750,000 from $50,000 and its premium increase 22 times, reports Jenny Fink, assistant vp and risk manager.

Chicago-based CNA Financial Cos. is First National's insurer, and one of the few insurers active in the D&O insurance market for financial institutions.

First National's bond premium increased 4.5 times, while its deductible increased to $1 million from $250,000, Ms. Fink says. The bank also had to agree to a 20% coinsurance payment that was not part of the previous bond. The bond was issued by Aetna Casualty & Surety Co. of Hartford, Conn.

Another bank risk manager recalls that when his institution recently sought to renew its $50 million D&O coverage, it could only get $27.5 million—and at a 500% premium increase. The risk manager, who asked to remain anonymous, says the bank had not filed a D&O claim.

Also, almost all financial institution D&O insurance is written on an annual basis instead of the once-traditional three-year policies. ■

Allis-Chalmers terminates pension plan

Continued from page 2

The supplemental benefit plan provides workers who retire with 30 years of service a monthly benefit of $700 until they reach age 62, when they are eligible for Social Security benefits.

Company officials say the number of retired Allis-Chalmers workers receiving supplemental benefits has increased substantially in recent years.

In fact, the number of retirees collecting benefits under the Allis-Chalmers plan far outnumbers active plan participants. Retirees number 6,311 compared with 1,299 employee participants in the plan, which provides for 10-year vesting.

The plan pays about $2 million in benefits each month.

No benefit improvements have been sought since the company began to experience financial difficulty in the early 1980s, said Alan Reuther, UAW's associate general counsel.

PBGC Acting Executive Director David Walker hopes the Allis-Chalmers termination will trigger congressional action on the requested increase in the annual termination insurance premium employers with defined benefit plans pay the agency to $7.50 per plan participant from the current $2.60 per participant. Several bills in Congress call for increasing the premium to $8.50.

"The size of this termination reinforces the need for the administration's request for a premium increase and related legislative reform to the single-employer termination insurance program," Mr. Walker said.

The PBGC's deficit now may exceed $600 million. ■



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Union Indemnity

Continued from page 1

However, a state court judge did grant an extension until July 12, by which time Union was expected to present financial information including a statement of assets as of the first quarter 1985; a statement of the extent of its insolvency as projected by its auditors, Touche Ross & Co. and Tillinghast Nelson & Warren; and the company's plan for curing any insolvency.

At the time of the July 12 hearing, though, Union and its auditors were still trying to assess the company's exact financial position, according to a July 10 affidavit of Union Chairman Douglas L. King and an accompanying letter from the insurer's law firm, Kroll, Pomerantz & Cameron.

Union's 1983 and 1984 annual statements were inaccurate, and any reliance the Insurance Department places on those statements "is likely to be substantially misplaced," said the letter from attorney Roy E. Pomerantz.

At the end of June, Union began reviewing all of its computerized claims information following a Touche Ross audit that found errors in more than 50% of the 1984 loss reserves it tested, according to Mr. King's affidavit.

As of the date of the affidavit, Mr. King said Union had reprogrammed information on 7,000 claims files, with more files due for review. The preliminary results of the review suggested Union was in better financial shape than its annual statements indicated, Mr. King and Mr. Pomerantz said.

While Union reported reserves of $54.2 million on unpaid losses and expenses arising from direct insurance business in 1984, the review indicated that reserves were overstated by $14.6 million and that losses actually amounted to only $39.6 million, Mr. King said.

The overstatement could also affect the calculation of additional reserves for incurred-but-not-reported losses, though Union isn't yet able to assess the impact on IBNR reserves, Mr. King said.

This picture differs substantially from late May, when Hall Vice Chairman William C. Bartholomay wrote to the New York department that a Tillinghast study would show a maximum deficit of $30 million due to underreserving.

Also, Union overstated its liability for unauthorized reinsurance in 1984 by $5 million, said Mr. King.

Together, these amounts add up to a $19.6 million overstatement of Union's liabilities which, when added to the $14.6 million deficit reported in 1984, would create "a literal unimpaired position. . .subject to ultimate determination of applicable reinsurance," says Mr. Pomerantz's letter.

Union also needed more time to analyze its assumed reinsurance business, records of which were generally kept by the ceding companies or the managing general agents and intermediaries producing the business, said Mr. King.

In many cases, ceding companies communicated directly with Union's retrocessionaires on their business, and Union was provided with claims information only after ceding companies collected from Union retrocessionaires, he said.

Mr. King's affidavit added that much of Union Indemnity's unauthorized reinsurance related to its book of assumed reinsurance business, and that if Union has "unauthorized reinsurance problems," those problems are tied more to its assumed reinsurance risks than to its direct business.

Union reported gross assumed reinsurance premiums of $25.8 million in 1984 and direct written premiums of $68.3 million. The company ceded reinsurance of $54.1 million, leaving it with net written premiums of $40 million in 1984.

Arguing that the New York department had insufficient financial information to request Union's liquidation, Mr. Pomerantz asked the court to allow the company a six-month period in which to assess its condition and implement a rehabilitation program.

Union officials had earlier broached several rehabilitation proposals to the Insurance Department, one of which involved a loss portfolio transfer deal with F&G International, a Bermuda-based unit of United States Fidelity & Guaranty Co.

Also, Union suggested it negotiate agreements with ceding companies under which ceding companies would deal directly with Union's retrocessionaires, removing Union from the transactions, says Mr. O'Brien, adding this would have reduced Union's liability for losses and for unauthorized reinsurance.

But, the department disapproved of the rehabilitation ideas, he said.

Union wrote nearly half of its 1984 direct premiums—$30.4 million—in New York, and a total of about $21 million in New Jersey, Florida, Illinois and Michigan.

Union wrote 1984 direct premiums of $3.8 million in New Jersey, including $1.5 million in surety business that won't be covered by the state's guaranty fund, an Insurance Department spokesman said.

Union's direct premiums in Illinois in 1984 amounted to $3.2 million, including $500,000 in surety business that the state fund won't cover, says John E. Washburn, director of insurance.

Florida's guaranty fund also does not cover surety claims, though the Florida Insurance Department doesn't yet know how much surety business Union wrote in the state, according to Dennis Threadgill, chief attorney for the division of rehabilitation and liquidation.

