MAY 25, 1987

business insurance®

Reporting weekly for corporate risk, employee benefit and financial executives / $1.75 a copy; $68 a year

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update

Jury awards $1.6 million against MMRMA member

EAST DETROIT, Mich.—The Michigan Municipal Risk Management Authority is facing what could be its largest-ever single claim following a $1.6 million jury award last week against the city of East Detroit.

A Macomb County Circuit Court jury awarded $1.6 million in compensatory damages to Craig Doherty, a former East Detroit police

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A $25 billion bill

Kennedy calls for mandatory health plans

By JERRY GEISEL

WASHINGTON—Legislation unveiled last week requiring employers to offer group health insurance coverage is much less onerous than earlier proposals and would exempt employers from costly state benefit mandates.

Some business groups still denounce the $25 billion plan, contending that it is too costly for small employers, but some major employers are beginning to endorse mandatory employer-provided health insurance.

The minimum health benefit legislation was introduced by Senate Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass.

In outlining the legislation last week at a press conference in Washington, Sen. Kennedy said his plan is not a "Cadillac plan," but that it would provide basic protection against the financial burden of major illness.

"This is not a complicated plan," Sen. Kennedy explained. "It creates no burdensome regulations. It requires no massive government bureaucracy. It is not back-door national health insurance. It simply extends the current system of employment-based private health insurance to millions of families that are now unfairly denied participation."

Earlier proposals prepared by Sen. Kennedy's staff to mandate that employers at least offer "a minimum bare-bones plan" protecting employees from catastrophic health care expenses were sharply criticized by business groups because the plans would have been far more generous than those currently offered by many employers (*BI*, April 27).

As a result, most employers would have had to overhaul their health care plans to comply with the mandate.

But the latest proposal, developed after Sen. Kennedy's staff met dozens of times with business groups, will not have a substantial effect on major employer plans, experts say.

For example, under Sen. Kennedy's plan, annual health care deductibles for hospital and physician services could not exceed $250 per person or $500 for family coverage. Most major employer plans offer lower deductibles, benefit experts say.

By contrast, an earlier proposal prepared by Sen. Kennedy's staff called for annual deductibles of $150 per person or $300 for family coverage—which are lower than the deductibles offered by many major employer plans, the experts say.

In addition, the new proposal sets the maximum annual out-of-pocket expense for covered services at $3,000 for individuals, compared with a $2,000 limit under a previous outline.

However, like earlier outlines, copayments for covered services could not exceed 20%, and no deductibles could be applied to prenatal, well-baby or child preventive care.

In addition, employees generally could not be required to pay more than 20% of the annual premium.

However, in a move welcomed by employers, companies would be free to alter benefit provisions as long as the overall value of the plan is not reduced.

For example, a company would be able to impose higher deductibles if it paid a higher percentage

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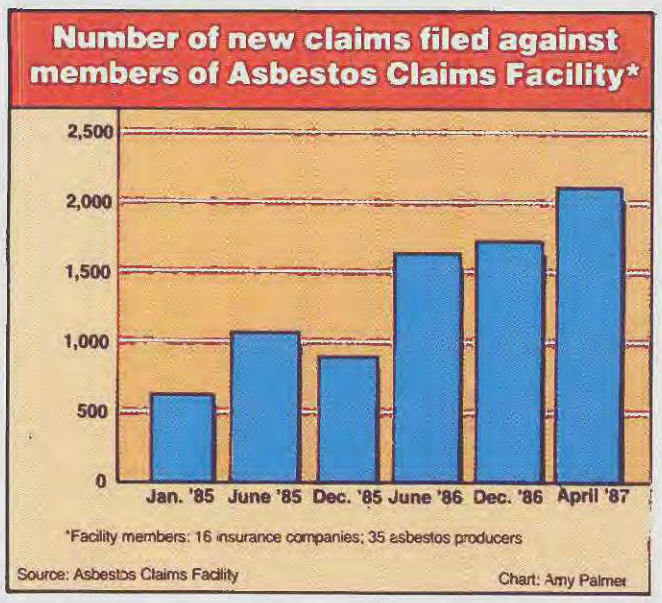
Photo: Jerry Geisel

"It is not back-door national health insurance," Sen. Edward Kennedy said last week of mandating that employers provide health insurance plans.

New avalanche of asbestos claims hits



By STEPHEN TARNOFF

PRINCETON, N.J.—A new avalanche of asbestos personal injury claims is hitting major asbestos producers and spreading to other defendants.

The number of new asbestos claims filed has doubled in the last few months to 2,100 a month, compared with about 1,000 a month at year-end 1985.

Moreover, one major insurer is projecting that notices of new asbestos claims it receives could hit 4,000 per month by the end of the year—counting each insured defendant in a multiple-defendant lawsuit as a claim notice.

"It causes me to think this is going to go on forever," says Floyd H. Knowlton, vp of the The Travelers Corp.

Screening programs to identify potential or existing asbestos-related diseases funded by unions and plaintiffs attorneys are creating the new wave of plaintiffs, who for the first time include significant numbers of steelworkers, tire workers and sheet metal workers.

Asbestos producers already are defending 40,000 to 50,000 asbestos personal injury cases, mostly filed since the late 1970s and involving shipyard and insulation workers exposed to asbestos in the 1940s and later.

While the traditional asbestos producers are named in this new wave of lawsuits, for the first time additional small and large manufacturers who used asbestos in their products are also being named.

"I'm a little surprised by the increase in the numbers," says Lawrence Fitzpatrick, vp-law for the Asbestos Claims Facility, where claims against its member producers have increased during the last six months.

The Princeton, N.J.-based facility currently is receiving 2,100 new claims per month—more than three times the 660 claims filed in January 1985 (see chart). The facility represents 35 major asbestos producers and 16 insurers in asbestos litigation that signed the Wellington agreement to more efficiently resolve asbestos claims.

Notices of claims against Travelers' policyholders are coming in at a rate of 2,900 per month now, compared with 2,000 a month during most of 1986 and early 1987 (see chart, page 45).

From 1982 until early 1986, claims against Travelers' policyholders numbered no more than 1,000 per month.

If the claims continue to mount at the same pace, the number of suits producers and insurers must cope with would far outstrip earlier estimates of the extent of the asbestos problem.

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update

MMRMA faces $1.6 million hit

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officer who was fired in 1983 for allegedly having sex with a woman while on duty. The city was ordered to pay $1.3 million of the award, while a former chief of police and a former city manager were ordered to pay the remaining $300,000.

Stephen Bonczek, East Detroit's current city manager, said the city would request a new trial and ask that the award be set aside or reduced. If necessary, he added, the city will appeal the award.

East Detroit has been a member of MMRMA—a municipal self-insurance pool that has come under criticism—for the last five years (*BI*, Feb. 16).

Mr. Bonczek confirmed that East Detroit is fully reserved for its $50,000 retention in the MMRMA program, adding that he does not know the level of reserves being carried by MMRMA's reinsurers excess of $50,000.

Fireman's buys 9.2% of A&A

NEW YORK—Fireman's Fund Corp. has acquired a 9.2% share in Alexander & Alexander Services Inc. but does not intend to take over the company, the insurer said in a Securities & Exchange Commission filing.

Fireman's Fund also said in the filing that it plans to eventually acquire more than 15% of A&A's common stock. But it did not specify how many A&A shares it will buy.

Of the 3.8 million A&A shares Fireman's Fund now owns, a total of 1.9 million shares were purchased between April 13 and May 13 at between $23.47 and $28.07 a share. The stock closed at $25.38 last Thursday, a 9.1% jump from $23.25 on May 14.

A&A Chairman John A. Bogardus said at the broker's annual meeting last week that he understands Fireman's Fund acquired the stock as an investment and that it has similarly acquired large positions in other companies for the same purpose. He added that A&A's board consistently has taken the position it is in A&A's best long-term interest to remain independent.

The purchase of A&A stock by Fireman's Fund once again raises the question in Lloyd's of London of whether an insurer should own or control a Lloyd's insurance broker. Insurers currently are not barred from owning Lloyd's brokers, noted Lloyd's Chairman Peter Miller.

However, he said, "the Council of Lloyd's is considering regulations on Lloyd's brokers at the moment."

With the purchase of A&A stock by Fireman's Fund, there will now be three major Lloyd's brokers partially owned by insurance groups: A&A, Sedgwick Group P.L.C., which is 39% owned by Transamerica Corp., and Minet Holdings P.L.C., which is 25% owned by St. Paul Cos.

Separately, as expected, Tinsley H. Irvin, A&A's president and chief operating officer, was named chief executive officer by A&A's board of directors following its annual meeting. Mr. Irvin succeeds Mr. Bogardus, who will continue as chairman until he retires next May.

In addition, Michael K. White, chief executive officer of A&A Inc., and William M. Wilson, chief executive officer of A&A International Inc., were both named A&A Services executive vps. They will retain their current positions with the A&A subsidiaries.

Humana renews bid for IMC

TALLAHASSEE, Fla.—Humana Inc. again is offering to buy International Medical Centers Inc. of Miami, the financially troubled health maintenance organization placed in receivership by the state earlier this month. Humana is offering $40 million for the HMO.

Louisville, Ky.-based Humana had ceased negotiations to purchase the HMO late last month following the indictment of IMC President Miguel G. Recarey Jr. for conspiracy and bribery as part of an alleged effort to secure a health care contract with a union's welfare fund (*BI*, May 11).

The purchase would enable Humana to extend its health insurance business in a state where it already owns hospitals. However, Humana's proposal does not include the purchase of Miami General Hospital, which is part of the HMO company, a Humana spokesman said.

New York-based investment banker D.H. Blair & Co. also submitted an offer to the department, but it did not name a price. Blair offered to "enter into negotiations to create a joint venture with health care providers," and create a new company to operate the HMO, a Blair spokeswoman explained.

Interested purchasers had until last Friday to submit their offers to the Florida Insurance Department.

IMC, which provides medical benefits to some 137,000 Medicare beneficiaries, has more than 170,000 members (*BI*, Sept. 8, 1986).

Fraud probe results in arrests

DESTIN, Fla.—Three principals of a company that promised insurance for the owner of a fleet of trucks but apparently failed to deliver have been arrested and charged with grand theft.

The Walton County Sheriff's Department confirmed that James F. Beck, Sidney Evans and Judy A. Carter of Transportation Services Inc. in Destin, Fla., were arrested last week. They were charged with collecting $35,000 from a Dade City, Fla., trucker for liability and cargo coverage they promised to arrange for him but never purchased, according to authorities.

All three have been released after posting $10,000 bonds.

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errors & omissions

Robert DeMichele, who has been elected president and chief executive officer of United Reinsurance Corp. of New York, retains his post as president of The Reinsurance Corp. of New York. This was incorrectly stated in Comings & Goings Industry (*BI*, May 18).

American Centennial sale prompts shareholder suit

By DOUGLAS McLEOD

WILMINGTON, Del.—Several directors and officers of Beneficial Corp. are facing a shareholder lawsuit over the sale of American Centennial Insurance Co. and other Beneficial insurance units to a management group.

The shareholder derivative action was filed last Wednesday, two days before Beneficial announced completion of the sale of the insurance units to a group led by ACIC Chairman and Chief Executive Officer Robert Rothman.

The suit charges that the directors and officers—including Mr. Rothman—participated in a fraudulent scheme to sell the insurance units to the management group for "inadequate consideration in a highly leveraged buyout."

In selling to the insider group, Beneficial's directors ignored a better offer from a group led by James L. Bentley Jr., a former Georgia insurance commissioner, the complaint says (*BI*, April 6).

The alleged scheme also intended to "perpetuate the cover-up of the massive problems and losses incurred by Beneficial's reinsurance operations," and thus allow Beneficial managers and directors to "entrench themselves in their positions at Beneficial," the suit charges.

A Beneficial spokeswoman called the charges "completely without merit," but declined further comment.

Attorneys representing the shareholder who filed the suit could not be reached to comment on the impact of Beneficial's consummation of the sale, which was announced last Friday.

In March, Beneficial announced the sale of ACIC and five other insurance units to a management group led by ACIC's Mr. Rothman (*BI*, March 9).

In addition to ACIC, the sale included New Mexico-domiciled Wesco Insurance Co., Bermuda-based Beneficial International Insurance Co. and three Beneficial International subsidiaries.

Under the complex sale agreement, ACIC and Wesco are subsidiaries of First Delaware Holdings Inc., a newly formed Delaware holding company that operates as a subsidiary of Beneficial International.

Another newly formed Bermuda holding company, RCK Holdings Ltd., is the parent company of Beneficial International.

Beneficial received $10 million in cash for the insurance units—paid out of Beneficial International funds contributed to First Delaware Holdings—along with a package of 10-year notes with a face value of $98 million. About $60 million of the notes are related to ACIC and Wesco, and the value of the ACIC notes will depend on the future profitability of the insurance operations.

The sale agreement also called for Beneficial to indemnify ACIC's new owners for liabilities and costs arising from three lawsuits that grew out of business produced for ACIC by one of its former managing general agents, The Underwriters Inc. of Parsippany, N.J.

Before approving the sale of Delaware-domiciled

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HCA offers 100 hospitals to an ESOP

By DONNA DiBLASE

NASHVILLE, Tenn.—Hospital Corp. of America, the largest hospital chain in the nation, wants to sell about 100 of its hospitals to employees through an employee stock ownership plan.

While exact details of the proposed restructuring plan have not been finalized, "discussions are well under way with potential lenders, underwriters and other parties" that would be involved in financing the ESOP, said a spokeswoman for the health care company.

"We are exploring this potential restructuring because we believe it could significantly improve HCA's financial strength and future operating performance," Thomas F. Frist Jr., HCA chairman and chief executive officer, said in a statement issued last week.

A final decision on whether the company will proceed with the

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Lloyd's stands by its PCW settlement

By STACY SHAPIRO

LONDON—Lloyd's of London will not reduce the 34 million pound ($57.3 million) contribution members of PCW Underwriting Agencies Ltd. must make under a settlement Lloyd's offered last month, Chairman Peter Miller said last week.

However, Lloyd's will extend the deadline for PCW names to accept the settlement to June 19 from May 30 to allow them more time to discuss the offer with advisers, said Mr. Miller in a letter to the names.

The PCW names have been offered 103 million pounds ($173.6 million) and immunity from further PCW losses (*BI*, April 13).

In addition, those PCW members who want to continue underwriting at Lloyd's and accept the offer can pay their contribution by July 10 to meet Lloyd's solvency requirement, said Mr. Miller.

Those PCW members who accept the offer but do not intend to continue their membership at Lloyd's can have an unspecified amount of time to pay their debt, although the members must tell Lloyd's as soon as possible.

Mr. Miller's May 21 letter was in response to requests by PCW members through the PCW 1985 Committee and Additional Underwriting Agency No. 3 Ltd. to extend the deadline of the offer and to reduce the amount that PCW members would contribute.

The request followed a meeting of the PCW members on May 15 (see related story, page 16).

However, "Lloyd's believes that the proposals are fair," Mr. Miller said in his letter.

"The payment by members is not out of line with other market results. The proposals provide the immediate benefit of over 100 million pounds to be contributed by other parties to the resolution of

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inside

- Pinnacle Reinsurance Co. Ltd. can pursue legal action in Bermuda against the liquidators of Mentor Insurance Ltd., but the reinsurer remains a defendant in federal court in New Orleans, a judge in New Orleans has ruled. **PAGE 4**
- The insurance industry invites state and federal intervention into its business by refusing to be responsible and responsive, this week's editorial warns. Ultimately, the insurance industry could be appropriated. **PAGE 8**
- Risk management information system vendors analyze hardware needs for risk management information systems in RMIS Commentary, a Perspective column by David A. Tweedy. **PAGE 27.**
- Many employers are either eliminating payroll-based employee stock ownership plans or freezing the plan assets, according to a recent study by consultants Hewitt Associates. **PAGE 23**
- The insurance industry should be careful about forming an "artificial link between the issues of insurance regulation and tort reform," warns William H. Bolinder, president and chief operating officer of Schaumburg, Ill.-based Zurich-American Insurance Group. **PAGE 38**

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Vol.21, No.21—*Business Insurance* (ISSN 0007-6864) is published weekly at 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation department, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1611. Copyright 1987 by Crain Communications Inc.

Manage cases to cut health bills: Experts

By DONNA DiBLASE

SAN DIEGO—As the savings from health care cost containment programs diminish, case management programs are becoming employers' best defense against spiraling health care costs, according to one expert.

"The easy savings are diminishing from many of our early initiatives, like second-opinion programs, health maintenance organizations and outpatient surgery programs," noted Dr. David Rosenbloom, president of the Health Data Institute in Lexington, Mass.

"The cases are more complicated, and these complicated cases are more costly to manage," he added.

Case management programs are the most effective way to provide more cost-effective, quality treatment for patients with catastrophic illnesses.

The programs involve the coordination of benefits coverage for alternative treatments that may not usually be covered by an employer's benefit plan.

"Case management will take more skill and more dedication than any of our earlier initiatives," he predicted.

Dr. Rosenbloom discussed the evolution of case management at the annual conference of the National Assn. of Employers on Health Care Action, held May 13-14 at the Hotel del Coronado in San Diego.

"There may be three or four generations of case management. The bulk of our efforts in this area began in rehabilitation" of patients with long-term or catastrophic illnesses and injuries, he said.

The illnesses and injuries usually covered by case management programs include orthopedic problems, cardiac cases, burns, cancer and neurological cases, he added.

But, the use of case management then evolved from rehabilitation of persons with only certain illnesses and injuries into "adapting hospital utilization review modes to focus on all cases identified as high cost cases," he noted.

In this stage, high cost cases are identified through the pre-admission review process.

Then, the case manager suggests and coordinates benefit coverage of more cost-effective, quality treatments or settings that may not usually be covered by the benefit plan.

"Now we're moving toward applying case management not only to long-term illnesses, but also toward complex new issues," Dr. Rosenbloom said.

These new health care issues include treatment of patients with acquired immune deficiency syndrome, neonatal cases, organ transplants and artificial organ implants, he explained.

"Case management is moving toward combining medical management of a patient's illness with the delivery of alternative care," he predicted.

"Medical technology is advancing very rapidly, and making possible the survival of patients with catastrophic illnesses involves more long-term planning," he continued.

"Medical technology now makes it possible to provide therapies in many more places than in the hospital," he added.

