WEEK OF MARCH 8, 1982

business insurance®

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update:

Agent Orange makers offered defense by judge

UNIONDALE, N.Y.—A federal judge has allowed a class action suit against manufacturers of the herbicide Agent Orange to go to trial, but also has offered the companies a possible defense against claims.

U.S. District Court Judge George Pratt ruled that if manufacturers successfully plead the so-called "government contractor

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Dumping requirements?

EPA apparently will drop rules on pollution cover

By JOHN W. MILLIGAN

WASHINGTON—With the compliance deadline a little more than a month away, the federal Environmental Protection Agency apparently will drop its pollution liability insurance requirements.

Last September, the agency announced that it was going to suspend regulations issued in December 1978 that would have required companies handling hazardous waste to buy insurance or provide other proof that they could pay for any third-party damages caused by pollution. But the notice of suspension has yet to be published and in recent weeks the rumors were that the regulations would not be dropped.

If the rules are dumped, it will be over strong objections from the chemical and hazardous waste management industries and state regulators who want a consistent federal rule. This leaves the EPA caught in the middle with these groups on one side and the Reagan Administration's philosophy of limited involvement in what it considers state matters on the other.

The financial responsibility requirements, as mandated by the Resource Conservation and Recovery Act, would require companies that treat, store or dispose of hazardous wastes to demonstrate their financial ability to respond to a third-party liability claim following either sudden or gradual pollution.

Companies could meet the standards with commercial insurance coverage, a letter of credit, a trust fund or a bond.

The agency first postponed these regulations last September (*BI*, Sept. 14, 1981) and promised that a formal notice of suspension would quickly follow. That notice has been delayed several times (*BI*, Jan. 4), but time is running out since the regulations take effect April 13.

Complained one environmental consultant, disheartened by the frequent delays: "EPA takes so long to do anything. It's typical. I don't find it unusual. Unconscionable, yes. But not unusual."

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Florida medical malpractice pool wants hospitals to fund big deficit

By BILL DENSMORE

TALLAHASSEE, Fla.—Years of artificially low "premiums," a series of multimillion-dollar jury awards and the apparent political clout of the medical profession are threatening the solvency of a Florida medical malpractice pool.

The Florida Patient's Compensation Fund, a state-chartered, excess liability pool, faces at least $177 million in ultimate net losses for six policy years in which it generated just $78 million in premiums and interest, fund officials say.

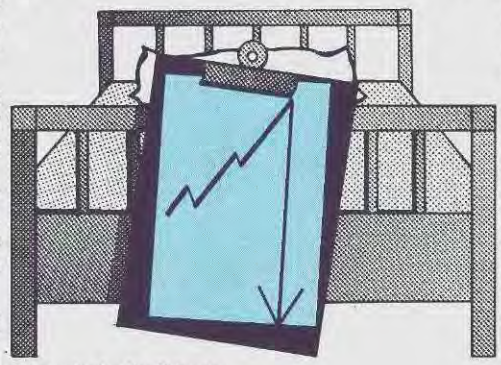

Illustration by Jim Bakasetas

And now a court has stopped it, at least temporarily, from imposing a whopping retroactive assessment on participating hospitals to bridge the gap.

The hospitals say they are being unfairly assessed compared with doctors in the plan, who some say used their political clout to guarantee lower assessments even though they have higher losses.

"We have settled several cases on a 'when we get the money we'll pay you' kind of basis, and I was told by the general manager that those settlements were in excess of the funds we had on hand and we were counting on the assessment to pay those," says Richard B. Collins, a fund attorney.

"The solvency of the fund is very much at issue," says G. Bruce Hill, an Orlando, Fla., attorney representing the hospitals protesting assessments totaling $14 million for the 1978-1979 plan year alone—twice what the hospitals originally paid in plan fees, or premiums.

He said the assessments range from $26,000 to $300,000 for each hospital or about $610 per hospital bed.

The Patient's Compensation Fund was established in 1975 by an act of the Florida Legislature when major medical malpractice insurers stopped writing business in the state because of huge losses. The fund provides unlimited liability coverage excess of $100,000 per claim and $500,000 per occurrence to 120 hospitals in the state and to about 7,000 physicians and professional association members.

The state's 260 hospitals must either join the fund or prove by posting a bond, buying insurance or self-insurance that they can cover claims of up to $10,000 per claim per bed, not to exceed a $2.5 million annual aggregate. The state Department of Insurance checks to make sure hospitals comply.

For losses under the excess layer, the hospitals self-insure the risk, buy commercial insurance or use a state-sponsored joint underwriting authority.

"We've never had a (retroactive) assessment before and that's what I think the big flap is about," says Catherine M. Sims, administrative manager of the Tallahassee-based fund.

Like other pools around the nation, the Florida pool underestimated in early years the rate at which medical malpractice verdicts would escalate. However, unlike most other pools, the statute under which it was created puts no cap on covered liability.

It also is difficult for the fund to estimate its losses since 1,025 of the 1,521 claims filed against it are still open.

The situation, brewing for years, reached the boiling point Jan. 22 when Florida Insurance Commissioner Bill Gunter issued an order requiring fund members to pay $13.9 million in retroactive assessments for the 1978-1979 plan year. During that year, fees and interest previously collected totaled $10.5 million, yet paid losses, reserves and expenses already have reached $24.4 million.

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Cost control

Benefits backlash?

When insurers' cost-containment practices collide with rising medical bills, does the employee benefit manager pay a price in employee relations? How do benefit managers handle payment schedules that leave workers with unexpected bills? **Page 13.**

The bill-hunters

Insurers and self-insurers are asking for more frequent medical bill audits to reduce excessive charges. **Page 24.** And here's some of the companies that offer medical claims auditing services. **Page 34.**

Negotiating discounts

Self-insured corporations are taking their cost-containment story directly to local health care providers and negotiating discounts with promises of steady business and prompt bill payment. **Page 36.**

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Agent Orange trial to begin

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defense," they can assume the government's immunity from liability in the 3-year-old suit.

According to Leonard Rivkin, a Garden City, N.Y., attorney for Dow Chemical Co. of Midland, Mich., the ruling means manufacturers will have to prove three things: the government established the specifications for Agent Orange, the manufacturers complied with those specifications and the government knew more or as much as the manufacturers about possible side effects.

Agent Orange was used to defoliate jungles during the Vietnam War. Some U.S. servicemen are suing the manufacturers, charging that exposure to the product has led to skin disorders, personality changes and stillbirths.

Bermuda may extend tax

HAMILTON, Bermuda—The government may extend its employment tax to include offshore companies doing business on the island, Finance Minister David Gibbons says.

"Consideration will be given to proposals later in the year which will have the effect of taxing the notional payroll of international companies," Mr. Gibbons told the House of Assembly.

The finance minister, who recently stepped down as premier, did not go into details but did say the tax would be "at an equivalent rate to that currently applied to the payrolls of local companies."

Bermuda employers currently pay a tax of 5% of employees' annual salaries. Exempt international companies employ about 2,200 workers, almost 7% of the island's workforce.

Mr. Gibbons also said the government intends to borrow about $20 million from non-resident insurance companies and other international firms in 1982 to provide new mortgage money for the island's housing market.

Special unit to probe METs

CHICAGO—The Illinois Insurance Department and attorney general's office have formed a fraud unit to investigate multiple employer trusts that collapse and leave workers with unpaid medical bills (*BI*, Feb. 22).

Calling such METs a leading consumer problem in Illinois, Insurance Director Philip R. O'Connor said insurance investigators and trial lawyers will combine forces to track unlicensed insurance operators that provide health insurance to small and medium-sized employers at a low premium, only to go broke at a later date.

Hyatt settlements curtailed

KANSAS CITY, Mo.—A federal judge has postponed a decision on whether insurers should receive "credit" before a jury for pretrial out-of-court settlements they negotiate with victims of the Hyatt Regency Hotel skywalk collapse (*BI*, Feb. 8).

Attorneys for Northbrook Excess & Surplus Insurance Co. say they will indefinitely continue their embargo on negotiations with victims after U.S. District Judge Scott O. Wright delayed the "credit" decision.

Northbrook had settled $18.3 million worth of claims against Hyatt Corp., Hallmark Cards Inc., Crown Center Redevelopment Corp. and several other defendants through Jan. 25, the date that Judge Wright certified as a class action claims filed by victims.

The death of 64-year-old John T. Dixon of Warrensburg, Mo., on Dec. 1 raises the number of people killed in the collapse to 114.

University settles DES suits

CHICAGO—The University of Chicago has agreed to pay $225,000 to three women, including former U.S. Rep. Patsy T. Mink of Hawaii, who say they were given the anti-miscarriage drug DES by the university without their knowledge during the 1950s.

The settlement, negotiated during a trial in U.S. District Court in Chicago, also calls for the university to provide diagnostic examinations to children exposed to DES as a result of their mothers' participation in the university study. The women sought compensatory damages of $70,000 each and about $2 million in punitive damages.

Women file Dalkon Shield suits

LOS ANGELES—Nineteen women are seeking $11.8 million in compensatory and $91.2 million in punitive damages in separate lawsuits filed in a Los Angeles federal court against A.H. Robins Co. Inc., maker of the Dalkon Shield intrauterine device.

The plaintiffs, all represented by San Bernadino attorney Douglas F. Welebir, allege that use of the device caused them serious injury, including spontaneous abortion, blocked fallopian tubes, sterility, ovarian failure and perforation of the uterus. Mr. Welebir said he will file 35 more lawsuits against Robins in the next two weeks.

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J-M did not willfully conceal asbestosis dangers: Court

By RHONDA L. RUNDLE

MARTINEZ, Calif.—The jury verdict in the first of about 1,000 lawsuits brought against Johns-Manville Corp. by former plant workers suffering from asbestos-related diseases is a qualified victory for the asbestos maker.

A Contra Costa County Superior Court jury recently awarded $150,000 in compensatory damages to former Pittsburg, Calif., plant worker Bob Alan Speake, who suffers from asbestosis, but denied his request for $1 million in punitive damages.

"The verdict reaffirms the company's position that there was no willful misconduct," said a Johns-Manville spokeswoman. The company considers the compensatory damage award high but has not decided if it will appeal, she added.

Johns-Manville Corp. technically was not the plaintiff's employer so Mr. Speake could sue the asbestos maker as a third party outside the workers compensation system. He was employed from 1933 to 1975 by Johns-Manville Product Co., a J-M subsidiary.

Many people have misunderstood this case, said George Kilbourne, a Pleasant Hills, Calif., attorney who represents Mr. Speake and about 70 other Pittsburg plant workers in suits against Johns-Manville. He said the workers compensation exclusive remedy rule was not a factor in the case.

Because corporations are considered separate entities under the law, an injured employee may be able to sue a parent corporation when he is barred from suing the subsidiary that employs him, Mr. Kilbourne explained.

The California Supreme Court's landmark Rudkin vs. Johns-Manville ruling opened the way for employees to sue employers directly if an employer's fraudulent concealment of a worker's disease leads to aggravation of the condition (*BI*, March 19, July 28, 1980).

But this cause of action was not

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U.S. companies freed from liability

By STEPHEN TARNOFF

BLOOMINGTON, Ill.—Four U.S. companies have been freed from liability for the asbestos-related disease of a former UNR Industries Inc. worker and could be off the hook in 53 pending lawsuits, too.

McLean County Circuit Court Judge James A. Knecht, citing a procedural flaw, on Feb. 19 dismissed UNR, formerly known as Unarco Industries Inc., Johns-Manville Corp., Johns-Manville Sales Corp. and North American Asbestos Corp from a lawsuit.

While the ruling applies only to the case of plaintiff Geneva Mau, the defendants also may avoid liability for millions of dollars in damages in 53 other cases because of the same procedural error, an attorney for one of the defendants said.

This is the second blow to the plaintiffs, who may now end up with no compensation.

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20 airlines reveal only half of $6 billion in liability cover

By BILL DENSMORE

WASHINGTON—Twenty major U.S. commercial airlines buy at least $3.06 billion in liability insurance, new certificates filed with the Civil Aeronautics Board reveal.

But the actual limits purchased by the same airlines are more than double that, or $6.5 billion, according to insurance market sources.

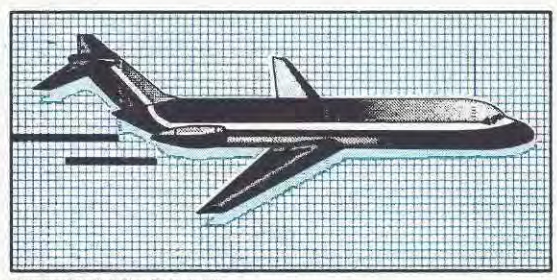

Illustration by Jim Bakasetas

The major players in the aviation insurance market—but not always their stakes—also are revealed for the first time in the certificates required under a new CAB rule effective last month.

USAIG, the common name of the New York-based pool of domestic insurers entitled United States Aviation Insurance Group, appeared most often on the certificates filed by the 20 major U.S. commercial airlines. Lloyd's of London was the second most frequently named insurer.

Many of the major airlines detailed their insurance programs in the certificates filed to comply with the Feb. 23 effective date of the CAB rule. Others stated merely that they met the $300,000-per-passenger liability insurance requirement for all domestic and U.S.-operating foreign airlines, which also was established by the new rule.

At least one underwriter is concerned that plaintiffs' attorneys will use this $300,000 liability insurance requirement to justify $300,000 as the minimum liability award due victims of air accidents. Other insurers and brokers are most concerned that the minimum insurance requirement will increase the rates charged smaller airlines.

Aviation insurance underwriters and brokers are still debating, however, the additional requirement that insurers cannot deny coverage in an accident involving a violation of federal laws. Such exclusions have been common on policies for smaller airlines.

The highest liability limit disclosed by a major U.S. carrier was $400 million on the certificates filed for Delta Air Lines and for Western Airlines, a *Business Insurance* review of the certificates found. The certifi-

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Pension promise should be kept: Suit

By JERRY GEISEL

WASHINGTON—After working for Lidz Brothers Inc., a New York-based button wholesaler, for 35 years, Saverio Ramputi thought he had earned a pension.

His length of service exceeded the 10 years of employment the Lidz pension plan required for first and full vesting.

Although the defined benefit plan had insufficient assets to pay vested benefits when the company terminated it in May 1978, Mr. Ramputi still thought he'd get his pension.

Just four years before, as part of the Employee Retirement Income Security Act of 1974, Congress created the Pension Benefit Guaranty Corp., a federal agency that is supposed to guarantee workers' pensions when a plan folds with insufficient assets, as the Lidz plan did.

But Mr. Ramputi has yet to receive a dollar from the PBGC.

Now, he and Gene Rettig, the widower of a former Lidz employee, are suing the PBGC, demanding that the agency pay their pensions, which amount to less than $275 a month apiece.

The suit, filed in U.S. District Court in Washington, says the PBGC won't pay the pensions because the promised benefits resulted from Lidz's attempt to improve its pension plan to comply with ERISA.

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Captive management directory

The annual *Business Insurance* captive management directory will appear in the April 19 issue.

This special issue, which will spotlight the developing offshore insurance market, including captives, and recap U.S. captive growth, will be distributed to the participants of the annual Risk & Insurance Management Society Conference in Washington.

To be included in the directory, write Sallie Drury, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5398.

Don't miss this year's captive management directory. The deadline to return forms is March 26.

Worker fitness plan wins savings, honors

By MARGARET LeROUX

RESEARCH TRIANGLE PARK, N.C.—An employee fitness program is saving money for Burroughs Wellcome Co. and winning it honors.

The savings comes from detecting potential health problems among 2,488 employees at its two North Carolina facilities and reducing absenteeism; the honor comes from winning the North Carolina Governor's Award for Fitness and Health in Business and Industry, the first award of its kind in the United States.

Savings, described as incalculable by the company's director of occupational health and safety, were realized when potential health problems were discovered among 196 employees last year during routine physical examinations that are part of the fitness program. Key to this accomplishment is the company's operation of a health clinic at its corporate headquarters here and a plant hospital at its Greenville manufacturing facility.

"It's hard to calculate the monetary savings in a program like this," said G. Henry Leslie. "We're talking about saving or lengthening someone's life."

The program also has cut the absentee rate at the pharmaceutical manufacturer to 3.5% last year from 6% five years ago, the company says.

Photo: Margaret LeRoux

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West Virginia groups pushing bill to stop suits against employers

By EILEEN NORRIS

CHARLESTON, W.Va.—Business groups in West Virginia are rallying behind legislation they hope will quash a state high court ruling that allows workers to sue employers whose disregard for job safety leads to injury or death.

There are at least 200 individual lawsuits pending in lower courts against employers in West Virginia, and a $4 million award —the highest so far—is on appeal.

Another major lawsuit seeks several billions of dollars in damages for 150 workers at a Monsanto Co. plant in Nitro, W.Va.

It, too, is based on the 1978 Mandolidis decision by the state Supreme Court, which has the state's business community up in arms.

In that case, the high court ruled that injured employees who receive workers compensation may sue their employers for deliberately intending to harm them if they can show that the employer's willful, wanton disregard for safety led to their injury.

Since then, employers have been swamped with lawsuits from workers.

A coalition representing 85% of the employers in West Virginia is pushing hard for legislation to grant employers complete immunity from employee suits for work-related injuries.

The bill also would extend workers compensation benefits to employees who are injured because of the employee's willful misconduct, disobedience or self-exposure and failure to use protective or safety devices, except in cases when the injury is self-inflicted or the result of intoxication.

While the workers compensation system in most states covers all employee injuries, West Virginia's does not cover all injuries that are an employee's fault.

Although the bill still allows employee suits on the basis of deliberate intent to harm, it redefines those words to mean "a conscious, subjective and deliberately formed intention to produce the specific result of injury or death to an employee."

The new bill requires a showing of an actual, specific intent and not an allegation of negligence or willful, wanton or reckless misconduct.

Employers in the state were jolted into action last year when 150 workers filed a lawsuit against Monsanto Co.

The employees, who are said to have varying degrees of bladder cancer and other occupational-related diseases, claim their illnesses are directly linked to the toxic chemicals they were exposed to at work. Thirty of the plaintiffs are survivors of dead workers.

The suit, filed last year, alleges workers were not adequately protected against dangerous chemicals at the plant, which manufactures paper, agriculture and rubber products.

Their attorney, W. Stewart Calwell of Nitro, says the case is directly tied to the Mandolidis decision because Monsanto "knew or had reason to know" its work environment was dangerous to its employees.

Business, trade and professional associations are contending the Mandolidis decision erodes the concept of workers compensation.

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Dental charges peak in the West

By JAMES C. LAWSON

NEW YORK—Corporations following the sun to California and Texas are walking into the nation's highest dental costs, reveals a new survey.

Dental charges for cleaning, filling and extracting teeth, the three most frequently used dental procedures, are highest in the nation in San Francisco, Los Angeles and Houston, according Johnson & Higgins, an international broker and employee benefits consultant.

And, in Los Angeles and Houston, charges for these procedures increased more than the national average increase from 1979 to 1981.

The J&H survey focused on 34 major metropolitan and suburban areas and was designed to study charging practices and help companies design dental plans for employees across the country. It reviewed 5.1 million insurance claims from J&H clients filed in 1980 and three-quarters of 1981.

San Francisco and Los Angeles dentists charged the most for cleaning, $24 compared with a national average of $18. Houston dentists charged $22.

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TVA moves nuclear coverage to mutual

By JOHN W. MILLIGAN

CHATTANOOGA, Tenn.—After years of self-insuring its nuclear power plants, the Tennessee Valley Authority has decided it can no longer afford to pay for a major accident.

To offset this threat, where losses can easily exceed $1 billion, the TVA will join Nuclear Mutual Ltd., a Bermuda-based mutual insurance company. Composed of electric utilities owning nuclear reactors, NML provides its members with $450 million in primary property insurance. This limit will rise to $500 million on Aug. 1.

The first TVA facilities to be insured through NML would be three reactors at its Browns Ferry Station in Alabama.

The TVA will become the first publicly owned utility to join NML's ranks. Other U.S. public utilities have insured their nuclear reactors with two commercial insurance pools—American Nuclear Insurers and Mutual Atomic Energy Liability Underwriters.

It also signals the TVA's recognition that it can no longer self-insure an exposure which—in a worse-case scenario—could consume 25% of its annual revenue.

The TVA also is taking quotes from NML, ANI and MAELU for coverage on its two reactors at the Sequoia Plant in Tennessee.

In a study conducted by a consultant some 10 years ago, the TVA estimated its maximum annual loss from damage to one of its plants at 4% of revenue, a figure that made it feasible to self-insure the risk.

But now when losses of up to $1.5 billion are possible, the maximum annual loss becomes an eye-popping 25% of revenue.

And that, notes Howard Higgins, a power financing analyst in the TVA's Office of Power, is simply too much.

"From a financial standpoint, we just can't afford not to have (insurance) in case we have one," says Mr. Higgins of a really big accident.

"That's the problem TMI has," he added, referring to the March 1979 accident at the Three Mile Island nuclear power plant in Middletown, Pa. Its owner, General Public Utilities Service Corp., is faced with an es-

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Tort reform bills reopen strategy debate

By JERRY GEISEL

WASHINGTON—Enactment of federal product liability legislation proposed by Rep. Norman Shumway, R-Calif., would be a dream come true for manufacturers.

But the legislation, H.R. 5214, may never see the light of day.

The bill, "Products Liability Act of 1982," would provide solutions to the major product liability problems facing U.S. corporations today (*BI*, March 1).

But the measure, backed by a growing number of manufacturers who have formed a lobbying group known as the Coalition for Uniform Product Liability Laws, won't get very far in Congress because it does too much, some lobbyists say.

Introduction of the Shumway bill, which would drastically reduce manufacturers' exposure to product liability lawsuits involving older products and cap punitive damage awards at $1 million, has reopened a sharp debate among business groups on the best strategy to get federal tort reform legislation enacted.

The debate is particularly timely because the Senate Commerce Committee this week begins hearings on product liability legislation proposed by Sen. Bob Kasten, R-Wis. This is the first time in five years Congress has made a serious effort to tackle the tort reform issue.

In addition, many business and insurance trade groups now support a federal solution to product liability problems and this should increase the chances of serious congressional consideration. Five years ago, insurers favored tort reform exclusively at the state level.

At the same time, manufacturers are coming under increasing pressure to take a stand on federal product liability legislation.

The Coalition for Uniform Product Liability Laws, for example, sent telegrams to 500 large manufacturers last month asking for support to get a bill passed on the federal level.

Although no money was mentioned in the telegram, it is understood that corporations are expected to contribute $3,000 and up to enable the group to carry on its battle.

The coalition has retained Steptoe & Johnson, a prestigious Washington law firm, as legal counsel.

"Three thousand dollars is very little when you consider what the transaction (legal) costs alone are in product liability suit," said a source.

The coalition sees itself as an "action-oriented" group whose indi-

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Dental costs peak in California and Texas

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Fillings cost the most in Houston, $34, compared with $27 nationwide. In Los Angeles, filings cost $33 and in San Francisco, $31.

Extractions cost the most in San Francisco, $26, compared with $21 nationwide. In Los Angeles, the cost averaged $25 and in Houston $24.

Across the nation, the cost of fillings in 1981 compared with 1979 increased 17%. In Los Angeles the increase was 18% and in Houston 21%.

Likewise, the cost of extractions in 1981 compared with 1979 increased 17% nationwide. In Los Angeles, costs were up 19% and in Houston, 20%.

However, in San Francisco, the percentage increases in cost for fillings and extractions were lower than the national averages, 15% and 13% respectively.

For cleanings, San Francisco Los Angeles and Houston all came in above the national percentage increase in cost. Nationwide, cleaning costs increased 6%, but in San Francisco, it was 9%; in Los Angeles, 14% and in Houston, 16%.

In most cases, according to the survey, newer cities on the West Coast and in the Sun Belt had higher than average costs for these three frequently performed dental procedures.

Thomas G. Patzau, a senior vp and director of J&H's employee benefit plan department, attributes the higher West Coast and Sun Belt dental costs to "the high cost of doing business: salaries, equipment and supplies, office rental rates and other overhead."

Those factors, adds James W. McDonald, J&H vp who directed the survey, affect fees paid for dental services and the cost of group dental benefits.

The lowest charge in the nation for teeth cleaning was in Cincinnati, only $14, up $2 or 17%.

In Louisville, Richmond, Atlanta, Boston and Minneapolis, cleanings only cost $16, $1 to $2 higher than 1979.

Besides coming in on the high side of the fee schedule for cleanings, fillings and extractions, the cost of a set of dentures was highest in Los Angeles, too.

Patients needing a complete upper denture in Los Angeles last year paid $381, $35 more than they paid in 1979 and $54 more than the national average. Dentists in Birmingham charged $232 for an upper denture, the lowest fee in the country.

Birmingham dentists also charged the lowest prices in the nation for a pulp cap, $8; porcelain bridge fused to gold, $182; and procelain crown with gold, $163.

Houston dentists charged their patients $19 for a pulp cap, leading the country.

Suburban New York-Northern New Jersey dentists charged their patients $308 for a procelain bridge with gold and $311 for a porcelain and gold crown, the highest in the nation for those services.

But overall, New York City and Chicago, traditionally expensive cities fell in the midrange for cost for dental services. New York dentists charged $19 for a cleaning, $24 for a filling and $21 for a single tooth extraction.

Chicago dentists charged $18 for cleaning, $26 for fillings and $21 for an extraction.