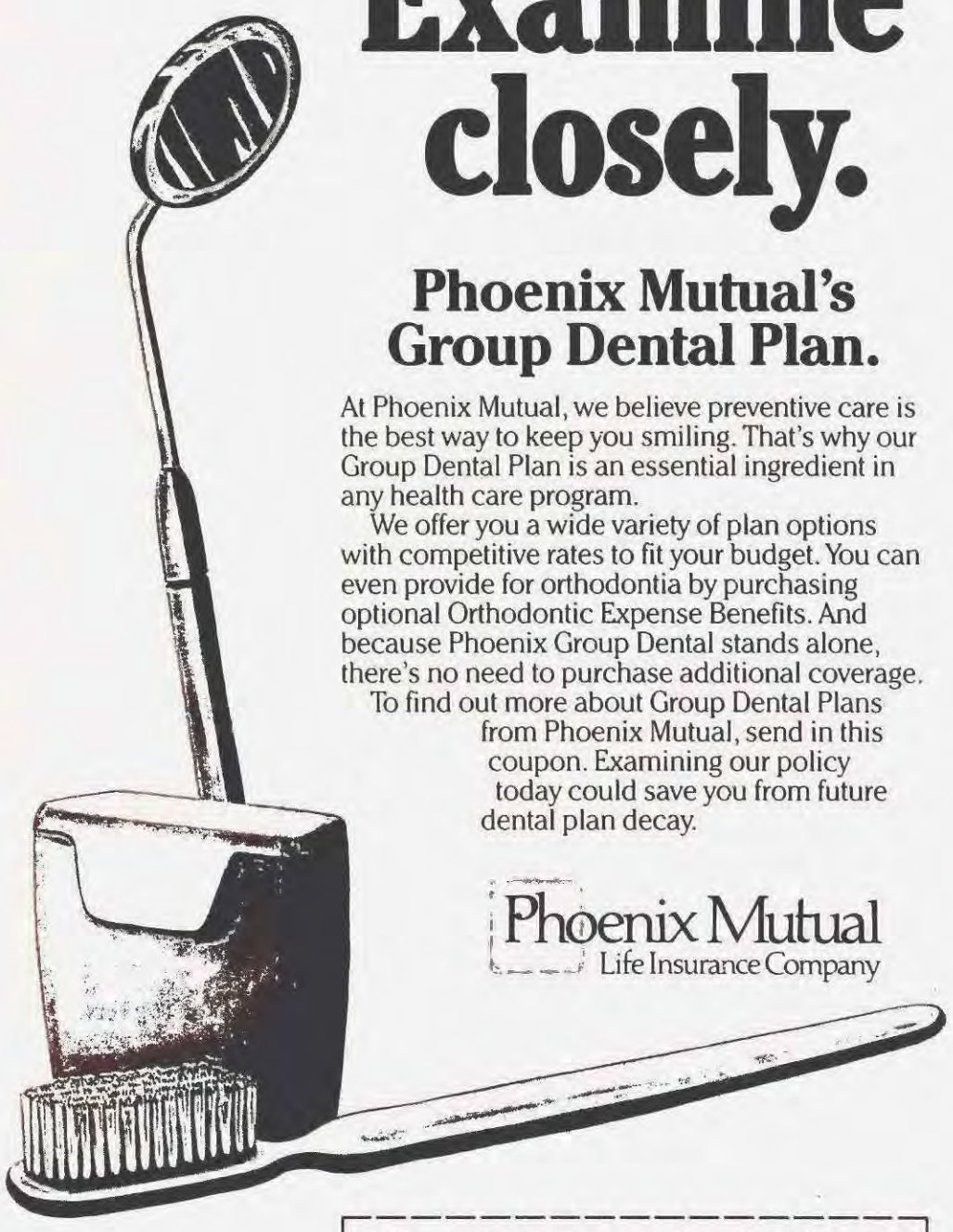
New York and Michigan guaranty funds will cover surety claims, regulators in both states say.

One bond written by Union in New York is the subject of litigation. New York-based Apple Bank is suing Union and Flexo Contracting Co., which used a $750,000 Union surety bond to obtain a construction loan from Apple.

Flexo defaulted on its loan, and Apple filed a surety claim of more than $733,000 with Union, which it did not pay, according to Dennis Yeager, Apple's lawyer.

Apple is seeking payment on its claim and $1 million in punitive damages for Union's bad-faith refusal to pay, Mr. Yeager said. The case was tried in June before a New York Supreme Court judge, who has yet to issue a judgment.

Mr. O'Brien said any judgment against Union would have to be submitted to the liquidator for payment. ■



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Wellington

Continued from page 2

"There are no official instructions to defense counsel to go out and seek stays," he said.

Mr. Gilbert said producers that have signed the agreement are considering whether to seek stays in "appropriate" cases, but he added that no decision has been made.

However, he stressed it would not be appropriate to seek a stay in a case about to go to trial.

He added Wellington participants will keep plaintiffs' attorneys informed on the issue.

Asbestos plaintiffs' attorney Thomas Henderson, with the Pittsburgh law firm of Henderson & Goldberg, declined to comment last week on developments with producers and insurers in Wellington.

However, after a recent meeting in Chicago, plaintiffs' attorneys indicated they would not tolerate any delays in litigation.

"We expect no further delays in the orderly administration of justice with respect to asbestos disease claims presently pending before various courts," they said in a prepared statement.

The statement also said plaintiffs' attorneys "unanimously" agreed to invite representatives of Wellington producers and insurers to a meeting within the next month.

In addition to the comments on seeking stays of litigation, the letter sent by Wellington producer members to their attorneys advised the attorneys on what to do in litigation involving other producer members.

The letter recommends that:

- Cross-claims should not be filed against producer members.
- No discovery proceedings should be taken against them.
- All efforts to implicate the products of any facility member should cease.
- When possible, depositions, meetings and any activity not required by the courts should be postponed.

With respect to litigation between insurers and producers that joined Wellington, Mr. Gilbert said court papers are being prepared for final dismissals in the massive coverage litigation in California involving five asbestos producers and numerous insurers over coverage.

Two of the five producers in the litigation, Armstrong World Industries and Fibreboard Corp., have signed the Wellington agreement. And, many of the insurers involved also have signed. ■

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Secretaries, treasurers, controllers and other financial personnel 7,167

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,206

Sub-total 22,627

Associations 1,081
Government, unions and educational systems 944

Commercial Consumers
Sub-total 24,652

Insurance agents and brokers 9,524
Insurance companies 5,867
Financial institutions 556
Actuaries, attorneys, adjusters, appraisers and consultants 3,265
Others allied to the field, ... 1,143

TOTAL 45,007

* Source: Business/Occupational breakdown of qualified circulation, Nov. 5, 1984 issue, as submitted to BPA for Dec. 1984, BPA Publisher's Statement.

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Lloyd's report

Continued from page 2

surance arrangements.

According to the report, the Howden units from which funds were misappropriated include Sphere Drake Insurance P.L.C. and Capital Marine Insurance Co. Ltd. Mr. Carpenter had been chairman of Sphere Drake and senior underwriter at Capital Marine.

In addition, funds were misappropriated from the Lloyd's syndicates underwritten by Mr. Posgate, the report says.

- Messrs. Grob, Comery, Carpenter and Page "dishonestly" capitalized a Panamanian real estate company, Southern International Re Co. S.A., with misappropriated funds. The company later was used to write reinsurance.
- Howden's accounts were falsified by Mr. Grob and Mr. Comery.

Specifically, Mr. Comery and Mr. Grob falsified the 1980 accounts of Drake Insurance Co. of New York, subsequently renamed Atlanta International Insurance Co., "to decieve the United States regulatory authorities, the board of directors of Alexander Howden Group, its shareholders, its directors, its auditors and generally the public."

Two volumes of the report contain findings of a disciplinary committee that investigated charges against Messrs. Grob, Comery, Posgate and Benbassat. The committee was chaired by trial lawyer Johan Steyn and included J.S. Greig, chairman of Lloyd's broker Greig Fester Ltd., and A.B. Gray, a former deputy chairman at Lloyd's.