And, health care providers are more interested in coordinating and participating in case management

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Photo: Michael Le Poer Trench

A computer-controlled revolving set is essential to the production of Les Miserables, now playing in New York City.

Show stopper

Play's policy pays off for equipment malfunction

By ROBERT A. FINLAYSON

NEW YORK—The producers of the play "Les Miserables" are anything but miserable following their receipt of $128,000 on what is thought to be the first business interruption claim stemming from the malfunction of computer-controlled theatrical equipment.

In December 1986, while Les Miserables was on its tryout tour in Washington, D.C., the malfunction of a computer-controlled revolving set forced the cancellation of two performances before the equipment could be repaired.

Pacific Indemnity Co., a member of the Chubb Group, paid the claim under the extra-expense—or business interruption—endorsement to a theatrical productions policy purchased by the producers.

The claim filed by the producers of "Les Miserables" was the first time producers of a play have filed such a claim, according to Robert A. Boyar, president of R.A. Boyar Inc. of New York, the broker for the policy and one of the largest insurance brokerage firms for theatrical productions.

The $128,000 payment by Pacific Indemnity to the producers of "Les Miserables" covered all the expenses associated with the production and lost profits, according to Mr. Boyar, who noted that the show was sold out during its Washington, D.C., engagement.

The expenses were higher than they normally would have been, Mr. Boyer said, because the engagement was part of the show's tryout tour in preparation for its opening on Broadway and the show's director, writers and choreogra-

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Workers sue post office, chemical firm

By MICHAEL BRADFORD

OKLAHOMA CITY—A Missouri chemical company and the Oklahoma City post office are facing a lawsuit seeking $75 million after workers complained that a cleaning solution used at the post office made them ill.

Attorneys for about 100 employees of the post office filed an amended complaint in the suit on May 12 in the U.S. District Court for the Western District of Oklahoma in Oklahoma City. The suit charges that a chemical in Scent-Go, which was sold by Senoret Chemical Co. Inc. in Kirkwood, Mo., is responsible for numerous medical problems suffered by the plaintiffs.

Workers at the Oklahoma City post office are blaming symptoms such as respiratory problems and allergic reactions on their exposure to ortho-dichlorobenzene, an ingredient in the solution, which was used as an all-purpose cleaning solution.

The suit charges that the chemical company failed to warn workers of the danger of exposure to the chemical and says the product was not adequately labeled to indicate proper "handling, diluting and otherwise using the product."

The complaint says the U.S. Postal Service "failed to provide proper medical attention and medical care and has failed to monitor the health of its employees as required by the Department of Labor, United States Government, and union contracts between the employees" and the postal service.

The suit further charges that officials at the Oklahoma City post office conspired to conceal from workers the "inherent dangers of the toxic chemical, Scent-Go." Officials ignored medical and scientific data that showed the product to be harmful, according to the complaint.

The plaintiffs are seeking compensatory damages of $25 mil-

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EPA outlines Superfund indemnity rules

By ROBERT A. FINLAYSON

WASHINGTON—Contractors hired to clean up Superfund hazardous-waste sites may have to meet more stringent risk-financing requirements to be eligible for federal indemnification.

The requirements are outlined in interim guidelines proposed by the Environmental Protection Agency to implement the Comprehensive Environmental Response, Compensation and Liability Act—better known as Superfund—which was reauthorized last fall.

The proposed guidelines are expected to take effect either at the end of June or in early July. However, they will be replaced by definitive regulations, which EPA officials say probably will be even more severe, in about two years.

The proposed guidelines, along with the easing of contractors' liability last year, have a two-pronged purpose, explained Robert Mason, chairman of the EPA's task force on Superfund indemnification. The changes are designed to encourage the development of commercial insurance for contractors and to force contractors to purchase such insurance when it is available rather than relying on federal indemnification.

Under the negligence standard, contractors would face Superfund liability only in cases of gross negligence or willful misconduct.

The guidelines stem from provisions included in the Superfund law, reauthorized Oct. 17, 1986, which provided for federal indemnification of contractors that clean up Superfund sites and reduced cleanup contractors' liability from a strict to a negligence standard.

Under the negligence standard, contractors would face Superfund liability only in cases of gross negligence or willful misconduct in cleaning up a dump site.

Congress approved the change in the liability standard in response to complaints from contractors hired by both the government and private parties to clean up hazardous-waste dump sites. They charged that Superfund's strict liability standard made it virtually impossible for them to buy the insurance they need to stay in the waste cleanup business.

The contractors warned Congress that unless the law was changed so they could more readily obtain pollution liability coverage, no reputable company would be willing to perform hazardous-waste cleanup work.

At that time, Congress also gave the federal government authority to indemnify contractors for pollution liability arising out of their work at Superfund sites. Under the proposed guidelines, the federal indemnification would impose a $1 million self-insured retention but effectively has no caps on limits.

According to Mr. Mason, to qualify for federal indemnification, contractors now must:

- Submit to the EPA written documentation of their efforts to obtain pollution liability insurance.
- Submit a copy of the policy and the declaration page, if the contractor has obtained pollution insurance, to the EPA.
- Submit written documentation every six months showing additional efforts the contractor has made to secure pollution liability coverage, including copies of applications submitted to three known markets; a status report on any coverage obtained; a summary of the reasons why the contractor was denied coverage; and a status report on the alternative risk transfer mechanism the contractor has pursued.

According to the interim guidelines, contractors are expected to continually "moni-

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BI adds associate editor

CHICAGO-Laura Mazzuca has joined the staff of *Business Insurance* as associate editor of Agent/Broker Topics, the special demographic section of *BI* published for insurance agents and brokers.

Ms. Mazzuca succeeds Linda J. Collins, 31, who has been promoted to Agent/Broker Editor. In her new position, Ms. Collins will oversee the Agent/Broker Topics section and continue to report on the financial results of the publicly traded insurance brokers for the weekly edition of *BI*. She also will report on news and trends in risk management and commercial insurance.

Ms. Mazzuca

Ms. Collins

Ms. Mazzuca, 32, most recently was associate editor at "Screen," a Chicago-based weekly magazine for the local advertising production industry. She also has worked as a general assignment reporter for City News Bureau, an editorial assistant at Lerner Newspapers and as a free-lance writer.

Ms. Mazzuca holds a bachelor of arts degree in journalism from Columbia College in Chicago. She can be reached at 312-649-5274.

Judge frees Pinnacle to litigate

By ROGER SCOTTON

HAMILTON, Bermuda—Pinnacle Reinsurance Co. Ltd. can pursue legal action here against the liquidators of Mentor Insurance Ltd., but the reinsurer remains a defendant in federal court in New Orleans.

Judge Marcel Livaudais of the U.S. District Court for the Eastern District of Louisiana in New Orleans refused to extend an injunction against Pinnacle or reconsider his earlier ruling that Pinnacle is subject to the court's jurisdiction.

Earlier, Judge Livaudais had granted a temporary injunction to the liquidators of Mentor, who are suing Pinnacle and 10 other defendants in New Orleans for allegedly devising a scheme to defraud Mentor, which is the Ocean Drilling & Exploration Co. subsidiary ordered into liquidation almost two years ago.

The liquidators—Charles Kempe and Michael Arnold—had applied to extend the pretrial injunction to prevent Pinnacle from taking any action that would interfere with the prosecution of their suit.

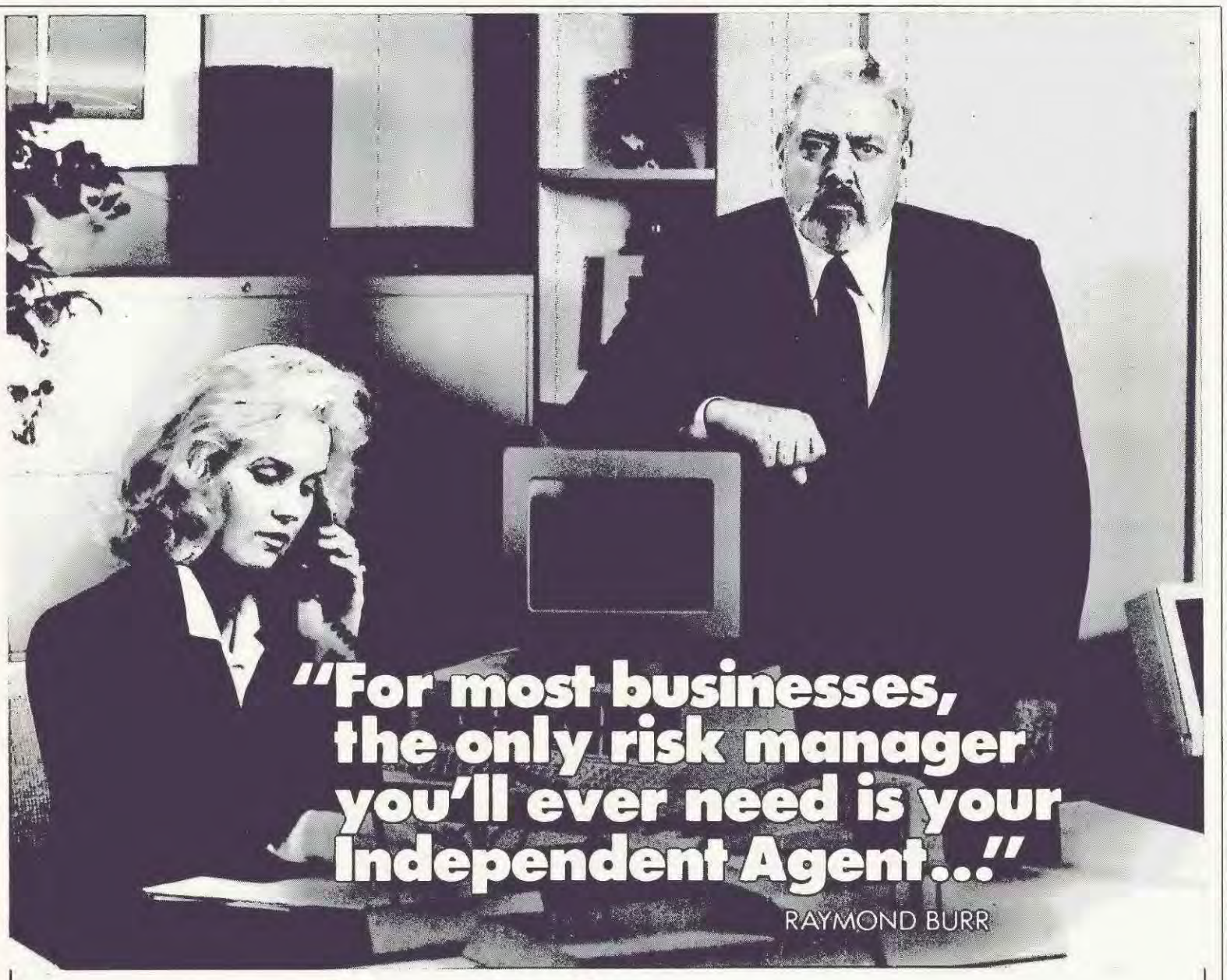
But, on May 14, Judge Livaudais ruled that the liquidators' request failed to satisfy a vital legal test. He said that the likelihood of the liquidators obtaining a permanent injunction preventing Pinnacle from pursuing legal action in Bermuda was a slim one.

His judgment said: "The plaintiffs (Kempe and Arnold) are asking this court to enjoin a Bermuda corporation from seeking a remedy in a Bermuda court against the liquidators, appointed under Bermuda law, of another Bermuda corporation. This court does not find that it has authority to do so."

Judge Livaudais also rejected Pinnacle's request for a reconsideration of his earlier ruling in which he refused to dismiss Pinnacle from the federal court suit on the grounds that the court lacked jurisdiction over the company. Judge Livaudais said Pinnacle's challenge was "irretrievably without merit."

Though the judgment has blocked the liquidators' bid for an injunction and appears to have left Pinnacle free to weigh its legal options, the judge did not refer to a promise Pinnacle made to Judge Livaudais last year that it would not seek injunctive relief against the liquidators without warning. Pinnacle says it does not now know if the promise is in force or not.

Pinnacle Chairman Bruce Swann said May 21 that the company is now contemplating new legal steps in Louisiana and elsewhere. ■



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PCW settlement

Continued from page 2

the problems of these syndicates. They offer the only path of finality for the members.

"For all these reasons the Council would not think it right or reasonable to alter the proposals already put forward," the letter continued.

The PCW members wanted Lloyd's to reduce their contribution to the offer by about 12 million pounds ($20.22 million), which is the amount of money Lloyd's would benefit from currency exchange rate gains between the time the offer was calculated on Dec. 31, 1986, and now.

However, Mr. Miller responded in his letter: "The U.S. dollar exchange rate is, of course, only one, and a relatively small part of the overall calculation on which the offer was based; it was moreover debated with AUA3 during negotiations."

In addition, in the last few months questions have been raised about whether the PCW syndicates will be able to recover under their reinsurance programs, which could increase the amount of losses the syndicates eventually have to pay, Mr. Miller noted.

About 180 million pounds ($303.3 million) of reinsurance recoverable has been included in the syndicates' assets, but reinsurers now are questioning their duty to pay because underwriter Peter Cameron-Webb overwrote insurance premium income limits and may have given wrong information.

"So Lloyd's, who may or may not benefit on the dollar exchange (to the pound), has to take into account that there may be a bloody great hole in the reinsurance program," Mr. Miller said in an interview.

Also, the PCW members are not suffering any worse losses than other syndicates in the market during the years in dispute, although the losses are accumulated into one payment, according to Mr. Miller.

"I can show you 34 other syndicates who did worse," he added.

Mr. Miller said that he is making himself available to PCW members by telephone or for meetings in his office.

Lloyd's also has a PCW "hot line," which has already received "hundreds of calls," Mr. Miller said.

About a dozen PCW members also have pleaded financial hardship to have their contributions reduced, as provided for under the settlement offer.

"The cases are being considered," according to Mr. Miller.

In addition, Lloyd's will assist any PCW member having trouble collecting for PCW losses under stop-loss reinsurance policies, Mr. Miller said. ■

Thanks to modern medicine, he'll now be able to outlive his savings.

Advancements in medicine are helping Americans live longer than ever. But not everyone is financially prepared for a longer life.

Particularly retirees who end up needing expensive long-term care. Currently, that's 6 million people. That number should be 14 million by the year 2020.

Personal savings are seldom enough to pay the costs of retirement health care. And Medicare and Medicaid are only a partial solution. Companies with retirement health care benefits also face the problem of unfunded future liabilities.

Additional solutions must be found to address this retirement health care cost issue that will eventually affect every person, company and institution in our country. Ideas that go beyond traditional products.

At NWNL Group, we're developing an employee benefit program called LifeScope® that would provide for a person's retirement and working years. What makes the LifeScope Program unique is its comprehensive approach to providing benefits. It is more than life insurance and a nursing home policy.

By managing the delivery of health care and planning for future needs, the LifeScope Program can find alternatives that make health care more affordable, while allowing individuals to live independently. The program's benefits would be voluntary, flexible and portable.

Many elements of the LifeScope Program have already been put into place through current NWNL Group benefit programs. Using our resources as the nation's 10th largest group insurance company, we will soon be adding more elements.

To find out more about NWNL Group and the LifeScope Program, contact Ginny Patrick, NWNL Group, Box 20, Minneapolis, MN 55440 or call (612) 372-5784. Because now is the time to begin solving the problems of providing health care in the future.

NWNL GROUP

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Sources for statistics: Employee Benefit Research Institute, 1985; National Underwriter, 1986.

A division of Northwestern National Life Insurance Company, Minneapolis, MN (not admitted in the State of New York). The North Atlantic Life Insurance Company of America, Jericho, NY (a member of the NWNL Companies).

The cast of "Les Miserables," a musical adaptation of Victor Hugo's novel of the same name, was paid as a result of an extra expense endorsement to a policy written by Pacific Indemnity Co. (Photo: Michael Le Poer/Bob Marshak)

Theater cover

Continued from page 3

phers were traveling with the company.

"So you have a lot of extra expense going out because those people have to be housed and fed," Mr. Boyar says.

Some of the extra expenses typically include the performers' salaries, office expenses, equipment rental, advertising and the cost of renting the theater.

Under the terms of the policy, for each missed performance, Pacific Indemnity indemnified the producers of "Les Miserables" for expenses and lost profits based on one-eighth of the show's average weekly revenues. This is because there are eight performances each week.

The policy limits are $3.6 million, and although the policy is renewed on an annual basis, coverage for expenses and lost profits is limited to a maximum of four weeks of lost performances, Mr. Boyar says. Most damaged equipment can be repaired or replaced within this time period, he explained.

The time period can be extended to a maximum of eight weeks if the theater itself is damaged, Mr. Boyar added.

Both the price and availability of theatrical coverage has been relatively stable over the past few years, Mr. Boyar said.

He noted that during the soft insurance market, the premiums for theatrical coverage never came down significantly, so they did not increase sharply during the hard market.

"It's been quite stable. It was down a little. Then it went up. It's easing off a little, but not much," he said.

The extra-expense claim was paid to Les Miserables Co. on April 7. Les Miserables Co. is a limited partnership that financed the production of the musical.

The loss reflects the emerging use of sophisticated, computer-controlled stage lighting and scenery equipment in American stagecraft and the importance of including coverage of such equipment in the extra-expense endorsement, according to Mr. Boyer.

Coverage for computer-controlled theatrical equipment is 'a whole new area,' says Al Forte.

Al Forte, a staff adjuster with Chubb who handled the claim filed by the producers of "Les Miserables," says coverage for computer-controlled theatrical equipment is "a whole new area."

And, Mr. Forte says he expects to see more claims filed under these provisions in the future.

Typically, theatrical production policies cover the expenses incurred and profits lost when a show must be canceled due to damage to scenery, costumes or even the theater itself.

But Mr. Boyar says the advent of computer-controlled lighting and scenery equipment has created a new risk because equipment now is so vital to a production that its failure means the show literally cannot go on.

"Some years ago we persuaded Chubb to extend the business interruption cover—we call it extra-expense these days—to include the failure of computerized stage lighting controls. That was when 'Sophisticated Ladies' opened in New York (in 1981)," Mr. Boyar said.

Several years later, when Mr. Boyar and his wife saw "Dream Girls," which employed electronically controlled set changes, he said he realized that the production would be vulnerable to a failure similar to the risk associated with computer-controlled stage lighting.