While dental treatment fee jumps seem high, dental costs have not risen as fast as the cost of living, according to the dental industry.

Last year dental costs rose only an average of 10.2% while the consumer price index rose 13%, according to the American Dental Assn.

"Dentistry really hasn't passed on the inflation cost to consumers as have other services," an ADA spokesman told *Business Insurance*.

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Copies of the Johnson & Higgins survey can be obtained for free by writing the firm at 99 Wall Street, New York, N.Y. 10005.

TVA to insure three reactors

Continued from page 3

timated $1 billion in cleanup costs. Through November, it says it also has paid an average of $24 million a month for replacement power.

The TVA will purchase $450 million in primary property insurance from NML with a $10 million deductible. The utility's three-member board of directors voted Feb. 17 to join the NML organization, and its membership should be final sometime this month.

The TVA will pay annual premiums of $3.3 million for property coverage on the three Browns Ferry reactors.

The TVA is also considering purchasing replacement power coverage from Nuclear Electric Insurance Ltd. in Bermuda.

And while the TVA's customers might object to paying higher electric rates to cover the cost of insurance, Mr. Higgins believes most would prefer this to the alternative of funding a $1 billion disaster.

"I think we'd be in for much more criticism somewhere down the road if we have an accident, than in this case where we decided to buy insurance," he predicts.

The utility serves a portion of seven Southeastern states, selling electricity to some 160 municipalities and cooperatives.

The TVA did receive coverage quotations from the ANI and MAELU risk pools on its Browns Ferry plant before deciding to go with NML.

"The quote (from NML) was better, frankly," Mr. Higgins says.

Public utilities have generally favored the two pools, notes MAELU Manager Ambrose Kelly, since their programs do not include a post-loss premium assessment. Under such an arrangement, all participating utilities help pay for a major loss, paying a post-loss assessment on a predetermined formula.

NML members are subject to assessments of up to six times their annual premium. Public utilities feel they would have trouble explaining this liability to public service commissions, which must rule whether insurance premiums can be passed on to the customer, Mr. Kelly explains.

NML's post-loss assessment requirement was not a big problem for the TVA, Mr. Higgins said. Since the program's inception in 1973, NML's maximum assessment has dropped from 14 times annual premium to its present level.

When the TVA enters the program with its Browns Ferry Station, notes Mr. Higgins, this assessment will drop further to 5.6. And he can envision the day MNL will eliminate the assessment all together. ■

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Differing bills reopen tort reform debate

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vidual members will lobby Congress to get legislation passed.

By contrast, the much larger Product Liability Alliance, composed mainly of trade associations, is working to develop a business consensus on what should be the key elements in a federal product liability bill. It does not see itself as a lobbying group and has not asked for monetary contributions to support any one bill.

The two groups do not believe they are rivals. In fact, Colt Industries Inc. of New York, the prime mover behind the Coalition for Uniform Product Liability Laws, is a member of the Product Liabiliy Alliance's steering committee.

"There is room for both groups since they serve different purposes," one observer said.

But there is growing division on the *realpolitik* of getting legislation passed. One source close to the Coalition for Uniform Product Liability Laws, which has 65 manufacturer members, says there is a need for a hard-line, conservative, business-oriented bill, like Rep. Shumway's.

"You begin with your maximum objectives. . .that should be your starting point," the source said. "You can compromise, but not before the battle begins," he added.

But other experts say consideration of a "dream" bill, like Rep. Shumway's, could turn Congress away from the entire tort reform issue.

"I'm sympathetic to that (Shumway's) approach," said veteran Washington observer Tom O'Day, government relations officer with the Alliance of American Insurers, an industry trade group. "But if a proposal is too far-fetched, you are likely to lose the whole proposal. You lose the audience (Congress) before you have them," Mr. O'Day said.

"The center has the best chance of flying," said Les Cheek, the asute lobbyist and vp for federal affairs for insurer Crum & Forster. "Congressmen like bills that offend the fewest and are supported by the most," Mr. Cheek observed.

Most agree that Sen. Kasten's second draft bill (*BI*, March 1) represents the center, while the Shumway proposal is on the right and a bill soon to be introduced by Rep. Henry Waxman, D-Calif., a liberal, is on the left of the product liability spectrum.

Although full details on Rep. Waxman's bill are not known yet, the bill is not expected to set any limit on the time in which a consumer must file suit. Rep. Shumway and Sen. Kasten's measures contain such statutes of repose.

Supporters of the Kasten legislation concede that the proposal, despite its "centrist" tag, has no chance of passing Congress this year. But they say consideration of a moderate bill now will lay the groundwork for passage in the future.

Under both the Kasten and Shumway proposals:

- Wholesalers and distributors would be immune from most product liability suits unless they also made the product.
- Manufacturers no longer could be held liable for failing to warn of obvious product dangers.
- Manufacturers would be protected from product liability lawsuits if their products were altered or modified without their permission and the alteration caused the accident.
- Product liability awards would be reduced by the extent that a plaintiff's negligence caused an accident.
- An employer or its insurer could not obtain compensation from the manufacturer to recover its workers compensation costs in product liability cases involving workplace accidents.

However, the two bills differ dramatically in their approach to punitive damage awards and the length of time a manufacturer should be liable for the safety of its products.

The Kasten proposal would allow punitive damages only in cases where the harm suffered was "the result of the reckless disregard of the product seller for the safety of the product user." However, no cap would be placed on the amount of damages that could be awarded.

By contrast, the Shumway bill would limit punitive damage awards to twice a plaintiff's actual damages, not to exceed $1 million.

In addition, Sen. Kasten's draft would bar product liability lawsuits 25 years after a product is delivered in cases involving major capital goods. No time limitations would apply for consumer products, home appliances or in cases where the injury was caused by prolonged exposure to a product.

Under the Shumway bill, consumers generally would be barred from filing personal injury suits in cases involving products more than 10 years old.

In cases where the injury is caused by prolonged exposure to a product, the statute of repose would be extended to 15 years.

Thus, in a single stroke, Rep. Shumway's bill would bar recovery by thousands of workers exposed to products like asbestos. The diseases generated by these types of products often do not manifest themselves for more than 15 years.

Rep. Shumway says suits should have to be filed in a "reasonable" amount of time to restore more certainty and fairness to the legal system.

But one source says the Shumway bill's proposed statute of repose is so extreme that it is inviting devastating attacks from consumers and trial lawyers. "It just won't fly," he said.

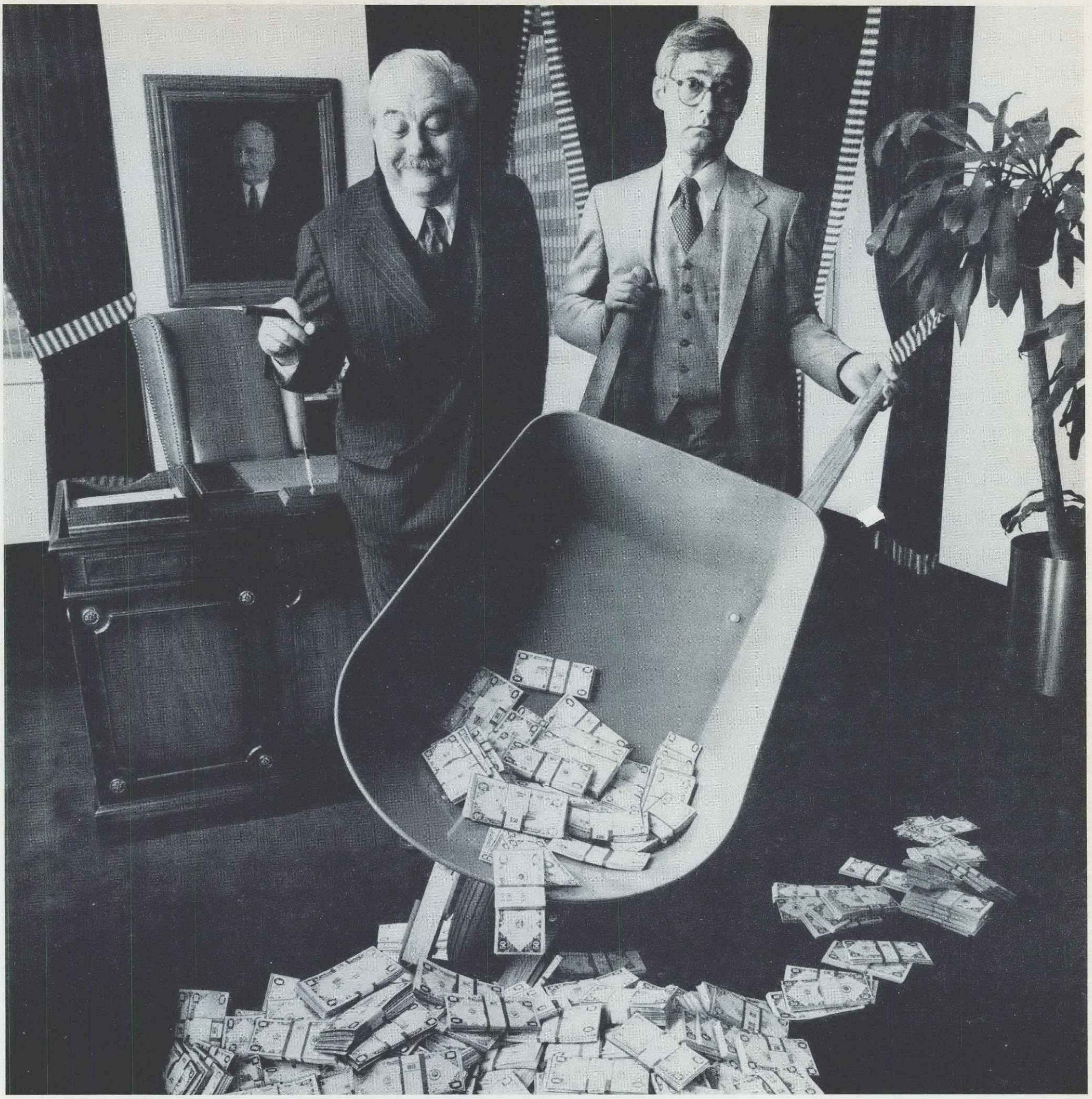
Another source close to the manufacturers' product liability coalition says: "No one is under any illusion about the difficulty of getting that statute of repose enacted. But you don't start out by selling out," a reference to Sen. Kasten's decision to narrow his statute of repose from what he originally proposed.

In his first draft, Sen. Kasten proposed a 20-year cutoff for suits involving major home appliances and a 10-year cutoff for consumer goods.

Those cutoffs were removed because of a recognition that product liability lawsuits involving old products are, by and large, limited to manufacturers of capital goods built to last for decades, according to an aide to Sen. Kasten.

For the immediate future, one expert believes only one tort reform provision has any chance of clearing Congress. It is one that would bar evidence of post-accident design changes from being introduced during a trial.

That provision is contained in Sen. Kasten and Rep. Shumway's proposals. ■



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editorial opinions

A 'reasonable' approach

WHO'S IN control here?

Our special report on employee benefit cost control reveals one startling fact: Few insurers want to discuss the specifics of how they decide how much to pay on medical claims, leaving group health insurance buyers in the dark about how their employees' claims are paid.

Many benefit managers don't discuss with their health insurers how "reasonable and customary" charges are set, and those charges can vary from insurer to insurer.

Considering the consistently rising costs of major surgical procedures and the general tightening of payment criteria by insurers and claims administrators, we see an employee relations powder keg getting ready to blow up in the face of benefit and personnel managers.

Contract concessions requested and received by the nation's auto industry teach the business community an important lesson: Get the support of employees to make any corporate cost-control technique work, from production cost reduction to employee benefit cost containment. To get that support, you need to keep employees informed.

We recommend that benefit managers:

- Stay constantly in tune with their insurers' reasonable and customary medical fee schedules and consider requesting quarterly summaries of the value of major surgical procedures.
- Communicate the logic, potential values and liabilities of the R&C system to workers to avoid after-the-fact confrontations with employees who find they have unexpected bills to pay.
- Establish and communicate predetermination agreements with insurers and administrators that allow employees to check going rates for elective treatments in advance. Giving employees the information they need to be wise medical care shoppers could do for medical consumption what unit pricing has done for buying groceries.
- Make health care costs an important topic in the benefit communications program.

We also suggest that employee benefit managers get the specifics on how an insurer establishes and uses reasonable and customary data when negotiating new policies. Benefit executives should ask insurers:

- How often are R&C limits revised?
- At what R&C survey level do you pay claims?
- Are you willing to adjust the payment level at our request to meet employee or community relations needs?

We have always maintained that a corporation's best buying decision is an informed decision. We also believe that a corporation's best way to control costs is to stay in control of how its money is spent.

letters

HMOs can save employers money

To the editor: Judging from their letters, both Eileen Wilson (*BI*, Jan. 25) and C.R. Mykrantz (*BI*, Feb. 1) apparently missed the point in my letter (*BI*, Dec. 28, 1981). I never said that HMOs do not save money.

The example of $70,000 in paid claims were claims on those individuals had they stayed on a fee-for-service basis, not HMO-paid claims.

The only point to be made in my letter was that the smart benefits manager must look at the long-term effect of the HMO on his other health programs before a "savings" can be made rather than by just comparing premiums; I did not mean that HMOs cannot save money.

If a $5,000 reduction in premiums with the HMO causes by itself an $8,000 increase in the other plan's premiums, is there a savings?

The answer would be no, because the change in the ratio of claims to premium will, at the next renewal, automatically adjust the other plan's premiums to compensate for the change in the loss ratio, thus defeating the value of comparing the HMO premium with the other plan's premium to determine savings.

My original letter was a protest of blanket statements made in *Business Insurance* editorials that could cause more harm than good when not totally researched.

Norman A. Tapper
Senior underwriter
American BBC Inc.
Carol Stream, Ill.

Inaccurate analysis

To the editor: The Perspective article by Barry Martin (*BI*, Jan. 18) comparing workers compensation systems provided by state funds and private industry insurance is another analysis that compares apples and oranges.

I wonder if Mr. Martin's discussion and conclusions would have been the same if the private industry loss ratio had been based on paid losses rather than incurred losses? Forty percent of the earned premium for the state funds in Mr. Martin's exhibit develop a loss ratio comparing earned premiums to paid losses.

Since the five state funds in which paid losses are used are monopolistic and have complete control over premium income, the need to recognize incurred losses does not exist. Also, the fact that expenses for administration and loss adjustment are not available, and may not be paid out of premium income, raises serious questions about the credibility of the article.

Overlooked in the discussion is the statistic revealing that in states with a competitive state fund, only two funds have garnered more than 50% of the market. In those states the funds had a pricing advantage not available to private insurance.

Paul G. Klein
Leawood, Kan.

Third-party audits

To the editor: Robert A. Chorak's Perspective article, "A crucial question" (*BI*, Jan. 25), addressed an important matter that is often ignored by those who administer self-insurance plans.

It is my personal perception that it is good business to have a third disinterested party audit the functions of those who settle your claims. I agree wholeheartedly with his comments.

R.H.Loney
Director of safety
General Telephone Co. of Indiana Inc.
General Telephone Co. of Michigan
Fort Wayne, Ind.

N.Y. Regulation 41

To the editor: Your editorial "Better late than never" (*BI*, Feb. 8) was highly appropriate for launching the New York Insurance Exchange beyond the boundaries of New York state for direct business. It brings the focus of attention to the insurance exchange as a non-admitted carrier and makes me wonder if another cliche is also timely: "Do as I say, not as I do."

It is no secret that the NYIE is a pet project of the New York Legislature and regulators. While its unique stucture will create some interesting technical challenges for gaining approval as a non-admitted insurer in states outside New York, it certainly will not encounter elsewhere the regulatory hobbles that its own home state applies to the flow of business to non-admitted insurers. I'm referring to the overbearing trade handicaps of New York's revised Regulation 41, which governs the use of surplus lines markets.

The NYIE will thrive best in an atmosphere that encourages insurance creativity. The severe regulation of non-admitted transactions in New York will drive creativity and insurance commerce elsewhere.

There is now a clear dichotomy between the NYIE and Regulation 41. Time will tell if it is possible to "have your cake and eat it, too."

James H. Bryson
James H. Bryson Associates Inc.
Jenkintown, Penn.

Who was punished?

To the editor: I was very interested In the article, "NRA liable for stolen gun used in Washington killing" (*BI*, Feb. 22).

It seems that the man who owned the gun was in trouble and the importer of the gun was in trouble. Everyone seems to be in trouble for having a weapon except the man who pulled the trigger.

My curiosity is fast at work, and I would like to know whether the man firing this weapon was or is in prison or if he has been released. At least if the criminal has been justly sentenced, the rest might be slightly easier to swallow.

Patricia V. Marazo
Sentry Insurance
Miami, Fla.

■ *Both John F. Hart, the man who fired the stolen gun, and his accomplice, Joseph Nicks Jr., were convicted of murder. Both are now in prison, according to James E. Rooks Jr., the lawyer for the family of Orlando Gonzales-Angel, the slain man. Two of the three people involved in the burglary at the NRA are also serving time, Mr. Rooks added. The third, a police informant, was released.*

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

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Reporting weekly for corporate risk, employee benefit and financial executives

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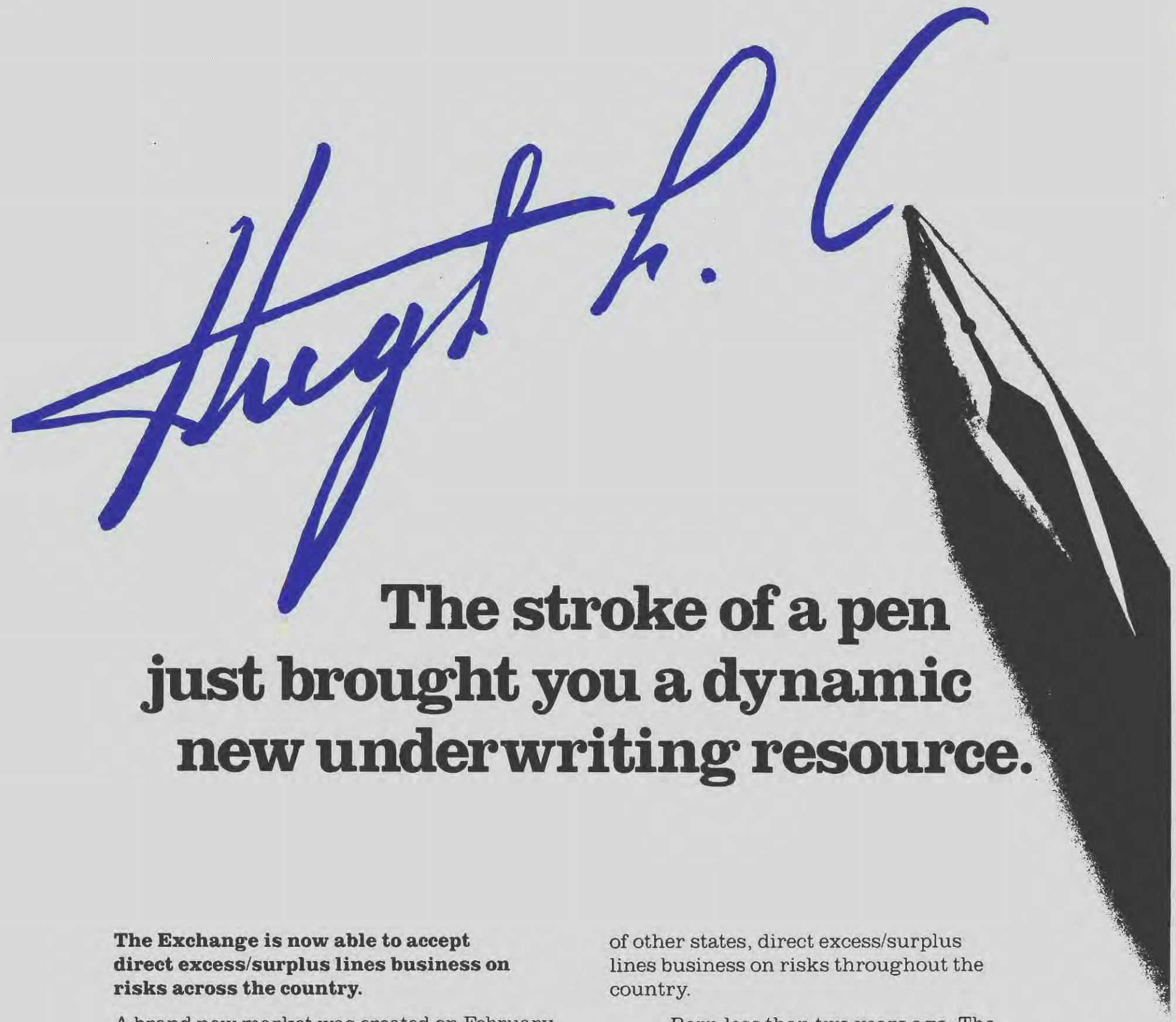

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Loss reserves funding offered to self-insurers

markets

Armco Reinsurance Managers Inc., a newly formed member of the Armco Financial Services Group, is offering self-insurers and insurance companies a way to unload unwanted liabilities for long-tail risks like workers compensation and product liability.

Established in January, Armco Reinsurance Managers specializes in the marketing of loss reserves funding.

This enables the self-insurer to unload contingent liabilities for which it no longer wants to be responsible and possibly receive a tax deduction in return. It also allows an insurance company to escape from business that may have been written at a loss to generate cash flow.

Loss reserves funding is a relatively new concept, says Charles R. Miller, vp of the new subsidiary.

A typical example, explains Mr. Miller, would involve a self-insurer that retains a portion of risk on a particular exposure.

This self-retention limit could be either on an aggregate or per-claim basis.

Should it decide it no longer wants to self-insure this exposure, it can transfer the risk to Armco.

The self-insured would pay Armco a "discounted premium," discounted in the sense that the premium is less than the amount of reserves equaling the projected loss, he says. Armco would in turn issue the company a policy by name of one of several Armco Financial Services Group insurance companies.

The policy would cover both known and unknown losses for specific years.

While Armco sells the coverage at a discount, it hopes to make money by investing the premiums in either Eurodollars or Eurobonds with investment maturity dates pegged to that time when the heaviest claim activity is expected to occur.

And, in addition to getting rid of unwanted liabilities, the self-insurer should be able to claim a tax deduction on the premium it pays Armco.

When claims do occur, Mr. Miller concludes, they are still paid by the self-insurer, which is later reimbursed by Armco.

The transaction is essentially the same for an insurance company.

In this instance, says Mr. Miller, it might involve an insurer that wants to unload liability for a particular class of business.

If the insurer had $10 million in loss reserves for workers compensation claims, for example, it would transfer liability to Armco by paying a premium of $8 million.

As with the self-insurer, Armco will issue the insurer a policy—in this case called a loss portfolio reinsurance policy. Armco then invests the discounted premium in either Eurodollars or Eurobonds.

Once again, the insurer will pay all claims and later be reimbursed by Armco.

All arrangements include a provision that Armco will assume responsibility for claims should the policyholder go out of business. Policyholders also may negotiate to receive a letter of credit from Armco, protecting them should the Armco subsidiary fold.

Armco has yet to negotiate a loss reserves funding arrangement with a self-insurer, although Mr. Miller says it is now working on a few deals.

Pollution cover

The Hartford Insurance Group is marketing a pollution liability policy for gradual and non-sudden pollution resulting from hazardous wastes or toxic substances.

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Benefit cost control

Insurer rules leave workers, bills hanging

By RHONDA L. RUNDLE

Benefits backfire.

That's what happens when an employee is stuck with payment for more than the coinsurance portion of a medical bill because the insurer or claims administrator judges it to be excessive.

Employees who are asked to shell out big bucks for medical care that they expect to be paid by group insurance feel shortchanged. They may accuse their employer of buying a cheap insurance package or of deceiving workers about the true value of health care benefits.

It's a tough problem that can land in the lap of an employee benefit manager. Such employee relations dilemmas may be growing as insurers respond to pressure for health care cost containment.

Some employers already have noticed stricter adherence to reasonable and customary guidelines by third-party payers—especially for high-priced surgeries and specialized medical care.

Claims administrators typically consider hospital and doctor fees ranked within the 90th percentile for a local area to be "reasonable and customary."

However, charges that exceed those levels can wind up back with the employee, who more than likely takes them to the benefit manager.

Jacquelyn Pellet, corporate manager of employee benefits at Mattel Inc. in Hawthorne, Calif., detected a tougher stance by the company's health insurer in early 1981.

"We see it on obstetricians' fees—as much as $500 to $600 cut out of a $1,500 total bill," she says. Certain types of surgeries, especially expensive heart operations, also have been affected.

"But there are rarely cutbacks on general office visits," she adds.

The most common benefit reductions pertain to major surgeries, agrees Richard Drake, a consultant with William M. Mercer Inc. in Los Angeles.

"Most insurance carriers and third-party administrators do not apply strict guidelines for medical services other than surgery and anesthesia. It's not cost-effective," he says.

If an employee is dissatisfied with the payment, the first avenue of appeal should be with the insurer. Sometimes additional information may be obtained from the doctor or surgeon to justify a fee over and above the

Continued on next page

Insurers disagree on 'reasonable' fees

By EILEEN NORRIS

You hear the phrase "reasonable and customary charge" and it sounds like a medical payment system that must be fair and logical.

But critics of the system, which profiles average surgical and dental charges by geographic area, say it's inconsistent from insurer to insurer and from state to state.