The other volume deals with the findings against Mr. Carpenter, who was included in the other proceeding until he underwent open-heart surgery late last year. A separate disciplinary committee, headed by trial lawyer Henry Brooke, subsequently heard the charges against Mr. Carpenter.

The charges are based on investigations conducted by Lloyd's and the accounting firm of Deloitte, Haskins & Sells after accountants discovered the misappropriated funds during a fair-value audit of Howden after Howden's acquisition by Alexander & Alexander Services Inc. in January 1982.

A&A subsequently filed a lawsuit against Messrs. Grob, Page, Comery, Carpenter and Posgate, alleging among other things that they misappropriated $55 million of Howden underwriting funds for their own personal use.

The claims were dropped against Messrs. Grob, Page, Comery and Carpenter after the four men aggreed to return some assets to A&A, but claims against Mr. Posgate are still pending (*BI*, April 23, 1983; June 25, 1984).

A&A has recovered $30 million of the misappropriated funds.

Most of the charges against the five men investigated by Lloyd's revolve around the purchase of the Banque du Rhone and Southern International Re.

According to the report, the Howden board decided in 1979 to sell the Banque du Rhone.

In September 1979, the report continues, a meeting was held at Mr. Grob's villa in southern France that included Messrs. Grob, Comery, Page, Benbassat and George Zilkha, who is not a Lloyd's member. At the meeting, according to the report, the men agreed to form a syndicate to secretly buy the Banque du Rhone.

Besides the five men at the meeting, the group decided to offer Mr. Posgate and Mr. Carpenter an opportunity to join the syndicate, the report says, adding that all seven men would buy a 10% share in the bank.

A 14% interest was also offered to bank employees, 15% was offered to a consortium headed by Peter Dixon, then principal director of PCW Underwriting Agencies Ltd., while the other 1% was offered to other parties, the report says.

The group, meeting at the villa, decided to first buy a 51% interest in the Banque du Rhone with an option to buy the other 49%. The first 51% of the bank was to be bought in three installments.

Later in September, the Howden board met. The minutes of the meeting show Mr. Benbassat told Mr. Grob, the board's chairman, and the other board members that a group of private investors wished to buy the bank. The board authorized Mr. Grob to continue negotiations with Mr. Benbassat.

Messrs. Grob, Comery and Page made no mention of their interest in the bank, according to the report. Nor did Mr. Carpenter or Mr. Posgate, though they may not have been invited to join the syndicate at the time of the meeting, the report says.

On Dec. 14, 1979, the purchase agreement was signed, the report says. Another board meeting was held on Dec. 19, at which no disclosure of the Howden officials' interest in the bank was made, it says.

At a Howden general meeting in August 1980, Lloyd's underwriter Richard Outhwaite said he assumed it was the Howden board's intention to sell 100% of the bank, and that neither Howden nor its directors would have any interest in the bank, according to the minutes of that meeting. Mr. Grob confirmed this to be the case, according to the minutes.

The Howden officials' share of the first 51% of the Banque du Rhone was eventually bought from Howden in three installments between 1979 and 1981 with funds that were misappropriated from Sphere Drake, Capital Marine and syndicates underwritten by Mr. Posgate, Lloyd's alleges. The first installment, totalling $1.15 million, was made by five Panamanian companies that were owned or controlled by five Liechtenstein trusts associated with Messrs. Grob, Comery, Carpenter, Page and Posgate, the report says.

The funds that flowed to the Panamanian companies were ultimately traceable back to premiums paid by Sphere Drake and Capital Marine for reinsurance arrangements called "profit policies" written by SNA Re (Bermuda) Ltd., which Lloyd's says was controlled by Mr. Carpenter.

These policies "were so designed and written as to constitute merely a means of transferring funds owed by Sphere Drake and Capital Marine out of their control," the report states.

The second installment, according to Lloyd's, was paid through the trusts and through another company the Howden officials controlled along with Mr. Zilkha, known as New Southern Reinsurance. The $1.4 million paid at this time was misappropriated from quota-share reinsurance policies purchased by Mr. Posgate's syndicates, the report says.

The money was paid to Alexander Howden Insurance Brokers, then to Southern International Re, the Panamanian company, and eventually to Liechtenstein trusts.

The third installment of 2.6 million Swiss francs ($700,000) was also misappropriated from Mr. Posgate's syndicates' quota-share contracts with SIR, says Lloyd's.

On Dec. 29, 1981—after A&A had announced that it was going to acquire Howden—the option to buy the remaining 49% of the Banque du Rhone was exercised. The remaining shares were again funded by quota-share reinsurance placed by Mr. Posgate's syndicates and paid shortly after A&A finalized the purchase of Howden in January 1982, according to the report.

The report notes Mr. Grob and Mr. Comery were found guilty by the Council of Lloyd's for capitalizing SIR with misappropriated funds, using SIR as a reinsurer of Lloyd's syndicates and secretly acquiring the Banque du Rhone.

While acquiring the Swiss bank, Messrs. Grob, Carpenter, Comery and Page "secretly proceeded in 1980 to acquire another company using other people's money to capitalize the company," the report says, referring to SIR.

SIR's initial capital of $1 million and $2 million in additional capital came from "profit policies" purchased by Sphere Drake and Capital Marine and from the quota-share reinsurance of Mr. Posgate's syndicates, the report says, noting that the funds were again funneled through Panamanian and Liechtenstein trusts.

Although Mr. Benbassat was considered SIR's underwriter, Mr. Carpenter admitted to Lloyd's that Mr. Benbassat acted on his instruction, the report says.

In addition, Messrs. Grob and Comery were found guilty of benefiting from their secret ownership of SIR. Some of the benefits included the payment of $975,000 in dividends to Messrs. Grob, Comery, Page and Carpenter on April 29, 1982—four months after A&A acquired Alexander Howden Group.

In addition, Mr. Comery and Mr. Grob were also found guilty of:

- Giving Mr. Posgate a Pissarro painting valued at $90,000 "with the intent of influencing Mr. Posgate as an underwriter to act improperly for the benefit" of Howden and one of its brokerage units.
- Two charges of "window dressing" the accounts at Howden. Specifically, Mr. Grob and Mr. Comery allegedly helped falsify accounts of Drake Insurance of New York after it suffered an $8.5 million loss.

Mr. Grob and Mr. Comery pleaded not guilty to all charges, but their defense only stated that each "denies the charges." After three days of hearings, Mr. Grob's and Mr. Comery's attorneys withdrew from the disciplinary proceedings.

Mr. Grob and Mr. Comery have not appealed their expulsion.

Mr. Carpenter, after recovering from his heart operation, pleaded guilty to two of the eight charges he faced; Lloyd's did not pursue the other charges. Because he pleaded guilty, the disciplinary committee did not have to prove that his acts "necessarily involved dishonesty."

Mr. Carpenter was probably "at all material times No. 3 in the hierarchy of directors that controlled the affairs" of Howden, said Lloyd's. Mr. Carpenter admits that he "committed acts of defaults" that "constituted the conduct by him of (carrying on) insurance business in a discreditable manner."

Mr. Carpenter did not challenge his expulsion.

Mr. Benbassat was expelled from Lloyd's for his part in capitalizing SIR with misappropriated funds, using SIR as a reinsurer of Lloyd's syndicates and for his part in the acquisition of the Banque du Rhone.