"The Chubb people happily extended the cover so that both the scenic controls and the scenic moving equipment as well as the lights were all covered under the extra-expense policy," Mr. Boyar explained.

"Les Miserables," a musical adapted from the book of the same name by Victor Hugo, a 19th century French poet, opened at the Broadway Theater in New York March 12. ■

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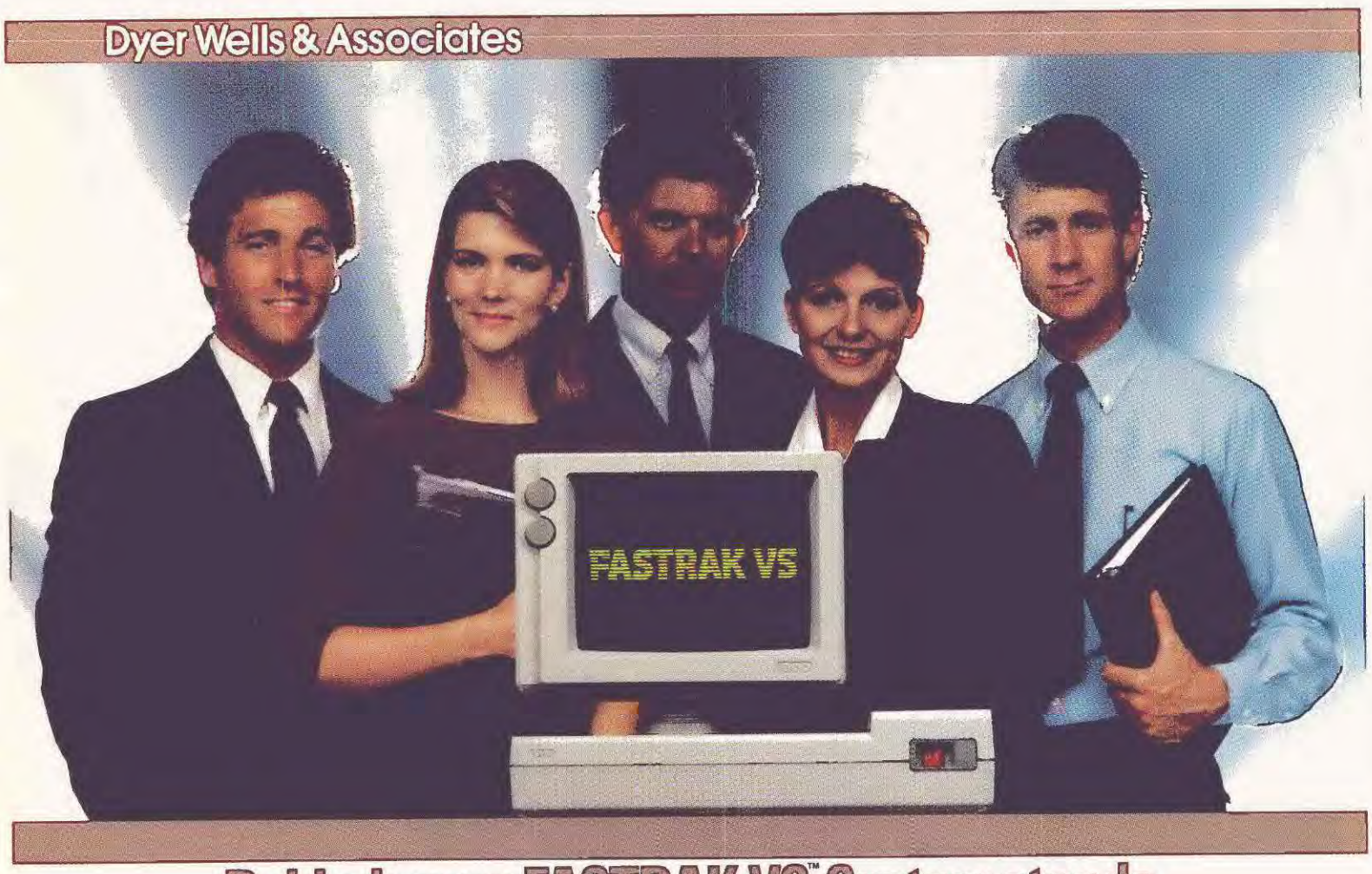

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opinions

Wake up and smell the coffee

THE INSURANCE INDUSTRY must become more responsive and responsible or it, indeed, eventually will lose its place in the free enterprise system.

But insurers do not seem to be aware of this. Instead, industry leaders for the most part are working hard to defend state regulation of insurance and to ward off federal regulation.

It isn't federal regulation per se that insurers have to fear as much as state and federal intervention in the business of insurance: in rate-making, in policy terms and in whom insurers must insure. Eventually, such controls could result in a government-owned insurance business.

That message came through loud and clear at the annual meeting of the Alliance of American Insurers held earlier this month (*BI*, May 18).

State legislators and insurance regulators reminded insurers that the insurance product is needed by individuals and companies to own homes, drive cars and conduct their businesses. When insurers refuse to provide the product, government is going to construct ways to make them provide the product or the government will provide the product, they warned.

This is true already in the form of residual markets for workers compensation, automobile and property insurance and joint underwriting associations for medical malpractice insurance. And now we have joint underwriting associations for all lines of liability insurance activated in two states, with 16 more states holding the authority to create new JUAs if the insurance industry fails to provide a needed insurance product.

As Alliance President Franklin W. Nutter told his membership: Insurance companies must find ways and the capacity to underwrite the more difficult risks as well as the routine risks.

Major corporations for the most part weathered the liability insurance crisis by forming alternative risk funding mechanisms, including policyholder-owned insurance companies. But small businesses, lacking the risk management savvy to solve their problems and generally ignored by the major insurance brokerage firms that could have found solutions but were too busy chasing bigger clients and commissions, are frustrated by the cost of insurance and the lack of available coverage.

No one should think that insurance availability problems have been solved now that insurers' profits have increased and there are reports of stabilizing rates and increased capacity. For example, nurse practitioners recently lost their market for liability insurance (*BI*, May 11).

When voters call on their legislators to solve their insurance problems, the legislators are going to respond to the demands of their constituency. And, the legislators will not be inclined to respond to insurers' demands for tort reform as the way to solve the root problem without linking tort reform to reduced insurance prices and/or more availability of insurance.

Buyers of commercial insurance, generally, would prefer to have a competitive insurance marketplace in which they are free to shop for the best insurer providing the best product at the best price. But, when the insurance industry fails to offer them any options, insurance buyers are not going to oppose state or federal intervention.

Government appropriation of the insurance industry is not imminent, but it could happen if insurers continue to fail to provide needed insurance

letters

Sir Peter did not see himself above the law

To the editor: I have been an admirer of Sir Peter Green as well as, hopefully, a friend, and I think that it was very much to his credit that during his years as chairman of Lloyd's of London he led his colleagues in the direction of better regulation and policing of the Lloyd's market, despite the fact that he was aware of certain skeletons that could come home to haunt him as a result of the new watchdog mechanisms he was setting in place (*BI*, May 11).

I think enough of the man to conclude that he did not see himself above the law, but was really committed to a new Lloyd's with new rules to maintain its integrity, despite the effect it might have on him personally.

I am prepared to recognize that my feelings for Sir Peter may be that of a country boy overwhelmed by the tradition and stature of the Lloyd's institution, but I am always prepared to err on the side of friendship.

Sen. John R. Dunne
6th District
Deputy Majority Leader
Albany, N.Y.

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Cut-rate underwriting shows short memory

To the editor: Once again it is becoming apparent that most companies within the industry (rather, "the people") do not have the fortitude to control, and therefore cannot manage, the underwriting of excess casualty business—particularly umbrellas.

Our branch excess underwriters recently have reported noticeable reductions of rates on first-layer umbrellas by the industry. My initial thought was: "No, it can't happen in an enlightened, sophisticated, 1987 business environment where there was a serious financial condition for most companies only a few months ago." So, I asked for specific examples and they sent them to me. It is real.

There is no point in citing all the things that make such action foolhardy; however, our experience shows that yes, large losses do actually occur, particularly in the automobile line. Even with our controlled approach to underwriting, we have had our share of losses in 25 years of writing umbrellas, and at this late date we still get new reports on occurrences from the 1970s. All costs in the casualty insurance sector continue to go up relentlessly, not down. Our actuaries conservatively project ultimate losses that clearly show prices cannot be reduced without serious consequences.

So, where does the buck stop on this cut-rate activity, which will bring a repeat of the early 1980s and inevitably, again, do irreparable harm to the industry and its relationship with the public and government? There is no escape; the finger is on the CEOs. They are the ones who must direct and control. They must prevent another disaster.

CEOs must look at reality from those who know what will happen from underpricing that first $5 million limit. This comes from the actuaries, on projected development of losses on long-tail business.

At Fireman's Fund Insurance Cos. the CEO, in addition to evaluations from the company actuaries, asked for a review from not one, but two independent firms. The results of all three indicated a reduction in pricing would be irresponsible. A similar study by the major reinsurer in

Continued on page 10

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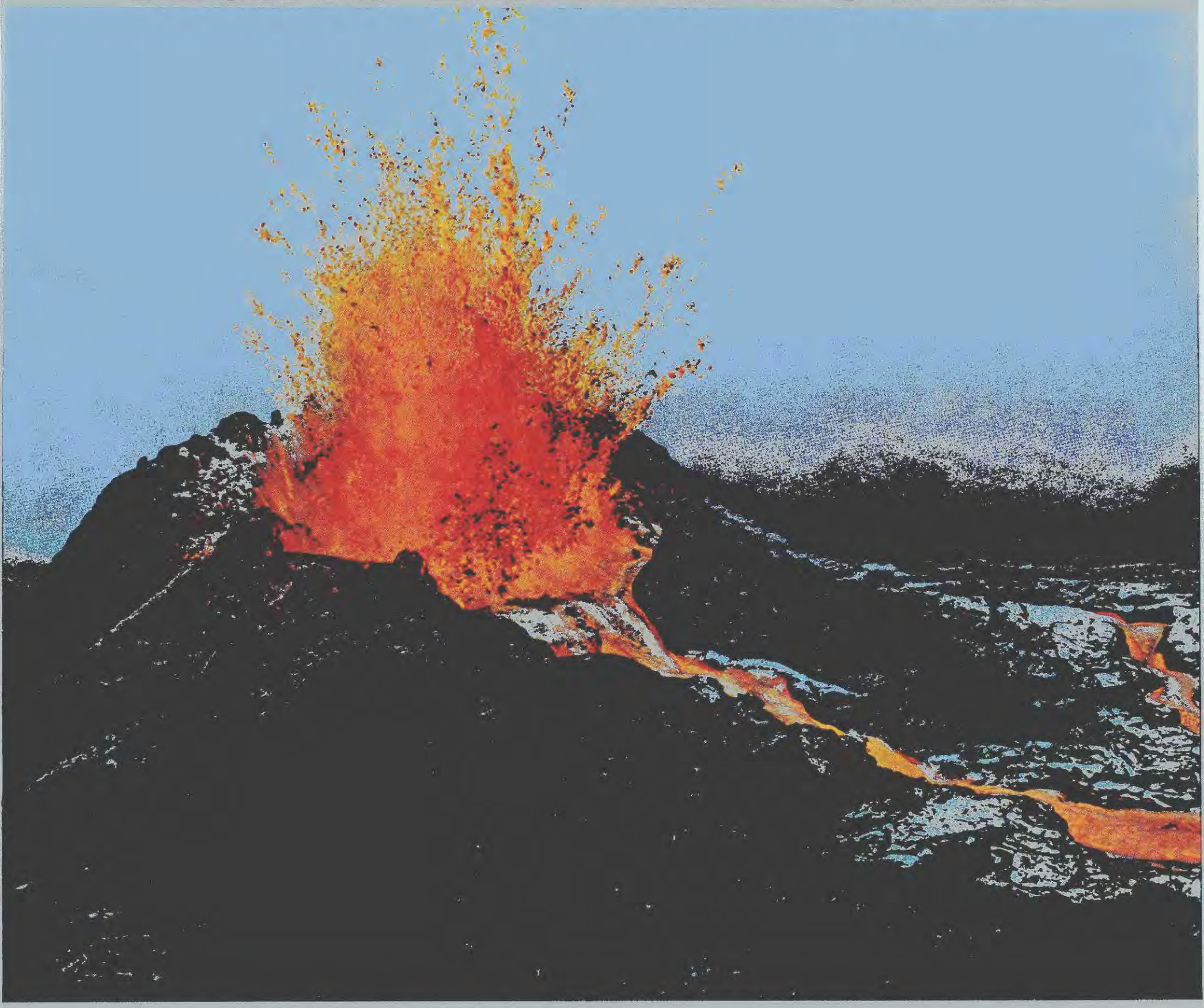
EVER TRY TO PUT A LID ON RISING DENTAL COSTS?



In recent years, the cost of dental care has risen even faster than the cost of medical care.

As a country, we're spending nearly $27 billion on trips to the dentist. By 1990 that figure is expected to reach over *$42 billion*.

If the dental cost explosion doesn't subside, many people may simply postpone seeing a dentist. So a minor dental problem turns into a major problem. And a costly one.

What does all of this mean to an employer? Loss of productivity. Dental problems have resulted in the loss of over 100 million working hours a year. What's more, a company's benefits budget may not be able to support unmanageable dental costs.

At CIGNA, our companies have long been committed to making dental costs less painful. We've worked closely with the dental community for the last twenty years, designing dental plans that are responsive to employers' benefit needs. And we've succeeded not only in holding down costs but in improving the quality of care.

We were the first major insurer to offer our own prepaid dental plan in addition to traditional indemnity plans. Plans that encourage preventive care.

We've even revolutionized claim review, with a unique three-tier process. It combines review by professionals with the most sophisticated claims processing system available. And, in 1985 alone, we saved our clients over $138 million.

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Putting a lid on dental costs. It's one more example of CIGNA's commitment to personalized service to business.

CIGNA

letters

Continued from page 8
the United States on industry excess rating produced the same result.

To stop the rate cutting, I suggest insurers:

- Do not allow the same underwriter to price both the primary coverage and the umbrella policy. With all the pressure applied to that underwriter—subtle and direct—to produce gross premiums written for the company and/or to help that good producer, something will give; it will be in pricing and the cut will come from the umbrella.
- Don't reduce primary limits requirements. This only drives price-cutting to a lower level of limits with a result of greater disaster downstream.
- Make sure branches are carrying out directives. The CEO must have a Lt. Colonel in branch office underwriting.

CEOs could not responsibly direct or condone cut-rate activity on catastrophe limits. However, intervening layers of management can, and usually do, dilute the well-thought-out home office policy.

One last sobering thought: Because umbrella rating is usually a percentage of primary, are these excess price reductions a result of an even larger problem? Think about it.

E. Ray Gardner
Vp, Excess Casualty
Excess & Special Risk
Fireman's Fund Insurance Cos.
Novato, Calif.

Quality health care lacking in HMOs

To the editor: Bravo for your opinion that HMOs be required to provide quality health care (*BI*, May 11).

Since 1978, I have seen our company—and our employees—snowballed by:

- An HMO that went bankrupt, leaving hundreds of employees uncovered and owing for services that were to be covered through their premiums.
- An HMO whose services were so poor that an infant will suffer a heart disability for the rest of his life.
- An HMO whose concern with cost allowed five doctors to see a patient over a six-month period of time without properly diagnosing or treating her, resulting in her death at age 23 of tuberculosis!

I grow weary of the HMO sales pitch to employees—no claims to file, no copayment, no hassles. If only the employees realized that it also means: little or no quality care; that "doctors" listed as providers may not even be licensed in this country; that premiums are higher because the whole community is rated, not just one particular *healthy* group.

I marvel at the ignorance of employees who think that they are paying $2 for an office visit—the cost is the same for all patients; only the *quality* is different.

The concept of prepaid health maintenance is a good one; unfortunately, there is not an HMO in the marketplace today that I have found that couples quality with service. I look forward to the time when government does not require an employer to blindly offer substandard coverage to employees to satisfy "fairness."

Karen T. Baumgardner
Employee Benefits Manager
H&C Communications Inc.
Houston

Car rentals favor corporate clients

To the editor: Beware when renting a car! As a risk manager, I feel better knowing companies get higher limits; but as an individual, I resent Budget Rent a Car Corp. offering corporations better coverage on rental vehicles (*BI*, April 27).

When on vacation I have sometimes paid more for the deductible buy-down insurance than for the use of the rental car. Nevertheless, if by some unlucky happenstance I was liable for damages in a severe accident, the rental company's insurance may pay only minimum limits. Would the excess come from my savings?

Because I'm aware of this problem I ensure that my personal auto policy wraps around to protect me. Who protects the *un*aware?

Perhaps in your litigious country someone will question this matter in court—or if you're lucky, Ralph Nader or 60 Minutes will get their teeth into it!

Edna I. Taylor
Coordinator-Risk Management
Home Oil Co. Ltd.
Calgary, Alberta

Male, female health costs alike: Study

NEW YORK—Medical utilization by injured workers is similar for male and female claimants, according to a study conducted by the National Council on Compensation Insurance.

"While injuries sustained by women in the workplace cost less, on average, than injuries to men, after controlling for the nature of the injury and the body part injured, we find there is little difference in medical expenditures between male and female workers," explained David Appel, the NCCI's vp for economic and social research and one of the study's three authors.

The data for the NCCI study is from a 1979 Call for Detailed Information, which involved weighted samples from 12 states.

"In 11 of the 12 states in the sample," Dr. Appel noted, "medical expenditures by females are less than those by males. In the twelfth state, there was virtually no difference in the average expenditure."

"Females spend less, regardless of the body part that is injured," he said.

Dr. Appel noted that injuries sustained by females differ from those sustained by males.

For example, the study found that women are 25% more likely to suffer strains and injuries of the lower back or upper extremities than men.

The study also found that there was a relationship between wages and medical utilization and age and medical utilization, Dr. Appel noted.

"High wage workers tend to demand more medical care and older workers usually take more time to recuperate from their injuries," Dr. Appel said.