Every major health insurer has its own formula, based on past claims experience, to calculate how much a certain medical procedure is worth by geographic area and how much it will pay for each treatment.

Other smaller insurers and claims administrators rely on the data base of the Health Insurance Assn. of America, which collects and publishes surgical and dental charges contributed to the data base by 30 large insurers (see related story on page 18).

Says one consultant in the field, "It's like trying to have everyone in the nation agree on the definition of 'normal.'

"It's impossible," consultants say, and frustrating for employee benefit managers (see releated story).

Doctors and dentists compound the problem. Drastically different bills for the same treatment vary from physicians renting office space in the same building, say insurance industry sources.

And complicating the dilemma are antitrust laws that say insurance companies can be accused of price-fixing if they share pricing information.

Health insurers contacted by *Business Insurance* would not give specific examples of reasonable and customary charges.

CNA Insurance Co. and New York Life Insurance Co. refused to comment at all on the touchy subject, saying the information was proprietary.

Of those insurers willing to discuss how they arrive at R&C charges, there was little uniformity of method.

Prudential Insurance Co. relies on its own claim data to calculate what is a reasonable and customary charge, says Ed Harris, director of group underwriting.

For example, 10 appendectomies performed in the same ZIP code area would be ranked by the highest to lowest charge. The charge that corresponds to the ninth-highest charge (90%) would be deemed "reasonable and customary" at Prudential and the charges equal to or below the ninth appendectomy would be within the R&C level.

Prudential updates its R&C levels every three months, says Mr. Harris. Medical costs are increasing at a rate of 11% a year, he added.

There are few exceptions made when paying surgical claims on an R&C basis, he said, but Prudential does try to recognize unusual circumstances.

"For instance, if a 400-pound man is rushed to the hospital at 4 a.m. with an appendectomy and has unusual complications, we might look at that situation and decide to pay a higher fee than is customary," he said.

Like Prudential, Aetna Life & Casualty Insurance Co. produces new R&C profile data every three months to keep pace with inflationary changes in medical rates and has been since 1977, says Gary

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Are physicians inflating health care costs? Page 21

Medical auditors check bills for errors Page 24

Preferred providers offer health care discounts Page 36

High charges can injure worker morale

Continued from page 13
reasonable and customary charge.

Unfortunately, employees tend to be skeptical of requests for additional information, Mr. Drake says. But often such documentation is all that is needed to explain unexpected complications in a surgery that justify a higher fee.

If the original decision sticks, then the employee may request peer review by a panel of doctors from the local medical society. The process can take up to nine months, but often results in an upward adjustment of the reasonable and customary limit, says Ms. Pellett.

Physicians are not compelled to accept the findings on fair fees by the peer review committee of the Los Angeles Medical Assn. But some local medical societies require advance agreement by the physician to accept binding arbitration, perhaps to avoid subsequent charges of price-fixing by the disgruntled doctor.

Even if the review process eventually succeeds in winning a higher reimbursement, however, damage to good employee relations may be done.

To avoid employee misunderstanding about reasonable and customary charges, many firms are starting to incorporate information about these guidelines into an overall benefit communication program.

Over several months last year, Illinois Central Gulf Railroad used paycheck stuffers to communicate a number of benefit messages to employees. One of them asked the question: Who pays the difference if a bill exceeds reasonable and customary charges?

The answer: the patient.

"People are reluctant to discuss fees with their doctor," observes Tony Cuccio, benefits analyst with the Chicago-based railroad that employs 18,500 people. "We encourage people to question their physicians' fees—like any good consumer."

Illinois Central is asking employees to take advantage of an informal predetermination plan set up with the company's insurers and health claims administrators.

"We ask them (employees) to find out three things: the surgeon's fee assuming no complications, an accurate and complete description of the procedure and the provider's ZIP code," explains Mr. Cuccio.

The employee telephones a claims administrator with the information and finds out if the charge falls within reasonable and customary parameters.

"Our administrators were skeptical initially," he concedes. "They were reluctant to disclose R&C guidelines because they feared that doctors charging below the upper limit might raise their fees."

Since the predetermination program is still new, Mr. Cuccio does not have a clear picture of how many employees are using it.

John Garner, a consultant with Towers, Perrin, Forster & Crosby Inc. in Los Angeles, suggests the predetermination approach to many of his clients.

"Whenever possible, we like employees to know if the fee for the proposed surgery will be covered," he explains. Besides the charge, employees should ask for the procedure number, which will help claims administrators pinpoint the precise treatment, he says.

"Most insurers don't like to make commitments over the telephone because unforeseen complications can change the picture," he adds.

Insurers also balk at the administrative costs of providing such a service to their policyholders, he says.

Joe Outram, an assistant vp of the Equitable Life Assurance Society in Los Angeles, disagrees. He says most insurers would cooperate with a predetermination request.

"We're happy to do it anytime somebody wants to check with us," he says. "Of course, if the person uses the wrong words to describe a surgical procedure, then there's going to be a lot of confusion."

Although Mr. Outram is not aware of any Equitable policyholders that have a formal contract to receive a predetermination service, some "involved personnel managers" regularly check with the insurer on behalf of employees who need medical treatment.

Harris Trust & Savings Bank in Chicago also uses predetermination of medical benefits. "The procedure requires surgeons to describe a surgical procedure prospectively just as dentists do," explains Thomas Parfitt, vp in charge of benefits.

Since Harris Bank administers its own health insurance plan, which is written by CNA Insurance Co., it can respond quickly to an employee's request for predetermination unless the proposed surgery is highly unusual or complicated.

But few employees exercise the option, reports Mr. Parfitt. It may be because of a strong reluctance to ask the doctor what the treatment may cost. Or it may be because Harris Bank has not had much experience with bills that exceed reasonable and customary levels, Mr. Parfitt suggests.

Who should be fighting the battle of the overcharges? Most benefit consultants emphasize the need for insurers and health claim administrators, not employees, to take the initiative in contacting providers when fees exceed reasonable and customary levels.

"The employee is not in the health care business and doesn't know how to respond when a claim is paid at a lower level," says Mercer's Mr. Drake.

Reasonable and customary charges are not a cost-containment device; they merely shift costs to the employee, adds Sam Kaplan, president of U.S. Administrators, a health claims administration company based in Los Angeles.

"When we have determined a bill is excessive, the provider gets a call from a physician trained in the same speciality who asks for additional information to justify the claim. About one-third of the time such additional information is forthcoming," says Mr. Kaplan.

About 60% of the time, the doctor is told the charge is unreasonable and is asked to reduce the amount.

"If the physician persists, and assuming the employee never agreed to a fee at the outset, we go to court and hold the employee harmless," says Mr. Kaplan.

"A physician can't justify an unreasonable charge if the cost was never discussed with the client. We can march in our expert witnesses who explain reasonable fees."

Mr. Kaplan said the company has pursued several cases into court and has not lost one yet.

"Somebody has to go out and do battle for the patient," he says. ■

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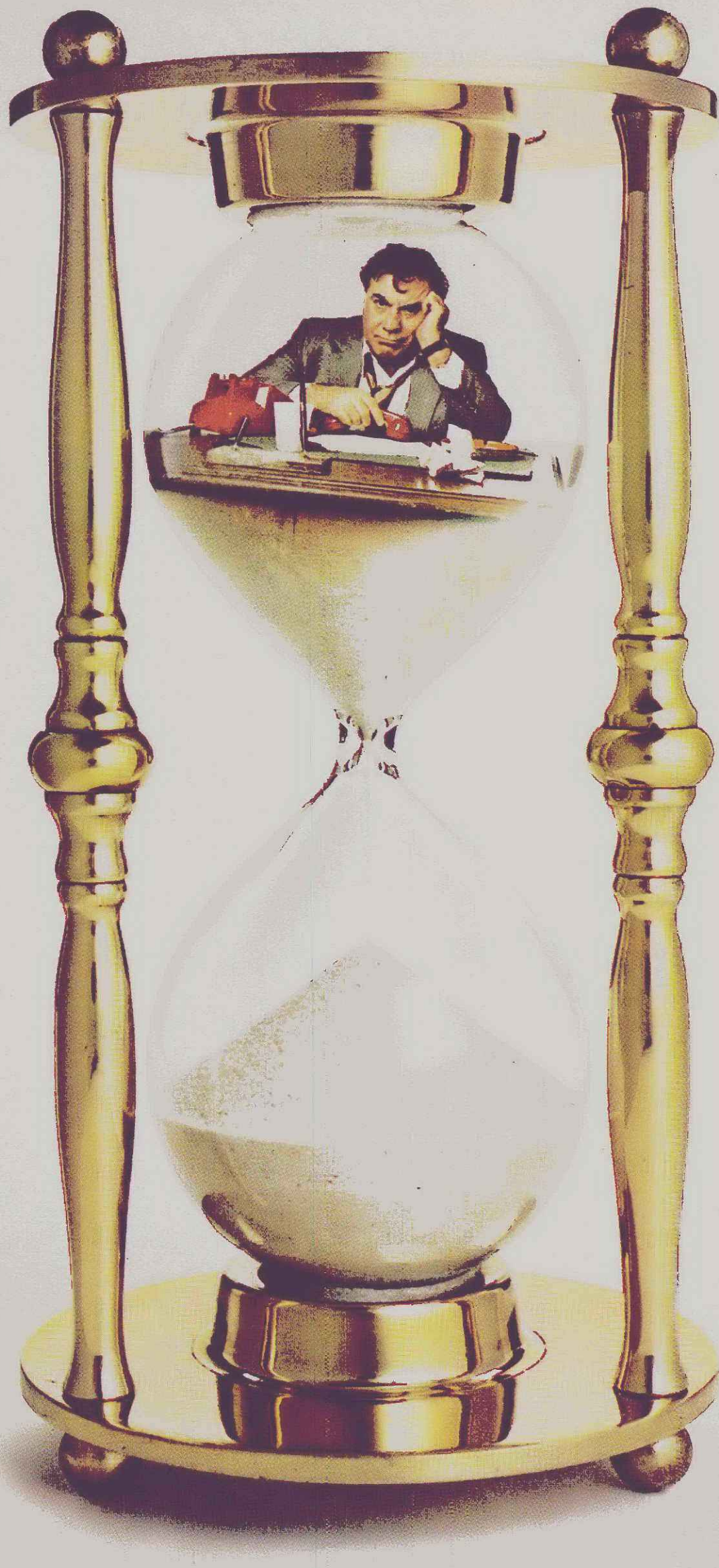

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Insurers differ on what is 'reasonable'

Continued from page 13
Schade, director of claims relations.

"Each time we process a claim, it's entered into our computer by a procedure code that identifies the service. The doctor's identification number ties the claim to a certain geographical area," says Mr. Schade.

The amount and date of the charge is fed into the computer and every three months an R&C profile is produced that arrays the charges made for each service, he says.

Aetna pays at the 85th percentile of all like claims recorded in a geographic area. So, 15% of all charges would be above Aetna's prevailing R&C rate and 85% will be equal to or below what the insurer is willing to pay.

"The doctors' charging patterns vary so there are substantial variations in charges from area to area," says Mr. Schade.

"And we're always looking at 12 months of claims data, so when we add on a new quarter, we drop off the oldest three months of claims experience.

"We've found that most doctors charge less than the maximum R&C level," he adds.

R&C levels are not calculated for hospital room and board or ancillary fees so insurers usually pay whatever a hospital charges for a semi-private room.

"The charges for room rates vary tremendously," said Mr. Schade. "Chicago, New York and California are a lot more expensive than Mississippi.

There have never been R&C guidelines for hospital rates, primarily because unions have always bargained for full coverage for employees, theorized Prudential's Mr. Harris.

"There's nothing we can do about that," he said. "Private insurers have no real basis for negotiating prices with hospitals, which hike room rates about 16% every year."

The Travelers Insurance Cos., another major health insurer, has its own system of evaluating 3,000 procedures within specific geographic areas to establish its R&C guidelines. It also updates on a quarterly basis and pays at the 90th percentile.

"If a geographic area doesn't have sufficient volume and the charge looks excessive, we will look at the larger configuration in the HIAA data," said Dick Sleezer, director of group underwriting.

The Travelers says physicians' charges are increasing 10% to 12% a year.

"Cost containment is a very current topic," he adds, "but R&C guidelines are only one area. Many employers are more concerned about excessive utilization and hospital stays."

Metropolitan Life Insurance Co. updates its screening guidelines twice a year, relying, as most large insurers do, on its own claims data first.

In a few instances when its own data is thin, it will turn to the HIAA information as a supplement to its own claims experience, said George Harper, vp of claims.

But the cost monitoring isn't much of a cost-control device and insurers can't do much alone.

Insurance companies, he says, have to work together to get quality care at a lower cost.

Connecticut General Insurance Co. uses a base schedule it developed several years ago, says Louis Venezia, director of medical claims services.

Connecticut General updates its R&C schedule every six months based on HIAA data.

"The reasonable and customary charge is what's being charged. Insurers don't set it, the marketplace does," said Mr. Venezia.

Although the insurers feel their system keeps a finger on the pulse of the market, many consultants and administrators disagree.

"But there isn't a consistent R&C pattern across the country or even in the same state," criticizes Joe Rossman, senior consultant with A.S. Hansen Inc. in Chicago.

"The reasonable and customary charges for a D&C (dilatation and curettage) in Chicago can be 30% higher than 50 miles west of Chicago," he says.

Another health insurance consultant recommends employers use the HIAA tables at a 90% percentile rate, but also agrees that the R&C system is a self-defeating mechanism that does not reflect market competition.

"Schedules are based on what physicians are charging, and not on how much the insurer or self-insured employer is willing to pay," says Robert Cardinal, president of Mass Insurance Consultants & Administrators in Chicago.

"A doctor submits a bill for $1,000, but the insurer's R&C for the procedure may average at $750. It's ultimately a catch-up game because the next time the R&C is calculated out, it's based on what's charged, which is usually an inflated fee," he says.

More and more employers will be asking their health insurer or administrator for fixed pricing schedules for surgical and dental work, with limits on how much an insurer will pay for a particular procedure, predicts Mr. Rossman of A.S. Hansen.

If the doctor or dentist charges the patient more than what the insurance company is willing to pay, it will be up to the employee to negotiate for lower rates, Mr. Rossman explains. ■

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Group compiles medical fee data for its members

By EILEEN NORRIS

NEW YORK—The Health Insurance Assn. of America makes no bones about it: The organization wants no credit for putting together a top-secret list of nationwide surgical and dental charges.

"All we do is provide subscribers with information on what doctors are charging for various procedures," says Donald D. Jones, associate director of research at the HIAA.

"It's up to them to interpret the data."

The HIAA has been compiling what it calls its "prevailing health care charges" for the past seven years at the request of member insurers.

The insurance companies had asked for the organization's assistance in determining reasonable and customary charges.

Now some 30 major insurance companies, each insuring more than 100,000 workers, contribute their claims experience data to the HIAA data base.

The insurers, however, usually do not use the compiled data solely because they generally desire calculations tailored to their geographic and demographic service areas. They also fear price-fixing complaints (see related story).

Each member insurer or medical claims administrator has its own way of determining fees, Mr. Jones says, though "many use our listings as a guide."

However, the HIAA tries for greatest accuracy. About 5% of the information that comes into the HIAA is rejected, according to Mr. Jones.

'All we do is provide subscribers with information on what doctors are charging,' Mr. Jones says.

"Sometimes we'll see a ZIP code that doesn't exist or a charge that is way above the prevailing norm," he says.

"We didn't create a system to let inferior data in," Mr. Jones says. "We're constantly checking for quality data."

The data is neither cheap nor easily accessible.

Only insurers and claims administrators can purchase the HIAA's report on what's being charged by doctors and dentists nationwide.

"We're not at liberty to give or sell the information to others," says Mr. Jones.

"We have to keep a tight lid on the information. Otherwise, there would be no incentive to become a subscriber.

"We don't look for advertising with this program. It's a service we provide to our members."

The HIAA doesn't charge data contributors for the listing, but the group's 170 other member and nonmember subscribers pay for the schedule, with fees varying according to the number of employees covered under their medical plans.

Currently, HIAA member companies must pay from $2,000 to $28,500 for a surgical data output and $8,500 to $103,500 for a dental data output. These list doctors' and dentists' going rates for various procedures according to ZIP code.

For non-members, the prices range from $2,340 to $29,650 for a surgical output and from $9,000 to $106,500 for a dental output.

The HIAA soon may broaden its tracking of charges for other medical services, too.

The association is studying the feasibility of expanding its program to include reasonable and customary charges for anesthesiology and other non-surgical procedures, but Mr. Jones would not discuss whether the group is likely to tackle the new areas. ■

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These publications are designed for benefit managers who are attempting to control the rising costs of their companies' health care benefits:

• Northwestern National Life Insurance Co. has produced a new package of informational material entitled "Cost Management Strategies." The package describes **cost-containment ideas** and Northwestern National's employee benefit services. Brochures are devoted to Northwestern's computerized claims services, rehabilitation programs, services for dealing with health maintenance organizations and other services. The free package can be obtained by writing "Cost Management Strategies," Northwestern National Life Insurance Co., Box 20, Minneapolis, Minn. 55440; Attention 6115.

• Blue Cross & Blue Shield of South Carolina has published a new booklet, "Employee Wellness: A Renaissance of Health," which describes the Blues' **wellness consulting services** available to business and industries in South Carolina. The booklet cites reasons for employee health management programs, describes the success of the Blue Cross wellness program and details the components of an employee program. A free copy of the booklet can be obtained by writing the Office of Health Education, Blue Cross & Blue Shield of South Carolina, Columbia. S.C. 29219.

• A free **catalog of books about employee benefits** is available from the International Foundation of Employee Benefit Plans. The 1982 edition of the catalog lists more than 80 books published by the IFEBP in recent years. The publications cover a spectrum of employee benefit topics, including cafeteria-style benefits and cost containment. Copies of the catalog can be ordered by contacting the Internation Foundation of Employee Benefit Plans, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-7000.

• An **employee wellness and cost-containment program** is covered in the bimonthly newsletter, "Healthier Life." For a free copy of the newsletter write Dick White, Healthier Life, 4182 Gann Store Road, Hixson, Tenn. 37343.

• "What Should Your Company Get for Its Health Benefit Dollar?" is a free pamphlet that gives **an overview of health care benefit cost issues** facing most companies. For a copy write Jay Wolfson, Jay Wolfson Associates, 2125 Augusta Drive, Houston, Texas 77057.

• **Prepaid health care programs** are reviewed in the promotional brochure "A New Option in Health Care," published by INA Corp. For a free copy write INA Super Service, Insurance Co. of North America, Department R, 1600 Arch St., Philadelphia, Pa. 19101.

• "An Apple a Day" is a free brochure from Mutual of New York that explains **what employees can do to help reduce health care costs.** For a copy write Mail Drop 11-38, Mutual of New York, 1740 Broadway, New York, N.Y. 10019.

• A booklet on alternative methods of **funding health care benefit programs** is available from Imperial Industries. For a copy of "Knowing Your Alternatives" write Daniel J. McCune, Imperial Industries, 3200 Wilshire Blvd., Los Angeles, Calif. 90010.

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Physicians charging too much: Consultant

By EILEEN NORRIS

CHICAGO—Doctors are inflating health care costs by charging as much as they think insurers will pay, says one employee benefit consultant.

And the inflation of these "reasonable and customary" payment schedules shows no sign of abatement, other experts agree.

As the number of physicians increases while the population remains steady, doctors accelerate their fee level to make up for the fewer number of patients they are treating, explains Joe Rossman, senior consultant in the Chicago office of A.S. Hansen Inc.

It is these physician charges —not what insurers and self-insurers actually pay out—that are used in calculating insurers' reasonable and customary payment schedules.

The system creates an incentive for doctors to charge higher fees and eventually increase what insurers will pay, Mr. Rossman says.

"If a doctor charges $25 for an office visit and decides to test the maximum an insurer will pay, all he has to do is submit a fee of $35 and the insurance company writes back saying it will only pay $32. Now the doctor knows he can get $32 for an office visit and that's what he charges," Mr. Rossman says.

"The word gets out quickly among doctors," he adds. "And don't forget that higher charge is calculated into the insurers' data for new R&C schedules."

Employers who purchase health insurance coverage for employees are caught in the middle. The firms generally feel there is no consistent pattern of R&C charges across the country, let alone the same state, says Mr. Rossman. And they are correct.

"The charges are not comparable from one level to another," he says.

The higher cost is passed to the employer in the form of a higher premium, he adds.

Insurers aren't very happy with the system either, even though they created it. They have found that it is not to their advantage, he notes.

Although the system's accuracy could be improved with shared data, health insurance companies, by law, cannot agree on set charges among themselves because they can be accused of price fixing, a violation of antitrust laws.

But the "abuse" of the R&C system will be dealt with sooner or later, predicts Mr. Rossman.

More and more employers, and especially self-insured companies, are seeking fixed price schedules for their employees' health insurance.

Many health insurers, he adds, still offer a group policy that specifies the maxiumum amount an insurer will pay for treatments or procedures.

"The hope is that an employee will complain to the doctor that his or her employer's insurance company will only pay so much for the treatment and that the worker then is forced to make up the difference.

"Insurers can't tell doctors to lower their fees, but their customers can," he adds.

Until cost-containment practices take hold, there is one thing consistent among reasonable and customary payment schedules—the level of payment is increasing, an administrator and consultant adds.

Reasonable and customary charges increase at a rate of 18% to 20% annually, says Robert Cardinal, president of Mass Insurance Consultants and Administrators.

"The claim that's rejected last month by the insurer gets in there eventually in another form, but it introduces a time lag. Ultimately it's a catch-up game," he adds, which costs buyers more in the long run. ■

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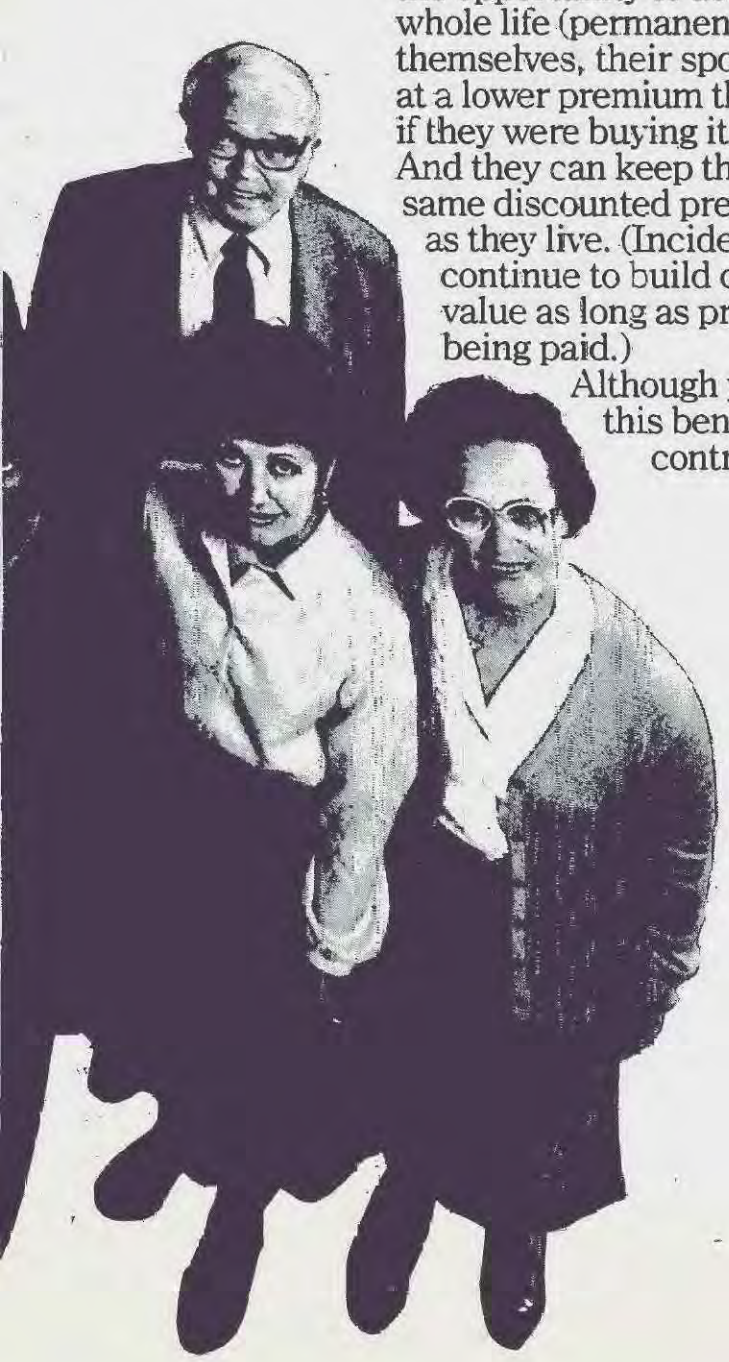

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Auditors check for hospital billing errors

By STEPHEN TARNOFF

Insurers and self-insurers, faced with rapidly rising health care costs, are asking for more frequent medical bill audits to reduce excessive charges and lighten financial burdens.

By comparing hospital charges with the items and services actually rendered, the medical auditing firms are discovering that just what the doctor ordered is not always what the patient gets.

"Hospitals make a lot of errors in their billings," said Richard Mandel, president of Republic Service Bureau of Oakbrook, Ill. "The larger the hospital, the more discrepancies you will find."