Mr. Benbassat's attorney appeared at the disciplinary proceedings for only one day, and Mr. Benbassat did not appeal the expulsion.

Mr. Posgate was found guilty of two of the eight charges brought against him by Lloyd's. The most serious charge—that Mr. Posgate played a part in filtering the funds from his syndicates to purchase the Banque du Rhone—was dropped.

Lloyd's found that although Mr. Grob and Mr. Comery were directly responsible for the misappropriation of funds, it did not follow that Mr. Posgate also "knew that money from his Lloyd's syndicates was used to finance" the Banque du Rhone acquisition." Mr. Posgate denied under oath that his syndicates were the source of the funds.

Mr. Posgate was found guilty of secretly owning shares in Banque du Rhone and failing to inform the Howden board of this interest and of secretly accepting the Pissarro painting "in breach of the duty to his names."

Mr. Posgate knew the painting was given to him to influence his underwriting, Lloyd's said.

In his defense, Mr. Posgate noted he had a "queasy" feeling about accepting the 10% share in the bank from Mr. Grob. Mr. Posgate also said he questioned whether the ownership of the bank should be kept secret, adding that he relied upon advice from Mr. Grob and Mr. Page that no disclosure was necessary.

However, Lloyd's did not accept this argument. "We cannot uphold the contention that this was Mr. Posgate's state of mind. . . .He knew what the honest answer would have led to," said the report.

In sentencing Mr. Posgate, Lloyd's admitted that Mr. Posgate was "one of the most dynamic underwriters in the history of Lloyd's," and "there is no evidence that his names have suffered loss as a result of the use of Mr. Posgate's reinsurances."

Lloyd's gave Mr. Posgate a six-month suspension for accepting the Pissarro painting, but said he should be expelled for owning a secret interest in the bank, which was designed to influence Mr. Posgate's underwriting.

"We have found Mr. Posgate guilty of very serious misconduct. . . .We have found that he acted dishonestly."

Lord Wilberforce, who heard Mr. Posgate's appeal, agreed with the charges against Mr. Posgate but disagreed that Mr. Posgate should be expelled. The share of the bank controlled by Mr. Posgate could have been used "to keep Mr. Posgate within the Howden Group—rather than to influence his insurance decisions," Lord Wilberforce said. He reduced Mr. Posgate's sentence to two six-month suspensions to run concurrently.

Mr. Posgate may reapply to underwrite at Lloyd's after Jan. 8. ■

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CGL forms

Continued from page 1

Continental Corp. plans to adopt its own new policy forms by July 1, 1986, which will be similar to the ISO forms but written in simpler language, Continental says. St. Paul is taking a similar step.

Chubb Corp., USF&G Corp., Hartford Insurance Group and Ohio Casualty Corp. also say they will adopt the new policy forms, but have set no date for implementation.

Aetna Life & Casualty Co., which also has not set a firm date for adoption of the new forms, will adopt only the claims-made form while retaining its current occurrence form.

Mission Insurance Group Inc. and Sentry Insurance Cos. have not decided if they will adopt the new forms.

Meanwhile, the four insurers that have decided to include defense costs within policy limits are Continental, Travelers, Fireman's Fund and Crum & Forster.

St. Paul says it probably will adopt the defense-cost endorsement, but has not made a final decision. In addition, Royal, Hartford and CNA say they support the endorsement but have not decided if they will implement it.

Six other insurers say they are studying the defense-cost issue and have reached no decision: Chubb, Fremont, SAFECO, Kemper, Ohio Casualty and Reliance.

Spokesmen for Mission, Sentry, CIGNA and USF&G would not comment on their companies' stand on including defense costs within policy limits.

Insurers, many of whom say they are adopting the new forms because they will be "the industry standard," say the transfer to claims-made policies is necessary to reduce their liabilities to a "known dimension," as one remarked.

Some insurers also admit they have been pressured by their reinsurers to write liability policies only on the claims-made form.

ISO says it will issue rating advisories that will propose discounts for certain risks written on the new forms. Insurers say they will study the discounts and most likely will use them as a base for determining their own rates.

Insurers are gearing up for the change to the new policy forms with training programs for employees and agents. Nationwide, insurance personnel connected with major insurers are being summoned into seminars and sessions aimed at making the transition as smooth as possible.

Following are reactions from the insurers that plan to use the new ISO forms:

Aetna Life & Casualty

Aetna Life & Casualty Co. will adopt ISO's new claims-made form while retaining its current occurrence form and continuing to offer unlimited defense coverage.

Aetna will implement the claims-made form after Jan. 1 as state insurance departments approve it, an Aetna spokesman commented.

He explained that Aetna underwriters will be issued guidelines that will specify which risks are to be written on the claims-made policy form.

CIGNA Corp.

While company officials were unavailable to comment on CIGNA Corp.'s plans for implementing the new forms, a spokesman for the insurer said CIGNA plans to offer both forms beginning Jan. 1.

Although CIGNA plans to offer both new CGL forms effective Jan. 1, the insurer will not be set up for widespread use of the new forms until about October 1986, when its computers will be reprogrammed to handle the new contracts, said the spokesman.

A training program for underwriters is now under way.

CNA Financial Corp.

CNA Financial Corp., headquartered in Chicago, is switching to the new CGL forms after working with other industry personnel and ISO to develop the contracts.

A spokeswoman for CNA said the insurer "supports the ISO simplification program because it will reduce substantially the number of policy forms we are using."

CNA will implement the new forms Jan. 1 and is supporting the ISO defense-cost provision.

The insurer will make the retroactive date on the claims-made policy the effective date of the policyholder's first claims-made policy.

CNA is still determining if it will use ISO's recommended discounts or another method of setting rates.

A training program is being structured for CNA field and office personnel and the company's agents.

Chubb Corp.

Management at Chubb Corp., based in Warren, N.J., has yet to decide when the insurer will begin using the new CGL forms, says Vp David S. Decker. But Mr. Decker says the insurer does plan to offer both the new claims-made and occurrence forms to its policyholders.

A high-level task force at Chubb currently is developing recommendations on what type of risks will be written on each form. The task force, whose recommendations are expected in about 30 days, will also recommend a date for implementation of the new forms.

Mr. Decker says that no decision has been made on whether Chubb will adopt ISO's defense cost provision. However, he notes that there is a "tremendous amount of pressure from the reinsurance community to cap defense costs."

Continental Corp.

Continental Corp. will not be ready to implement new CGL policy forms until about July 1, 1986, according to Senior Vp Phillip Ben-Zvi.

Continental's new CGL policy forms will be written in the insurer's own language, but will mirror the forms introduced by ISO. Continental expects to begin filing its form with state insurance departments in a few months.

Mr. Ben-Zvi says Continental now is determining which types of risks should be written on the claims-made form and which should be written on the occurrence form. He says he expects that "short-reporting pattern" risks will remain on the occurrence form, while risks with long-tail exposures would be on the claims-made form "to the extent feasible."

Continental suppports ISO's plan to include defense costs within policy limits, effective July 1, 1986. Ideally, Mr. Ben-Zvi says, Continental will implement both the new CGL forms and the defense cost-containment provision on July 1, 1986.