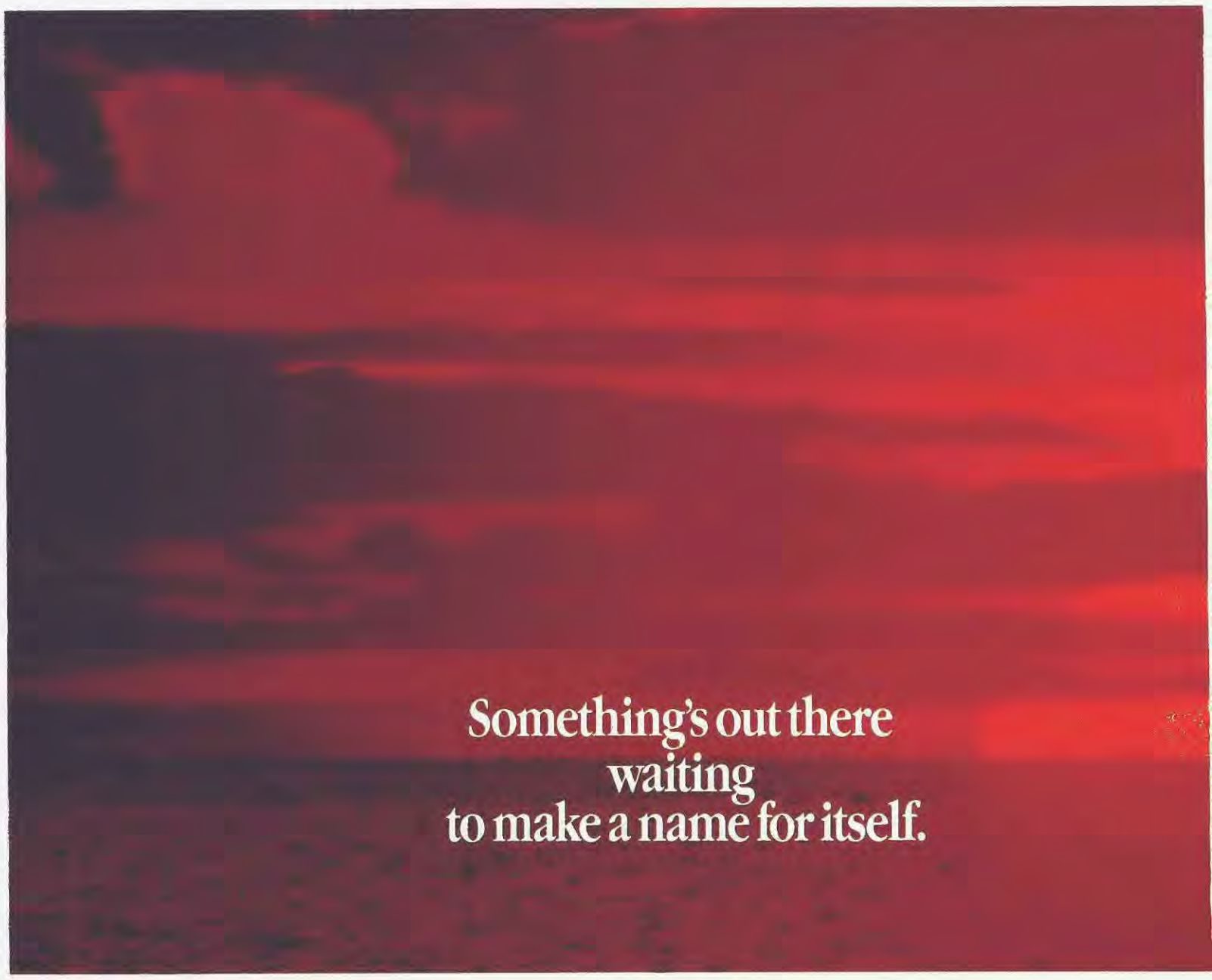
Dr. Appel cautioned, however, that the study is not necessarily representative of the general population's health care costs.

"For instance," he said, "our data doesn't include expenditures that would arise from gynecological care.

"Also, most of the workers in the sample are between the ages of 18 and 65 and, because younger workers are far more likely to be workers compensation claimants, medical expenditures associated with old age are not observed," Dr. Appel explained.

•

For a copy of the study, which appears in the April issue of the NCCI journal Digest, contact Kathy Spicer, National Council on Compensation Insurance, 1 Penn Plaza, New York, N.Y. 10119.



Alicia $1.27 billion. Elena $622 million. Gloria $618 million. First there's the calm. Then the storm. The losses pile up.

When the next devastating hurricane happens, will your catastrophe reinsurance limits be adequate?

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Finally, the latest technological advances in computer science and weather analysis combine to create a hurricane and tornado catastrophe risk model that dares to look to the future. CATALYST.

Using National Weather Service Data and Monte Carlo mathematical simulation, the CATALYST model can estimate your Probable Maximum Losses due to either hurricane or tornado catastrophe.

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By simulating both the frequency and the severity for as many as several thousand storms, we develop a profile of potential losses. From this you can more confidently decide how much catastrophe reinsurance to buy.

Test cases prove CATALYST is reliable.

The CATALYST model has been run using the measured storm characteristics of Hurricane Gloria and applied to sample companies. Estimated losses were within 8% of those actually incurred.*

Comp board rejects AIDS disability pay

around the states

SAN FRANCISCO—A state workers compensation appeals board overturned a ruling that would have granted disability benefits to a construction worker who contracted AIDS-related complex while working in Zaire for a U.S.-based civil engineering company.

The worker, Paul Trejo, 46, was one of about 30 Americans assigned to work on various construction projects in the Congo between 1977 and 1980 by Boise, Idaho-based Morrison-Knudsen Corp.

Mr. Trejo sought workers compensation disability benefits on the grounds that his illness was job related because his employer, Morrison-Knudsen, allegedly condoned the practice of procuring local women for sexual relations.

The company denies that it condoned such practices by its employees.

In overturning a March decision by Judge Maurice Carey granting disability benefits, the California appeals board May 8 rejected Mr. Trejo's contention that his illness was job related.

"Applicant's development of acquired immune deficiency syndrome-related complex resulted from his participation in off-duty, social or recreational activity that did not constitute part of his work-related duties and was not expressly or impliedly required or a reasonable expectancy of the employment," the board said in its decision.

"We are pleased with the decision and feel it is a just one," said a spokesman for Morrison-Knudsen.

The spokesman also said Mr. Trejo no longer works for the company.

Mr. Trejo based his claim on two rules of case law: the "bunkhouse rule" and the "commercial traveler's rule."

The bunkhouse rule holds that if an employee's job requires him or her to live in company housing, the employer is responsible for leisure-time activities that take place in the living quarters.

The commercial traveler's rule holds that if an employee is required to travel as part of his or her job, the employer is responsible for all reasonable activities that occur during the time the employee is traveling, including recreation.

The appeals board said that the bunkhouse rule didn't apply in Mr. Trejo's case because "the applicant has not met his burden of showing that his sexual activity was caused by his employment."

The board said the traveler's rule did not apply because Mr. Trejo was stationed in Zaire for 30 months and therefore had a "home base" in Zaire.

Alfred E. Marotta, Mr. Trejo's attorney, says the board's reasoning "can't be justified under existing case law."

Mr. Marotta contends that the company knew of and condoned the sexual relations between its employees and the local women. Thus, he says, the sexual relations were a reasonable use of the employer-provided living quarters.

Mr. Marotta says he will file an appeal shortly with the state appeals court in Los Angeles.

"I think we probably will win the appeal," Mr. Marotta said, adding, "The poor guy doesn't have much else to look forward to."

Mr. Marotta says that Mr. Trejo is seeking temporary disability benefits of $196 a week.

AIDS-related complex is marked by symptoms less serious than acquired immune deficiency syndrome, but may later develop into AIDS.

Reform challenge

LANSING, Mich.—Michigan Mutual Insurance Co. will test the constitutionality of a new workers compensation reform law that requires retroactive payments to some disabled workers, a spokesman says.

Michigan Mutual, other workers compensation insurers and some self-insurers may file a joint suit within a month, said Tom Hoeg, vp and general counsel for Michigan Mutual and The Amerisure Cos.

The Lansing-based Michigan Insurance Federation, a lobbying organization for 30 member insurers, plans to challenge the constitutionality of retroactive payments in court, said Executive Vp Nancy Nowak.

And, the Accident Fund of Michigan, the state's largest workers comp insurer covering about 31,000 businesses, is reviewing the statutory language of the law and is "deciding how to act," said Frank Nerat, assistant manager and general counsel for the Lansing-based fund.

The law, signed earlier this month by Gov. James Blanchard, requires some insurance companies and self-insured employers to make retroactive payments to workers injured before March 31, 1982, if those workers' benefits were reduced in accordance with a 1985 Supreme Court ruling.

The reform legislation—a compromise between the House and Senate leaders and the governor—also changes the definition of disability and makes it harder for injured workers to sue employers in court, supporters say.

The new law could force Michigan Mutual to pay some 400 previously injured workers a total of $5 million, according to Mr. Hoeg.

"We believe that any kind of attempt to change the law retroactively is unconstitutional, and we will litigate it," he said. "You can't have a law that goes back retroactively and changes what was legal to illegal."

Mr. Hoeg estimated some 4,000 to 6,000 workers injured up to 30 years ago may be eligible for retroactive payments, and the total repayment could reach $16 million a year for at least the next 20 years.

General Motors Corp., Ford Motor Co. and Chrysler Corp.—all self-insured companies—would have to make the largest repayments because they employed the majority of injured workers eligible for the retroactive payments, industry sources predict.

"There is not nearly the impact for insurance companies that there is for the automakers," said the federation's Ms. Nowak.

However, several other self-insured companies in the Detroit area say the new law will have little effect on them.

Self-insured Michigan Bell Telephone Co. in Detroit may have to make retroactive payments to injured workers of less than $500,000, but does not plan to

Continued on next page

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around the states

Continued from previous page
challenge the new law, although "we do have reservations about its constitutionality," a spokesman said.

And, Troy-based K mart Corp., also self-insured, "does not expect to have to make any reimbursement under the new legislation," said Bill Szykula, director of workers compensation for the retail store chain.

Right to know council

OLYMPIA, Wash.—Nominations are being sought for five openings on the Washington State Right to Know Advisory Council.

The 16-member council advises labor and industries about administration of the Worker and Community Right to Know Law adopted in June 1984, according to the Department of Labor and Industries.

Members receive no compensation, but are reimbursed for expenses such as travel. The type of candidates sought are:

- One person with knowledge and experience in the field of industrial hygiene recommended by recognized labor organizations.
- One person recommended by recognized agricultural organizations.
- One person recommended by recognized environmental organizations.
- One person recommended by recognized petroleum industry organizations.
- One person recommended by recognized business or trade organizations.

Other members currently serving on the council represent migrant labor, public interest organizations, chemical industries, community organizations, professional accident and safety organizations, technology-based industries and environmental researchers.

Nominations should include a description of the candidate's professional involvement, and must be submitted by May 29 to Marcia Holt, Administrative Assistant, Right to Know Program, Department of Labor and Industries, P.O. Box 207, Olympia, Wash. 98504.

Michigan market

LANSING, Mich.—Michigan's Commissioner of Insurance, Herman W. Coleman, reports that 15 lines of insurance generally are not available from insurers licensed to do business in the state.

In an April 25 letter addressed to "all surplus lines agents and interested parties," the Insurance Bureau listed the 15 coverages, which included:

- Liability for entertainment, recreational or sporting events or facilities written to include injury to participants.
- Property and liability insurance on mobile, traveling or fixed recreational or amusement businesses.
- Product liability, when written alone.
- Liquor liability insurance.
- Environmental impairment insurance.

The Insurance Bureau publishes the list quarterly, as required under the Michigan Insurance Code, and will consider written requests that a line of coverage be added or removed from the current list.

Meanwhile, Commissioner Coleman released a list of 63 insurers not licensed in the state that are eligible to write insurance on a surplus lines basis in Michigan. Among the insurance companies listed are: Lloyd's of London; St. Paul Surplus Lines Insurance Co.; National Fire & Marine Insurance Co.; and California Union Insurance Co.

In addition, the bureau reports four insurers are no longer writing business in the state, either by department order or insolvency. They are: American Special Risk Insurance Co., removed by order of the commissioner; Hudson Insurance Co., which ceased writing new and renewal business July 1, 1985, and is running off business; Illinois Employers Insurance of Wausau, removed by order of the commissioner; and Mutual Fire, Marine & Inland Insurance Co., removed by order of the commissioner.

New Oklahoma laws

OKLAHOMA CITY—Oklahoma Gov. Henry Bellmon has signed legislation that imposes penalties for filing frivolous lawsuits and protects professional review boards from some liability suits.

Under the law, an Oklahoma judge can force a plaintiff and plaintiffs' lawyer to pay the attorneys' fees and reasonable expenses of the defendant if a suit is determined to be frivolous.

S.B. 183, which was sponsored by Sen. Tim Leonard, R-Beaver, also affords some protection for professional review boards such as those set up in hospitals to assess the performance of doctors.

For example, Sen. Leonard said a hospital board that ruled for good reason that a doctor could no longer practice at its facility could not be sued by the physician.

In addition, the law reduces the statute of limitations to seven years for medical malpractice lawsuits brought by minors, Sen. Leonard explained.

Under previous law, a minor plaintiff had until the age of 19—one year older than the age of majority in Oklahoma—to file a medical malpractice suit.

The law also prohibits plaintiffs from listing in lawsuits the amount of damages sought above $10,000.

New commissioner

HARRISBURG, Pa.—Constance Foster will be sworn in as Pennsylvania's Insurance Commissioner on May 29.

Ms. Foster, an attorney, was appointed acting commissioner in January when Democrat Robert Casey took office as governor.

Ms. Foster

Her appointment was confirmed by the state's senate last month.

She has specialized in insurance law as a managing partner with the Philadelphia-based law firm of Baskin, Flaherty, Elliott & Mannino P.C. and before that, with Dilworth, Paxson, Kalish & Kauffman.

Ms. Foster, 40, received a bachelor's degree in history from the University of California at Los Angeles and a law degree from Rutgers University's in New Brunswick, N.J. She is a native of Slayton, Minn.

Ms. Foster said her goals include maintaining an accessible department, providing insurance information to consumers, enhancing regulatory procedures and staff responsibility as well as updating the department's computer auditing and data processing ability.

In a statement before state legislators, she said: "The insurance regulator faces numerous challenges over the next four years: the availability and affordability of commercial and personal insurance lines, quality regulation of the many new and varied forms of health care concepts and arrangements and monitoring of new insurance packages tailored to meet the needs of our senior citizens." ■

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Susan Werner, Director of Risk Management, Hardee's Food Systems, Inc.

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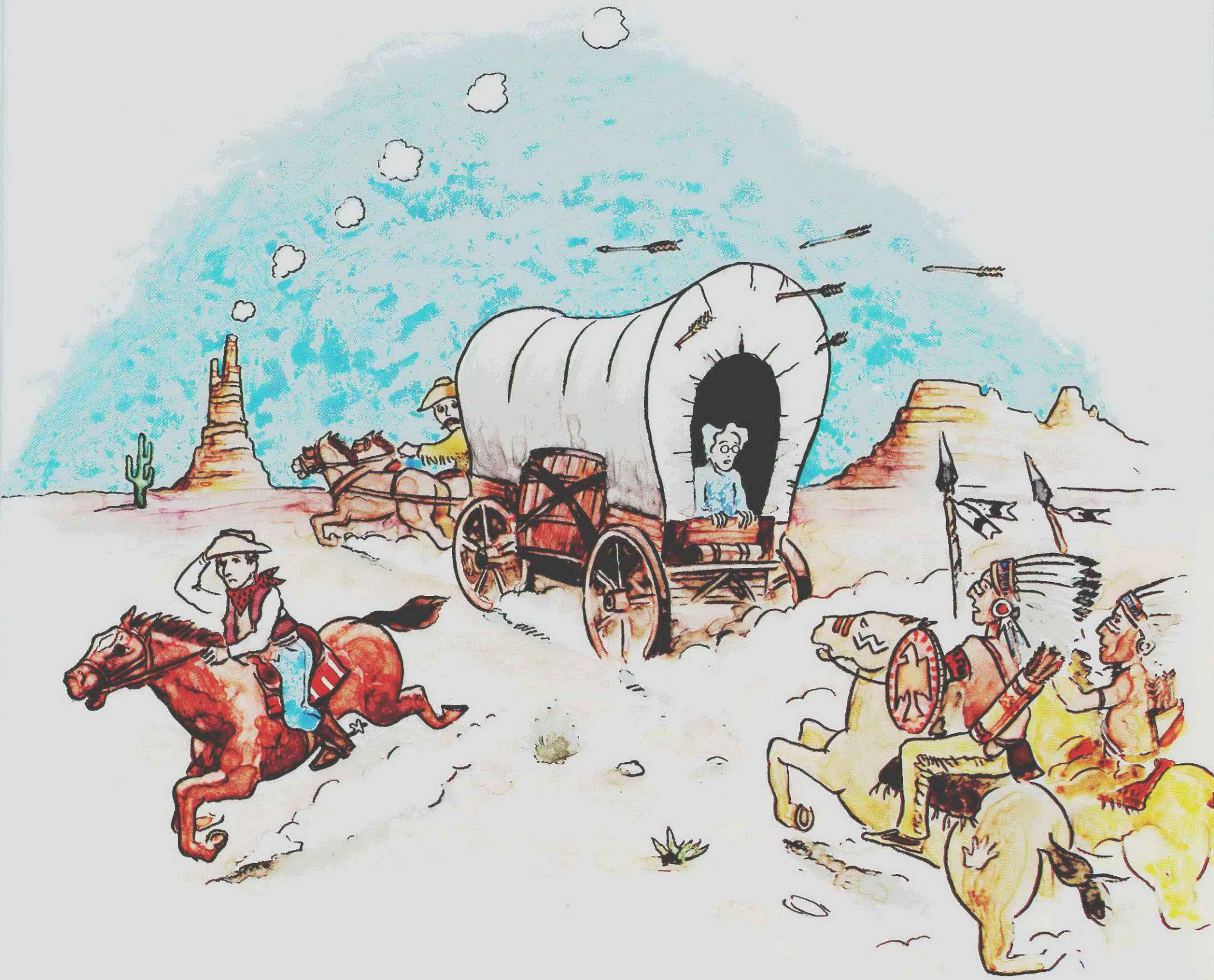