"The biggest problem is that hospitals are paid as they have billed," adds Dr. Alvin Saidiner, president of PCC/Drug Data Systems Inc. of Burbank, Calif., which monitors pharmaceutical, intravenous and supply costs.

"Hospitals have not had to be credible," he said. "No one's ever questioned them."

> 'We're there to make sure that the patient received what he or she pays for. We're not in the business of determining rates,' explains John Hall of Equifax.

By becoming the corporate consumer's devil's advocate, auditing firms are entering the sometimes hostile turf of hospitals and dental clinics, examining the cost and quantity of services rendered.

Armed with medically trained employees, they pour over hospital records and meet with hospital personnel to spot and correct errors in billing.

For their hourly fees, the auditors produce some savings and many tales of staggering medical bill overcharges:

- A $400,000 bill in one case contained a $250,000 overcharge when the level of services for a patient was wrongly recorded.
- A hospital charged a patient for 100 pills ordered by a doctor even though the patient was given only five. The hospital had resold the remaining pills.
- A $245,000 bill for a hemophiliac was found to have a $47,000 error mostly in charges for drugs the patient did not receive.
- A Sun Belt hospital charged $216 for 24 aspirin tablets.

Most of the overcharges auditors spot are not this large and many hospitals do a good job in billing, the auditors are quick to point out. But medical auditing firms all claim substantial savings for clients, from 6% to 40% of medical fees, which can amount to millions of dollars.

What are the reasons for the billing errors? Auditing firms blame hospital inefficiency, poor bookkeeping methods and understaffing.

"The hospital and the methods of billing are what cause the errors," said Jeffery Littes, president and owner of Canyon National Cos., an auditing firm in Upland, Calif.

Since hospital procedures require charge slips to go through at the time the service is ordered by the doctor, they often don't track whether the patient actually receives the service, auditors agree.

Since orders are often changed, the patient might never receive the drug or services he or she was charged for.

Utilization errors also crop up as patients can mistakenly receive unnecessary or duplicative services, Mr. Littes notes. He estimated that errors in hospital bills usually range from 0.5% to 11% of the total bill.

No one claims hospitals are out to cheat the public, although some auditors say this has occurred in individual instances.

Auditors' approach to researching discrepancies can differ. Some firms are neutral observers while others take a more adversary approach, often questioning the hosptial rates that are charged.

Some require patient authorizations before conducting an audit and some will recommend whether to pursuse an audit based upon the hospital's reputation and track record for billing accuracy.

Most said they compare the hospital's itemized bill with hospital records to make sure that they agree.

"We take each of the items on the bill and match them against the medical records," explains John Hall, products reasearch and devlopment manager for Atlanta-based Equifax, one of the largest auditors in the country. "This validates the services rendered."

After completing an audit, the firms use various techniques in remedying problems.

Equifax takes a "totally objective" approach, according to Mr. Hall. This means finding undercharges as well as overcharges in a bill and reporting it to the client and the hospital.

"Whatever we find is what we report," Mr. Hall says.

Once the audit results are reported, Equifax will not recommend any particular course of conduct to the client even if over-

Continued on page 26

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The Liabilities

Business people and professionals find themselves subjected to more frequent and increasingly costly lawsuits. The fruits of their success–from stock portfolios to yachts–make them tempting targets.

INA examines personal liability exposure and reviews the best forms of protection.

Americans are taking to the courts. They sue more often, litigate a wider range of claims and win spectacularly larger judgments than ever before.

As a result, a growing number of business people and professionals are looking into personal liability insurance.

Many more, however, do not realize how much they stand to lose. They're not familiar with the details of their present coverage or aware of the extent of their exposure.

The homeowners policy vs. the golden retriever

Personal injury cases lead to a large portion of all liability insurance claims. In 1979, the last year for which full figures are available, the average judgment for an injured knee was nearly $40,000. The average for an accident that caused a death was over $350,000. And verdicts of a million dollars or more were reached in 80 personal injury cases.

The typical homeowners coverage limits personal injury liability to $100,000. Other than automobile insurance, it is the only liability coverage many families own. And there are frequently substantial gaps in its protection.

Unintentional libel and slander are not covered by most homeowners insurance. Neither is borrowed property–a country house loaned for a weekend, a neighbor's station wagon, even a visiting, valuable, golden retriever.

Conspicuous consumption makes a tempting target

The very hallmarks of success in business–a handsome

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residence, a boat, an expensive car–are also signs a family is well worth suing.

This does not mean, however, that a family with fewer, or less visible, assets is safe. A massive judgment still could mean a loss of home or savings. And if the award exceeds a family's total assets, then *future* earnings can be attached.

Fortunately, increased liability protection isn't difficult to purchase or especially expensive. The normal vehicle is generally called a personal umbrella policy. And a million dollars in added coverage costs as little as $100 a year.

A personal umbrella closes a number of gaps that other types of policies leave open. Owners of planes, large yachts or recreational vehicles, however, should make sure these are covered–since some umbrella policies exclude them. Those of very substantial means might want to raise their policy limits to $5 million or even $10 million in added coverage.

Business and pleasure: Each has its own liabilities

Personal umbrellas carry one important caveat: They specifically *exclude* all liabilities incurred in business. Thus people who serve as directors and officers, even if the corporations they serve are small, would be well advised to consider special directors and officers liability insurance.

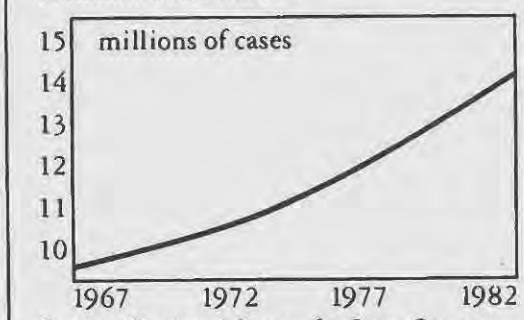
Doctors, lawyers and other professionals must also be on their guard. Judgments against professionals have become increasingly costly and very common. Those with coverage should periodically review and update their protection.

INA and other large business insurers offer personal liability umbrellas as well as more specialized liability products. One division of INA, INAPRO, deals exclusively with professional liability.

The Insurance Company of North America was founded in 1792 in Independence Hall in Philadelphia. Today, it is the largest component of INA Corporation's international network of insurance and financial service companies.

A leap in litigation

Civil lawsuits have grown from an estimated 10 million a year in 1967 to a projection of 14 million cases in 1982.



Source: National Center for State Courts

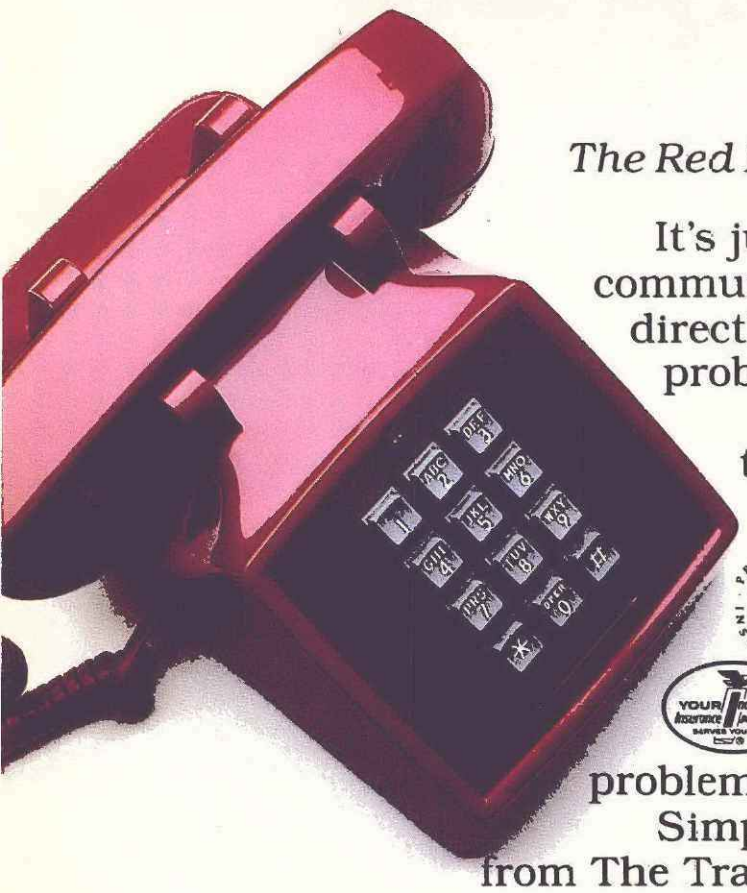
Sophisticated liability coverage–for individuals, for professionals and for businesses–is typical of inventive products for which the company is known.

For an informative booklet on personal liability write INA, Dept. R, 1608 Arch Street, Philadelphia, PA 19101.

Buying umbrellas in bulk

Once it was unusual for a company to take an interest in protecting its employees against illness–today some companies have gone so far as helping to protect them against lawsuits. Personal liability umbrellas are available as part of employee benefit arrangements. The company may pay for key employees or umbrellas may be offered to all those who wish to buy them. Often the cost of coverage is lower, thanks to the economies of scale.

INA
The Professionals



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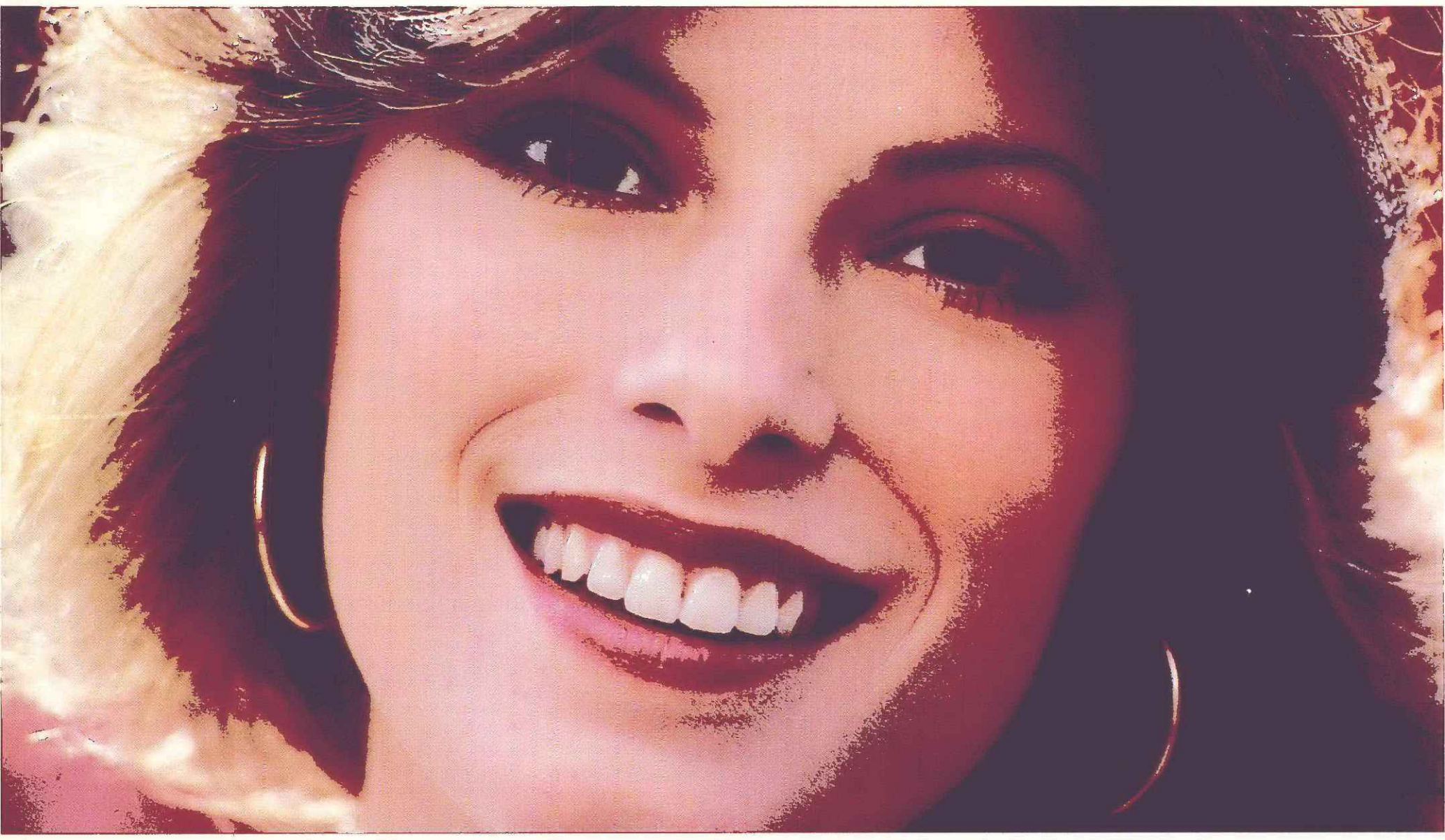

ANOTHER REASON WHY THE TRAVELERS IS NUMBER ONE IN INSURING SMILES.

perspective

CONTROLLING HEALTH COSTS

Technology and industry help hold the line

By Harry J. Gray

WHEN INDUSTRY LOOKS at health care today, we see a major problem: escalating costs.

According to the U.S. Department of Health and Human Services, total health care costs rose by more than 15% in 1980, the largest increase in 15 years. Hospital costs rose even faster, nearly 20%, between July 1979 and July 1980.

Business is concerned because we pay a lion's share of medical bill, either directly through premiums or indirectly through taxes. Health insurance premiums paid by employers in 1981 are estimated to have surpassed $60 billion, compared with $50 billion in 1980.

United Technologies' U.S. medical insurance premiums, excluding dental, amounted to more than $140 million in 1981. At current trends, without any improvement in existing programs, the company's premiums are expected to hit $238 million in 1985.

We view medical expenditures as an investment in the well-being of our workforce. To some extent, higher costs reflect advances in the quality of care. This translates into a happier, healthier population and ultimately, increased productivity. We don't discount the importance of the achievements of contemporary medicine, and we do not begrudge legitimate and worthwhile medical expenditures.

When these costs get out of line, however, they become a drag on the economy. They add to the cost of doing business. They make goods more expensive to produce. They undercut industry's ability to achieve the productivity growth that's needed to compete internationally and raise real income and living standards. These accelerating costs also deter the expansion of medical technology.

Because of the way health care is financed, patients have little incentive to try to control rising costs. Between 1950 and 1975, average hospital charges per day rose nearly 10 times. But during that same period the net expense to the consumer after insurance reimbursement remained unchanged, adjusted for the purchasing power of the dollar.

Today, the primary incentive to control costs lies with employers and the federal government. In recent years, corporations have begun working on this issue. Industry has been cooperating with our insurers, the health care delivery system and the government.

A new administration, however, has introduced a new approach to diminish federal involvement and regulation and encourage competition in the health care delivery system. This approach will place new pressures on the private sector.

The weakening of these restraints could give rise to further cost escalation or it could produce savings. It depends on how the private sector reacts. Business can make a contribution by supporting local initiatives where employees live and work.

Our company is responding to local circumstances in many cases.

We are trying a new approach in our corporate contributions. This year, part of our contribution to one hospital's capital fund drive is contingent on the hospital's success in meeting performance goals. This sort of stimulus could produce positive results for the whole community. We plan to use this incentive approach for all hospital fund drives that we support.

We encourage our executives to join hospital boards and the boards of health agencies like professional standards review organizations and health system agencies. United Technologies encourages discussion with sectors of the health care delivery system on a continuing basis.

In Florida, a location that had no effective medical peer review committee, we talked directly with local physicians about fees.

In Indiana, one of our subsidiaries helped establish the Business Alliance for Health Care Cost Control.

Our insurance coverage is supporting trends to use more home health care as an alternative to hospital or nursing home care.

We sponsor an alcohol and drug rehabilitation program, which enables employees to continue working and contributing to the company and society while receiving treatment and counseling.

We operate screening programs, checking thousands of employees for high blood pressure, diabetes, elevated blood fats and other conditions. If these conditions are detected and treated early, we can prevent the development of serious, costly disease.

In the Hartford, Conn., area, we support a program of review of medical care on a concurrent basis. The program was established through the efforts of the county medical association and supported by local hospitals and private companies. This approach reviews treatment while the patient is in the hospital, before unnecessary costs are incurred.

In some areas, the company gives employees the choice of joining a health maintenance organization or a conventional group coverage plan.

In addition, an independent practice association HMO is being formed by the staff of a Hartford hospital, and this will provide still another health care alternative for employees.

As chairman of a company involved in high technology, I believe we are having a positive impact on health care and that we contribute to medical cost savings. Too often, I think, people overlook the contributions made by technology.

Coronary bypass surgery is one form of treatment that has been made possible by modern technology. Although such surgery is very expensive, a study by a group of Virginia surgeons determined that the operation paid for itself within an average of a little more than 1½ years since people who otherwise would have been disabled were earning wages and paying taxes, rather than collecting disability payments.

Technology developed to meet industrial needs has been applied to the medical field, with beneficial results. Yet, big-ticket technology, like computerized scanners, sometimes is blamed for driving up medical costs. But some medical authorities maintain that high technology is less responsible for high costs than routine procedures like blood counts and chest X-rays.

Technology in medicine could significantly change in the near future. In the past decade, we had an explosion of medical technology that affected relatively few people, like open heart surgery patients and kidney dialysis patients.

In the next decade, we could see more technology being directed toward a larger number of people, reducing the cost of routine procedures.

The electronic thermometer is an example of an non-glamorous device that saves time and, therefore, money. Work is being conducted on new equipment to take blood pressure and other routine tests more quickly, accurately and economically. Diagnostic and research testing equipment made by one of our subsidiaries saves money by doing one test in place of several that were needed in the past.

Advances like those won't make headlines. They won't win Nobel Prizes. But they will improve the efficiency and quality of medical care for millions of people.

Technology also will provide better ways to transmit and collect medical information. Electronic data processing and communications technology offers great potential to improve efficiency in the hospital and, eventually, in the doctor's office.

The private sector also must show that it can better manage the nation's medical resources.

The Business Rountable recently joined with five medical and labor organizations, including the American Medical Assn. and the AFL-CIO, in a voluntary effort to try to control health costs. Groups that join together to discuss issues from different points of view demonstrate the seriousness of this problem and the willingness of the private sector to address it. I believe this effort warrants cooperation from all of us.

In the current environment, the private sector will have to give cost considerations a higher priority than we ever have before. If we don't live up to the demands these new responsibilities are placing on us, costs will continue to balloon.

Then, I fear, the public, desperate about runaway costs, could pressure Congress toward heavy-handed regulatory and legislative controls on health care, perhaps even federal controls. ■

Graphic: Amy Palmer

Harry J. Gray is chairman and chief executive officer of United Technologies Corp. in Hartford, Conn. This article is excerpted from remarks he made Jan. 23 to the American Academy of Orthopaedic Surgeons in New Orleans.

perspective

Sharing medical costs with workers may not curb health care inflation

By William E. Hembree

EMPLOYERS SHOULD use extreme caution if they think shifting health care costs to employees will reduce those costs.

Much is being discussed about the desirability of employer involvement in employee health care costs, and not without good reason. There is no question that the effect of fixed deductibles as deterrents to excessive use have been significantly eroded by the declining purchasing power of the dollar. In addition, many employers have nearly eliminated cost sharing, such as eliminating hospitalization deductibles or individual stop-loss, in the name of improved security for employees. But now costs are soaring and planners are rethinking the advisability of near zero cost sharing with employees.

As a consequence, many employers are considering or implementing increased cost sharing through new payroll deductions, by increasing existing deductions or using more administrative provisions more stringently. Undoubtedly, steps like these will have the intended effect of shifting a larger proportion of medical costs to employees.

However, there are significant flaws hidden in cost sharing that employers should consider. The cost shift could not only be ineffective, but there are also reasons why shifting costs to employees may be counterproductive:

- Employee charges not covered by the plan, proportions of charges shifted to employees and payroll deductions are tax disadvantageous to the employer and employees.

Although few employees would identify it as such, $1,000 in medical bills not paid by insurance requires gross earnings of $1,200 to $2,000. Although this is offset slightly if an employee's itemized medical tax deductions exceed the 3% limitation, the gross earnings are also reduced by payments to Social Security. Therefore, reduced discretionary income may be translated as increased demands for direct salary. Over time, the employees' demands for more money may cost more than if the employer had paid the $1,000 in the first place.

- Because of generally poor communication with employees about medical care claim payments and non-payments, employees seldom understand whether amounts not paid are attributed to deductibles, charges over maximums or service charges not considered "reasonable and customary."

Because of this confusion and lack of effective communication, employees seldom see the unpaid portion as a cost-containment feature; rather they see it as a serious plan inadequacy. Consequently, they vent their anger at the plan and their employer rather than at spiraling medical care costs and providers that charge too much.

And worst of all, because employees are ill-equipped and disinclined to "bargain" with providers, they pay without argument and have no effect whatsoever in changing the providers' charging and practice patterns.

- The perception of "entitlement" is expected to affect costs as well. In employee benefit theory generally, and especially in medical care, when an employee pays part of the cost of the benefits, they may pass a point of entitlement that may cause them to respond to charges differently than if they had not passed this point.

For example, if deductibles or employee payroll deductions are increased past the employee's point of entitlement, he or she may respond, "I'm paying my part of the cost, so I'll get my money's worth."

In this case, an employee who passed this point may not question a weekend hospital admission when little work would be done. Therefore, purchasing decisions made after reaching the point of entitlement may increase costs rather than decrease them.

- Employees and dependents are seldom able to value the quality of medical services other than by price. Thus, the physician that charges twice as much for a procedure is considered "twice as good" as the physician that charges half as much. Consequently, because employees gauge medical procedures by price rather than other objective criteria, cost sharing may exacerbate an employee's reliance on price in judging quality of services.
- In order for employers to contain and reduce costs over a period of time, the cooperation and understanding of employees is necessary. If users are alienated through a counterproductive move like cost shifting, they may be far less inclined to be cooperative in the future.
- When employers conduct an employee utilization study, they expect to find employee use of health care near the average per-claimant cost. Yet what really occurs is that a large number of claimants use the plan significantly less than the average claimant cost. So a very small number of employees are high utilizers who create a disproportionately large part of the costs.

Thus, cost sharing may cause the large

Continued on next page

William E. Hembree is director of the Health Research Institute in Walnut Creek, Calif.

management

Baby boom to cause 'promotion squeeze'

By Kenneth P. Shapiro

THE POST-WAR baby-boom logjam is upon us.

In the next 10 years, although the total workforce will shrink, the number of workers in the 25-to-44 age group—the baby-boom generation—will increase by one-third. This age group will grow to more than 50% of the workforce by 1990.

The disproportionate number of workers in the 25-to-44 age group not only will slow the upward management flow, but potentially disrupt it as well. With too many people entering management at the same level at almost the same time, young men and women will eventually face a so-called "promotion squeeze."

In the coming years, greater numbers of low- and middle-level managers will find their career paths blocked, not so much as a consequence of their abilities or performance, but more as an accident of birth. Thus, this human resource dilemma: a management force that may become overly competitive, more quickly "burned-out" and potentially frustrated, unhappy and less productive.

Solutions to the problems of an oversupply of young managers must encompass a combination of human resource strategies and total remuneration, organizational design, motivation and training and development. To prepare wisely, therefore, managers must consider more than just numbers. They must examine the experience, values and aspirations of the baby-boom generation.

Kenneth P. Shapiro is a vp at Hay Huggins & Co. in Philadelphia. His column on management appears monthly in Business Insurance.

Most members of this group, for instance, will be more highly educated than their predecessors, perhaps with a better notion of how they want their careers to progress. Unlike the children of the Depression, few have any experience with protracted economic hardship. Despite recent economic fluctuations, most are probably still imbued with a general faith in the opportunity available in America—an attitude that flourished as they were growing up in the years following World War II.

Solutions to the promotion squeeze problem include a mix of traditional and new techniques for managing a workforce, including:

- Total remuneration. Raises for superior performance will help distinguish and encourage outstanding achievement, but only where these raises are significantly higher than any automatic cost-of-living increase. This will show the "blocked" manager that his or her contribution is recognized and appreciated, even though the "promotion" may not be readily available.

Long-term incentives can create an allegiance to the organization that could offset any discontent about the lack of "room to grow."

Flexible benefits and perquisites could ease the impatience of the talented performer who must wait for advancement.

- Motivation. For many in the post-World War II generation, the financial reward is not the dominating career goal. Young managers are often looking for more impact and the feeling that their work is important. Where advancement must be delayed, companies can take a number of steps to motivate their younger managers.

Mentoring puts a young manager under the "tutelage" of a senior executive.

Job enlargement is a creative management technique that allows young managers who are caught in the career bottleneck to expand their responsibilities.

Non-linear work patterns can provide an escape valve for the projected management surplus. Employees who choose, for a time, not to buck the heavy career traffic may instead leave the job market for a period of time, work part-time or change career directions.

- Planning. Companies must develop corporate plans and policies that confront the blocked managers role in the organization.

One of the ways a company can accomplish this is to refine selection and assessment procedures to anticipate changes in the overall composition of the company's work and management force and to identify the kinds of people who can operate well under these expected conditions.

Careful planning for management succession takes on a larger importance since the generation that will follow the baby boom into the workplace will provide a smaller pool of talent.

Training and retraining programs may increase the chances that a restless group of potential managers can overcome the problems of the promotion squeeze and remain satisfied and productive in their work.