The retroactive date provision for claims-made policies will be decided on a risk-by-risk basis, according to Mr. Ben-Ziv.

Continental also is working on new excess and umbrella policies to be used in conjunction with either the claims-made or occurrence policy forms.

Mr. Ben-Ziv says the movement to a claims-made form is the result of a "recognization by the industry that the liability problem is becoming almost impossible to handle on the old occurrence-type approach."

"The answer otherwise is that certain insureds would have an extremely difficult time getting coverage," he adds.

Mr. Ben-Ziv pointed out that gearing up to use the new CGL forms is a massive effort that requires "tremendous product development, tremendous systems implications, and tremendous training needs."

Crum & Forster Inc.

Crum & Forster Inc. will be ready to use both of ISO's new CGL forms on Jan. 1, 1986, according to Senior Vp Ian Heap. However, Mr. Heap adds that Crum & Forster's "preference" is to write most risks on the new claims-made policy form.

But, whether the insurer can realize this goal will depend on market conditions, he adds.

Mr. Heap also says Crum & Forster plans to adopt ISO's defense cost-containment provision in states where it is approved.

Generally, Mr. Heap says, the claims-made form will be used for any risk that involves "an inherent exposure to latency-type injury or disease."

Pharmaceutical companies are a good example, he says.

Other risks, such as "straight OL&T, (owners, landowners and tenants)" would be written on the new occurrence form, he explains.

Mr. Heap says implementation of the new CGL forms may differ among Crum & Forster's various insurance operations.

Mr. Heap say he sees no problem getting the insurer's underwriters up to speed on the new forms prior to Jan. 1, 1986.

Fireman's Fund

Fireman's Fund Insurance Cos. will be ready to implement the new ISO forms as they are approved by the states, says Vp James C. Smith.

Classes of risks that involve long-latency exposures, such as chemical and pharmaceutical companies, will be written on the claims-made form, he says. Most other risks will be written on the occurrence form, he adds.

For example, "The retail flower shop has no long-latency exposure and would be written on an occurrence form," he says.

Most Fortune 500 accounts likely would be written on the claims-made form, he says. These companies' cash-flow insurance plans "mesh better with the claims-made form," he says, because the claims-made form improves the insurer's ability to predict losses and price cash-flow plans.

Mr. Smith says pressure from reinsurers did not sway Fireman's Fund to adopt the claims-made form. Rather, the insurer wants to get "a handle on general liability claims," he says.

In fact, Mr. Smith said that Fireman's Fund would have liked to see ISO go even further in capping insurers' liability under the new CGL policy forms.

"We would like to see the current unlimited tail coverage capped in some way," he says.

Fireman's Fund officials have not yet made a decision on how to set the retroactive date on new claims-made policies.

However, Mr. Smith says that Fireman's Fund insurers will likely make the retroactive date for most policies the inception of the first claims-made policy. But, he points out, this likely will be negotiated on a case-by-case basis.

Fireman's Fund also will begin including defense costs within policy limits on July 1, 1986.

Fireman's Fund underwriters will begin formal training on how to write coverage under the new forms in September. Shortly thereafter Fireman's Fund's producers will be trained.

Freemont General Corp.

Fremont Indemnity Co. recently finished a draft of its basic plan to implement the new CGL forms, targeting Jan. 1, 1986, explained Marion A. Perkins, president of Comstock Insurance Co., the property/casualty arm of Fremont Indemnity Co.

Exactly how Fremont will use the forms depends on the state of the market, Mr. Perkins says.

Initially, he says, Fremont plans to offer both the claims-made and the occurrence forms. But, ultimately, the Los Angeles-based insurer will seek a transition to claims-made only, Mr. Perkins says.

However, he says, this shift will depend on how well the insurance market accepts the claims-made form.

"The longer the tail on a risk, the more likely it is that we would only want to write it on claims-made," Mr. Perkins explains, "whereas your typical OL&T risk would be acceptable on the occurrence form."

Although no decision has been made yet, Fremont expects to make the retroactive date on a claims-made policy the inception date of the policyholder's first claims-made policy.

Fremont has not yet determined whether it will use ISO's manual rates for the new forms. But, Mr. Perkins says, "Obviously there will be a discount for claims-made policies. But whether we'll be tracking exactly with ISO, I don't know."

"There are a lot of details that we certainly haven't figured out. We've got six months and a lot of hard work to nail this stuff down," he said.

Mr. Perkins said a decision on including defense costs within policy limits is complicated because Fremont writes both primary and excess coverage.

While including defense costs within policy limits will help to limit liability under a primary policy, it will put excess insurers on a risk much sooner than if defense costs were outside of policy limits, he said.

"If the industry as a whole moves to the claims-made form, I think the umbrella policy as we know it today will become an extinct animal," Mr. Perkins said.

Insurers will likely shift to "follow-form" excess policies, Mr. Perkins adds.

Fremont plans a very extensive training program during the fourth-quarter of this year to prepare its employees to underwrite the new policies and pay claims on them.

Hartford Insurance Group

Hartford Insurance Group is "totally in support of the ISO policy form changes and will implement

Continued on next page

Forms approved in 27 jurisdictions

The following states have approved the Insurance Services Office's new claims-made and occurrence commercial general liability forms:

Alaska, California, Colorado, District of Columbia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Missouri, Montana, New Jersey, New Mexico, Nevada and North Dakota.

Also, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Washington, West Virginia and Wisconsin.

Approval of the forms was automatic in California, Colorado, Indiana, New Mexico, Ohio and Tennessee. Those states do not require regulatory approval of forms filed by ISO.

A hearing on the forms is set for Aug. 6 and 7 in South Carolina. And, a forum, rather than a formal administrative hearing, is set for Thursday and Friday in Illinois. Regulators from 11 states will participate.

Hearings also have been held in New York and Arizona, but no decision has been announced in those states yet.

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Continued from previous page

them as soon as it is materially possible," says Paul Jurgens, vp of commercial insurance.

Mr. Jurgens said the Hartford, Conn.-based insurer will wait for insurance departments in "significant states with big premiums" to approve the new form before it will implement them. He mentioned New York and Illinois as large-premium states that have not acted on the forms.

"Hartford is a very large general liability underwriter with a couple of hundred thousand policies. The mechanics of consulting and negotiating with agents is time-consuming. It would be extremely difficult (to put the forms in force) by Jan. 1," he said.

He said Hartford is enthusiastic about the new forms because current policies "no longer contain the kind of words that allow us to predict the dimensions of our losses.

"The policies are liability policies and the courts have established new ways of determining liability. It opens up dimensions that can't be measured."

"There was great pressure from reinsurers to use the form," Mr. Jurgens adds. "They took the same position as the primary companies, pushing extremely hard for claims-made on the first protection."

The new CGL forms will be used for both primary and excess coverage written by Hartford, he noted.

Rates suggested by ISO will be used "as a base from which to depart up or down," Mr. Jurgens added. "It depends on the risk. Most insurers build in factors of their own effectiveness in doing business."

Before Hartford decides if it will include defense costs within policy limits, "We want to see if it is approved from a regulatory point of view," Mr. Jurgens said.

Hartford is training employees and agents with a 12- to 14-hour workshop course, using ISO materials. "It is a major, major change," said Mr. Jurgens.