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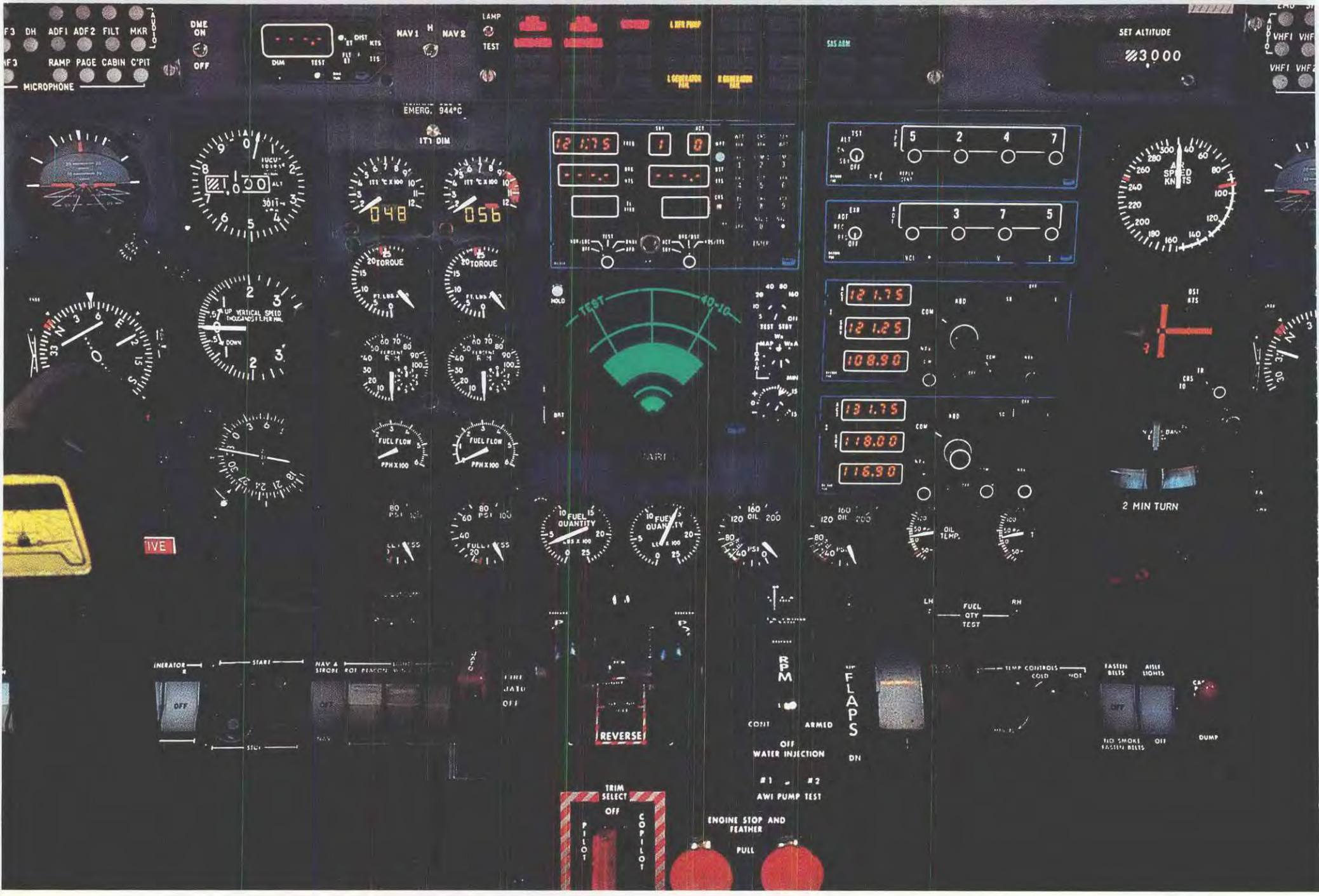

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PCW names holding out on settlement

By STACY SHAPIRO

london

LONDON—Although members belonging to syndicates formerly managed by PCW Underwriting Agencies Ltd. are interested in settling their losses, they want to pay less than Lloyd's of London wants under its settlement offer.

Lloyd's has proposed a 103 million pound ($173.6 million) settlement, but PCW names want to reduce their 34 million pound ($57.3 million) contribution to the settlement by as much as 12 million pounds ($20.22 million).

Because much of their losses were in dollars, the members argue, they want their contribution reduced to reflect the increased strength of the pound against the dollar since the offer was proposed, said a spokesman for the PCW 1985 Committee.

"We will ask Lloyd's for an improvement of the offer."

In addition, a majority of the 1,547 members belonging to PCW non-marine syndicates want more time to consider the settlement offer and are asking Lloyd's to extend the deadline for accepting the offer to June 19 from May 30 as it may under the terms of the offer, confirmed the spokesman for PCW.

However, the PCW members are interested in Lloyd's proposal to set up a reinsurance company to settle PCW claims and give PCW members immunity from any further losses.

At the moment, "Lloyd's is considering the PCW members' request" to extend the offer's deadline to June 19, said a Lloyd's spokesman.

For the settlement to move forward, at least 90%, or 1,392 of the 1,547 PCW members, must accept Lloyd's settlement offer, which includes immunity from further losses.

Representatives of the PCW members are expected to meet with Lloyd's in the next few weeks to try to hammer out a settlement considered equitable by the majority of PCW members.

Under terms of the offer, the PCW members must contribute 34 million pounds, relinquish their rights to sue Lloyd's and transfer their rights to sue other parties to the settlement to Lloyd's.

For its part, Lloyd's will contribute 45 million pounds ($75.9 million) from its Central Fund as a premium to the reinsurance company, and 37 other organizations will contribute 55 million pounds ($92.7 million) to the settlement.

In addition, Lloyd's will pay 2.9 million pounds ($4.9 million) to the Inland Revenue to end tax disputes involving PCW members.

A total of 134 million pounds would then be used as a reinsurance premium to close PCW syndicates' accounts. The premium would be paid to a special syndicate, which would be reinsured with a company owned by Lloyd's.

Representatives of 450 PCW members facing the heaviest amount of losses met in London for two and a half hours on May 15 to discuss the offer. The atmosphere was hostile at the meeting, chaired by British lawyer Lord Goodman and attended by other British and American lawyers representing PCW members, according to one PCW member who attended the meeting.

PCW members decided that Lloyd's should be asked to extend the deadline of the offer and reduce the members' contribution by the amount the value of the pound has increased against the dollar, said the PCW 1985 Committee spokesman.

The PCW members claim that Lloyd's calculated the 134 million pound reinsurance premium—of which 87%, or 116.6 pounds, would be used to pay dollar losses—using the exchange rate as of Dec. 31, 1986, which was $1.48 to the pound, said the PCW members' spokesman.

Since then, the pound has strengthened to around $1.65. Therefore, 134 million pounds in a fund at the moment would be worth 11% more in dollars due to exchange rate fluctuations after the time the amount was calculated, according to the PCW spokesman.

The PCW members want to benefit from this profit—which would stand at about 12 million pounds—and have their portion of the settlement reduced by the exchange rate gain, according to the PCW spokesman.

"Lloyd's ought to make this (profit) available to the names," he said. However, "Lloyd's may say this isn't fair."

"The exchange rate is unsavory," said a PCW member who attended the meeting.

However, the PCW member said that, overall, the settlement "is reasonable in global terms and is probably a fair figure, but it is not equitably spread among members. It does fall heavy on the few."

The majority of PCW members are expected to accept the Lloyd's offer, however, the PCW member believed.

"I don't know yet if I will accept the offer," said the member. "But I think (only) the hard core 80 or 90 people won't accept the offer."

"Some names will accept and some names won't," said the PCW 1985 Committee spokesman. "The PCW members are not acting together. Their decisions will be personal.

"It would be a step in the right direction" to extend the offer's deadline, however,, he added.

In the meantime, one of the 37 contributors to the Lloyd's settlement offer, Minet Holdings P.L.C., the parent of PCW, recently issued its 1986 qualified annual results, which were audited by accountants Neville Russell.

Minet set aside 12.9 million pounds ($19.1 million) in its 1986 results to pay its contribution to the settlement and any other matters related to PCW, Neville Russell says. Various claims related to the affairs of Richard Beckett Underwriting Agencies Ltd., PCW's successor agency, have been and may be made. In addition, the outcome of "certain investigations is not yet known," says the auditor's note.

Therefore, Minet's 1986 results are "subject to adjustments," Neville Russell says.

Important market

North America remains the most important insurance market in the world, both because of volume and sophistication, according to a London-based stock analyst.

Continued on page 18

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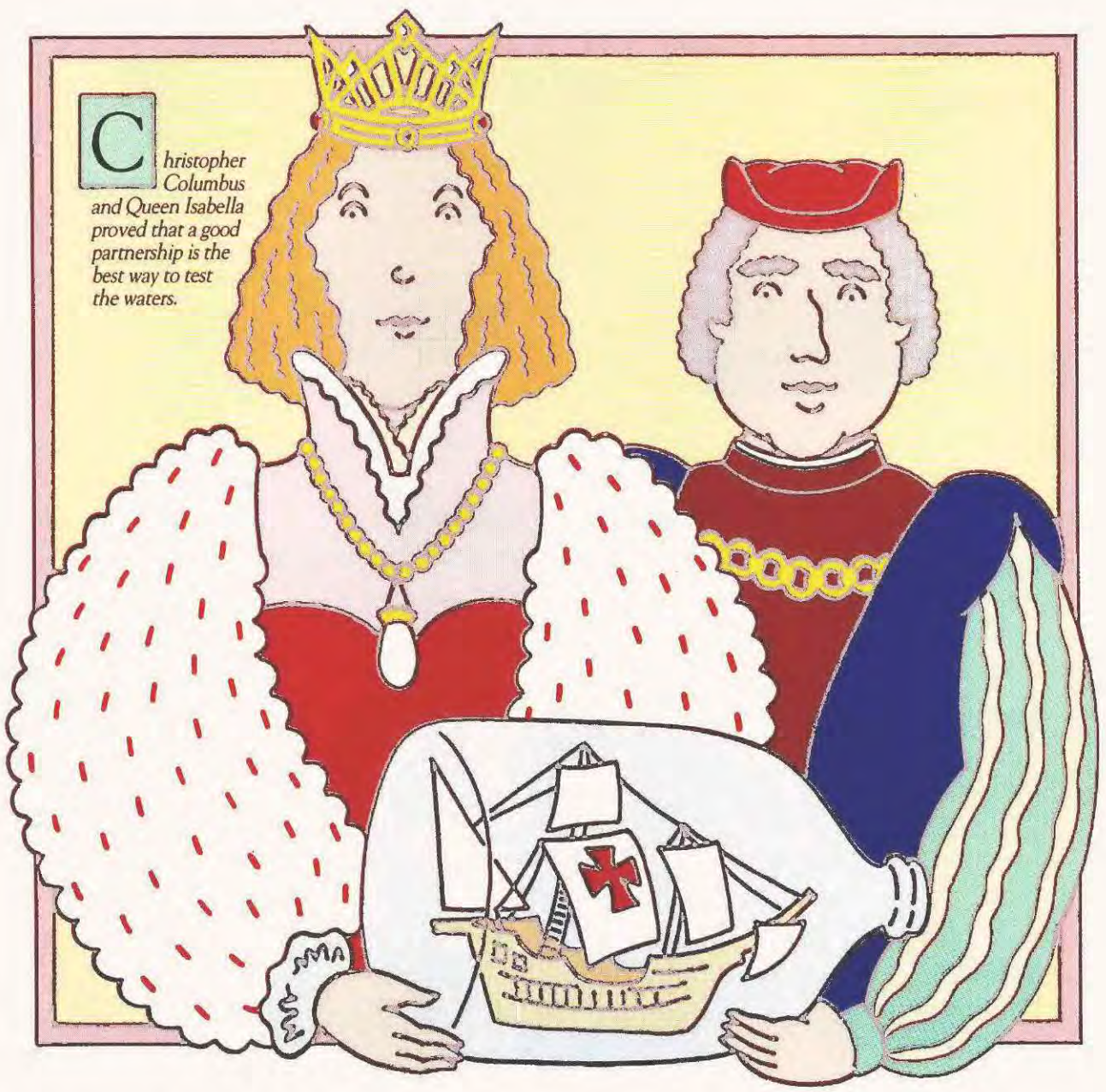

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london

Continued from page 16

"With Canada, North America is now the single largest source of revenue geographically for the London brokers," says Lee Coppack, an analyst with Sheppards, a London stockbroker, in a survey of the London insurance brokerage industry.

"The thrust of (British insurance) brokers' development and expansion has been into the United States, and we believe that in 1986 more than half the sector revenue will have come from the U.S. and Canada, compared to 24.8% in 1984 and 46.6% in 1985," the report adds.

For example, the North American-based revenues of six London brokers jumped 212.2% to 456.4 million pounds ($661.8 million at year-end exchange rates) in 1985 from 146.2 million pounds ($169.6 million) in 1984.

However, much of the increase is the result of Sedgwick Group P.L.C.'s acquisition of Fred S. James & Co. Inc., now the fourth-largest U.S. broker, the report notes.

In 1985, the same six British brokers reported revenues of 317.5 million pounds ($460.4 million) from British-based business and only 89.3 million pounds ($129.5 million) from Europe.

"In the past three years, the main direction of the major brokers' expansion has been across the Atlantic, headed by Sedgwick, which had long been expected to establish a significant U.S. presence," the report says.

Sedgwick's U.S. acquisitions include Fred S. James in August 1985 for about 533 million pounds ($639.6 million) (*BI*, April 8, 1985); Tennessee-based Armistead Corp. for $32.5 million in August 1986; The Crump Cos. Inc. for $307 million in November 1986; and Dallas-based broker Arthur L. Owen Co. Inc. for $16.5 million in January 1987.

Other U.S. brokerage acquisitions by London brokers, according to the report, include:

- Globe Agency Inc., a Michigan-based broker acquired by Hogg Robinson Group P.L.C. in January 1987 for $7.6 million.
- 90% of Continental Underwriters, a New Orleans surplus lines broker, acquired by Minet Holdings P.L.C. for $4.8 million in December 1986.
- Major Surplus Holdings Inc., a surplus lines broker with offices in New York and New Jersey, and S.L. Alexander Inc., a surplus lines broker with offices in Los Angeles, Sacramento and Prescott, Ariz., both acquired by by Stewart Wrightson Holdings P.L.C. The total price is not expected to exceed $14.75 million.
- McAlear Associates Inc., a Grand Rapids, Mich., surplus lines broker, acquired by Willis Faber P.L.C. for between $18.5 million and $19.5 million in December 1986.

The typical London broker will report a 15% increase in brokerage revenues for 1986, and these revenues will grow an average of 19% for 1987, the report predicts.

In addition, the U.S. property/casualty insurance industry will not produce "bad" results before the 1990s, said stock analysts Chris Pountain and Peter Rice of Wood Mackenzie & Co. Ltd., in a report following a visit to the United States.

"Attitudes are heavily influenced by the losses of the last (market) downturn: Market share is not being aggressively sought and few new players are entering the game," they said.

Lloyd's cartoons

The most famous series of comic drawings on Lloyd's of London this century are on exhibit until June 20 at the Royal Festival Hall and the National Theatre.

The exhibition of 275 original works by Henry Mayo Bateman, including cartoons and caricatures, marks his 100th birthday. It is sponsored by Lloyd's broker Stewart Wrightson Holdings P.L.C. and organized by the Langton Gallery.

Mr. Bateman, one of the best loved cartoonists in Britain, was a master at satirizing British life in the first half of this century.

Mr. Bateman was "concerned with depicting a proliferation of gaffes: lonely, embarrassed figures, having just committed some unpardonable breach of convention," noted the The Times in the cartoonist's obituary in February 1970.

His mid-1930s cartoon entitled, "The underwriter who missed the total loss," which appeared in the high society magazine The Tatler, is believed to be the first time a comic artist penetrated the "inner sanctum" of the insurance world and interpreted it, according to Stewart Wrightson.

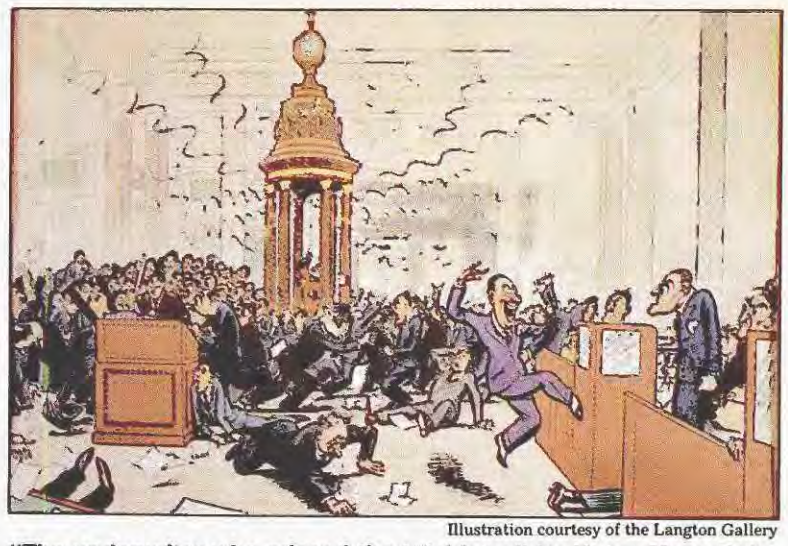


Illustration courtesy of the Langton Gallery

"The underwriter who missed the total loss," by Henry Mayo Bateman, appeared in the high-society magazine The Tatler.

After World War II, George J. Stewart, chairman of Stewart Smith—the forerunner of Stewart Wrightson—asked Mr. Bateman to part with the original drawing and draw a companion cartoon, "The broker who insisted on having his commission reduced."

At the suggestion of Mr. Stewart, Mr. Bateman drew a total of 20 cartoons on Lloyd's of London, 17 of which hang in the current exhibition by permission from the Stewart family.

Some of the captions on the Lloyd's cartoons include, "Dynamic Effect of a Black Cat at Lloyd's" or "Welcome;" "Embarrassing Predicament of Chairman of Joint Hull Committee during a Cross Channel Trip;" "Marine Underwriter Caught Writing a Non-Marine Risk;" and "The Underwriter Who Never Missed a Total Loss."