Physicians, other providers must lead drive to control soaring medical costs

By Richard D. Quinn III

JOE JONES WORKS for a firm that provides him with the choice of a good health insurance plan or joining a health maintenance organization.

Joe pays nothing for health insurance, but he would pay $10 if he and his family joined the HMO. His potential out-of-pocket cost for all medical care is limited to a small deductible and coinsurance percentage. It would take a catastrophic illness for Joe to incur out-of-pocket expenses even equal to the down payment on his new car.

Joe rarely thinks about health care costs except at those few times a year when he gets a bill for a $35 office visit that he submits to his company's insurer.

Last year, Joe's wife had surgery. She spent three days in the hospital. As far as Joe was concerned, the total cost of those three days was $12.87.

Joe and his wife aren't concerned about the fact that his employer's multimillion-dollar health insurance bill rose by 22% last year. Joe is even less concerned about the increasing fees charged by the physicians in his town.

What would it take to change Joe's attitude about health care costs?

Dr. Bill Green is an independent family practitioner in Joe's town. Dr. Green works about 60 hours a week and earns $75,000 a year. He considers his fees reasonable and since he rarely gets a complaint, he has no reason to believe otherwise. In fact, he usually never discusses fees with his patients. His secretary does all the billing and filing of health insurance forms.

He participates in the local Blue Shield plan because most of the town doctors do and it assures him of payment for many of his services. In reality, the bulk of his income comes from third-party payments, not his patients.

Recently, a physician friend of his talked him into joining an individual practice association HMO. His friend told him the move was a good hedge against the government taking away some of his independence.

Why should Dr. Green care about health costs?

Business, organized labor, patients and physicians have not acted responsibly on the problem of increasing health care costs. The portion of the gross national product devoted to health care has risen from 5.9% in 1965 to nearly 10% today. The cost of Medicare has increased more than 800% in 10 years. A recent survey of the nation's largest employers by the Health Research Institute shows average health care costs in 1980 were $1,015 per employee. In 1978, the average was $763.

The fact that employers are really concerned about health care costs is a myth. A recent wave of articles has created the impression that employers have united to control health care costs. Even though more than 50 employer health cost-containment coalitions have been formed, little of substance has been accomplished. Much of what has been done is no more than administrative maneuvering to change funding methods or shift costs to employees.

A recent survey of 727 companies conducted by Hay Huggins & Co., a Philadelphia-based consultant, concluded no real progress has been made in containing costs. In 1980, 58% of the companies reported individual coverage premiums of $30 or more per month. In 1981, 76% of the companies reported such an expense. Sixty-eight percent of the companies provide health benefits to their employees at no cost, while 40% cover dependents on a no-cost basis. Employers apparently will not or cannot change the health care system.

Most labor unions do no better. They appear to only want more benefits and less patient involvement in paying costs.

The government's current cost-cutting idea is price competition. Yet consider Joe's and Dr. Green's situation. Dr. Green charges $35 for an office visit regardless of Joe's choice of health insurance or HMO. The plan chosen is irrevelant to Dr. Green. As far as he is concerned, Joe engaged his services and he is responsible for the payment of the bill. In fact, physicians frequently control, if not create, much of their own demand. So how can competition between third-party payers, the insurance companies, relate to the fees charged by physicians?

Some people believe that insurance companies control health care costs. By creating artificial competition among them, costs can be controlled.

In fact, insurance companies have very little control. It would seem they are in an ideal position to put pressure on providers, yet they receive little, if any, direction or support from employers and patients. Patients only ask why the insurance company didn't pay more. And corporate benefit managers are rarely asked why the physician didn't charge less.

Competition needs to be started among providers, not third-party payers, in the health care delivery system. Physicians control approximately 70% of the medical costs. Dr. Green must be encouraged to think twice about his fees and the total cost of health care, not Joe's ability to pay.

Accordingly, we must structure an alternative system that will eliminate cost-related decisions, yet provide incentives and controls to insure cost-efficient use. Such a system will be in direct competition to fee-for-service care.

Real cost containment will occur when the new system involves a large portion of the working population and:

- Dispells the idea that, unlike any other living expense, everyone has the right to free health care. It is not unreasonable to expect a minimum level of individual financial responsibility.
- Prevents employers from paying more than 80% of employee health insurance premiums. Individuals should be aware of and concerned about health care costs, even if they aren't using the system. Premium payment involvement is one way to accomplish this.

This does not mean a windfall savings for employers. The savings could be used to stimulate more personal savings or other employee asset accumulation.

- Develops viable alternatives to fee-for-service medicine. Those alternatives should draw 30% to 40% of the population away from private physicians.

Such alternative systems must provide incentives for efficient use of services and remove existing incentives for abuse. Such reorganization should also be a part of that segment of the system that remains essentially fee-for-service.

- Educates patients, perhaps through employer groups, in the basics of health care economics. They must see a meaningful relationship between their 20% share of costs and the health care delivery system. For example, the notion that high cost means high quality must be dispelled. How many patients would question their physician's exorbitant fee if they had to pay it themselves?
- Makes physicians realize that they are part of the delivery and payment functions in the health care system. It must be made clear that rising health care fees have been possible only because of the existence of third-party payers.

Regardless of other steps taken, no significant progress toward health care cost containment will be made until there is a viable alternative to fee-for-service. Physicians simply have too much control and influence over the system for any scheme to work that does not directly involve them. ■

Richard D. Quinn III is president of Personnel Research Associates in Verona, N.J., and editor of the Employers Health Benefits Newsletter.

Sharing costs may not be right answer

Continued from previous page

number of moderate users to modify their purchasing patttern slighty, as found in a recent Rand Corp. study. But the change in the moderate users' behavior affects cost control less than if the high utilizers changed their behavior.

Unfortunately, concern about costs is inversely proportionate to the seriousness of the illness or accident that must be treated. Most employees aren't inclined to seek more cost-effective providers for routine medical care. They are even less inclined when they or loved ones are seriously ill. Consequently, cost sharing, in almost all forms, has a minimal potential for reducing the small number of high utilizers' costs.

It is important that shifting costs to employees be called precisely that and no more. If it is the company's goal to shift costs to employees in order to achieve short-term savings, management should be aware of the pitfalls outlined. And importantly, management should be fully aware that the step is not designed or expected to reduce costs in the long run.

Accordingly, employers should be very cautious about setting high expectations. Inform management that cost shifting will not cause employees to change their consumption patterns in a way that will reduce costs. Actually, consumption behavior might change, but the potential exists for costs to increase.

Finally, employers must be cautious if they consider this simplistic step as the only solution to medical care cost problems. Not only is cost shifting ineffective in the long-run, but more effective measures will have to be started at a time when implementation is more difficult and costs will have continued to increase.

After thoughtful consideration, if an employer still decides to use cost sharing, expecting it to reduce costs by changing consumption patterns, the employer should eliminate the stop-loss feature of the plan. The logic of cost sharing, assuming employees consume differently as a result of cost sharing, breaks down when we use a $1,000 or less out-of-pocket expense cap to protect employees from large expenses. Thus the small number of high users will face higher expenses if they don't spend less on health care.

Also employers considering shifting costs to employees face an important decision on whether they wish to shift costs to individual users of the health care system or to all employees.

For example, costs may be shifted to all employees through increases in payroll deductions for benefits. Costs may be switched to individuals by increasing deductibles to $500 or $1,000, removing combined family or single accident deductible maximums, indexing deductibles to increases in the medical component of the Consumer Price Index or using percent-of-pay deductibles.

In addition, an employer could use an ascending coinsurance scale. For instance, on charges up to $1,000, the plan might continue paying 80%. But for charges between $1,000 to $5,000, the employee's portion would increase to 30%, between $5,000 to $10,000 the coinsurance would increase to 40% and so on.

By contrast, there are far more effective methods employers may use to control and reduce costs. In addition to short-term steps, incentives can be provided for outpatient care, wellness programs, good health bonuses and eliminating health-harming habits.

The reward approach is viewed as a much more positive step by employees. So actions designed to reward "correct" behavior will be far more effective than trying to punish "wrong" behavior.

Spotlight Report

Companies that audit medical or dental charges

Here is a listing of some of the firms that audit medical, hospital or dental charges:

• **American Dental Examiners Inc.,** 37 W. 57th St., New York, N.Y. 10019; 212-755-9700.

Founded in 1976, the company has 35 major insurance companies and a few self-insured companies as clients. It employs 80 dentists and 44 non-medical staffers.

The auditor reviews more expensive dental claims including crowns, bridges, periodontal surgery, oral surgery and orthodontic care. Compensation is on a per-claim basis. Other offices are located in Chicago, Monterey, Calif., and Houston, and one will open soon in Atlanta.

The company's president is Dr. Robert Leaf.

• **American Service Bureau,** 211 E. Chicago Ave., Chicago, Ill. 60611; 312-440-5100.

ASB handles all types of claims investigations and hospital bill auditing for about 450 insurance companies. The firm has 54 offices nationwide.

Principal officers include Robert F. Richardson, president; Glenn D. Smith, vp of operations; and H.S. Rhoads, vp of marketing.

• **Canyon National Cos.,** Box 1808, Ontario, Calif. 91762; 714-946-7617.

The firm provides a variety of claims auditing services and operates in California, Arizona and Nevada. Canyon generally charges an hourly fee for service.

The president and owner is Jeffery Littes.

• **Equifax Inc.,** Box 4081, Atlanta, Ga. 30302. 404-885-8000.

Equifax provides hospital auditing services on behalf of various insurance companies and self-insured corporations. The company has 250 employees in offices in all 50 states and several foreign countries. Clients are charged an hourly fee.

The president of Equifax Services, the hospital auditing division of Equifax Inc., is Dene Merringer.

• **Medata Inc.,** 801 North Parkcenter Drive, Santa Ana, Calif. 92705; 714-953-1770.

Medata reviews medical bills for 60 insurance companies and some self-insured employers. It has 190 employees and also reviews medical bills for workers compensation claims and no-fault automobile claims in New York. Bill audits are charged on the basis of how many procedures are reviewed while hospital auditing is compensated at an hourly rate.

The firm operates in California, New York, Florida, Massachusetts, Hawaii and Arizona.

The president is Dr. Constantine Callas.

• **National Dental Consultants,** Box 14, Islip, N.Y. 11751; 516-581-2350.

The firm was founded in 1976 and has more than 75 clients, mostly insurance companies. National Dental performs claim and record reviews, physical examinations and appears at arbitrational litigation.

It has offices in Boston-Lexington, Mass., Fairfax, Va.,-Washington, D.C., Atlanta, Puerto Rico and San Francisco. It will be opening a office in Chicago this year.

• **PCC/Drug Data Systems, Inc.,** 828 Hollywood Way, North Burbank, Calif. 91595; 213-843-8551.

Founded in 1969, the company has more than 1,100 clients including insurance companies and corporations that self-insure workers compensation and employee benefit programs.

It monitors cost of drugs, IVs and supplies with a full-time staff of 68 people. All accounts are serviced from the California office. Its president is Dr. Alvin Saidiner.

• **Republic Service Bureau Inc.,** 2603 W. 22nd St., Oak Brook, Ill. 60521; 312-789-2999.

Formed in 1963, the nationwide company serves insurance companies, third-party administrators and self-insurers. Charges are based on the amount of the hospital bill audited. Its president is Richard Mandel. ■

Dental expenses under scrutiny

Following the growth of medical claims auditors comes a new breed of health care fee-watchers: the dental claims auditing company.

Among this new group of auditors is National Dental Consultants of Islip, N.Y., which audits dental claims under insured group benefit packages, according to Dr. Charles Silberstein, its national director.

The firm makes sure that there are legitimate reasons for the dental work being provided and that treatment for an employee falls within the employer's insurance contract.

For every dollar a client spends with National Dental, it saves $10 or $11 or an average of 30% of billed fees, the firm says.

Other firms offer similar services.

American Dental Examiners Inc. of New York City, for example, reviews employee claims to make sure that they conform to the employer's insurance contract and helps insurers design equitable master insurance contracts, said its president, Dr. Robert Leaf.

American Dental reviews 8% to 10% of the claims that each of its clients receive, said Dr. Leaf. ■

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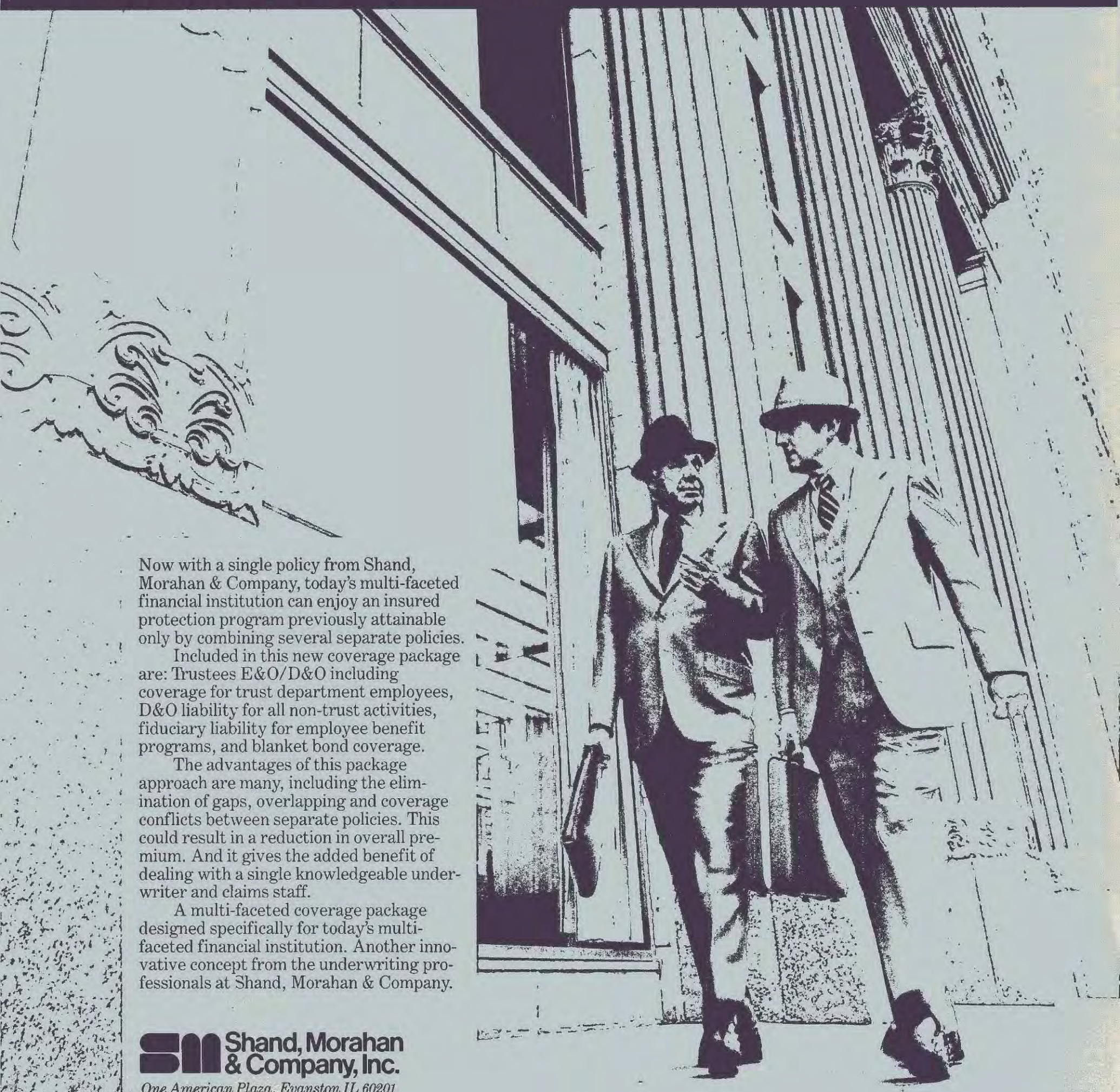

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Preferred provider plans offer firms up to a 10% discount

By JAMES C. LAWSON

NEW YORK—They're hard to negotiate, but special discounts from preferred health care providers can cut medical costs by as much as 5% to 10%, consultants and employee benefit executives say.

While few employers or health care providers like to discuss privately negotiated discounts, preferred provider plans—which offer companies cost savings for utilizing local medical facilities—are nothing new.

"The concept of the preferred provider is an old idea," explains Bernard Backer, senior vp and director of health services with New York-based consultant Martin E. Segal Co. "Blue Shield started under these arrangements."

But there has to be an incentive for hospitals to provide low-cost health care, he says. "Someone has to look at the community and determine whether there's anyone who wants to provide low-cost health care."

The incentive, many consultants and benefit managers say, is speed. Preferred providers want to be paid faster.

They also are seeking to improve their cash flow, maintain steady use of hospital beds and services and help local physicians build up their practices.

However, the key attraction for hospitals remains prompt payment because "hospitals have a substantial amount of losses due to bad debts," notes Richard Ostuw, a benefit consultant with Towers, Perrin, Forster & Crosby in Cleveland.

Large employers in rural areas, employers with operations concentrated in one area or firms in areas where there are few health care providers have a better chance of negotiating such arrangements with local doctors, clinics and hospitals, consultants say.

And self-insurers that can offer prompt payment also have a better chance of receiving a discount.

For example, Chautauqua County, N.Y., a rural county that employs 1,200 people, switched from a Blue Cross plan to self-insurance for its health insurance program 2½ years ago, hoping to cut costs.

Seven months ago, it secured discounts ranging from 3% to 7% from three local hospitals.

The combined program of self-funding and local discounts has saved the county $500,000 since the program began, personnel technician Conrad Howard explains.

"We managed to get the discounts by promising quick payment of claims. We agreed to pay the hospitals within 10 days of receiving the bills," Mr. Howard says.

Chautauqua County's claims are paid by a third-party administrator, A.W. Lawrence & Co. of Albany, N.Y.

"Using the third-party administrator was an advantage in getting the discount because that enabled us to process claims faster," he explains.

The county, Mr. Howard notes, had additional clout because it pays hospital bills totaling $400,000 to $500,000 a year.

Employers that are changing their benefit programs also have a negotiating edge, he adds.

"Hospitals are much more willing to make arrangements if you're switching from a 'Blues'-type plan," Mr. Howard says.

"It would be very easy to get a discount arrangement," he says, because if the Blue Cross plan was receiving a 15% discount from the hospital, it "would be willing to give you about 7% or 8% (under a self-insured plan)."

With hospital discounts in hand, the county may attempt to negotiate a similar arrangement with 25 local pharmacies in the area. The county currently offers its employees a prepaid prescription plan with a $2 per-purchase deductible.

Other employers are trying the same approach. A large Cleveland bank, seeking to cut its hospitalization costs, has managed to secure a 10% discount from several area hospitals, according to one benefit consultant. ■

What you need

If you want to try to negotiate a discount from local health care providers, Conrad Howard, personnel technician for Chautauqua County, N.Y., says you should:

- Have statistics on past claims volume available.
- Know what you have paid the hospital in the past year.
- Know how quickly the provider has been paid in the past.
- Determine whether you can improve that payment schedule.

Trucking trade group decides to challenge multiemployer law

By JERRY GEISEL

JACKSON, Miss.—Broadening the assault on the Multiemployer Amendments Act, the nation's major trucking trade group has filed suit in U.S. District Court to have the law declared unconstitutional.

The suit by the 18,000-member American Trucking Assns. marks yet another escalation in the battle to overturn the 1980 federal law that gives the country's 2,000 multiemployer pension plans power to collect huge payments from employers that withdraw.

Although individual employers, particularly trucking firms, have filed more than 60 suits attacking the law, the ATA's suit marks the first time a major, national trade association has thrown its resources behind a suit challenging the Multiemployer Pension Plan Amendments Act of 1980.

"We are looking to win," said Harold Brodeur, director of the ATA's industrial relations department in Washington. "It is a straight-and-narrow shot aimed at overturning the law. Withdrawal liability is damaging a great diversity of carriers," he said.

The suit names as defendants the Pension Benefit Guaranty Corp., the federal agency that administers the law, and the Central States, Southeast & Southwest Areas Teamsters' pension fund, the multiemployer plan that has slapped enormous withdrawal liability bills on some ATA members.

The suit comes at a time of mounting pressure for a legislative remedy to problems the law has caused some employers.

For example, more than 150 different employers, trade associations and attorneys have asked to testify when the Senate Labor subcommittee holds hearings during the next two weeks on a bill, S. 1748, that would allow employers to withdraw from the plans without having to pay a share of the promised benefits (*BI*, Nov. 2, 1981).

Employers are closely following the pending litigation and legislation because the stakes are enormous: Who shall pay for the billions of dollars of unfunded pension benefits promised to the 8 million workers and retirees enrolled in multiemployer plans?

Congress thought it answered that question when it passed the 1980 law without significant dissent. It says an employer that leaves a multiemployer plan must pay a share of the plan's unfunded vested benefits.

That was a dramatic change from the original requirement in the Employee Retirement Income Security Act of 1974 that said a withdrawing employer could escape paying for the plan's unfunded vested benefits if the entire plan did not collapse within five years of the employer's withdrawal.

Because employers' contributions often failed to match promised benefits, some of the plans are badly underfunded. This means employers that now want to withdraw face a huge withdrawal liability bill.

Mr. Brodeur says the fear of incurring enormous new liabilities is causing employers to shun the plans, further weakening them.

But the PBGC, which says it will "vigorously defend" the suit, disputes this. Baruch Fellner, the federal pension agency's associate general counsel, notes that under the Multiemployer Amendments Act, a new employer has to be a member of the plan for six years before being liable for a share of the vested benefits.

In its suit, the ATA says the withdrawal liability provisions are causing "severe, irreparable injury" to employers throughout the nation.

The group, which was joined in the suit by several individual companies, argues the multiemployer law is unconstitutional because it allows property to be taken away without a trial, a violation of the Fifth and Seventh Amendments.

The suit also notes that the multiemployer law creates new liabilities that employers never bargained for when they joined a multiemployer plan. Employers thought their liability was limited to what they were asked to contribute at the bargaining table.

But some experts argue that the prior system of limiting employers' pension liabilities is what caused today's funding problems. ■

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MARCH 15-16. Fourth Annual Hazardous Waste Management conference in Washington, sponsored by The Energy Bureau; $650. Carol A. Hertzoff, Planning Manager, The Energy Bureau Inc., 41 E. 42nd St., New York, N.Y. 10017; 212-687-3177.

MARCH 15-17. Corporate Benefits Management conference in Hollywood, Fla., sponsored by the International Foundation of Employee Benefit Plans; members, $470; non-members, $545. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 15-19. Fundamentals of Money Management seminar in Philadelphia, sponsored by the International Foundation of Employee Benefit Plans; members, $650; non-members, $775. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 15-19. Total Loss Control Management seminar in Houston, sponsored by the International Safety Academy; $570; for three or more participants from the same company, $525. ISA, 10575 Katy Freeway, Box 19600, Houston, Texas 77024; 713-932-9400.

MARCH 16. Fundamentals: Risk Financing and Captives seminar in Bermuda, held in conjunction with the Sixth International Captive Insurance Company conference; $200. Eileen B. Callahan, Risk Planning Group Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

MARCH 16-17. Fire Safety in Buildings conference in Orlando, Fla., sponsored by the Society of Fire Protection Engineers and the Engineering News Record; $477; two or more participants from the same company, $420. Also **April 21-22** in New York. D. Peter Lund, Executive Director, Society of Fire Protection Engineers, 60 Batterymarch St., Boston, Mass. 02110; 617-482-0686.

MARCH 16-18. Reasoning Reinsurance seminar in Dallas, sponsored by the Risk Management Institute, University of Dallas; $445. Professor Bruce Evans or Julie Allan, Risk Management Institute, University of Dallas, International Center, University of Dallas Station, Irving, Texas 75061; 214-579-5360/5330/5299.

MARCH 17. Managing Risk More Effectively conference in Boston, sponsored by the Massachusetts Chapter of the Risk & Insurance Management Society; $50. Richard Rubin, Dennison Manufacturing Co., 300 Howard St., Farmingham, Mass. 01701; 617-879-0511.

MARCH 17-19. Sixth International Captive Insurance Company conference in Bermuda, sponsored by the Risk Planning Group Inc.; $650; $595 for additional participants from the same company. Eileen B. Callahan, Risk Planning Group Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

MARCH 17-19. Self-Insurance, Risk Retention and Paid Loss Retro Plans seminar in New York, sponsored by the American Management Assns.; members, $590; non-members, $680. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 212-246-0800.

MARCH 17-20. Institute for New Trustees, Advanced Trustees and Administrators program in New Orleans, sponsored by the International Foundation of Employee Benefit Plans; members, $390; non-members, $465. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 18-19. Fourth Biannual Marine seminar in San Francisco, sponsored by the Board of Marine Underwriters of San Francisco; $85. Board of Marine Underwriters of San Francisco Inc., 233 Sansome St., Suite 500, San Francisco, Calif. 94104; 415-981-0350.

MARCH 22. Economic Recovery Tax Act of 1981 seminar in Chicago, sponsored by the International Foundation of Employee Benefit Plans; members, $130; non-members, $155. Also **March 23** in Tarrytown, N.Y., and **March 24** in San Francisco. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 22-23. Health Care Cost Containment workshop in Denver, sponsored by the Health Research Institute; $395. Also **April 13-14** in New York. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

MARCH 22-23. Safeguards Against White-Collar Crime conference, sponsored by the American Society for Industrial Security; members, $240; non-members, $325. ASIS, 2000 K St. N.W., Suite 651, Washington, D.C. 20006; 202-331-7887.