Kemper Corp.

Kemper Corp. will commit itself to the new CGL program "as soon as we are mechanically able to do so," says George Kasbohm, vp in charge of underwriting.

"At this point it is impossible to do it at the first of the year because of our data processing needs," he said. "It isn't carved in stone, but we hope to make it effective by mid-year 1986."

Kemper will adopt both new CGL forms, said Mr. Kasbohm, but has not decided how they will be used.

"We believe (the new forms) will become the standard of the industry," he added. "They will provide some ability to measure general liability results. It will add to the capacity of the marketplace. Without this type of major revision, there would be a severe shrinkage."

While he couldn't say firmly whether Kemper will accept ISO's endorsement to include defense costs within policy limits, Mr. Kasbohm did say that the insurer will "certainly consider adopting it."

He also said Kemper will follow ISO's rating recommendations, "the same way we do now."

Ohio Casualty Corp.

"We are going to adopt the claims-made and occurrence forms," said a spokesman for Ohio Casualty Corp., "but at this point we are reviewing the forms to decide which ones to make available for which risks."

The spokesman was unable to pinpoint when Ohio Casualty would implement the forms. "We would like to say Jan. 1, but we still don't know as far as a target date."

The spokesman said Ohio Casualty's reinsurers did prod the insurer some to adopt the new claims-made form.

The new forms will be used for primary and excess coverage, according to the spokesman.

Ohio Casualty has not yet decided whether the insurer will include defense costs within policy limits.

Ohio Casualty is holding training sessions for its employees in various parts of the country.

Reliance Insurance Co.

"We are in the throes of switching to the claims-made policy," said Susan Sersha, assistant secretary for Reliance Insurance Co. in Philadelphia. "I've been in meetings all day long."

Reliance is shooting for Jan. 1 implementation of the new ISO forms, depending on further state approvals.

She said a major reason for switching to the forms is "loss ratios in general for general liability." Ms. Sersha said she hopes the new forms will enable Reliance to "deal with some of our problems and give us more options."

Ms. Sersha said Reliance would give its underwriters guidelines that will specify which risks are to be written on a claims-made form. "We hope to identify risk characteristics that mature slower than average. . .From that we can give some guidance to our field people."

She said the insurer will for the most part use ISO's recommended rates but added, "there are always judgment ratings. If there is a peculiarity in a risk, we can always modify a rating."

Reliance is not yet taking a position on whether to adopt the ISO defense-cost provision.

As part of its training program for employees, Reliance will bring in outside expertise to help employees learn how to underwrite the new forms and pay claims.

Royal Group

The Royal Group in New York will implement both new ISO forms on Jan. 1, but "we're going to have some problems in immediately applying them all at once," a spokesman said. He said complex data processing changes have to be made to accommodate the forms.

"But we will continue as effectively as possible."

He said the forms will be used for both primary and excess coverage and "we also intend to use most of the ISO discounts. It's a general endorsement of the ISO plan," he said. The insurer also endorses ISO's proposal to include defense costs within the aggregate limits of the claims-made policy.

SAFECO Corp.

SAFECO Corp. does not plan to implement the new ISO liability forms until Jan. 1, 1987, a year later than most of the other insurers.

The delay is caused by the need to reprogram data processing equipment, says Dale E. Lauer, home office casualty manager for the Seattle-based insurer.

Mr. Lauer expects most of SAFECO's business will be written on the occurrence form because the insurer underwrites mostly "main street" business that doesn't have long-latency exposures.

However, most claims written through SAFECO's special risks department will be written on a claims-made basis.

"At this point we're not seeing the need to write all business on a claims-made contract to control late-developing claims," he says. Mr. Lauer says risk selection and adequate pricing also can be used to control long-latent claims.

The retroactive date on claims-made policies would be the inception date of the first claims-made policy.

SAFECO is still studying the inclusion of defense costs within CGL policy limits.

A training program for SAFECO employees will begin Sept. 1. Included will be underwriters, claims adjusters and data processing staffers.

St. Paul

St. Paul Fire & Marine Insurance Co. plans to begin using its own new claims-made and occurrence CGL policy forms after Jan. 1, 1986, says Fred P. Themmes, senior underwriting officer.

The forms contain the same provisions as the ISO forms but are written in St. Paul's "easy-to-read format," he said.

St. Paul has not determined what risks will be written on a claims-made basis, Mr. Themmes said.

In general, risks with latent injury potential would be written on the claims-made form, he said. "That's where we see need for a claims-made policy."

Mr. Themmes says that St. Paul "supports the need to control defense costs," adding that the insurer will likely adopt the ISO defense cost containment provision.

St. Paul plans to set the retroactive coverage date on claims-made policies it writes at the inception date of the risk's first claims-made policy, according to Mr. Themmes.

"If Hartford writes the first claims-made policy for a risk on 1-1-86, and the risk came to St. Paul on 1-1-89, we would use 1-1-86 as the retro date," he explains.

"In this fashion, there should be free movement of insureds between companies," Mr. Themmes maintains.

Mr. Themmes says that St. Paul still has a lot of work to do to develop excess policy forms that will be compatible with the new claims-made CGL contract.

Travelers Corp.

Travelers Corp. plans to begin switching its policyholders to the new CGL forms at renewals as soon after the Jan. 1, 1986, implementation date as possible.

However, a spokesman added, management believes that a Jan. 1, 1986, implementation date is "unrealistically optimistic."

Travelers is shooting for full-scale implementation of both the claims-made and occurrence policies by July 1, 1986, according to the spokesman.

"We feel that many exposures can only be written on a claims-made basis," Travelers said in a policy statement.

" In addition," the statement continues, "several judicial interpretations of sudden and accidental pollution coverage provided in the past have made it impossible to continue offering that coverage to all insureds on a blanket basis.

"Finally, there are risks on which it will not be possible to provide unlimited defense coverage," the statement concluded.

"Difficult exposures" will be switched to the claims-made form as it is approved by various states, the spokesman added.

Training programs for Travelers' underwriters are under way, the spokesman said.

USF&G

United States Fidelity & Guaranty Co. would not comment on its plans for use of the new ISO forms other than to say it will adopt them.