Mr. Bateman's drawings, which have been copied and framed, adorn many insurance offices around the world. ■

American business has one word for our safety programs:

Subject insurers to anti-trust laws: NFIB

By JERRY GEISEL

washington

WASHINGTON—A major business organization is recommending Congress repeal insurers' exemption from federal antitrust law.

That limited exemption, contained in the McCarran-Ferguson Act, can no longer be justified, says the National Federation of Independent Business.

"Because there is no market-based justification, continuing the exemption is unfair and represents intrusion into the free economy by the federal government," according to John Motley, director of federal governmental relations for the 500,000-member NFIB.

In testimony submitted this month to the House Small Business Committee, Mr. Motley said NFIB members want to see a level playing field for all companies, including insurers.

"They (NFIB members) believe the antitrust exemption hinders competition," Mr. Motley said.

"We need to simply accept that the business of insurance is, in fact, interstate commerce and needs to be under the scope of antitrust laws," he added.

While the NFIB supports the elimination of the antitrust exemption in the McCarran-Ferguson Act, the trade group favors continued state regulation of insurers as also provided for in the act. The NFIB opposes the establishment of any new federal department or agency to regulate or oversee insurers, Mr. Motley said.

The Washington-based trade group is composed primarily of smaller companies and is the first major business organization to support repealing a portion of the McCarran-Ferguson Act.

PBGC reform bill

Rep. James A. Traficant Jr., D-Ohio, has introduced legislation, H.R. 2268, that would almost triple termination insurance premiums charged by the Pension Benefit Guaranty Corp.

Under the legislation, known as the Pension Benefit Guaranty Corp. Reform Amendments Act of 1987, the annual PBGC premium charged employers with defined benefit pension plans would rise to $23 per plan participant, up from the current $8.50.

In addition, premium payments to the PBGC would be due in quarterly installments, not annually.

Each July 1, the PBGC would have to submit an "accounting report" to the congressional committees with jurisdiction over the PBGC. This report would review whether the current premium is producing sufficient revenue.

This flat-rate premium approach contrasts sharply with the Reagan administration's so-called variable-rate PBGC premium structure, in which premiums would be based on the financial condition of a pension plan (*BI*, March 30).

The legislation also would require companies seeking Internal Revenue Service permission to delay making required annual funding contributions to their plans to document how they intend to pay the waived funds.

This documentation would have to be filed at the time a company sought a funding waiver.

The legislation also would reduce the maximum number of funding waivers that the IRS could approve for a company in a 15-year period to three from five.

Also, employers would be required to give each plan participant and beneficiary a quarterly report disclosing the actuarial position of the plan. The report would have to be written in terms that could be easily understood by the typical plan participant.

Wilbur Cohen dies

Wilbur J. Cohen, 73, a former secretary of the Department of Health, Education and Welfare and a key architect of the Social Security program, died this month of a heart attack suffered while in Seoul, South Korea.

After graduating from the University of Wisconsin in 1934, Mr. Cohen came to Washington, where he helped draft legislation that ultimately became the Social Security Act of 1935, one of the most far-reaching pieces of benefits legislation enacted by Congress.

Mr. Cohen also was an early advocate of federal health insurance insurance for the elderly. That idea was adopted by Congress in 1965 when it passed the landmark Medicare legislation and when Mr. Cohen was an undersecretary at the old Department of Health, Education and Welfare—now known as the Department of Health and Human Services. Mr. Cohen became secretary of HEW during the last year of Lyndon Johnson's administration.

During his later years, Mr. Cohen fought against proposed cutbacks to the Social Security program.

HHS survey

The Department of Health and Human Services is launching what it says is the largest survey of medical expenditures in the nation.

The survey, which will be conducted by two HHS units—the National Center for Health Services Research and Health Care Technology Assessment—will examine health care expenditures by 40,000 persons living in 14,000 households nationwide.

The household survey will obtain information on use of health care services, health-related expenditures, sources of payments, insurance coverage and personal characteristics of participants and their dependents.

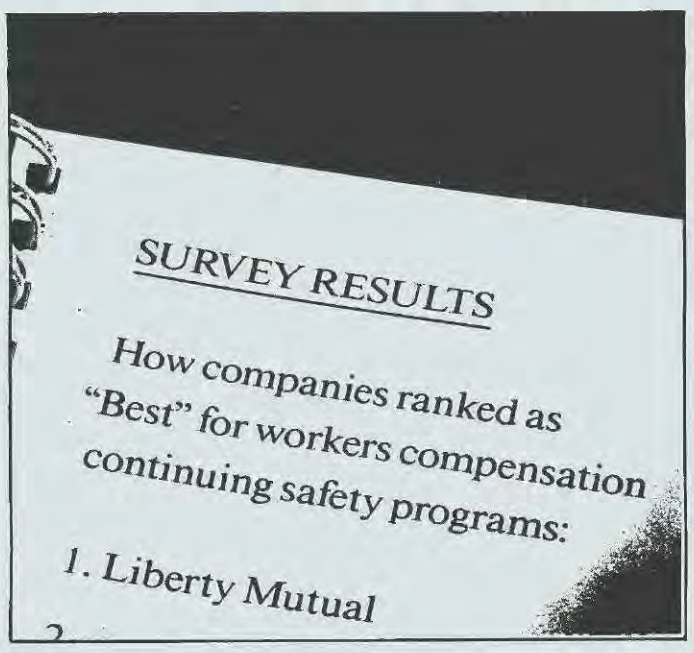
Topics to be addressed in the survey include:

- The structure and financing of health insurance, with particular emphasis on individual and group plan enrollment and benefit provisions.
- The availability and cost of health insurance.
- The effects of requiring all employers to offer a health insurance plan and taxing employer-paid premiums.

Preliminary results from the survey, known as the 1987 National Medical Expenditure Survey, are expected in 1988.

For more information, contact Daniel C. Walden, senior research manager, Division of Intramural Research, National Center for Health Services Research and Health Care Technology Assessment, 18-A-55, Parklawn Building, Rockville, Md. 20857; 301-443-4836. ■

Best.



In a recent national survey, more CFO's and Risk Managers rated Liberty Mutual *best* for "continuing safety programs" than the next two workers compensation carriers *combined*.

As the largest provider of workers compensation coverage to American business, Liberty Mutual has continually worked to lower the final cost of this vital insurance. In large part, this has been achieved through our innovative efforts to help customers prevent accidents before they happen.

Liberty's commitment to controlling and eliminating the causes of work-related accidents is exemplified by the work of the Liberty Mutual Research Center. Founded 33 years ago, the Center's pioneering research in safety-related fields has made a marked difference in the safety standards of thousands of American jobs. And helped lower the final cost of workers compensation coverage for employers.

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Results reported here are from an independent telephone survey conducted among a systematic sample of 300 respondents in selected industries.

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Chubb offers new excess umbrella policy

A new commercial excess umbrella liability policy that can be written on either an occurrence or claims-made basis is now available from the Chubb Group of Insurance Cos.

The new policy's "Coverage A/B" format offers both excess and umbrella coverages that respond as broadly as the primary layer in a single form, the Warren, N.J.-based insurer says.

Coverage A provides "follow form" excess coverage under the terms and conditions of the primary policy on either an occurrence or claims-made basis. Coverage B provides broad umbrella coverage on an occurrence form where no primary coverage exists.

The new policy, which replaces Chubb's previous comprehensive commercial catastrophe liability policy, also continues to pay for defense costs in addition to the limits of the policy.

products & services

In addition, the Chubb Commercial Excess Umbrella Policy is written in simplified language to enable policyholders to better understand the coverages and policy provisions, according to the insurer.

When coverage is written on a claims-made basis, the policy provides an automatic 60-day extended reporting period and an unlimited time for filing claims reported during this period. In contrast, the 1986 Insurance Services Office's commercial general liability claims-made form limits the filing of reported claims to five years, Chubb says.

Coverage limits and attachment points for both coverages vary by risk, a Chubb spokeswoman explained.

For more information, contact a local office of the Chubb Group of Insurance Cos.

Smoking policy

"How to Implement a Successful Worksite Smoking Policy" is a manual that gives readers a nine-step plan for successfully implementing a worksite smoking policy.

The 102-page manual is available from the National Center for Health Promotion, which predicts that by 1988, "thousands of firms will find themselves committing hara-kiri on 'smoking policy swords' which the companies themselves are laying in place right now."

Each smoker can cost a company close to $1,100 a year through increased absenteeism, higher operating costs and greater health care costs, according to the center.

These costs, combined with increased legislative activity regarding smoking, have prompted many employers to announce worksite smoking policies.

Unfortunately, however, many of these companies are treating too lightly the four steps that should come before announcing the policy, the center asserts. Further, these employers are ignoring four additional steps that should be taken after a policy is announced.

According to the center, the four steps needed before announcing a smoking policy are:

- Assess the present corporate environment by reviewing present policies, analyzing benefit plans, determining employee complaints and checking insurance programs.
- Research the issues by surveying employees, analyzing medical claims, reviewing union contracts, reviewing present policies, analyzing workers compensation claims and compiling health and safety statistics.
- Develop policy goals by summarizing internal information, distributing proposed goals to key players and discussing policy implications.
- Design the policy by composing a task force, establishing milestones, developing alternative policies and writing the final policy.

After the announcement, the center advises employers take four additional steps:

- Finalize the implementation plan.
- Provide smoking cessation assistance.
- Put the policy into effect.
- Track progress against pre-established target dates.

Copies of "How to Implement a Successful Worksite Smoking Policy" are available for $48 each from The National Center for Health Promotion, 3772 Plaza Drive, Suite 5, Ann Arbor, Mich. 48104; 313-994-3329.

COBRA compliance

Interface Benefit Administrators Inc. is offering companies with 20 to 1,000 employees administrative services that will keep them in compliance with the health care plan continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Recordkeeper system provides COBRA administrative services to employers that prefer not to set up an in-house administrative system, explained Bill Williams, president of the Houston-based firm.

Mr. Williams said an employer that uses the service first notifies Interface Benefit Administrators when an employee's health benefits must be continued as required under COBRA.

After receiving notification, the company uses the Corporate Cobra Manager software program provided by Travis Software Corp. (*BI*, Dec. 22, 1986; Sept. 15, 1986) to track eligibility, collect premiums, compile management reports for the employer and provide other administrative services.

In addition, the software system automatically prints letters notifying a COBRA participant when he or she no longer is eligible for continuation of benefits.

"The employer is relieved of the tedious tasks of notification, enrollment, premium collection and infinite record keeping and can be assured of data entry and storage of data for an indefinite period," said Mr. Williams.

Interface Benefit Administrators charges employers a one-time fee of $500 and $10 for each original notification letter. The cost is then $4 each month for each person that remains "active as a COBRA continuee," Mr. Williams said.

The COBRA Recordkeeper system also is being franchised to third-party administrators that can use it with the Corporate Cobra Manager program. Interface Benefit Administrators provides installation of the software system and staff training for $12,500.

Continued on next page

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Continued from previous page

For more information, contact Bill Williams, president, Interface Benefit Administrators Inc., P.O. Box 740971, Houston, Texas 77274; 713-266-5858.

Drug testing

"Straight Dope on Drug Testing," a video program designed to help answer employee questions on one of the most explosive employee relations issues of the '80s, is available from BNA Communications Inc.

Already, 45% of the Fortune 100 companies and hundreds of small organizations test employees or job applicants for substance abuse, according to a recent American Management Assn. survey.

And now, with recent presidential initiatives and media attention, many more employers are considering implementing drug testing policies, according to BNA Communications, a subsidiary of The Bureau of National Affairs Inc. in Rockville, Md.

Whether an employer has implemented a drug testing policy, or is considering one, drug testing for employees and applicants must be introduced and explained carefully, BNA Communications stresses.

Among the concerns addressed in "Straight Dope" are accuracy of tests, privacy, confidentiality of results, the length of time drugs remain in the system and the types of legal substances that can cause false-positive results.

The 14-minute video program, which is available in all popular formats, is accompanied by 10 pocket-sized booklets, and additional booklets are available at quantity discounts.

Prices for "Straight Dope" are: License, $475; one-week rental, $175; previews, $40, which may be applied to license or rental.

For more information, contact BNA Communications Inc., 9439 Key West Ave., Rockville, Md., 20850-3396; 800-233-6067. In Maryland, Alaska or Hawaii, call 301-948-0540. ■

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Tax changes put damper on PAYSOPs

Many employers are either eliminating payroll-based employee stock ownership plans or freezing the plan assets since the Tax Reform Act of 1986 eliminated employers' ability to take tax credits for contributions to PAYSOPs, a recent study shows.

According to the study conducted by Lincolnshire, Ill.-based employee benefit consultant Hewitt Associates in March, 34% of the employers have terminated their PAYSOPs and 26% have frozen their plans.

When an employer freezes a PAYSOP, it stops making contributions to the plan but saves the existing funds to distribute to employees when they leave the company.

The advantage to freezing the plan, rather than terminating it, is that employers can delay distributing the funds to plan participants.

Some 11% of the employers surveyed rolled the funds held in a PAYSOP into another employer-sponsored plan.

A small percentage of employers, 2%, chose to continue operating their plans with tax-deductible employer contributions instead of tax-credit contributions, according to the study.

While a tax credit directly offsets an employer's tax bill, a tax deduction simply reduces an employer's taxable earnings.

The remaining 27% of the employers with PAYSOPs are undecided as to how to react to the changes in the federal tax code, the study showed.

Hewitt studied 125 large and medium-sized companies that offered PAYSOPs during 1986, representing a wide cross-section of industries and geographic locations.

Of those employers that decided to terminate their plans:

- 56% did so without offering their employees a choice to roll over the money into another employer-sponsored plan.
- 42% offered their employees a choice.
- 2% said they have not yet decided whether or not to roll over the assets.

Twenty-one of the 125 employers surveyed indicated that their PAYSOPs were not operated on a calendar-year basis.

Of these 21 companies, 19 said they will make PAYSOP contributions for the part of the plan year beginning in 1986 and ending Dec. 31, 1986, while two said they will not make a partial-year contribution.

●

Copies of "Paysop Treatment After Tax Reform: A Survey of Employer Practices" are available at no charge from Cathy Schmidt, Hewitt & Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000.

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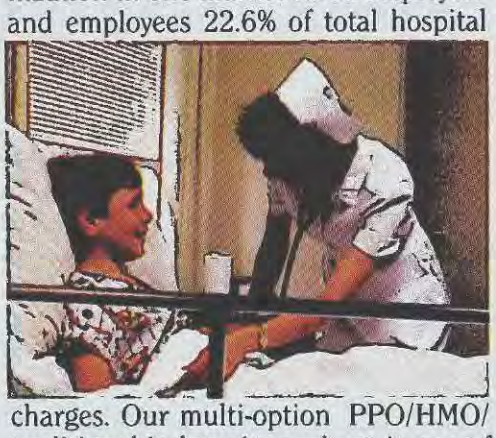

charges. Our multi-option PPO/HMO/traditional indemnity package is one of the best, most effective cost containment concepts available. Easy to administer, it's supported by an equally strong employee communications program.

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PLANNED MARKETS BY END OF '87

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Through the years we've been more than an ordinary insurance company. Commitment to our insureds goes well beyond the property coverages we provide.

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Harrington elected senior vp of USF&G

James Harrington has been elected executive vp of United States Fidelity & Guaranty Co. in Baltimore.

In this position, Mr. Harrington will be responsible for overseeing field operations, human resources, quality assurance and purchasing. Previously, Mr. Harrington was vp-field operations.

In the government industry affairs department of USF&G, **W. Minor Carter** elected senior vp.

In addition, the following people were elected vps: **John Andryszak** and **Nancy Haragan**, government industry affairs department; **Joe Kirk**, field operations department; and **William Somerville**, fidelity-surety department.

Also, **John Avery** elected president of Fidelity & Guaranty Life Insurance Co., a USF&G subsidiary.

comings & goings: industry

In other insurer changes:

James L. Davis named senior vp of The North River Insurance Co. in Basking Ridge, N.J., a subsidiary of Crum & Forster Corp. Mr. Davis will be responsible for loss control activities and managing the group's occupational health facility in Basking Ridge.

Also at North River, **Carl F. Manfra** elected vp-loss control. Mr. Manfra coordinates the company's loss control operations and departmental audits.

LeRoy S. Adams elected senior vp-claims of Fireman's Fund Insurance Cos. in Novato, Calif. He is responsible for environmental claims, extra-contractual matters, major claims litigation and staff counsel operations. Mr. Adams joined the company in 1969 as a resident senior claims representative in Greenville, S.C.

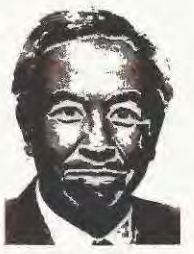
At the Fireman's Fund branch office in Greensboro, N.C., **Jeffrey R. Dehn** appointed resident vp and manager. He succeeds **Jack Cannon**, who was named vp, Texas regional manager and Dallas branch manager. Mr. Dehn joined the company as a loss control consultant in 1975.

At Trenwick Group Inc. in Westport, Conn., **Robert E. Brownley** elected senior vp. Previously, Mr. Brownley was president of Greenwich Claims Consultant Corp.

Also at Trenwick, **Michael F. Mather** and **Albert J. Pereira** elected vps. Most recently, Mr. Mather was with Ancon Insurance Co. S.A. in Bermuda. He joined Trenwick in 1986 as an assistant vp and was subsequently elected vp at Trenwick Syndicate Corp., an excess casualty insurance subsidiary. Mr. Pereira joined Trenwick in 1983 and was elected assistant vp and controller of the company's U.S. operations in 1985. Prior to joining the company, he was with Commercial Union, Metropolitan Property & Liability, and Allendale Insurance Co.

Galen R. Barnes promoted to vp-commercial insurance at Nationwide Insurance Co. in Columbus, Ohio. Previously, Mr. Barnes was president and chief executive officer of Colonial Insurance Co. in Anaheim, Calif. Mr. Barnes will oversee field operations.

Davis A. Pollock promoted to executive vp-employee benefits at Central Life Assurance Co. in Madison, Wis. Previously, he was senior vp-group insurance.


Mr. Fujino

Ken Fujino joined Fairmont Insurance Co. in Burbank, Calif., as executive vp and chief operating officer. Previously, Mr. Fujino was employed by Fireman's Fund Insurance Co. in San Francisco for 22 years, most recently as senior vp-commercial insurance.