MARCH 22-24. Techniques of Risk Management course in Calgary, Alberta, sponsored by the Risk & Insurance Management Society; RIMS members, $345; $195 for additional participants from the same company; non-members, $445. Rebecca Zimm, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292. ■

Consolidated Foods names Coffey insurance manager

comings & goings: buyers

Consolidated Foods Corp. in Chicago has appointed **Vincent F. Coffey** corporate insurance manager. Mr. Coffey will handle all property/casualty insurance operations and will report to William Irle, director of risk management. Mr. Coffey was previously vp of international insurance business at Reed Stenhouse Cos. Inc. and property manager of AIU, a division of American International Group. Mr. Coffey, 34, received a bachelor of business administration degree from The College of Insurance in New York. He replaces **Frank Recchia,** who is now director of risk management at Budget Rent-A-Car in Chicago.

Mr. Recchia now performs all insurance and safety functions for Budget. Besides his post with Consolidated Foods, he was also claims manager at Home Insurance Co. He received a bachelor's in mathematics from the University of Northern Illinois in DeKalb. He replaces **Myron Kuklock** and reports to Michael Armstrong, executive vp of finance.

* * *

Bruce Woodcock has been named manager of risk control at Creole International Co. in Houston. He will oversee all corporate risk management functions in connection with Creole's contracts with the oil and gas industry, as well as risk-control procedures within the firm. He previously served as corporate risk and benefit manager for Intermedics Inc. in Freeport, Texas, and in the insurance department of Brown & Root in Houston. Mr. Woodcock, 37, received a bachelor's degree in economics from the University of Texas and is a deputy member of the Risk & Insurance Management Society. He replaces **Jerry Hill,** now with Dolphin Titan International Inc. in Houston. Mr. Woodcock reports to Gary Dugger, corporate vp of administration.

* * *

Cameron J. Bruce Jr., 34, is the new corporate insurance manager at Lehman Brothers Kuhn Loeb Inc. in New York. He replaces **Bernard Perin,** who retired. Mr. Bruce is responsible for property/casualty insurance and other risk management functions. Prior to joining the firm, Mr. Bruce was risk and insurance manager for the New York Stock Exchange and an insurance analyst with Chase Manhattan National Bank. He received a bachelor of science degree in business from Providence College. Mr. Bruce reports to Patrick Borruso, the company controller.

* * *

Gilbert R. Crouse has been named corporate risk manager and assistant controller for The Penn Traffic Co. in Johnstown, Pa. He is responsible for both risk management and employee benefits. Prior to joining the firm, he worked at The Travelers Insurance Cos.' commercial lines department in Pittsburgh. Mr. Crouse, 27, holds a bachelor of science degree in public administration from Juniata College in Huntingdon, Pa., and a master of business administration degree from James Madison University in Harrisburg, Va. He replaces **James Hoy,** and reports to John F. Stewert, assistant treasurer and corporate controller.

* * *

Columbia Pictures Industries Inc. has promoted **Irene A. Benjamin** to risk and insurance administrator. She will report to Sheila P. Roberts, risk management and insurance director. Before joining the company, Ms. Benjamin was an insurance administrator with Merrill Lynch Hubbard and an insurance analyst with St. Regis Paper Co. In her new position she will assist in administering the firm's risk management and insurance programs. Ms. Benjamin replaces **Carol D. Meyer.**

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

International representatives to attend Philadelphia congress

PHILADELPHIA—Forty-four percent of the participants will come from abroad, representing 59 countries.

But the conference, to be held April 25-28 in Philadelphia, is not a United Nations gathering. It's the World Insurance Congress, part of the city's 300th anniversary celebration.

The congress, expected to draw 1,500 participants, will attract senior officers from the insurance and banking industries, corporate financial officers, risk managers, government officials and college and university professors from the United States and the rest of the world.

Three-quarters of the delegates hold the rank of vp or higher.

The sessions at the conference will be as varied as the participants. Topics will range from the effect of changing insurance-buying patterns on insurers' revenues to the future role of government in the insurance industry.

Five plenary sessions will be held April 26-28. The first of these, "The Future—A Radically Changing World," will open the congress and features Denis Healey, former British chancellor of the exchequer and a member of Parliament, and Alvin Toffler, author of "Future Shock," as speakers.

At another session, Fawzi Musaad Al-Saleh, chairman of the Arab Insurance Group, based in Manama, Bahrain, and J.O. Irukwu, managing director of the Nigeria Reinsurance Corp. in Lagos, will speak on "Markets in Transition—Changing Demand for Risk Transfer and Related Services."

Former French Prime Minister Raymond Barre will be one of the speakers at another plenary session, "Meeting Demand—Risk Transfer Mechanisms and Changed Realities."

The session also will feature Edward H. Budd, president and chief executive officer of The Travelers Corp. of Hartford, Conn., and Michel M. Gaudet, president of Comite Europeen des Assurances of Paris.

The plenary sessions are open to all congress registrants.

In addition, 23 concurrent sessions will be held April 26-28.

The speakers for the first of the sessions, "Changing Directions in Retirement Income Programs," will be Dr. Dan M. McGill, chairman of the insurance department at The Wharton School at the University of Pennsylvania in Philadelphia; Kiyoshi Murakami, director of Nippon Dantai Life Insurance Co. Ltd. of Tokyo; and Quentin I. Smith Jr., chairman and chief executive officer of Towers, Perrin, Forster & Crosby in Philadelphia.

Another concurrent session will discuss "Insurance Frontiers—Massive Risks." The speakers will include Edwin L. Knetzger Jr., chairman of Johnson & Higgins of Pennsylvania; Derek J. Martin, director of Willis Faber Ltd. in London; F.T. Nyammo, chairman and managing director of Kenya Reinsurance Corp. in Nairobi; Burt C. Proom, president of American Nuclear Insurers in Farmington, Conn.; and Ricardo L. Toledo, Officina para Estudios, De Riesgos Catastroficos in Mexico City.

Other concurrent sessions include:

- "Insurance Frontiers—Risks Without Precedent," featuring speakers A. Hunter Long, a vp at Frank B. Hall & Co. Inc. in New York, and Robin A.G. Jackson, director of Merrett Syndicates Ltd. in London.
- "Competitive Advantage—Disparate Responsibilities for Worker Safety," featuring John A. Schoneman, chairman and chief executive officer of Wausau Insurance Cos. in Wausau, Wis.
- "Competitive Advantage—Disparate Responsibilities for Product Safety," featuring Thomas W. Marriott, legislation manager at Norwich Union Insurance Group in Norwich, England.
- "Social and Political Unrest—Catalyst to a World Insurance Pool?" featuring Julian G.Y. Radcliffe, president of Investment Insurance International in London; Jean Pierre Sapy-Mazella, vp of Business International Corp. in New York; and Dr. Frank A. Southard Jr., president of Per Jacobsson Foundation and director of The Atlantic Council in Washington, D.C.
- "Risk Retention—Increased Responsibility Brings Increased Risk," featuring Dr. Robert L. Carter, professor of insurance studies at the University of Nottingham in Nottingham, England, and Eckart Russell, risk and insurance manager at Alcan Aluminum Ltd. in Montreal.
- "Reducing Demand for Risk Capital—A By-product of Risk Management," featuring H. Felix Kloman, president of Risk Planning Group Inc. of Darien, Conn., and C. James Spivey, executive director of the Insurance & Risk Management Committee of Charlotte-Mecklenburg, N.C., and president of the Risk & Insurance Management Society.

Admittance to these sessions will be on a first-come, first-served basis and attendance may be limited.

A session may be canceled if there is an insufficient number of participants.

Also, technological exhibits will be presented during the congress.

Not all the events at the gathering will take place in a meeting room. On the opening day, participants will be invited to a dinner and evening of entertainment aboard the ocean liner Queen Elizabeth 2.

Participants are also invited to attend a private performance of "La Boheme," starring Luciano Pavarotti.

The registration fee for the four-day World Insurance Congress is $1,000. Full-time employees of municipal, state and national governments and governmental agencies, legislators and full-time teachers at accredited colleges and universities are eligible for a courtesy registration fee of $250.

Complete details of affiliation must be supplied with the courtesy fee application.

For full details and a registration application, contact Philadelphia World Insurance Congress, Box 1982, Philadelphia, Pa. 19105; 215-563-5815; telex 831 519. ■

Indiana firms that don't buy comp cover face new fines

around the states

INDIANAPOLIS—Employers that have neglected to buy workers compensation insurance now face expensive penalties under a new state law.

Gov. Robert D. Orr signed a bill Feb. 24 that will give the Indiana Industrial Board new tools with which to deal with the problem of uninsured employers, said John N. Shanks II, the board's chairman.

The new law increases the maximum fine for violators to $10,000 from $500. It also allows the board to close businesses that operate without the coverage.

It also allows a court to require that an uninsured employer post a bond to guarantee payment of medical expenses and compensation due any injured worker.

In addition, an employee working for an uninsured employer is now eligible for statutory medical expenses and double compensation, with the attorney's fees of the employee paid by the employer.

The Industrial Board said last year it knew that a substantial number of small employers were skirting the law (*BI*, Nov. 30, 1981).

Like all states, Indiana requires employers doing business in the state to either maintain insurance to meet workers compensation obligations or have an approved self-insurance program.

Stadium not liable

LANSING, Mich.—A state appeals court has reversed a Wayne County Circuit Court jury's award of $258,000 to an Ann Arbor woman who was struck by a baseball during a Detroit Tigers baseball game in 1975.

The court ruled that Kathy Lynn Falkner had not proven that the stadium owner was the proximate cause of the injury, according to Robert A. Tyler, attorney for defendant Fetzer Inc., which owned Tiger Stadium in 1975.

Mrs. Falkner was struck in the eye while returning to her seat during the game. She, her husband, and their parents originally had seats near a protective screen but moved for a better view, he said.

Mrs. Falkner, who lost some vision in her eye, subsequently sued, alleging the defendant's failure to warn and to provide screened seating, among other charges.

The trial court jury had granted an award of $273,000 but subtracted 5% for Mrs. Falkner's slight negligence, possibly because she was not looking at the game when she was struck, Mr. Tyler said.

Pregnancy benefits

RICHMOND, Va.—Newport News Shipbuilding has asked the U.S. 4th Circuit Court of Appeals to reconsider its January ruling that said the company violated federal law by failing to provide equitable pregnancy benefits to wives of male employees (*BI*, Feb. 1).

In a decision with national implications, the appellate court upheld an Equal Employment Opportunity Commission guideline on the 1978 Pregnancy Discrimination Act. That guideline says companies must provide the same benefits to pregnant spouses of male employees as they offer female employees' husbands.

Newport News Shipbuilding resisted the guideline. It argues the law only requires companies to offer equal pregnancy benefits to employees.

Product liability

SAN FRANCISCO—Product liability awards are down in California, but the plaintiffs are winning more often.

The average award handed down by California superior court juries in 1981 was $351,515, an 11.9% decline from the $398,823 average award in 1980, says the Insurance Information Institute.

Plaintiffs, however, won 41% of the 136 cases in the 1981 survey, compared with 38% of 138 cases in the 1980 survey.

Jury verdicts, though, often are appealed and the final judgments can be substantially lower. ■

Labor Department looking for OSHA advisers

By JERRY GEISEL

WASHINGTON—Do you have a beef against the Occupational Safety and Health Administration? Do you have ideas to improve the safety and health agency?

The Labor Department is giving you a chance to put your ideas into action.

It has four openings on the National Advisory Committee on Occupational Safety and Health, a 12-member panel that advises the secretaries of labor and health and human services.

The committee, which was mandated as part of the Occupational Safety and Health Administration Act of 1970, represents management, labor, the public and the safety and health professions. There are now two-year terms available in each category.

Nomination letters should specify the category for which the candidate is qualified and should come from an organization representing that category.

Nominations should include the candidate's resume, qualifications, current address and phone number and a statement that the nominee is aware of the nomination and is willing to serve.

Nominations should be sent to Clarence Page, Division of Consumer Affairs, OSHA, Room N-3635, Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. The deadline is May 7.

washington

Social Security

The Social Security Administration has a new top technical adviser on policy issues.

Paul Simmons, a former aide to Illinois Gov. James Thompson, has been appointed deputy commissioner for programs and policy, the second most powerful position in the agency.

As an adviser to Gov. Thompson, Mr. Simmons, 40, led a drive to prune waste from the Illinois budget. Mr. Simmons later directed the state's Washington office.

He replaces Robert Myers, who recently resigned from the Social Security Administration after policy differences with the Office of Management and Budget over proposed benefit cutbacks. Mr. Myers, who helped design the program in 1934, now is the executive director of a bipartisan commission that is to find ways to shore up Social Security (*BI*, Feb. 22).

In his first public appearance in his new position, Mr. Simmons told the House Budget Committee that the administration favors retaining annual cost-of-living adjustments for Social Security benefits.

However, he said the administration would consider changes if they are endorsed by the bipartisan commission.

ERISA advisers

Four new pension experts have been sworn in as members of the Labor Department's Advisory Council on Employee Welfare and Pension Benefit Plans.

The new members are: Roy Brewer, a Tarzana, Calif., labor consultant; John L. Casey, a partner with the Scudder, Stevens & Clark in New York; Barbara Schlicher, vp at Midlantic National Bank in Edison, N.J.; and Myron Mintz, a partner at Dickstein, Shapiro & Morin in Washington.

The 15-member council advises the secretary of labor on how administration of the Employee Retirement Income Security Act can be improved.

Employer records

The Occupational Safety and Health Administration has extended for one year a partial stay of its standard providing employee access to employer's toxic exposure and medical records involving trade secrets in the flavor and extract manufacturing and fragrance materials industries.

Generally, the partial stay allows firms to delete trade secret information from records available to employees or designated representatives. However, it does not apply to requirements to preserve records nor to OSHA's right of access.

Notice of the extension was published Feb. 26 in the Federal Register.

Suit settled

Lee Dyeing Co. of Gloversville, N.Y., has agreed to settle a Labor Department suit by buying back a promissory note and mortgage from one of its employee benefit plans for $700,000.

The department had charged in a suit filed in U.S. District Court in Washington that the purchase of the note and mortgage by Lee's Employees Savings, Profit Sharing & Retirement Fund violated the Employee Retirement Income Security Act.

Under ERISA, employee benefit plans are generally barred from doing business with individuals or firms affiliated with the plan.

As part of the settlement, Lee rescinded the transaction and agreed to refrain from future ERISA violations, the Labor Department pointed out.

The court also ordered the appointment of an independent investment manager for the plan.

Senate hearings

Two Senate subcommittees soon will hold hearings on product liability and pension issues.

The Senate Consumer subcommittee will hold hearings March 9 and 12 on draft legislation proposed by Sen. Robert Kasten, R-Wis., that would, among other things, reduce many manufacturers' exposures to product liability lawsuits involving older products (*BI*, March 1). The hearings will begin at 9:30 a.m. in Room 235 of the Russell Senate Office Building.

Meanwhile, the Senate Labor subcommittee will hold hearings March 11 and 17 on problems caused by the Multiemployer Pension Plan Amendments Act of 1980. The law, which was designed to shore up multiemployer pension plans, has made participating employers responsible for enormous pension liabilities.

The subcommittee also will consider legislation, S. 1748, proposed by Sen. Orrin Hatch, R-Utah, that would allow employers to leave the plans without having to pay a share of the promised benefits.

The multiemployer hearings begin at 9:30 a.m. in Room 4232 of the Dirksen Senate Office Building. ■

Seaman named group vp at Transamerica Corp.

comings & goings: industry

Edwin Seaman, chief executive officer of Transamerica Insurance Co., has been named to head Transamerica Corp.'s life and property/casualty insurance operations.

As a group vp, Mr. Seaman will oversee Transamerica Occidental Life Insurance Co., as well as Transamerica Insurance Co, the corporation's property/casualty insurer.

Mr. Seaman has been with Transamerica since 1962.

Other insurer changes:

B.K. Vickrey promoted to president and chief executive officer of Bankers & Shippers Insurance Co. of New York, a subsidiary of RHR Inc. Mr. Vickrey was formerly executive vp. RHR Inc. is a holding company owned by Republic Steel Corp. and Hogg Robinson Group Ltd. Bankers & Shippers is headquartered in Burlington, N.C.

Jim L. Ridling named vp and sales executive for the commercial group division of Fireman's Fund Insurance Cos. Mr. Ridling was previously manager of the Little Rock, Ark., branch office. **Gary M. Malkmus** appointed resident vp and manager of the Little Rock branch office. Mr. Malkmus had been an assistant vp in San Francisco.

Robert V. McGuigan appointed vp of the Cincinnati division of Great American Insurance Cos. He will be responsible for underwriting and marketing operations in Ohio, Kentucky and Tennessee. Mr. McGuigan has been with Great American since 1954.

Frank T. Barley named vp of Hartford Specialty Co., a subsidiary of The Hartford Insurance Group. He is head of the errors and omissions line and also directs insurance programs for unique industry groups. Mr. Barley was most recently a vp of Union Indemnity Insurance Co. of New York.

Excess/surplus

Two people joined Puritan Excess & Surplus Lines Insurance Co. **Peter K. Colket** joined Puritan as vp of underwriting. He will also coordinate and work with specialized reinsurance functions. Mr. Colket most recently worked at Harbor Insurance Co. as assistant vp and regional underwriting manager. **Barbara A. Pascoe** joined Puritan as senior underwriter. Ms. Pascoe was previously with CMI in New York.

E.R. Kinnebrew III named senior vp at Crump Aviation Underwriters in Memphis, Tenn., a subsidiary of E.H. Crump Cos. Inc. Mr. Kinnebrew has been with Crump for 20 years.

At the same firm, **E.M. Saxon** promoted to vp. Mr. Saxon has been with Crump Aviation for the past 12 years.

H. James Cantwell named senior vp of L.W. Biegler Inc., the Chicago-based managing general agency and a subsidiary of Crum & Forster. Mr. Cantwell is responsible for claims and was most recently a vp.

Other suppliers

Douglas C. Moat named president of Russell Miller Inc. of New York, the new East Coast regional office for the San Francisco-based insurance consulting firm. Before he joined Russell Miller Inc., Mr. Moat was a senior vp at The Home Insurance Co.

Edward A. Foley named national director of defined benefit services and senior vp at Meidinger Inc. in Louisville, Ky. Mr. Foley was the corporate vp and manager of Meidinger's Kansas City office. Also, **Ronald G. Copeland** has joined the Meidinger's Richmond, Va., office as a senior consultant. Mr. Copeland was previously a vp with Frank B. Hall Consulting Co. of Cleveland.

Keith Geyer appointed dental benefits manager for Health Corp. of America in Wayne, Pa. His duties include installation and communication of new dental programs as well as preparation of sales proposals and eligibility audits. Mr. Geyer was recently with ABCO Oil Co. and Liberty Corp., both in Norristown, Pa. ■

RIMS Conference a showcase of new risk management ideas

WASHINGTON—Spring is the time to put away your winter garb and pull out your raincoat.

It's also time to look at matters with a new perspective and a time to try new ideas.

Risk managers and benefit managers will be exposed to lots of new ideas at the annual Risk & Insurance Management Society Conference April 18-23 at the Washington Hilton and the Sheraton Washington in the nation's capital.

Registration for the conference begins Sunday, April 18 at noon. The industry exhibition area will be at the Sheraton Washington, featuring more than 130 exhibitors. At 5 p.m. Sunday, the traditional RIMS Welcome Party will begin at the Washington Hilton.

On Monday, the RIMS annual membership breakfast meeting will begin at 8 a.m. Highlights of 1981 will be presented with a preview of 1982.

The conference will be divided into industry, general, split and minisessions, begining on Monday.

Industry sessions are based on topics affecting individual industries based on a poll of participants at last year's conference. These sessions are led by moderators chosen at the 1981 conference.

Industries sessions this year will cover agricultural products; apparel and textiles; banking; bulk grain handling; cement; construction; consumer beverages; drilling; drugs, chemicals and pharmaceuticals; electronics manufacturing; entertainment; farm cooperatives; food chains; food processing and fast foods; hospitals; hotels; insurance; leisure products; machinery; maritime; mining and metals; National Assn. of Real Estate Investment Trusts; new risk managers; non-profit organizations; oil; ports; public entities; publishing, printing and broadcasting; real estate; rentals and leasing; restaurants; retailing; retailers-employee benefits; school boards; telecommunications; trucking; university risk managers; and utilities.

The industry sessions are usually open to RIMS members only. At this time, only the cement business and school boards industry sessions are open to non-members.

General sessions, which are open to all registrants, are led by a moderator and a panel who will discuss broad topics.

The first general session on April 19 is "The Changing Age Mix of the Work Force," featuring as speakers G.H. Myford, director of employee benefits of the National Railway Labor Conference; Haeworth Robertson, vp of William M. Mercer Inc. and former chief actuary of the Social Security Administration; and Donald R. Fleischer, principal of Towers, Perrin, Forster & Crosby.

The second general session on April 21 is "Developments in Commercial Industrial Insurance Markets," featuring as speakers Jim Billett, president of Trenwick Ltd.; John Cox, chief operating officer of the Insurance Co. of North America; Frans Eliason, president of Northwestern National Insurance; and John Lock, deputy general manager of Mercantile & General.

Split sessions, also led by a moderator and panel, are discussions on diverse subject matters, from general management and employee benefits to captives.

The size of the audience at each session ranges from 200 to 500 employees.

The session topics and their moderators are: "Health Care Cost Containment," Benjamin H. Katcoff, corporate benefits manager of Polaroid Corp.; "Pre-Retirement Planning," Donald R. Morrisey, manager of benefits administration at IBM Corp.; "Tax Reform and Employee Benefits," Dr. Joseph E. Johnson, professor and head of the department of business administration at the University of North Carolina at Greensboro; and "Investment of Time," Gary C. Jordan, assistant vp and risk manager of The Northwestern Bank.

Also, "Catastrophe & Major Claims Management," Richard H. Soper, director of risk and insurance management for Levi Strauss & Co.; "Model the Risk," Charles Armstrong, manager of corporate risk management for Xerox Corp.; "Washington Update," Richard Heydinger, director of risk management of Hallmark Cards Inc.; and "Management—The Indispensible Ingredient," Walter B. Smith, vp of Rollins, Burdick, Hunter of Illinois.

Also, "Ethics in Risk Management," Eckart Russell, risk manager of Alcan Aluminium Ltd.; and "The Captive Movement," Duane Allen, assistant treasurer of The Hanna Mining Co.

The moderator for "International Liberalization of Insurance Services" has not been announced.

Miniseminars include panel discussions led by a moderator and workshops. Attendance is limited, and admittance is on a first-come, first-served basis. Eleven of the 86 sessions are restricted to RIMS members only.

Some of the miniseminars open to all conference participants include: "International Employee Benefits," "Self-insurance of Group Benefits Now Available to Small and Middle-sized Companies," "Social Security and Corporate Risk" and "Employee Benefits Analysis for Acquisitions and Divestitures."

Also, "Cost Control/Containment Through Claims Management," "What You Should Expect From Your Broker," "Legal Aspects of Security," "How to Protect Your Overseas Investment" and "The Insurance Department as a Profits Center."

The conference will close on Friday morning, April 23.

To receive a brochure or to register for the 20th Annual Risk Management Conference, contact the Conference Department, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

The registration fees for the full week are $420 for members and $520 for non-members. Fees for a partial week are $350 for members and $425 for non-members. ■

Retailers' comp pool growing

LAKELAND, Fla.—The first major self-insured workers compensation pool for Florida retailers now writes 20 times as much business as it did when it began operations three years ago.

In January 1979, the Florida Retail Federation Self-Insurers Fund started with 20 companies and an annual premium flow of $143,000.

Today, the fund's premium flow from its 1,000 participating members tops the $3 million mark.

"We attribute the rapid growth of the retail self-insurers fund to the premium savings members earn," said C.C. Dockery, president of Summit Consulting Inc., the Lakeland, Fla.,-based management firm that administers the pool.

Under the pooling arrangement, the amount of dividends a member receives is based on the firm's loss experience and the fund's profitability.

Sixty percent of retail fund members who qualified for dividends in 1979 received premium savings of more than 44% in dividends and discounts, he said.

The fund, which self-insures the first $100,000 of losses, has two layers of specific excess insurance. The first, which is supplied by INA Corp., covers any individual loss from $100,000 to $1.1 million. The second layer, supplied by Employers Re, covers losses from $1.1 million to $2.1 million.

The fund also has an annual aggregate stop-loss policy with INA. Under that policy, the fund puts aside 70% of premiums to pay for claims. Once that fund is exhausted, the INA policy pays the next $1 million in claims.

The average premium paid into the fund is about $30,000. The smallest premium is $100, while the largest premium is about $170,000. ■

Malpractice pool wants hospitals to fund deficit

Continued from page 1

Two policy-year 1979 occurrences resulted in jury awards during 1981 of $6.75 million and $2.25 million.

The first involved a woman who lapsed into a coma during routine surgery, and the second involved a couple whose child died days after birth.

On Feb. 25, Leon County Circuit Judge Donald O. Hartwell issued an injunction barring the fund from taking any action to suspend the coverage or the licenses of hospitals that refuse to pay the new assessment. But he also ordered the hospitals to pay about 15% of the fee—or $96 per bed—pending resolution of the dispute.

An appeals court extended the injunction the next day. In the meantime, the hospitals say they are paying the $96-per-bed fee.