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Royal	680	N/M	33 9	5.0	685—676	
Sun Alliance	460	22 1	21 1	4 8	463—456	
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CE Heath	615	10 1	30 0	4 9	615—610	
Hogg Robinson	248	12.7	11 4	4.6	248—243	
JH Minet	177	11.6	8 9	5.0	177—172	
Sedg Grp	350	15 4	14 3	4 1	350—343	
Stew Wrightson	568	14 9	25.7	4 5	572—565	
Willis Faber	618	21 2	18 6	3 0	620—612	

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

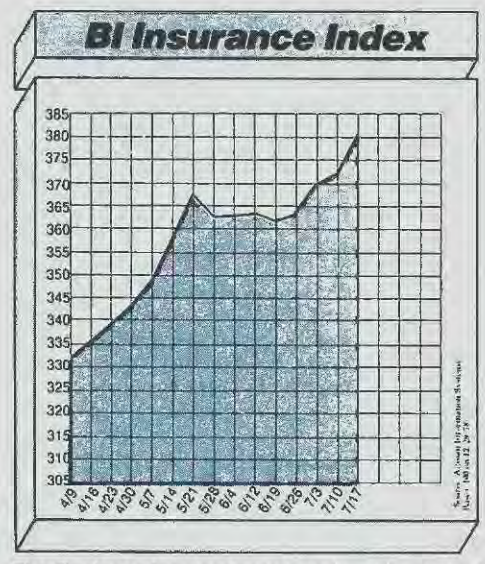
BI Industry Stock Report

July 17, 1985 7/11/85 thru 7/17/85

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	28.63	1.3	0.0	1.00	3.5	29.50	28.63	734.4
Baldwin & Lyons Inc	OTC	70.00	9.4	12.7	0.80	1.1	70.00	64.00	2.6
Corroon & Black Corp	NYSE	47.63	5.8	0.0	1.00	2.1	47.63*	44.88	152.7
Crump E H Cos Inc	OTC	34.25	3.8	25.8	0.50	1.5	34.25*	33.00	42.1
Emett & Chandler Cos Inc	OTC	25.75	4.0	122.6	0.00	0.0	25.75*	24.75	17.7
Gallagher Arthur J & Co	OTC	41.75	1.2	25.0	0.28	0.7	41.75	41.25	41.3
Hall Frank B & Co Inc	NYSE	31.25	0.8	0.0	1.00	3.2	32.00*	30.38	1,058.9
Marsh & Mclennan Cos Inc	NYSE	74.25	2.9	20.6	2.40	3.2	74.50*	71.75	334.2
Poe & Assoc Inc	OTC	8.00	0.0	0.0	0.80	10.0	8.00	8.00	11.1
Reed Stenhouse Cos Ltd	OTC	21.00	5.0	27.3	0.00	0.0	21.38	20.25	132.7
AGENTS/BROKERS	AVERAGE			46.2		2.0			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	48.25	2.1	16.5	1.28	2.7	48.25	46.25	2,702.7
Anderson Clayton(Ranger/PanAm)	NYSE	44.50	8.9	38.4	1.32	3.0	44.50*	41.50	173.0
Armco Inc	NYSE	9.25	7.2	0.0	0.00	0.0	9.25	8.50	755.9
Berkley W R Corp	OTC	19.50	21.9	0.0	0.32	1.6	19.50*	16.50	2,976.0
CIGNA Corp	NYSE	60.38	2.1	862.5	2.60	4.3	60.38*	58.75	1,222.3
City Investing Co. (Home Ins.)	NYSE	28.88	-21.4	4.5	0.00	0.0	36.63	28.75*	4,103.4
CNA Finl Corp (CNA)	NYSE	58.25	4.3	22.4	0.00	0.0	58.25	56.75	5,514.1
General Re Corp	NYSE	91.38	4.6	60.1	1.56	1.7	92.00*	90.00	469.6
ITT (Hartford Group)	NYSE	31.75	0.0	9.9	1.00	3.1	32.13	31.75	1,898.8
Optimum Hldg Corp	OTC	0.50	0.0	1.6	0.00	0.0	0.50	0.50	0.1
Sears Roebuck & Co. (Allstate)	NYSE	37.50	1.0	9.4	1.76	4.7	37.50	36.00	2,830.1
Teledyne Inc (Argonaut)	NYSE	257.88	1.8	5.5	0.00	0.0	261.50	255.25	250.5
Transamerica Corp (Occidental & Fred S. James)	NYSE	31.25	4.2	15.3	1.64	5.2	31.25	30.38	361.8
CONGLOMERATES/HOLDING COS.	AVERAGE			11.3		1.6			
Insurers									
Aetna Life & Cas Co	NYSE	49.63	6.1	25.2	2.64	5.3	49.63*	47.38	2,302.8
American General Corp	NYSE	35.63	1.8	11.6	1.00	2.8	35.63*	34.88	1,209.5
Amern Heritage Life Invt Co	NYSE	35.88	3.2	10.6	1.20	3.3	36.38*	34.50	8.7
American Indty Finl Corp	OTC	22.00	-0.6	0.0	1.12	5.1	22.13	21.50	9.7
American Intl Group Inc	NYSE	89.00	4.9	22.9	0.44	0.5	89.50*	86.00	926.2
Aneco Reins Ltd	OTC	1.25	0.0	0.0	0.00	0.0	1.25	1.25	0.9
Aveneo Corp	NYSE	31.00	6.0	14.4	0.60	1.9	31.25*	29.00	17.1
Business Mens Assurn Co Amer	OTC	26.00	0.0	7.1	1.04	4.0	26.25	26.00	30.2
Chubb Corp	NYSE	75.50	4.5	19.0	2.20	2.9	76.25*	73.38	335.4
Combined Intl Corp	NYSE	49.50	0.5	9.6	2.16	4.4	49.75*	49.25	356.0
Continental Corp	NYSE	44.00	0.3	22.4	2.60	5.9	44.00	42.75	790.4
Crown Life Ins Co	OTC	160.00	0.0	9.7	0.00	0.0	160.00	160.00	0.0
Durham Corp	OTC	40.00	0.6	7.5	1.28	3.2	40.00	39.25	47.3
Farmers Group Inc	OTC	68.50	3.2	12.0	1.76	2.6	68.63*	66.88	263.5
Fremont Gen Corp	OTC	27.63	3.8	0.0	0.48	1.7	27.75	26.63	85.6
Great West Life Assurn Co	OTC	395.00	-20.9	10.2	0.00	0.0	499.50	395.00	0.0
Hanover Ins Co	OTC	46.25	0.5	78.4	0.56	1.2	46.50*	45.75	25.4
Hartford Steam Boiler Inspctn	OTC	48.25	4.0	20.7	1.60	3.3	48.25*	46.38	70.8
Kans City Life Ins	OTC	24.25	0.0	9.5	0.87	3.6	24.25	24.25	18.4
Kemper Corp	OTC	61.13	2.1	26.3	1.80	2.9	61.13*	60.13	296.0
Liberty Corp S C	NYSE	29.88	-2.0	14.0	0.72	2.4	30.38	29.88	37.2
Lincoln Natl Corp Ind	NYSE	44.75	2.6	11.7	1.84	4.1	44.75	43.75	281.1
Mission Ins Group Inc	NYSE	6.25	-7.4	0.0	0.00	0.0	6.63	6.00*	257.4
Monumental Corp	OTC	30.63	0.0	20.3	1.30	4.2	30.63	30.50	28.4
Nobel Ins Ltd	OTC	11.75	10.6	15.5	0.25	2.1	11.75*	10.75	22.9
Northwestern Natl Life Ins	OTC	30.38	1.7	7.3	0.80	2.6	30.38	29.75	207.5
Ohio Cas Corp	OTC	66.38	5.4	24.6	2.80	4.2	66.38*	63.38	81.1
Old Rep Intl Corp	OTC	41.50	8.5	10.0	0.74	1.8	41.75*	39.13	388.9
Orion Cap Corp	NYSE	27.25	2.3	0.0	0.76	2.8	27.25	26.75	73.5
Protective Corp	OTC	22.00	4.8	7.7	0.66	3.0	22.00	21.00	131.2
Provident Life & Acc Ins Co	OTC	24.75	5.3	6.9	0.76	3.1	24.75	23.50	449.4
St Paul Cos Inc	OTC	74.25	5.3	0.0	3.00	4.0	75.00*	70.25	662.5
SAFECO Corp	OTC	44.50	6.9	15.9	1.60	3.6	44.88*	41.88	521.2
Sri Corp	OTC	22.75	10.3	108.3	0.68	3.0	22.88*	20.38	174.2
Seibels Bruce Group Inc	OTC	20.50	5.1	0.0	0.80	3.9	20.50	19.50	28.2
Statesman Group Inc	OTC	4.75	0.0	0.0	0.15	3.2	4.75	4.63	96.9
Tokio Marine & Fire Ins Co	OTC	205.25	-3.8	35.5	1.05	0.5	209.50	203.25	43.1
Torchmark Corp	NYSE	50.63	3.8	10.6	1.20	2.4	50.63	48.75	291.2
Travelers Corp	NYSE	48.75	5.1	11.7	2.04	4.2	48.75*	46.63	1,471.0
United Fire & Cas Co	OTC	22.00	0.0	0.0	0.80	3.6	22.00	22.00	0.5
United States Fid & Gty Co	NYSE	37.25	4.6	40.1	2.20	5.9	37.25	36.25	951.0
Uslife Corp	NYSE	39.88	1.6	9.1	1.04	2.6	40.00	38.88	216.4
Washington Natl Corp	NYSE	25.75	-1.4	7.6	1.08	4.2	26.13	25.25	116.2
Zenith Natl Ins Corp	OTC	19.25	0.0	0.0	0.68	3.5	19.25	19.00	107.5
INSURANCE COMPANIES	AVERAGE			19.1		2.2			