Robert L. Moyer joined Red Wing, Minn.-based Citizens Security Group—the holding company for Citizens Security Mutual Insurance Co. and Citizens Fund Insurance Co.—as senior vp.

Agents/brokers

Gary J. Bausom joined Jardine Emett & Chandler San Francisco Insurance Brokers Inc. as a vp. Previously, Mr. Bausom has worked with the BankAmerica Corp., Esmark Inc., Transamerica Corp. and Allis-Chalmers Corp.

Mr. Klecha

John J. Klecha promoted to vp at The Crump Co. of Connecticut in Fairfield. Mr. Klecha will be responsible for all commercial insurance marketing at the brokerage.

Reinsurance

Pennington H. Way II joined Johnson & Higgins Willis Faber (USA) Inc., as a senior vp. He is responsible for the administration and underwriting of treaty, facultative and direct business. Previously, Mr. Way was with the Home Insurance Co. in New York, where he directed the company's excess/surplus lines subsidiary, The Home Insurance Co. of Illinois.

Mr. Way

Other suppliers

James L. Clare joined Coopers & Lybrand in Toronto as a consulting actuary and director of pension actuarial services. Mr. Clare will be responsible for the pension and employee benefit operations of the Actuarial and Benefits Consulting Group in Canada. Most recently, Mr. Clare was managing principal of Hansen Consultants Ltd., the Canadian arm of A.S. Hansen Inc.

Mr. Robertson

At Coopers & Lybrand in Newport Beach, Calif., **James A. Robertson** joined the firm's Actuarial and Risk Management practice as a senior consultant. He will be responsible for providing insurance litigation consulting services on contract reviews, captives, risk retention groups and insurance product development. ■

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financial briefs

NAC Re's net income up 306% in first quarter

Greenwich, Conn-based NAC Re Corp. reported net income quadrupled in the first quarter of 1987.

Net income increased 306.2% to $2.7 million in the first quarter from $666,000 in the year-earlier quarter.

NAC Re reported first-quarter pre-tax operating income increased 167.1% to $1.79 million from $671,000 in the first quarter of 1986.

Net premiums written for the period totaled $38.6 million, a 115.8% increase from last year's figure of $17.9 million. Net premiums for the year are expected to exceed $170 million, a 38.6% increase from $122.7 million reported in 1986.

The first-quarter combined ratio improved to 107.6%, compared to 110.1% in the first quarter of 1986.

Stockholders' equity at the quarter's end was $139.6 million, an increase of 2%.

Record surety losses

Reflecting the depressed state of the U.S. construction industry, the surety industry suffered its worst year in 1986, sustaining a combined loss and expense ratio of 150%, according to Lloyd Provost, president of the Surety Assn. of America.

Underwriting losses were $1.1 billion on earned premiums of $1.25 billion for reporting members of the New York-based association.

Contract bonds alone recorded a loss ratio of 106%, with non-contract bonds resulting in a 60% loss ratio.

Mr. Provost attributed the losses to the high rate of failure among contractors, due to increased foreign competition, tax laws and changes in environmental and Occupational Safety and Health Administration regulations.

But improved performance was seen in the fidelity line, with the loss ratio decreasing from 57% in 1985 to 32% in 1986.

Financial guarantee bond results are excluded from the report, resulting in a more accurate picture of the surety industry.

CIGNA Corp.

Philadelphia-based CIGNA Corp. reported first-quarter operating income increased 77% to $126.9 million from $71.7 million in the first quarter of 1986.

Chairman and Chief Executive Officer Robert D. Kilpatrick said the "continued improvement of our property and casualty business" was largely responsible for the increase. The property/casualty group reported an operating income increase of 572.2% to $89.4 million from $13.3 million in the first quarter last year.

Net income for the quarter rose 81.7% to $175 million from $96.3 million.

First-quarter revenues inched up 5.3% to $4.2 billion from $4 billion in the initial quarter of 1986.

Shareholders' equity was $5.1 billion, up from $4.2 billion in the first quarter of 1986.

Continental Corp.

New York-based Continental Corp. reported first-quarter operating income increased 150% to $87 million from $34.8 million in the first quarter of 1986.

However, net income, including $37.7 million in realized capital gains, dropped 13.5% to $124.7 million. In the first quarter of 1986

Continued on next page

16th Annual

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business insurance Update

Agent/Broker Profiles
16th Annual Directory

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Trenwick Syndicate Corporation
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J&H acquiring Lloyd's broker Carter Brito

markets

In its first overseas acquisition, Johnson & Higgins is purchasing Lloyd's of London broker Carter Brito e Cunha Ltd.

J&H announced last week that it is buying Carter Brito for an undisclosed sum and changing the broker's name to Johnson & Higgins Ltd., subject to approval by Lloyd's.

Founders of Carter Brito, Nuno de Brito e Cunha and Charles Carter, will be the managing directors. Alan Parry, chairman of Carter Brito, will act in a non-executive capacity as J&H Ltd.'s chairman, while he remains junior deputy chairman of Lloyd's.

J&H Chairman Robert V. Hatcher Jr. emphasized that the acquisition will not affect the 90-year informal link between J&H and Lloyd's broker Willis Faber P.L.C.

In particular, the acquisition will not affect the U.S. reinsurance business brokered by U.S.-based Willcox Inc. Reinsurance Intermediaries, a joint venture of J&H and Willis Faber, he noted. Nor will it affect Willcox's wholly owned Lloyd's broker, Willis Faber & Willcox Ltd., which brokers U.S. business to Lloyd's underwriters.

Instead, the purchase of Carter Brito will expand J&H's reinsurance brokering of non-North American clients.

"This acquisition enhances our strategic goal of increasing our market share in international reinsurance," Mr. Hatcher said. "It will not affect our U.S. reinsurance activity which is conducted through Willcox."

"There are certain areas where we trade independently," said Dick Bowes, deputy chairman of Willis Faber. "They (J&H) are developing their international reinsurance business and in this area we trade separately. . .I don't think this (acquisition) will make any material difference" to the Willis Faber/J&H relationship. .

Carter Brito was formed in 1979 by Mr. Carter and Mr. Brito e Cunha and became a Lloyd's broker in December 1982. Mr. Parry joined the firm in August 1982.

With 70 employees, the Lloyd's broker specializes in marine and non-marine treaty reinsurance, with links in the United States, South America, Europe, the Far East and Central Africa.

Sources say that Carter Brito had 1985 brokerage revenues of 2 million pounds ($2.9 million at year-end 1985 exchange rates), but Mr. Parry would not comment.

New consultant

Risk Management Analytica has been formed in Reading, Pa., to offer risk management training and consulting services.

"Our primary thrust will be in the educational area," said President Raymond C. Sprow. "We provide training programs designed for various levels of expertise in risk management and insurance agency management."

The workshops cover the full spectrum of risk management techniques from basic skills used to train new employees to advanced skills on international risk management, Mr. Sprow said.

Risk Management Analytica brings its programs to the company, Mr. Sprow noted, saving risk managers time and expense.

"Seminars are always held in exotic, far-away places, where you get four hours of fluff and two hours of work," Mr. Sprow commented. "Our workshops are 100% work."

Fees run from $400 to $600 for the workshops, which last between three and four hours, depending on the level of difficulty, Mr. Sprow noted.

Mr. Sprow, who has been in the insurance and risk management profession for 22 years, most recently was senior vp-national and international accounts at broker KDN Corp. in Wyomissing, Pa.

For more information, contact Raymond C. Sprow at Risk Management Analytica, 701 Waverly St., Box 7971, Reading, Pa. 19603; 215-775-0298.

New Chicago PPO

Parkside Health Management Corp. of Park Ridge, Ill., has launched a preferred provider organization to complement its existing programs for self-insurers.

The Path Network, including 21 hospitals and 1,200 physicians, is available to employers throughout the Chicago area.

"PATH combines a preferred provider arrangement with hospital pre-certification, concurrent utilization review, claims processing, when desired, and information management services to provide a complete health care package," said Parkside President Robert French.

The PPO expands Parkside's existing services, which include third-party administration, client-customized programs for occupational health, diversified data collection and management programs, and 12 managed care programs including Psychiatric Case Management, Major Case Management, Certification Plus and Second Opinion.

For more information, contact Robert French, 205 West Touhy Ave., Park Ridge, Ill. 60068; 312-698-4848.

Travelers expands

Travelers Corp. has expanded its preferred provider network into Washington, D.C.

Travelers Preferred-Washington, D.C., has nine hospitals and more than 558 physicians in its provider network.

In addition, the PPO offers members the Patient Advocate utilization review program and the Taking Care wellness program.

Further information is available from Thomas Lerche, executive director, Travelers Preferred-Washington, 601 Whythe St., Alexandria, Va. 22314; 202-836-2206.

New offices

The Baltica-Skandinavia Insurance Co. has relocated to 2nd Floor, 367 Lonsdale St., Melbourne, Victoria, 3000; 03-600-0155.

Bayly, Martin & Fay of Washington has relocated to First & Stewart Building, 101 Stewart St., Suite 700, Seattle, Wash. 98101-1018; 206-441-1400.

The London Agency of Louisiana Inc. has relocated to 650 Poydras St., Suite 1000, New Orleans, La. 70130; 504-523-5465. ■

Does your employee belong in a psychiatric hospital?

Maybe so. Fortunately, serious mental illness is highly treatable. But what sort of treatment setting is most appropriate? If your group insurance plan offers mental health care benefits, you can't afford to be confused about what types of therapeutic services, hospitals and facilities are available. In fact, understanding who needs a private psychiatric hospital and who doesn't can help you manage your inpatient psychiatric benefits more efficiently.

Not all hospitals treating mental illness are alike—and you need to know the difference.

The diverse and individual needs of the mentally ill require an equally diverse range of health care facilities, from state institutions to general hospital settings to specialty psychiatric hospitals. The services and therapies offered by different types of hospitals also vary in scope and intensity.

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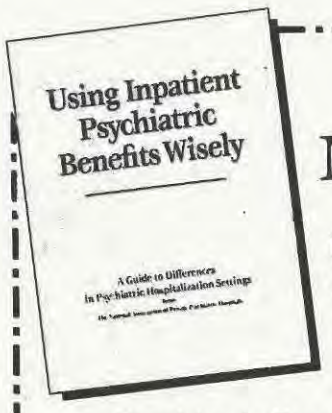

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MAY 31-JUNE 5. American Industrial Hygiene Conference in Montreal, co-sponsored by American Industrial Hygiene Assn., American Conference of Governmental Industrial Hygienists, and Assn. pour l'Hygiene Industrielle au Quebec; $90 for members; $115 for non-members; $65 for non-member speakers; $25 for spouses. American Industrial Hygiene Conference, 475 Wolf Ledges Parkway, Akron, Ohio 44311-1087; 216-762-7294.

JUNE 1-2. New York State Public Sector Coalition on Health Benefits' First Annual Conference in Albany, N.Y.; $95 for NYSPSC members; $150 for non-members. New York State Public Sector Coalition on Health Benefits, P.O. Box 15, Albany, N.Y. 12260; 518-473-6217.

JUNE 1-2. Utilizing, Negotiating and Litigating Letters of Credit and Trust Agreements in the Insurance Industry conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for each additional registrant from the same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 in New York.

JUNE 1-2. Preparing and Analyzing Property and Casualty Statutory Financial Statements conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for each additional registrant from the same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 in New York.

JUNE 1-2. Health Care Cost Containment workshop in Chicago, sponsored by the Health Research Institute; $495. **Also June 22-23** in Philadelphia; **July 27-28** in Honolulu; **Aug. 17-18** in San Diego; **Sept. 14-15** in Cleveland; **Oct. 5-6** in Boston; **Oct. 26-27** in San Francisco; **Nov.9-10** in New York; and **Dec. 7-8** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 1-3. Employee Benefits: Concepts, Planning and Administration course in Atlanta, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. Fran Jordan, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 2. How to Make Effective Use of the Excess/Surplus/Specialty Markets workshop in Pensacola, Fla., sponsored by the Gulf Coast chapter of the Society of Chartered Property & Casualty Underwriters; $125 for Society of CPCU members; $150 for all others. Julie Ann Juliana, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2735.

JUNE 3. Health Improvement/Wellness workshop in Chicago, sponsored by the Health Research Institute; $250. **Also July 29** in Honolulu; **Aug. 19** in San Diego; **Oct. 7** in Boston; **Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 3. Advanced "Post Graduate" Cost Management workshop in Chicago, sponsored by the Health Research Institute; $250. **Also June 24** in Philadelphia; **July 29** in Honolulu; **Aug. 19** in San Diego; **Sept. 16** in Cleveland; **Oct. 7** in Boston; **Oct. 28** in San Francisco; **Nov. 11** in New York; and **Dec. 9** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 3-4. Insurance Industry Mergers and Acquisitions: Financing, Negotiating, Valuing conference in New York, sponsored by Executive Enterprises Inc.; $875; $775 for each additional registrant from the same organization. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-223-0787; 800-831-8333 in New York.

JUNE 3-4. Solution to the High Cost Claim seminar in Beverly Hills, Calif., sponsored by Intracorp; $385; $340 if two or more registrants. Jackie Mazoway, Intracorp, 800-345-1075.

JUNE 3-5. Techniques of Finance and Accounting course in Philadelphia, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. Fran Jordan, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 3-5. Techniques of Loss Control course in Honolulu, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. Fran Jordan, Risk & Insurance Management Society Inc., 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 4. Assessing Vendors (HMOs, PPOs, Utilization Review Firms, etc.) workshop in Chicago, sponsored by the Health Research Institute; $250. **Also June 25** in Philadelphia; **July 30** in Honolulu; **Aug. 20** in San Diego; **Sept. 17** in Cleveland; **Oct. 8** in Boston; **Oct. 29** in San Francisco; **Nov. 12** in New York; and **Dec. 10** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 4. Cost Containment Through Communications and Education workshop in Chicago, sponsored by the Health Research Institute; $250. **Also June 25** in Philadelphia; **July 30** in Honolulu; **Aug. 20** in San Diego; **Sept. 17** in Cleveland; **Oct. 8** in Boston; **Oct. 29** in San Francisco; **Nov. 12** in New York; and **Dec. 10** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 4-5. Labor/Management Cost Containment workshop in Chicago, sponsored by the Health Research Institute; $495. **Also June 25-26** in Philadelphia; **July 30-31** in Honolulu; **Aug. 20-21** in San Diego; **Sept. 17-18** in Cleveland; **Oct. 8-9** in Boston; **Nov. 12-13** in New York; and **Dec. 10-11** in Chicago. Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 4-5. The 100th Congress: Mandated Health Care Coverage and Employee Benefit Reforms meeting in New York, sponsored by the National Employee Benefits Institute; free to NEBI members; $395 for non-members. National Employee Benefits Institute, 2550 M St. N.W., Suite 785, Washington, D.C., 20037; 800-558-7258.

JUNE 4-5. 1987 Workers Compensation Academy—Medicine and Law for the Defense course in Boston, sponsored by Defense Research Institute Inc.; $370 for DRI members; $395 for non-members. Defense Research Institute Inc., 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

JUNE 4-5. Meet the Markets conference in Chicago, sponsored by Crittenden Research Inc.;

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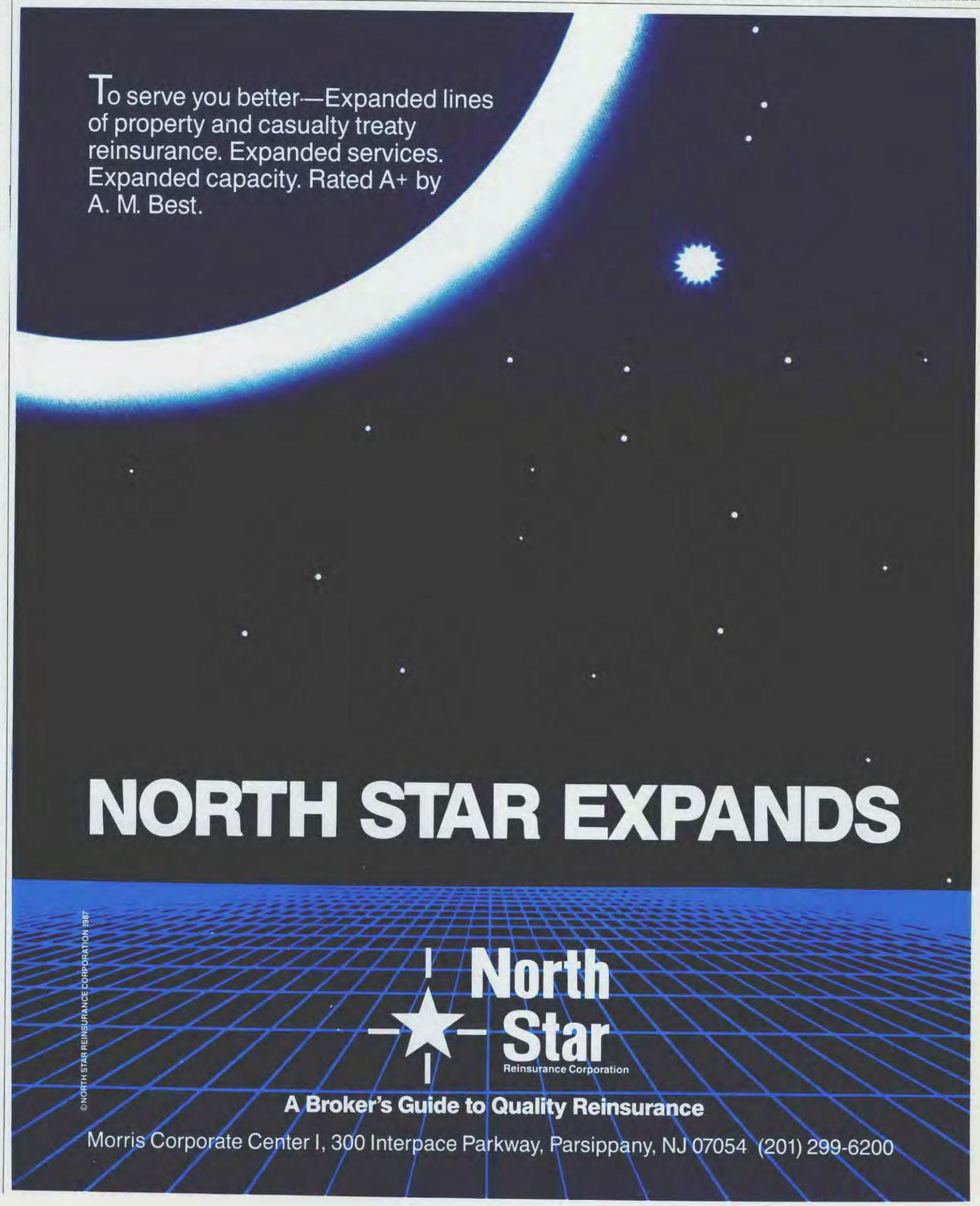

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$395. Crittenden Research Inc., P.O. Box 1150, Novato, Calif. 94948; 800-247-7119; 415-382-2440 within California.