The hospitals contend that a little-noticed section of the law allows physicians covered by the pool to avoid paying such whopping assessments while the hospitals, which have been responsible for a relatively smaller portion of the losses to date, bear the brunt.

The disputed section forbids the fund to retroactively assess physicians or professional associations more than 100% of the original plan-year fee while placing no such cap on the assessments that may be levied on hospitals.

As a result, fund officials note, they were forced to charge hospitals twice their original fees when it came time to figure assessments for the 1979 plan year.

Hospitals as a class are being asked to pay $11.5 million in retroactive assessments to cover the projected 1979 losses, after already contributing $6.9 million in fees. That compares with losses so far attributed to hospitals of $8.8 million —a pure loss ratio of 48%.

By comparison, doctors as a group are being asked to pay $2.4 million in assessments after contributing $2.9 million in fees. That compares with doctor-related losses, as computed by the fund, of $14.4 million so far—a pure loss ratio of 273%.

The lawsuit filed by the hospitals charges the 100% cap for doctors and professional associations is an unconstitutional denial of equal protection with no rational basis.

The fund argues the Legislature may have had a reasonable basis for the cap, but does not speculate on what it was. The fund's lawyer also argues that the hospitals were among the health care providers that argued during ratemaking hearings in 1978 against higher per-bed rates that would have made a retroactive assessment unnecessary.

"If you carry it back to the ultimate, they shot their own noses off," argues Mr. Collins, the fund's attorney.

Both Mr. Hill, the hospitals' attorney, and an official in Commissioner's Gunter's office suggest the politically strong medical lobby won the disputed statute language in exchange for its support of the Legislation.

"The American Medical Assn. and the Florida Medical Assn. are the largest professional contributors as a group (to political campaigns in Florida)," noted Alfred K. Chandler, coordinator of medical malpractice issues for Mr. Gunter.

Adds Mr. Hill: "To a certain extent, the physicians in the state used their clout to gain an advantage over the hospitals. That's nothing new. It's been going on for years."

But the attorney also sees other fundamental flaws in the 1975 statute. Frist, he says, it was a mistake to force hospitals but not doctors to participate. Secondly, the statutory limitation of $25 million—later reduced to $15 million—on the amount of cash reserves the fund could accumulate also was shortsighted at a time when ultimate losses could be twice those figures for any one policy year.

"The Legislature was afraid somebody would create a huge fiefdom of money if they didn't put in that cap," he says.

Now the fund is seeking amendments to the 1975 statute to allow doctors to be assessed up to twice their original plan fee. Any such fix, fund lawyers warn, won't solve the past problem of inadequate fees but could rescue the fund from any deficit in future plan years. ■

J-M not liable for punitive damages

Continued from page 2

argued in the Speake case. The plaintiff dropped initial charges against the subsidiary because of complications involved in proving aggravation of a prior condition. The jury absolved another J-M subsidiary of any liability.

Neither Johns-Manville nor the plaintiff's counsel would predict what impact the Speake decision might have on 1,000 other suits by plant workers pending against the company in California and in Waukegan, Ill., and Manville, N.J.

A J-M spokesperson said the company has not settled any of the lawsuits out of court.

Litigation-plagued Johns-Manville is also battling The Home Insurance Co. and more than 20 other excess insurers over coverage for millions of dollars in asbestos losses (*BI*, April 7, 1980). The Travelers Indemnity Co., J-M's product liability insurer from 1947 through 1976, claims it has paid out its limits for those years. J-M also is suing its former broker Marsh & McLennan charging it failed to put together an insurance package that would fully cover asbestos claims (*BI*, Jan. 18).

Testimony at the Speake trial showed that Johns-Manville had a deliberate policy of not telling workers they showed signs of asbestosis until they were disabled or became sick from their condition, said Mr. Kilbourne, the plaintiff's attorney.

The parent corporation acted as a third party in setting up the industrial hygiene and medical programs used by its Pittsburg subsidiary to monitor asbestos dust levels and to perform employee physical examinations.

Weyman Lundquist, a San Francisco attorney representing Johns-Manville, denied that the company had covered up knowledge of asbestos dangers from its workers. He said Johns-Manville's efforts to minimize health risks in its plants were reasonable and responsible by the standards of the times.

"The jury found no conduct warranting punitive damages," said Mr. Lundquist. "Punitive damages were the real issue in the case."

During the trial, defense attorney Lundquist described Mr. Speake as a self-mutilator who refused to give up a 40-year, pack-a-day smoking habit even after he was told to do so by doctors treating him for asbestosis.

Mr. Lundquist said that comparative fault had been argued in the case although it was impossible to say what bearing Mr. Speake's smoking habit had on the jurors' deliberations. "Ninety percent of the people who have asbestosis are also smokers," he said.

Johns-Manville has filed a motion to offset the $100,000 compensatory damage award with workers compensation benefits already paid to the 66-year-old plaintiff, who was forced to retire five years ago because of his lung disease. ■

Cargo ship covered

LONDON—A cargo ship sunk by Irish Republican Army terrorists last month off the coast of Donegal is insured for less than a million pounds under a war risks policy from Steamship Mutual Underwriting Assn. Property & Indemnity Club, sources said.

Neither the owners of the St. Bedan nor the club will be able to collect from the government, however. A law in Northern Ireland allows companies to file claims for terrorist attacks on land, but does not cover the sinking of ships. ■

PBGC failed to guarantee pension: Suit

Continued from page 2

The PBGC says it can't pay the benefits because it does not guarantee improvements made less than a year before a plan folds.

The PBGC's "arbitrary, capricious" interpretation of ERISA's so-called phase-in benefit guarantee limitation has resulted in the denial of vested benefits for thousands of others, according to the Pension Rights Center, a pension activist organization that is assisting Mr. Ramputi and Mr. Rettig.

The suit is a sensitive issue for the PBGC, which charges employers $2.60 annually for each person enrolled in a plan. The premiums collected are supposed to help pay for workers' vested pensions if their plan fails.

Robert Nagle, the PBGC's executive director, declined to comment on the suit. A spokesman said the agency is now studying the issues raised by it.

The heart of the issue centers on whether the PBGC must guarantee recent benefit hikes, even if those hikes were made to enable the plan to comply with ERISA's minimum vesting standards.

When Lidz set up its plan in 1956, an employee could not vest until he reached age 55 and worked for the firm for at least 15 years.

That long vesting requirement ran afoul of ERISA's vesting standards. Under the most popular of the three major vesting standards provided by ERISA, employees must be 100% vested after 10 years of employment.

In August 1977, Lidz amended its pension plan so that all employees, including Mr. Ramputi, and Mr. Rettig's wife, Herta, who both had worked for the firm for at least 10 years as of Jan. 1, 1976, were vested. By then, Mr. Ramputi had worked for Lidz for about 35 years and Mrs. Rettig for about 37 years.

On May 11, 1978, Lidz told the PBGC that it intended to terminate the plan at the end of the month. On April 22, 1980, the PBGC agreed to become trustee of the underfunded plan and guarantee all nonforfeitable benefits.

Following a series of delays and congressional inquires, the PBGC told Mr. Ramputi Feb. 8 that it would not pay his pension. A similar letter is expected to be sent soon to Mr. Rettig.

In a Sept. 12, 1980, letter, PBGC general counsel Henry Rose told then-Sen. Jacob Javits, R-N.Y., who had made inquires about the Rettig case, that under Section 4022(b)(8) of ERISA, guarantees of pension plan amendments that boost benefits are phased in at the rate of 20% a year.

For example, if a plan was amended to boost a participant's benefit by $100 a month, the PBGC would guarantee the first $20 of that hike one year after the amendment went into effect.

However, since the Lidz plan terminated less than one year after it was amended, the PBGC, under its interpretation, would not guarantee Mr. Ramputi's or Mrs. Rettig's benefit, Mr. Rose said.

In the suit, attorneys for Mr. Rettig and Mr. Ramputi say they understand why Congress placed a phase-in on PBGC guarantees of vested benefits.

Without such a limit, employers who knew they were going to terminate their pension plans might raise benefits at the last moment so that PBGC would be forced to guarantee the higher benefits after the plans folded.

However, that phase-in was not intended to apply to improvements required to meet ERISA's vesting standards, the suit says.

"The phase-in limitation was not intended to apply to the changes in entitlement required by ERISA, i.e., it was not intended to apply to pension benefits which became non-forfeitable as a result of pension plan amendments mandated by ERISA. . ." the suit says.

The suit asks the court to order the PBGC to guarantee all benefits that were made non-forfeitable as a result of pension plan amendments mandated by ERISA. ■

Asbestos companies held not liable in Illinois suit

Continued from page 2

Although they earlier were awarded more than $57 million in a lawsuit against Cape Industries Ltd. and two subsidiaries, it is uncertain whether they will be able to collect from the London-based company (*BI*, Feb. 15).

"I think the odds are that the plaintiffs will have no recovery at all," said Frederick Velde, an attorney for North American Asbestos with the Springfield, Ill., firm of Heyl, Royster, Voelker & Allen. "I think there is a 99% chance that's what will happen."

Unarco, Johns-Manville Corp., Johns-Manville Sales and North American Asbestos originally were named defendants in a class action in 1978 brought by Bloomington attorney James Walker on behalf of Ms. Mau and the 53 other plaintiffs.

Mr. Walker subsequently dropped all defendants except Cape from the class action with the expectation that the others would be brought back at a later date.

He then proceeded against Cape, obtaining a default judgment against it about 1½ years ago. Cape failed to appear on the grounds that a circuit court in the United States has no jurisdiction over the London-based firm.

When the case went to trial to determine the amount of damages in late January 1982, a circuit court jury awarded the 54 plaintiffs $57 million from Cape.

Of the $57 million, $850,000 was awarded to Ms. Mau of Bloomington, whose trial against the four defendants removed from the class action was to begin Feb. 16.

Shortly before trial, attorneys for the defendants filed a motion for a summary judgment. They contended that because the plaintiff already had been granted an award against Cape and previously dismissed the other defendants, she was barred from now suing the defendants because she would be seeking double compensation.

Nor could she pursue additional litigation whether or not the award from Cape is ever collected, the attorneys argued. Judge Knecht agreed with the defendants.

Mr. Walker could have waited to decide damages against Cape with the other defendants or proceed against Cape without opposition, Mr. Velde said. He elected to go against Cape alone.

He didn't realize that once the jury gave those awards, he gave up his remedy against the other defendants, Mr. Velde added.

"The real significance is that the same facts and circumstances apply to all his other clients."

Mr. Velde added that Mr. Walker's dilemma is that he now must decide whether to vacate the judgment against Cape and then try to proceed against the others.

But if the Cape judgment is vacated, and the court does not reinstate the suit against the others, he may be giving up the only source left from which to recover.

Moreover, Mr. Velde said that Mr. Walker did vacate the judgment against Cape on Ms. Mau's behalf but the judge refused to reinstate the case against the others.

Mr. Walker could not be reached for comment, but defense attorneys said they expect him to appeal.

Cape has never appeared in court to defend in the workers' asbestos suit, contending it never did business in the United States.

The circuit court jury on Jan. 28 and 29 awarded the plaintiffs $35 million in punitive and $21.8 million in compensatory damages against Cape and its two subsidiaries, Cape Asbestos Fibers Ltd. and Egnep (PTY) Ltd.

All of the plaintiffs were employees or representatives of former employees at a now-defunct Unarco Industries plant. Jury awards ranged from $200,000 to $900,000 each.

The workers suffered from asbestosis, mesothelioma, bronchogenic carcinoma and gastrointestinal cancer they say they contracted working at the Unarco plant, which made plastic pipe insulation and asbestos packing material. Raybestos-Manhattan, also named as a defendant in the suit, has filed a motion for a summary judgment. It is scheduled to be heard March 30.

The next trial against the defendants is set for May. The plaintiff is Earl C. Million who was awarded $250,000 in the Cape trial. ■

Airlines detail coverage

Continued from page 2

cate for Delta, whose broker is Johnson & Higgins in Atlanta, listed "USAIG and other insurance companies" as its insurers.

Among other high limits reported were: Midway Airlines, $300 million; Pan American World Airways, $200 million; Transamerica Airlines $200 million; Alaska Airlines, $200 million; New York Airlines, $200 million; and Texas International Airlines, $200 million.

Other major airlines appear to be reporting only the minimum insurance required and keeping up limits to themselves. For example, the certificate filed for United Airlines on March 1—six days late—contains no coverage limit. Instead, on a form signed by the giant airline's broker, Rollins Burdick Hunter, there is the notation "exceeds minimum limits shown above."

Among the 20 well-known U.S. carriers checked, Trans World Airlines, Braniff Airways, Air Florida Inc. and World Airways joined United in not disclosing the upper limits of their insurance.

Air Florida had up to $500 million in insurance Jan. 13 when one of its Boeing 737 jetliners crashed into the Potomac River, insurance sources said at the time. And World Airways had at least $350 million in coverage when one of its DC-10s overran a runway in Boston on Jan. 23.

Republic Airlines, which disclosed $40 million in insurance, actually has $300 million in liability insurance, industry sources said.

American Airlines, the nation's third major coast-to-coast carrier, is acknowledged on its CAB—filed certificate to have just $120 million in insurance—a figure that industry sources say is far below its actual limits. American's certificate also reports the coverage is on a quota-share basis with 23.5% placed with USAIG, 11.5% with Fireman's Insurance Co. of Newark, N.J., 38.8% with Lloyd's of London, 1.2% with Generali Insurance Co. of Italy and 25% with La Concorde of France.

It was not the CAB's intention to require disclosure of the upper limits of a carrier's coverage, said Joseph A. Brooks, a member of the CAB's office of general counsel who helped author the regulation.

The CAB rule requires an airline's broker or insurer to sign a certificate saying they provide insurance affording at least $300,000 worth of bodily injury, death or property damage coverage per person per occurrence and $20 million per aircraft.

This requires the airline to buy insurance of at least $300,000 per passenger or $300,000 multiplied by 75% of the number of seats installed in the airline's largest aircraft.

Alternatively, the insurer or broker may certify the dollar amount of coverage if the carrier has a combined single-limit policy, as long as the dollar amount exceeds the minimums.

In addition to USAIG and Lloyd's of London, other frequent underwriters of U.S. trunk airlines, according to the certificates, are Fireman's Insurance Co. of Newark, N.J.; the Dallas-based Aviation Office of American Inc., a subsidiary of Crum & Forster; Associated Aviation Underwriters Inc., agents for another New York-based pool; U.S. Fire Insurance Co., written through Aviation Office of America; American Home Assurance Co., an American International Group affiliate; Industrial Indemnity; and several foreign syndicates including La Concorde and La Reunion Aerienne, both of France, and Italy's Generali Insurance Co. and CAMAT.

Brokers and insurers interviewed said they are still evaluating the effect of the new rules and are particulary debating the impact of a subsection that prohibits insurers from denying an airline coverage when a crash involves violations of federal regulations for safe operating procedures.

Such exclusions have customarily been included in policies written for smaller airlines like charter operations, they added.

One major U.S. aviation underwriter said CAB lawyers have tried to clarify the rule on exclusions and other points through letters and conversations with attorneys for Lloyd's and others.

"The problem is the rule doesn't match up with the explanations the CAB is giving," said the underwriter, who asked that his name not be used. "They flat out refuse to change the law, but they gave us interpretations and that's what we have (to work with)."

Among other things, the CAB says it will continue to allow policy exclusions for environmental and noise damages, war risks and liability for injuries to flight crews.

The prohibition on safety-related exclusions could raise rates for smaller carriers.

Rates for commuter or charter airlines could rise as much as 20% because of the elimination of such exclusions, said Jeffrey R. Zito, an aviation broker with Atlanta-based Fred S. James & Co. of Georgia.

For some such carriers "it could be as much as several million dollars," Mr. Zito added. However, he said many underwriters and brokers have not yet decided how to factor the new CAB limits into their formulas or whether exclusions prohibited under the CAB rules for the minimum coverage can be added to coverage layers excess of the minimum.

For the commuters and charter operators, "I think there will be a (market) tightening, and especially for those who are less than firmly solvent, and particularly those who are new and not well-known in the business or have an unenviable safety record or no safety record at all," said Charles A. Tarpley, a senior vp of the Aviation Office of America Inc.

The rule on safety exclusions has serious implications, said Fred G. Schonenberg, a vp of Erg Management Corp. of New York City. The Duncanson & Holt Inc. subsidiary manages the Extended Reinsurance Group, an aviation reinsurance pool.

"But it's almost always the case with federal agencies that they back down to the point where commercial insurers can live with it."

Another U.S.-based underwriter also warned that another provision of the new rule will raise the hackles of insurers.

The underwriter, who asked not to be identified, says he expects insurers and brokers to dislike the CAB regulation that binds the insurers listed on the CAB-filed insurance certificate to the risk until a new certificate is filed. Insurers must be sure that they notify the CAB when a policy is terminated. ■

Bill would stop suits against employers

Continued from page 3

But opponents of the proposed legislation say a worker should be allowed to sue above and beyond workers compensation benefits if there is a blatant disregard for safety on the job.

James Manolidis, whose name was mistakenly typed into the official court record as Mandolidis, was an employee of Elkins Manufacturing in Elkins, W.Va., when a federal safety inspector cited the company for not having a safety guard on the saw Mr. Manolidis operated.

When the inspector left, management allegedly told Mr. Manolidis to operate the saw without the guard. Court records show that the worker accidently cut off part of his hand a few days later.

The success of his lawsuit has had quite a ripple effect.

"There are a whole bundle of lawsuits in West Virginia" based on this decision, says John Hurd, president of the state's Chamber of Commerce, the group that is leading the move to change the law.

"The largest award to date for $4 million is on appeal now, but even half of that amount would put the employer out of business," said Mr. Hurd. Backers of the legislation are taking no chances. They've introduced identical bills in both the House and the Senate.

"The Mandolidis decision is nonsense," says Robert Warden, president of the West Virginia Manufacturers Assn. "Anyone who says differently is not telling the truth."

He criticized the state high court for being too liberal.

The court based its decision in 1978 on a previous case that dates back to 1917 when the state added a provision to its law that allows an employee to sue in court for death or injury that is the result of the employer's deliberate intent to harm a worker, said a Supreme Court justice familiar with the case.

In 1933, the West Virginia Supreme Court ruled an employee has the right to go to court to prove deliberate intent, the source said.

"If an employer violates a safety law and his worker is injured or killed, the jury can infer it was intentional," said the judge.

But Mr. Warden says employees are taking advantage of the ruling and filing frivolous suits.

An employee can slip and fall on a grease spill, collect workers compensation and sue the employer for a willful, wanton, disregard for safety, says Mr. Warden. "That's no intent to injure an employee."

West Virginia's AFL-CIO President Joseph Powell says employees should have the right to sue their employer if there is a disregard for safety. But he said there might be some compromises to modify the bills before the Legislature adjourns March 13. ■

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Commercial Consumers Sub-total	**23,000**
Insurance Agents & Brokers	9,741
Insurance Cos.	4,735
Financial Institutions	303
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,208
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*Source: Business Occupational breakdown of qualified circulation Nov. 2, 1981 issue as submitted to BPA for December 1981 BPA Publisher's Statement

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EPA apparently will dump coverage rule

Continued from page 1

EPA officials will confirm only that the long-awaited suspension is being reviewed one more time, and if they decide to drop the regulations, a formal proposal will be published soon in the Federal Register.

Yet sources in the insurance, chemical, hazardous waste management and environmental consulting industries say the rules are definitely on their way out.

When the EPA moved last fall to postpone the regulation until April 13, it cited two objections raised by the Office of Management and Budget (*BI*, Sept. 14, 1981):

- Shouldn't the task of setting financial responsibility standards be turned over to the states?
- How will such standards protect public health since there is no direct relationship between indemnification against third-party liability and the prevention of pollution accidents?

Jim Tozzi, deputy OMB administrator for information and regulatory affairs, says that agency's objections to a federal standard still apply, and he thinks the EPA will drop the requirement.

He also says he assumes the EPA will take the OMB's position into consideration "if the merits of our argument are sound."

"We work for the president, and I think people would take our views seriously," he points out.

But on the other side is the strong support from several industrial and state regulatory groups for a federal regulation.

The Assn. of State & Territorial Hazardous Waste Officials has come out strongly for a federal requirement, citing the need for at least minimum standards across the country.

States could then set stricter requirements according to their individual needs, notes Norman H. Nosenchuck, president of the association.

"We've made our views known very clearly to the administrator (EPA Administrator Anne M. Gorsuch) and her staff," he says, adding it will have its say again.

The National Solid Waste Management Assn., based in Washington, also has come out strongly in favor of a federal standard.

Composed of some 2,000 member companies that are involved with hazardous wastes, the group agrees there would be too many regulatory gaps if financial responsibility standards were left to the states.

Richard L. Hanneman, director of government affairs for the organization, also wonders about the "availability and affordability" of environmental impairment liability insurance if the federal standard is dropped.

Although the market for the coverage has grown rapidly in anticipation of the regulations, Mr. Hanneman says he is afraid it will shrink if the rules are withdrawn.

Perhaps the industry group with the greatest clout is the Washington-based Chemical Manufacturers Assn., a 200-member organization that includes some of the nation's largest chemical companies.

Officially silent on this issue until recently, the CMA now publicly supports a federal standard.

One CMA official, who asked not to be indentified, said the EPA got "cold feet" on its decision to drop the requirements just about the time the CMA announced its support.

The agency was going to publish the proposal to drop the insurance regulations the same time it published proposals on closure/post-closure costs. Howver, at the last minute, it decided only to issue the latter (*BI*, March 1).

It "may or may not be a coincidence" that the agency made this decision shortly after the CMA came out in favor of the insurance regulations, the official says.

In its support of a federal regulation, the CMA cites concern about public acceptance of hazardous waste disposal sites. The group fears there may be a shortage of available sites in the years ahead and believes a federal standard for financial responsibility would help soothe public concern when new sites are proposed.

"It's not the be-all and end-all," notes the CMA official, "but it would sure help."

The organization also fears that if owners of hazardous waste sites do not have adequate protection against third-party liability claims, the public will look to the generators of hazardous wastes when they file lawsuits.

"And guess who that is? That's us," the CMA spokesman says.

The CMA does qualify its endorsement of a federal standard: It wants self-insurance to be allowed. This option has received some attention from the EPA.

The EPA's delay in making a decision on the requirements puts many companies in an awkward position, says environmental consultant Michael J. Murphy, chief executive officer of Risk Science International, a Washington-based division of brokerage Frank B. Hall & Co. Inc.

"It frustrates them," says Mr. Murphy of the many companies that might be affected by a federal regulation. "They want to know what they have to do to comply with federal regulations."

Mr. Murphy strongly supports a federal requirement and expects a suspension would raise a host of criticism.

"If the agency suspends the regulation, I believe that in the 60-day comment period that will follow, there will be comments overwhelmingly supportive of the federal requirement," he says.

"Therefore, it seems a tremendous waste of time and money to continue reviewing regulations that are meaningful and effective." Based on discussions he has had with EPA officials, Mr. Murphy says the agency conducted a lengthy review of its original proposal, which is one reason for the delay of the suspension order. Mr. Murphy also says the agency's "intent to suspend" is not nearly as strong as it was last fall, since EPA officials have not been able to find substantive reasons not to have a federal regulation.

"And they're only going through the exercises (to suspend) because they said they would," Mr. Murphy says.

Whit Field, special assistant to the EPA administrator for hazardous wastes, will only say that Ms. Gorsuch has decided to give any suspension an additional review.

The agency knows that it must act soon on the regulations, he admits.

Besides ruling on dropping the regulations, the administrator also must decide whether self-insurance will be allowed if the rules are adopted, Mr. Field says. ■

Rule change could affect landfill safety

WASHINGTON—The federal Environmental Protection Agency proposes to alter yet another regulation affecting hazardous waste sites: a ban on the disposal of drums containing liquid toxic wastes.

While lifting the ban would improve worker safety at landfills, one hazardous waste expert notes, the EPA's delay to alter the ban has led to a "dramatic increase in the risk of storage accidents" for many hazardous waste generators.

Since last November, companies have been prevented by the Resource Conservation and Recovery Act from burying liquid toxic wastes in drums, a long-time industry practice.

In a notice published Feb. 27 in the Federal Register, the EPA proposed an amended regulation allowing a waste site operator to dispose of containerized liquid wastes so long as those wastes do not exceed 25% of the site's capacity.

The agency also has suspended the RCRA's total ban on burying liquid wastes for 90 days, until May 26. The EPA will hear public comments on the proposed regulation in the meantime.

However, a ban on the disposal of bulk liquid hazardous wastes in landfills still exists unless the site is capable of detoxifying the waste, notes an EPA official.

But, at least until May 26, personnel at qualified disposal sites will not be required to open drums containing hazardous waste to determine if they contain liquids, says Dr. Reva Rubenstein, director of the Institute of Chemical Waste Management in Washington.

This inspection process exposes landfill workers to potentially dangerous chemicals and toxic substances, she says.

When the RCRA ban first went into effect last November, explains Dr. Rubenstein, the agency promised to quickly issue new interim regulations that would, in effect, have lifted the ban.

However, the EPA did not issue those regulations until some three months after the ban went into effect. Dr. Rubenstein says the delay has caused many smaller waste generators that do not have on-site storage permits to exceed storage capacity, increasing the risk of explosion or seepage.

But, the EPA's recent proposals could solve other problems that are plaguing waste site operators, she says.