System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* stock index set a record high for the third consecutive week. The index closed at 381.1 on July 17, up 9.7 points from 371.4 set on July 10. A total of 42 stocks posted gains, six stocks closed lower and 10 stocks remained unchanged. The largest gains were posted by W.R. Berkley Corp., up 21.9%; Nobel Insurance Ltd., up 10.6%; SRI Corp., up 10.3%; Baldwin & Lyons Inc., up 9.4%; and Old Republic International Corp., up 8.5%. The largest losses were posted by Great West Life Assurance Co., down 20.9%; Mission Insurance Group Inc., down 7.4%; Tokio Marine & Fire Insurance Ltd., down 3.8%; Liberty Corp., down 2%; and Washington National Corp., down 1.4%. The *BI* index rose 2.6% for the period, while the New York Stock Exchange composite rose 1.7%.

Smile.

It's the year of the stag.

You see a lot of long faces in the commercial lines market these days.

But not at the company with the stag.

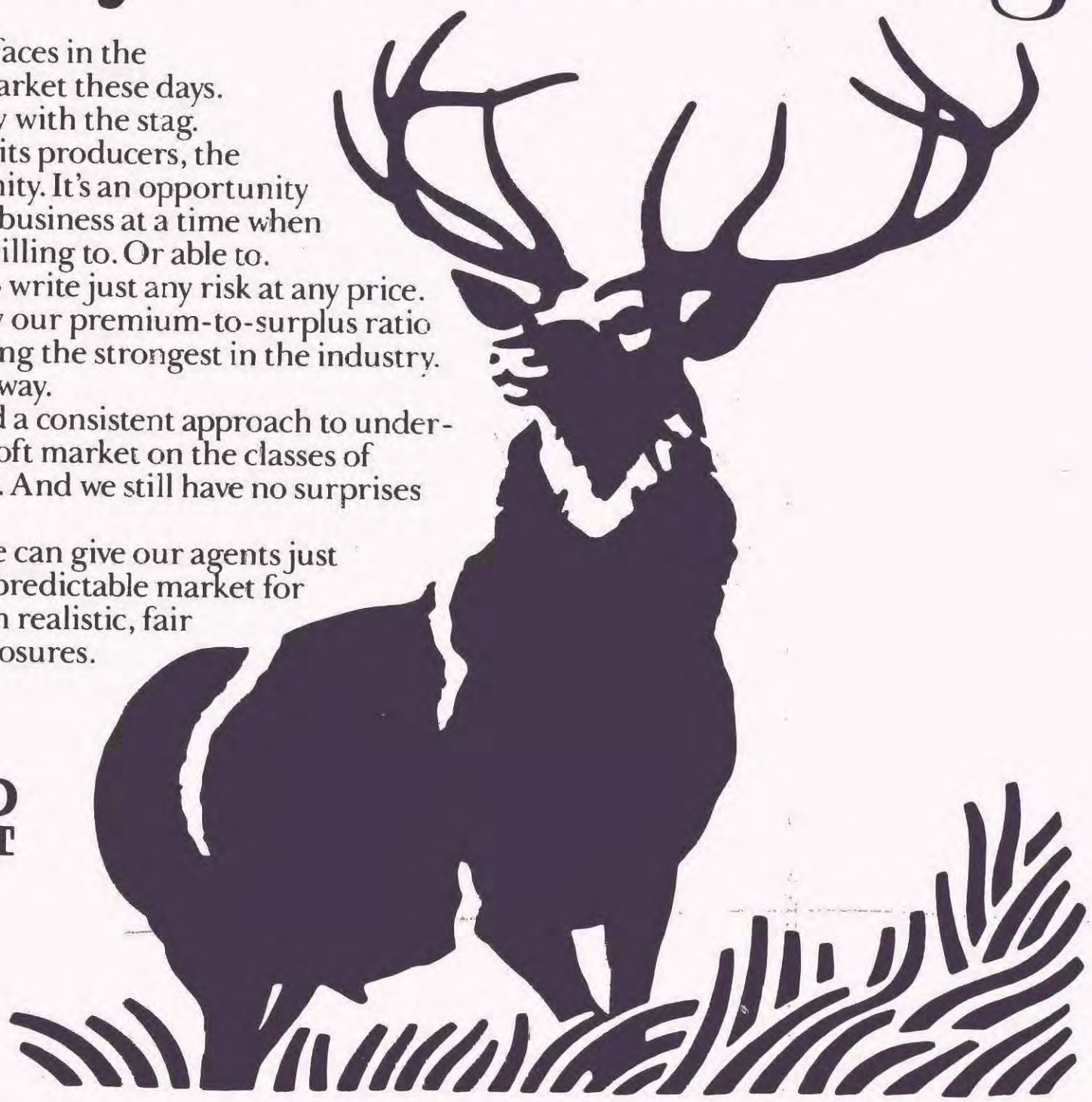
For The Hartford and its producers, the hard market's not a calamity. It's an opportunity —a chance to write good business at a time when other companies aren't willing to. Or able to.

Not that we're going to write just any risk at any price. We never have. That's why our premium-to-surplus ratio and loss reserves are among the strongest in the industry. We intend to keep it that way.

What's more, we've had a consistent approach to underwriting throughout the soft market on the classes of business we want to write. And we still have no surprises up our sleeve.

So it's not surprising we can give our agents just what they need: a stable, predictable market for all commercial lines. With realistic, fair rates based on actual exposures.

And that's something to smile about.



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THIS YEAR IS OUR 175TH ANNIVERSARY