Part of the problem, she notes, is that the EPA has never issued a definitive test to determine what is liquid waste and what is solid.

If a drum contained so much as a few inches of surface liquid, Dr. Rubenstein says, companies could run afoul of the RCRA's ban against burying liquid wastes.

Dr. Rubenstein further points out that such a test would be extremely difficult to develop, since a "myriad of wastes" from many industries must be taken into consideration.

Dr. Rubenstein describes the EPA's proposal and its temporary lifting of the ban as the "next best solution" in the absence of such a test.

However, the EPA's decision to alter the RCRA ban on liquid waste disposal has been severely criticized by several groups, including the Hazardous Waste Treatment Council and the Environmental Defense Fund, both based in Washington.

The former, a new group still in its organizational stage, has sued the EPA in U.S. Circuit Court in Washington to block the agency's action, charging that disposal of containerized liquid wastes will pose the threat of "imminent public health and environmental adverse consequences."

The Environmental Defense Fund says it opposes the disposal of containerized liquid wastes since resulting seepage may cause significant environmental damage.

"Man has yet to build a landfill that dosen't leak," claims Kristine Hall, a staff attorney for the fund. "When you put liquids in a landfill, it causes problems. That's why there was a ban in the first place."

"It's a giant step backward from what was a good regulatory approach," she says of the EPA's decision to lift the ban.

Age discrimination complaints rise

WASHINGTON—Although the mandatory retirement age was raised to 70 from 65 in 1978, age discrimination complaints are increasing, a House committee says.

Last year, employees filed 9,500 age discrimination complaints with the Equal Employment Opportunity Commission, according to the House Select Committee on Aging. The number of complaints has jumped 75% in just two years.

Employees in their 50s filed the most age discrimination complaints with the EEOC, the agency that handles the disputes. ■

Fitness plan wins award, savings for firm

Continued from page 3

Burroughs Wellcome spent more than $735,000 on employee health and fitness programs in 1981, although the company was going through "a rugged period," Mr. Leslie said.

The award-winning fitness program offers a variety of health services, company-sponsored recreation activities and a cafeteria that offers food to fit the Scarsdale diet and other low-fat and low-sodium entrees.

A progressive approach to employee health and fitness might well be expected from a company whose 47-year-old president, William M. Sullivan, runs several miles every day.

The moderate North Carolina climate makes jogging a popular lunchtime activity among Burroughs Wellcome employees at its corporate headquarters in Research Triangle Park.

But central to the company's effort to promote good health and fitness are the health center and Greenville plant hospital.

Doctors staff the hospital and health center for five hours each day and administer physical examinations to employees. A staff of nurses is on hand at each facility throughout working hours.

Physical exams are given to all new employees. Employees under the age of 40 receive a company physical once every four years, workers between 40 and 49 receive one every two years and employees over 50 are examined annually.

Last year, 55 Burroughs Wellcome employees were referred to their physicians for further treatment after company examinations discovered symptoms of hypertension. Forty-five were referred for eye, ear, nose and throat problems; 15 for obesity; and 11 for cardiovascular problems. Breast nodules were discovered in 13 female employees, who were also referred to their own doctors.

Burroughs Wellcome has coordinated its employee benefits plan with the fitness program. For example, any tests required after referrals from the company medical staff are paid by the company without an employee deductible, up to a limit of $100.

Besides routine physicals, the company's medical staff conducts annual blood cell counts for all employees exposed to potent drugs during the packaging process. Complete physicals are also given to employees who work with potentially dangerous chemicals.

Employees who do close work are eligible for vision screenings, and blood pressure tests are available for all employees.

"If they have three consecutive high readings, we refer them to their doctor," Mr. Leslie said.

Employees with back injuries are taught proper moving and lifting techniques at the health center and plant hospital, which are also used for classes on smoking cessation, medication and stress reduction and cardiopulmonary resuscitation.

Mr. Leslie said that 10% of those participating in a company-sponsored smoking cessation campaign in 1980 quit smoking, although no follow-up has been conducted to see if they quit for good.

Because the company considers mental health an important part of the fitness program, counseling services are available to employees during working hours, Mr. Leslie explained. Burroughs Wellcome contracts with an outside service, the Center for Growth & Development in Raleigh, N.C., to provide employees and their families with individual, marital or group counseling.

Up to 10 hours of free counseling are available each year to employees; additional sessions cost $10 per hour. Together, the two Burroughs Wellcome facilities in North Carolina average 270 hours of counseling per month, according to Mr. Leslie.

The health and fitness budget also pays for the maintenance of athletic fields at both North Carolina locations and funds the company's Unicorn Clubs. The clubs, whose name is derived from the company logo, provide recreational, social and cultural activities for Burroughs Wellcome employees. More than 1,000 employees participate in these programs.

Activities include basketball, volleyball and softball teams and jogging, golf, exercise and dance groups. The company also subsidizes two fishing and skiing trips each year.

Health information doesn't stop at the company's offices and plants, either. It includes health information literature in its mailings to employees. Recent brochures included "Your Child's Sight" and "Emergency Medical Procedures."

The fitness program itself has had the stamina to withstand a "rugged period" within the company, said Mr. Leslie. It has not marketed a new drug for eight years, although it is currently awaiting approval from the Food and Drug Administration for a new drug to combat herpesvirus, he said.

"There was never any indication during that period there would be any cutbacks or curtailments of the health and fitness programs," Mr. Leslie said. "It's been company policy for 102 years to encourage good habits of health in its employees."

The fitness award, sponsored by Blue Cross & Blue Shield of North Carolina and the Governor's Council on Physical Fitness and Health, cited the pharmaceutical manufacturer for "professionalism. . .obvious on inspection," according to Dr. Fred Drews, former chairman of the physical education department at North Carolina State University, who visited worksites of the three corporate finalists.

Some 40 companies entered the competition.

Ironically, a month before the award was presented, Burroughs Wellcome moved its hospitalization and surgical plan from Blue Cross to Metropolitan Life Insurance Co., which had insured the major medical and dental portions of the benefits.

The company was facing a $1.5 million annual premium increase from the Blues and was looking for a more efficient claims handling system at its facilities in Kansas City, Mo., and Burlingame, Calif., Mr. Leslie said. ■

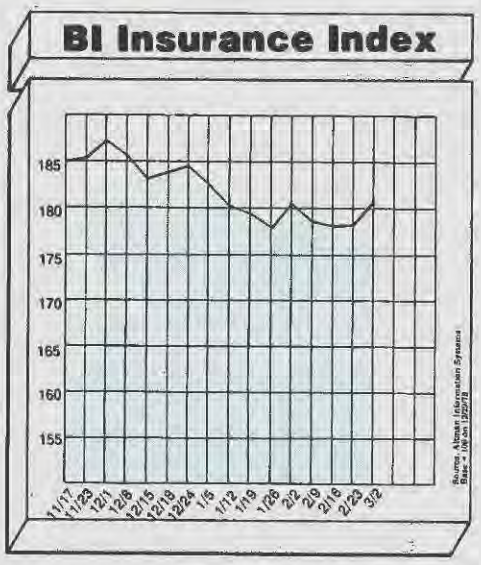
What if they become ill?

When Burrough's Wellcome employees get sick, they're covered under an employer-paid health plan that includes hospital, surgical and other medical expenses.

The company's hospitalization, major medical and dental plans require no employee deductible. However, employees must pay approximately $16 per month for dental coverage for dental coverage for dependents.

The company's basic hospitalization plan covers up to 120 days of care. Stays exceeding 120 days are covered under the major medical plan, says G. Henry Leslie, director of occupational health and safety.

The company pays a hefty premium—more than 40 cents of each payroll dollar—for the benefits, underwritten by Metropolitan Life Insurance Co. of New York. ■



Insurance industry stocks posted their best performance in a month as the *Business Insurance* stock index jumped 2.6 points to 181.1 from 178.5. Forty-three stocks increased, only 14 declined and 16 were unchanged. The leading performers were: Penncorp Financial Inc., 14.3%; Crum & Forster, 10.3%; Integrated Resources Inc., 7.4%; Avemco Corp., 7.2%; and Banks Iowa Inc., 7.1%. The largest losses were posted by: E.H. Crump Cos. Inc., 8.1%; Washington National Corp., 7.3%; Aneco Reinsurance Ltd., 6.7%; Tokio Fire & Marine Insurance Co., 6.1%; and Rollins Burdick Hunter Co., 5.8%. Despite its 1.4% gain, the *BI* index fell short of the increase in the Dow Jones 30 Industrials average.

British Issues

2 March Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commil Union	148	12.3	16.86	11.4	148—142	
Eagle Star	376	10.8	21.43	5.7	380—374	
Genl Accident	326	7.3	21.07	6.5	326—316	
Gdn Royal Exch	312	7.4	23.21	7.4	314—308	
Phoenix	254	8.5	22.43	8.8	256—242	
Royal	370	9.8	36.07	9.7	372—361	
Sun Alliance	904	9.3	53.57	5.9	906—892	
Brokers						
CE Heath	287	9.0	15.71	5.5	287—280	
Hogg Robinson	108	8.3	8.57	7.9	108—107	
Alex Howden	157	9.8	6.80	4.3	157—154	
JH Minet	n.a.	n.a.	n.a.	n.a.	n.a.	
Sedg Grp	153	9.9	7.50	4.9	153—148	
Stenhouse Hldg	104	7.6	7.28	7.0	111—104	
Stew Wrightson	222	10.1	17.14	7.7	222—217	
Willis Faber	405	12.1	17.85	4.4	405—402	

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

Rate cutting maximizes brokers' profit squeeze

By LEONARD M. WILSON

Special to Business Insurance

VERY FEW PEOPLE in the insurance brokerage industry are about to lament the passing of 1981. You can see the problem in the per-share earnings of the public brokers. Of the six that we follow most closely, only Marsh & McLennan and Frank B. Hall managed to post the narrowest of increases.

M&M increased its earnings per share to $3.27 last year from $3.12 in 1980. Hall managed a 4-cent increase to $2.65 from $2.61.

That's where the good news ends. Alexander & Alexander managed to maintain its earnings at $2.98 per share. Fred S. James declined to $2.14 from $2.33. Rollins Burdick Hunter's earnings fell 53 cents per share to $1.60 in 1981 from $2.13 in 1980, and Corroon & Black's fell 58 cents to $1.78 from $2.36. The culprit for this lackluster performance is, of course, the unremitting competition in commercial lines.


Mr. Wilson

What was the actual deflationary effect of lower premium rates on commissions? It is difficult to be precise, but industry experts suggest that the negative impact ranged from 10% to 15%.

The growth in property/casualty commissions and fees varied by broker. For example, Marsh & McLennan approached a 10% gain, but other public brokers reported virtually no increase in revenue from commissions and fees over 1980's results.

The group's composite premium gain for 1981 is estimated at 2% to 3%, not so bad in a rugged environment, but painful for operating results.

New business was the key to performance.

Leonard M. Wilson, a vp at L.F. Rothschild, Unterberg, Towbin in New York, specializes in insurance brokerage stocks. He is a member of the New York Society of Security Analysts.

BI ticker

A 20% gain in new-business revenue was common last year. With prices falling 10% to 15%, new business actually increased 30% to 35%, impressive by any standards.

New products undoubtedly contributed to the impetus, and quantitative techniques were commonly cited as a real door-opener. The new business momentum of the major public brokers as a group also implied some improvement in their market share.

Product lines outside of property/casualty generally performed well. Employee benefits posted gains in the 12% to 15% range. Actuarial consulting seemed to be a little less robust in 1981, but the generally increased emphasis on employee benefit consulting seemed to generate increased market penetration.

Reinsurance brokerage—most important to Marsh & McLennan, Fred S. James and Corroon & Black—also performed well. Reinsurance premium rates were soft, but the wider use of reinsurance markets spurred a 10% to 15% increase in commissions. And the advantages of reinsurance brokerage have not been lost on the other major public brokers, all of which are pushing ahead in this area.

International brokerage operations were stronger than domestic brokerage operations. Currency effects, though, tended to dilute the gains, given the strength of the dollar. C.T. Bowring Ltd., Marsh & McLennan's British subsidiary, posted appreciable progress in most areas. Leslie & Godwin Ltd., Hall's subsidiary, had a good year, presumably due in part to the continued shift of Hall's business at Lloyd's from other London firms.

Investment income was an important counterbalance to the paltry growth in commissions and fees. Yields probably averaged 16% to 17%, and close attention to prompt collection contributed to the brokers' investment income growth.

Even with an upsurge in activities outside of property/casualty lines, expenses rose faster than revenues. Costs were tightly controlled, however, and there was little expansion of staffs. Since the amount of insurance brokered continued to rise, it's clear that productivity has improved. The profit-margin squeeze has now plagued the industry for three years, and it will not abate in 1982.

Despite the cost pressures and their eroding profit margins, all the major public brokers stress their ongoing commitments to costly programs designed to generate growth in the future. Data processing is a magnet for multimillion-dollar investments that may provide a variety of new services and reduce internal processing costs.

What are some of the lessons of 1981?

First, size seemed to have helped performance. The larger public brokers posted the better relative earnings results. Frankly, we are not certain why. It could be related to product mix and the success of new products.

Second, diversification away from general property/casualty brokerage was advantageous. The best gains were realized in sectors immune to rate cutting.

Third, investment income was a significant source of earning power that was not affected by the market cycle.

Finally, it was possible to keep the lid on staff size without impairing customer service.

The outlook for 1982 is very much more of the same. Pricing may be competitive for much of the year, and the public brokers' earnings may be flat or even somewhat reduced. But the earnings picture should brighten in 1983 if premium rates stabilize. Next year's results are no longer that far away for investors, who typically are willing to consider prospects six to nine months down the road. ■

BI Industry Stock Report

MAR. 2, 1982 — 2/24/82 THRU 3/2/82

Insurance Cos.		Price	% Chg.	P.E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	46.75	3.9	7.7	2.52	5.4	46.75	45.13	698.6
American Bankers Ins Group	OTC	7.88	3.3	8.4	0.48	6.1	7.88	7.75	156.6
American Gen Ins Co	NYSE	42.13	2.1	6.4	2.20	5.2	42.13	41.50	66.9
American Indty Finl Corp	OTC	16.13	-2.3	7.7	1.12	6.9	16.38	16.13	12.5
American Intl Group Inc	OTC	68.25	4.2	11.8	0.40	0.6	68.50	66.00	199.8
American Natl Ins Co	OTC	14.00	1.8	5.9	0.76	5.4	14.00	13.75	45.8
American Sts Life Ins Co	OTC	16.50	0.0	5.3	0.80	4.8	16.50	16.00	1.6
Aneco Reins Ltd	OTC	1.75	-6.7	0.0	0.00	0.0	1.88	1.75*	4.1
Appalachian Natl Corp	OTC	2.63	2.4	0.1	0.00	0.0	2.63	2.56	5.3
Avemco Corp	AMEX	11.13	7.2	7.5	0.54	4.9	11.13	10.50	12.6
Banks Iowa Inc	OTC	37.50	7.1	5.8	1.48	3.9	37.50	36.00	3.1
Bitco Corp	OTC	38.75	2.0	4.7	2.40	6.2	38.75	38.25	2.0
Carolina Cas Ins Co	OTC	6.75	0.0	6.3	0.32	4.7	6.75	6.75	3.8
Central Natl Finl Corp	OTC	35.38	0.0	11.5	0.65	1.8	35.38	32.52	0.0
Chubb Corp	OTC	47.00	3.6	5.6	2.92	6.2	47.00	45.63	213.9
Combined Intl Corp	NYSE	20.75	5.7	5.6	1.80	8.7	20.75	19.50	133.0
Connecticut Gen Ins Corp	NYSE	50.00	0.5	5.8	2.04	4.1	50.25	49.25	112.6
Continental Corp	NYSE	25.50	-1.4	6.4	2.60	10.2	26.25	25.50	231.0
Crawford & Co	OTC	13.00	2.0	10.2	0.56	4.3	13.00	12.75	9.3
Crown Life Ins Co	OTC	80.25	-0.9	5.9	3.10	3.9	80.25	80.25	0.5
Crum & Forster	NYSE	32.25	10.3	5.2	1.64	5.1	32.25	29.38	179.3
Employers Cas Co	OTC	28.00	0.0	6.0	1.20	4.3	28.00	28.00	0.8
Equifax Inc	NYSE	30.25	2.5	8.7	2.60	8.6	30.38	30.13	31.2
Excelsior Ins Co	OTC	17.50	0.0	12.0	0.70	4.0	17.50	17.50	0.1
Farmers Group Inc	OTC	33.75	4.2	9.9	1.24	3.7	33.88	32.75	137.4
First Colony Life Ins Co	OTC	62.38	1.4	16.1	1.00	1.6	62.38	61.38	17.3
Foremost Corp Amer	OTC	25.50	3.0	7.0	1.12	4.4	25.50	24.75	16.9
Great West Life Assurn Co	OTC	235.00	0.0	9.1	10.00	4.3	235.00	235.00	0.0
Hanover Ins Co	OTC	31.63	-1.2	3.8	0.72	2.3	31.75	31.50	11.8
Hartford Steam Boiler Inspctn	OTC	40.00	0.0	6.9	2.80	7.0	40.00	40.00	2.5
Jefferson Natl Life Ins Co	OTC	33.50	0.8	10.3	0.76	2.3	34.50	33.50	13.5
Kemper Corp	OTC	33.13	5.6	5.4	1.80	5.4	33.13	31.50	108.9
Lincoln Natl Corp Ind	NYSE	41.75	6.4	6.8	3.00	7.2	41.75	39.75	102.0
Mgic Invt Corp	NYSE	50.38	-1.2	12.3	1.28	2.5	51.13	50.38	941.1
Mission Ins Group Inc	NYSE	36.50	4.7	9.5	1.00	2.7	36.50	34.75	46.1
Nationwide Corp Ohio	OTC	26.50	1.0	8.7	0.70	2.6	26.50	26.25	3.2
Northwestern Natl Life Ins	OTC	26.63	2.4	5.5	1.36	5.1	27.00	26.25	26.9
Ohio Cas Corp	OTC	44.50	6.0	6.7	2.36	5.3	44.50	42.88	72.0
Old Rep Intl Corp	OTC	18.63	0.0	4.4	0.92	4.9	18.63	18.63	36.9
Preferred Risk Life Ins Co	OTC	17.75	0.0	4.8	0.80	4.5	18.00	17.75	1.1
Provident Life & Acc Ins Co	OTC	49.50	2.1	6.1	2.20	4.4	49.50	48.50	15.0
Ryan Ins Group Inc	OTC	17.75	4.4	7.7	0.12	0.7	17.75	17.25	9.8
St Paul Cos Inc	OTC	50.25	0.5	6.6	2.60	5.2	50.25	50.13	126.2
Safeco Corp	OTC	39.88	0.6	6.9	2.20	5.5	39.88	39.63	134.3
Sri Corp	OTC	23.50	2.2	4.7	1.00	4.3	23.50	23.25	13.3
Selbels Bruce Group Inc	OTC	20.88	-4.0	10.0	0.80	3.8	21.50	20.88	38.1

MAR. 2, 1982 — 2/24/82 THRU 3/2/82

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Statesman Group Inc	OTC	5.63	0.0	4.9	0.15	2.7	5.63	5.63	3.7
Tokio Marine & Fire Ins Co	OTC	95.75	-6.1	7.6	1.00	1.0	101.00	95.75*	0.5
Travelers Corp	NYSE	49.00	3.2	5.8	2.88	5.9	49.00	48.00	854.6
United Fire & Cas Co	OTC	29.00	1.8	8.3	0.88	3.0	29.00	28.50	0.2
United States Fid & Gty Co	NYSE	44.88	6.8	7.5	3.60	8.0	44.88	43.25	144.9
United Svcs Life Ins Co	OTC	14.50	1.8	5.4	1.00	6.9	14.50	14.38	14.2
Usllife Corp	NYSE	21.13	1.8	4.3	0.84	4.0	21.50	20.88	52.3
Washington Natl Corp	NYSE	15.88	-7.3	5.7	1.08	6.8	17.38	15.88*	52.3
Zenith Natl Ins Corp	OTC	16.75	-1.5	8.4	0.76	4.5	17.00	16.75	27.9
INSURANCE COMPANIES	AVERAGE			6.1		4.4			
Agents/Brokers									
Alexander & Alexander Svcs	OTC	30.25	7.6	10.2	1.94	6.4	30.25	28.00	199.6
Baldwin & Lyons Inc	OTC	35.50	0.0	6.4	0.80	2.3	35.50	35.50	0.7
Corroon & Black Corp	NYSE	20.13	0.0	11.3	1.76	8.7	20.13	19.75	9.9
Crump E H Cos Inc	OTC	9.88	-8.1	18.3	0.40	4.1	10.75	9.88*	18.7
Hall Frank B & Co Inc	NYSE	28.00	-4.3	10.6	1.70	6.1	28.88	28.00	154.1
Integrated Res Inc	AMEX	16.25	7.4	6.6	0.00	0.0	16.25	15.38	28.6
James Fred S & Co Inc	NYSE	21.50	6.8	10.0	1.60	7.4	21.50	20.38	65.1
Marsh & Mclennan Cos Inc	NYSE	33.50	2.3	10.2	2.00	6.0	33.50	33.00	173.5
Penncorp Fincl Inc	NYSE	6.00	14.3	4.8	0.16	2.7	6.00	5.38	107.1
Pinehurst Corp	OTC	8.63	0.0	0.0	0.00	0.0	8.63	8.63	8.2
Poe & Assoc Inc	OTC	8.00	3.2	9.1	0.80	10.0	8.00	7.75	0.2
Reed Stenhouse Cos Ltd	OTC	11.13	1.1	9.1	0.60	5.4	11.50	11.00	14.2
Rollins Burdick Hunter Co	OTC	18.25	-5.8	11.4	1.32	7.2	19.00	18.00*	35.3
AGENTS/BROKERS	AVERAGE			9.5		5.3			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	46.38	4.8	8.3	2.20	4.7	47.00	45.13	890.3
Anderson Clayton(Ranger/PanAm)	NYSE	28.25	3.7	5.8	1.32	4.7	28.25	26.50	57.8
Armco Inc	NYSE	21.50	0.0	4.3	1.80	8.4	21.50	21.13*	315.7
City Investing Co. (Home Ins.)	NYSE	22.88	1.7	6.6	1.60	7.0	22.88	22.38	175.7
CNA Finl Corp (CNA)	NYSE	15.88	0.0	6.6	0.00	0.0	16.13	15.50	94.5
Control Data (Comml. Credit)	NYSE	36.75	7.3	8.2	0.55	1.5	36.75	35.13	1,038.9
General Re Corp	NYSE	85.00	0.1	10.5	2.16	2.5	85.25	83.63	91.6
Gulf Utd Corp	NYSE	17.88	0.7	6.0	1.32	7.4	18.13	17.75	78.3
INA Corp (Ins. Co. of NA)	NYSE	45.13	-0.6	6.1	2.40	5.3	45.75	44.88	322.1
ITT (Hartford Group)	NYSE	26.75	2.4	6.0	2.68	10.0	27.00	26.50	685.6
Optimum Hldg Corp	OTC	9.50	-2.6	12.2	0.00	0.0	9.75	9.50	5.4
Sears Roebuck & Co. (Allstate)	NYSE	17.88	10.0	8.9	1.36	7.6	17.88	16.75	4,918.1
Baldwin Utd Corp	NYSE	57.50	4.3	9.8	1.60	2.8	57.50	55.50	63.7
Teledyne Inc (Argonaut)	NYSE	128.38	2.7	6.4	0.00	0.0	131.75	126.63	378.2
Transamerica Corp (Occidental)	NYSE	21.25	2.4	6.2	1.40	6.6	21.25	21.00	152.4
CONGLOMERATES/HOLDING COS.	AVERAGE			7.2		3.5			

*Record high/low since Jan. 1, 1981.

System design: Altman Information Systems

Financial briefs

CG/INA

CIGNA Corp., the product of the pending merger of INA Corp. and Connecticut General Corp., will be a supermarket for corporate insurance buyers seeking property/casualty and group benefit products, according to INA's top top-ranking officials.

The new company will actively compete to meet the needs of the changing insurance marketplace, INA Chairman Ralph S. Saul said last week during testimony before the Pennsylvania Insurance Department, which must approve the merger since it is the home of INA's headquarters.

The merged organization will achieve that goal by doing what both companies do best, he said, pointing to INA's success in the property/casualty field and Connecticut General's expertise in group life and health insurance and annuities.

CIGNA also would actively seek an international presence, he said, and compete more effectively in the developing financial services market.

Mr. Saul said the merger would enable the new company to "provide the agents and brokers with whom we deal with a broader line of products than each of us has alone. The combination will enable to us to draw upon our collective experience and capabilities in the development of new products, products designed to give our customers what they want—not what we think they need."

CIGNA's thrust would be commercial, says Norman Rosenthal, an analyst with the Morgan Stanley, a New York securities firm. "The primary thrust is to become the predominant commercial insurance company in the world."

The proposed merger, already approved by shareholders of both companies, would make the new entity the second largest investor-owned insurer in the world behind Aetna Life & Casualty Co. Combined revenues would be about $10 billion—$5.3 billion from CG and $4.7 billion from INA. Total assets for the combined company would top $39 billion.

Besides Pennsylvania, New York state also must approve the merger because the new corporation plans to establish its headquarters there. However, no hearings on the venture are planned in New York.

CG and INA officials say they expect the merger to be completed by April 1. ■

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