JUNE 4-6. Practical Strategies for Pensions After Tax Reform seminar in Chicago, sponsored by Corbel & Co.; $395. Brenda Chatham, Corbel & Co., P.O. Box 17548, Jacksonville, Fla. 32245-7548; 904-731-4455.

JUNE 10. How Tort Reform Affects Workers Compensation speech and dinner, sponsored by the Oak Brook Assn. of Insurance Women; $15. Oak Brook Assn. of Insurance Women, 312-346-3000.

JUNE 10-12. Claims Management course in San Francisco, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. Fran Jordan, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 10-12. Techniques of Risk Management course in Boston, sponsored by the Risk & Insurance Management Society; $540 for RIMS members, $640 for others. Fran Jordan, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

JUNE 11. Claim Abuse/Fraud Seminar in Los Angeles, sponsored by the Self-Insurance Institute of America Inc.; $95 for SIIA members; $125 for non-members. Self-Insurance Institute of America Inc., P.O. Box 15466, Santa Ana, Calif. 92705; 714-261-2553.

JUNE 16-17. Basics of Captives and Captive Insurance Companies: A Canadian Viewpoint seminars in Toronto, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby; $50 Canadian (approx. $37) for Basics of Captives briefing (June 16); $350 Canadian (approx. $261) for Captive Insurance Companies seminar (June 17); $400 Canadian (approx. $298) for both. Eileen Callahan, Conference Director, Tillinghast/TPF&C, 722 Post Road, Darien, Conn. 06820; 203-655-9791.

JUNE 17. Pension Planning Workshop in Philadelphia, sponsored by the Insurance Society of Philadelphia and Delaware Tech; $65 for members; $75 for non-members. Insurance Society of Philadelphia, 737 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306.

JUNE 17-19. Western Assn. of Workers Compensation Boards' 15th Annual Convention in San Francisco; $125 for WAWCB members; $165 for non-members; $60 for spouses. WAWCB 15th Annual Convention, P.O Box 11356, San Francisco, Calif. 94101; 415-557-2250.

JUNE 18-19. Computer Fraud Detection and Investigation workshop in New York, sponsored by the Computer Security Institute; $545 for CSI members; $575 for non-members of CSI. Computer Security Institute, Dept. ERC, 360 Church St., Northborough, Mass. 01532; 617-393-2600.

JUNE 22-23. Solving Insurance Problems for Associations and Overview of Risk Financing Alternatives seminars in Chicago, sponsored by the Tillinghast Division of Towers, Perrin, Forster & Crosby; $50 for Overview of Risk Financing Alternatives; $400 for Solving Insurance Problems; $450 for both sessions. **Also June 24-25** in Los Angeles, **June 29-30** in Washington, D.C., and **July 1-2** in Dallas. Conference Director, Tillinghast/TPF&C, 722 Post Road, Darien, Conn. 06280; 203-655-9791.

JUNE 22-25. Corporate Benefits Management Conference in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; $605 for IFEBP members, $680 for non-members. International Foundation of Employee Benefit Plans, Registration Department, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JUNE 23. The Illinois Insurance Exchange—An Alternative Market seminar in Chicago, sponsored by the Illinois Insurance Exchange; no charge. Theresa L. Ryan, Illinois Insurance Exchange, 175 W. Jackson Blvd., Suite 1234, Chicago, Ill. 60604; 800-525-8471; 312-939-2400 within Illinois.

JUNE 25-26. Developments in Offshore Insurance conference in Douglas, Isle of Man, cosponsored by the Isle of Man Government Insurance Authority and the Risk & Insurance Research Group Ltd.; 285 pounds (approx. $479) plus 15% VAT. Risk & Insurance Research Group Ltd., 4 Henrietta St., Covent Garden, London WC2E 8PS; 01-836-0614.

JUNE 29-JULY 1. Hazard Communication: Worker Training and Right-to-Know course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; $400. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figüeroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

JULY 5-9. 23rd Annual Conference of the International Insurance Society Inc. in Seoul, South Korea; $900 for industry participants; $450 for academic or government representatives; $250 for spouses. International Insurance Society Administrative Headquarters, P.O. Box J, Tuscaloosa, Ala. 35487; 205-348-8974.

JULY 5-10. The 11th Annual National Symposium on Workers Compensation in Airie, Va., co-sponsored by J. Howard Bunn Jr. and Robert B. Collyer; $595. The Collyer Co., 366 W. Granada Blvd., Ormond Beach, Fla. 32074; 904-672-0675.

JULY 9-10. Non-Qualified Deferred Compensation Plans seminar in New York, sponsored by the Practising Law Institute; $390. **Also Aug. 3-4** in San Francisco. Practising Law Institute, Dept. 5W, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

JULY 12-24. Executive Management Program in Harriman, N.Y., sponsored by the College of Insurance; $1,995 for college sponsors; $2,295 for non-sponsors. The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

JULY 16-17. Introduction to Qualified Pension and Profit-Sharing Plans seminar in New York, sponsored by the Practising Law Institute; $390. **Also Aug. 6-7** in Chicago and **Aug. 20-21** in San Francisco. Practising Law Institute, Dept. 5W, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

JULY 16-17. Video Display Terminal Safety course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; $265. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

JULY 29-30. 1987 National Workers Compensation Seminar in Cape Cod, Mass., sponsored by Workers' Compensation Monthly; $195. Workers' Compensation Monthly, P.O. Box 590, Falmouth, Mass. 02541.

AUG. 2-7. Basic Reinsurance Program in Tarrytown, N.Y., sponsored by the College of Insurance; $950 for college sponsors; $1,115 for non-sponsors. The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

AUG. 2-7. Middle Management Program in Kansas City, Kan., sponsored by the College of Insurance; $950 for college sponsors; $1,115 for non-sponsors. The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

AUG. 5-6. The Sixth Annual Governmental Insurance Conference in Austin, Texas, sponsored by Professional Development Institute; $245. Professional Development Institute, North Texas State University, P.O. Box 13288, Denton, Texas 76203-3288; 817-565-2483.

AUG. 11-14. Supervisory Program in New York, sponsored by the College of Insurance; $630 for college sponsors; $715 for non-sponsors. The College of Insurance, 1 Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

SEPT. 8-11. Reinsurance Accounting and Finance for Ceders and Assumers seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,295 (includes lodging and meals). Robert W. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 914-832-9384 or 212-677-5974.

SEPT. 11. Managing and Controlling Asbestos Contamination course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; $160. University of California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

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Postal workers

Continued from page 3

lion from Senoret and $50 million in actual and exemplary damages from the postal service.

In addition, the suit is asking that the defendants be required to provide medical testing and care to injured employees.

It also seeks establishment of a fund to "help aid in the early diagnosis and treatment of plaintiffs' injuries and illnesses and for all physical and mental damages" caused by exposure to the chemical.

The U.S. Department of Labor's Dallas office has received 106 workers comp claims from postal workers who say they have suffered medical problems after exposure to Scent-Go.

However, only one of those claims has been approved, with the remainder rejected because of "a lack of medical evidence" to support them, according to a spokeswoman for the Dallas office.

A plaintiff's attorney in the case said postal worker Sandra Beall is receiving workers comp benefits after her exposure to the cleaning solution allegedly left her "immune system destroyed" and caused her to develop allergies to a wide range of products, including shampoos and household cleansers.

Robert S. Baker, an Oklahoma City attorney representing Senoret, said the chemical manufacturer believes that it has "absolutely no liability in this case."

Mr. Baker said other Scent-Go users have not complained of problems with the cleaner and that the product is labeled with "specific directions on how it should be used. People are saying the post office didn't follow the labeling."

Whether or not Senoret has product liability insurance that would cover any award in the case is "not germane under Oklahoma law," Mr. Baker noted.

"It is not admissible as evidence," he said.

But, Diana Mueller, an Oklahoma City attorney representing the plaintiffs, said Senoret has at least $1 million in primary product liability insurance. However, she was unable to identify the insurer.

"There is probably much more than that," she said.

Plaintiff's attorney Tom Stephenson of the Watonga, Okla., firm Shirley, Stephenson, Shirley & Webber, agreed, although he said he did not know which insurers wrote product liability insurance for Senoret. "It is my understanding that there are multiple levels of coverage. To what extent, I don't know."

Ms. Mueller said it is possible that another chemical company may be connected with the incident and could be brought into the lawsuit later.

She explained that it is unclear whether the ortho-dichlorobenzene was manufactured at another location and shipped to Senoret, where it was used in Scent-Go.

She could not identify any other companies that might be named in the suit.

Mr. Stephenson pointed out that Senoret officials are being asked where the chemical was produced and at what point it is mixed with others to make the cleaning solution. "We'll be getting some answers shortly," he said.

Ms. Mueller acknowledged that the lawsuit filed against the post office could turn into a protracted battle because of laws that provide government agencies with immunity from lawsuits.

"Let's face it, it's going to be a battle all the way with the post office," she said. "We'll be all the way to the Supreme Court and back on that one."

"Our deep pockets will be the chemical companies," she said.

Ms. Mueller said attorneys will use some theories in the case against the postal service that they believe are untested against government agencies.

She said charges of conspiracy are based on letters and inter-office memos that show postal officials in Oklahoma City ignored instructions from Memphis, Tenn.-based regional postal service health officials.

Ms. Mueller said regional officials urged the authorities in Oklahoma City to provide medical treatment and testing for employees exposed to the chemical, but those instructions were not followed.

The plaintiff's attorneys also will try to show that the postal service should be responsible for future medical testing and care "because ortho-dichlorobenzene is a suspected carcinogenic (chemical)," according to Ms. Mueller.

She said last week that the postal service had not responded to the charges in the suit. ■

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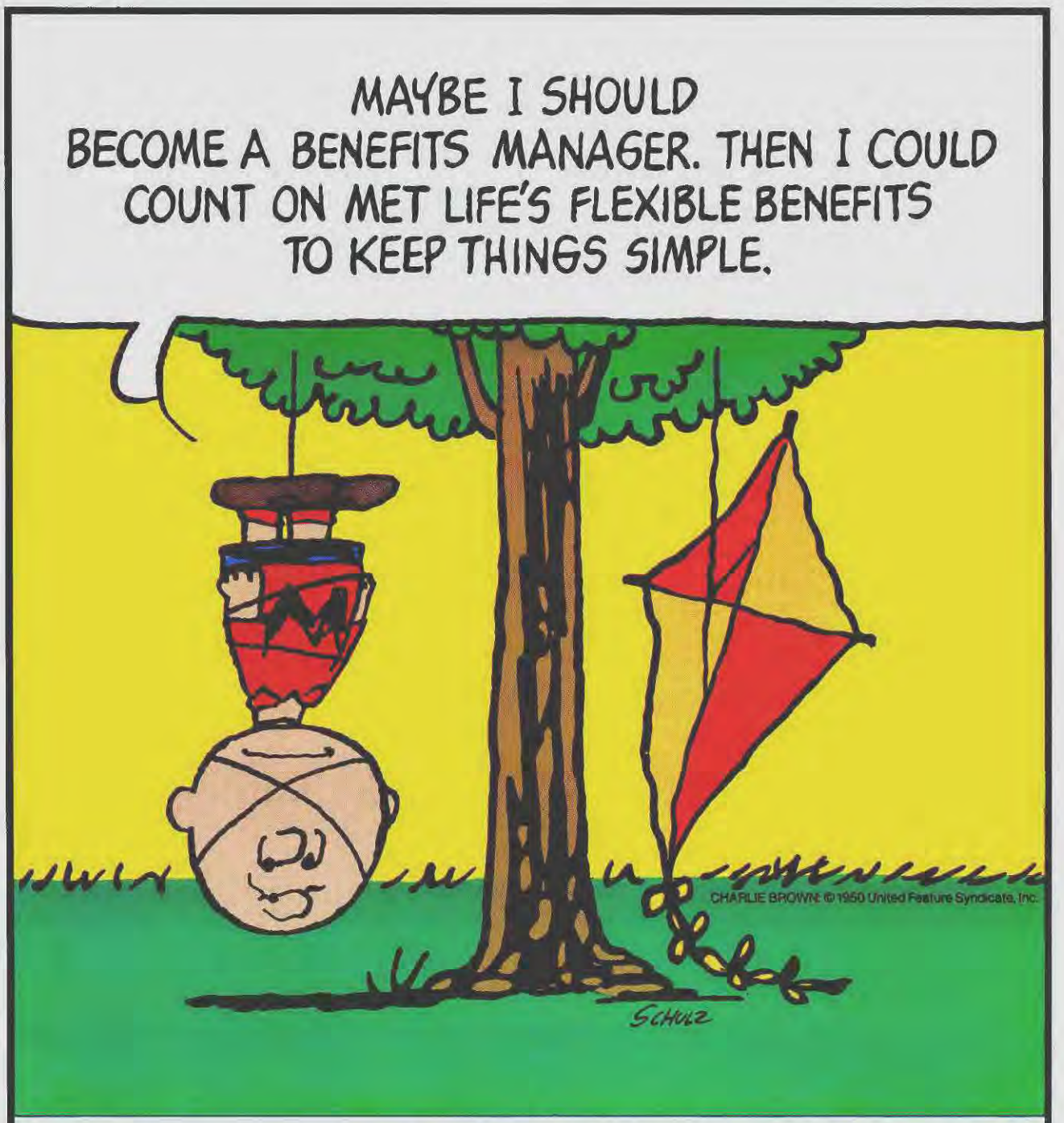

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Don't link regulation to tort reform: Exec

By LINDA J. COLLINS

CHICAGO—The insurance industry should be careful about forming an "artificial link between the issues of insurance regulation and tort reform," an insurance company executive warns.

The connection that many people have fostered between insurance regulation and tort reform is "coming together in the effort to repeal or amend the McCarran-Ferguson Act," which places most insurance industry regulatory authority at the state level, stressed William H. Bolinder, president and chief operating officer of Schaumburg, Ill.-based Zurich-American Insurance Group.

And the push for repeal or revision of McCarran-Ferguson could come to fruition because "the federal government's appetite to regulate insurance is becoming very apparent," Mr. Bolinder added.

'We must be on guard for the issue of insurance regulation being tied to tort reform,' says William H. Bolinder, president and chief operating officer of Schaumburg, Ill.-based Zurich-American Insurance Group.

Mr. Bolinder and Raymond Hayes, senior vp of brokerage Rollins Burdick Hunter in Chicago and president of the National Assn. of Insurance Brokers, spoke at a dinner meeting of the Suburban Chicago Chapter of the Society of Chartered Property & Casualty Underwriters.

The two industry executives discussed tort reform, insurer profitability, federal insurance regulation and the 1986 amendments to the Risk Retention Act of 1981 during the meeting, which was held May 12 in Des Plaines, Ill.

Mr. Bolinder said that instead of linking higher rates to the current tort system, insurance industry representatives should educate consumers on the costs and consequences of the tort system and encourage the use of alternative dispute mechanisms.

"We must be on guard for the issue of insurance regulation being tied to tort reform," he emphasized.

Complaints from consumers alarmed about high property/casualty insurance rates and lack of coverage availability have driven legislators to question the effectiveness of state insurance regulation, Mr. Hayes pointed out.

Members of the insurance community must "understand the mood of insurance buyers and legislators in Washington," he cautioned. These people, as a rule, do not understand the cyclical nature of the insurance industry.

They have watched as property/casualty premiums "increased an average of 75% in 1985 and 73% in 1986," and the ensuing insurance "crisis has particularly harmed the financial stability of small businesses. Insurer insolvencies are accentuating the problem," Mr. Hayes said.

"We have to listen to our policyholders who influence those legislators. . .and return to the principles and disciplines we were all brought up on," said Mr. Hayes. He added that "brokers have confidence that a return to sound underwriting practices by insurers will restore our credibility" with consumers and legislators.

Mr. Bolinder said that the industry "has come under some fire for unreasonable rate increases during a period when we are enjoying record profits."

However, he pointed out that insurer profits in 1986 were not directly related to rate hikes. He said that of the $12.7 billion in net income reported by property/casualty insurers in 1986, only $5.6 billion came from operating income.

Other factors contributing to the profits were capital gains from the sale of assets during the stock market rise in 1986, one-time federal income tax credits and a below normal amount of catastrophe losses for the year, he explained.

Mr. Bolinder

So while "the industry's return on net worth was 13.1%" compared to an average of 10.4% for other industries in 1986, "without the realized capital gains, federal income tax credits and low catastrophe losses, the industry's return on net worth would have been only about 9%," Mr. Bolinder said.

And the industry's combined ratio for 1986 of 107.9% "was the third worst year in the history of the business," he added.

However, Mr. Hayes stressed, "I urge underwriters to get back to the basics of price and selection. Even if those principles might be painful, they will flatten out the cycles of ups and down" that anger consumers and regulators.

He added: "There has to be a right price for every policy they put out."

And while Mr. Hayes acknowledged concern among some segments of the insurance industry about the formation and regulation of risk retention groups under 1986 revisions to the Risk Retention Act of 1981, he pointed out that those groups are responding to coverage needs that are not being met by the insurance industry.

"If the traditional marketplace will respond" to the insurance needs of consumers and businesses, "there would not be a need for an alternative marketplace," he stressed.

Mr. Bolinder said that "just as it appeared that the movement to self-insurance might be approaching saturation levels, the Risk Retention Act has created an environment that will probably result in an increase in the market share of self-insurance to about 45%." He added: "The marketplace for virtually every class of liability risk will be heavily affected by the act."

More than 1,000 risk retention groups and purchasing groups likely will be formed in the next three to five years and the marketplace for liability insurance in the 1990s probably will bear little resemblance to today's insurance industry, he predicted.

Commercial lines insurers that "do not quickly respond to these changes will experience a substantial decline in business," Mr. Bo-

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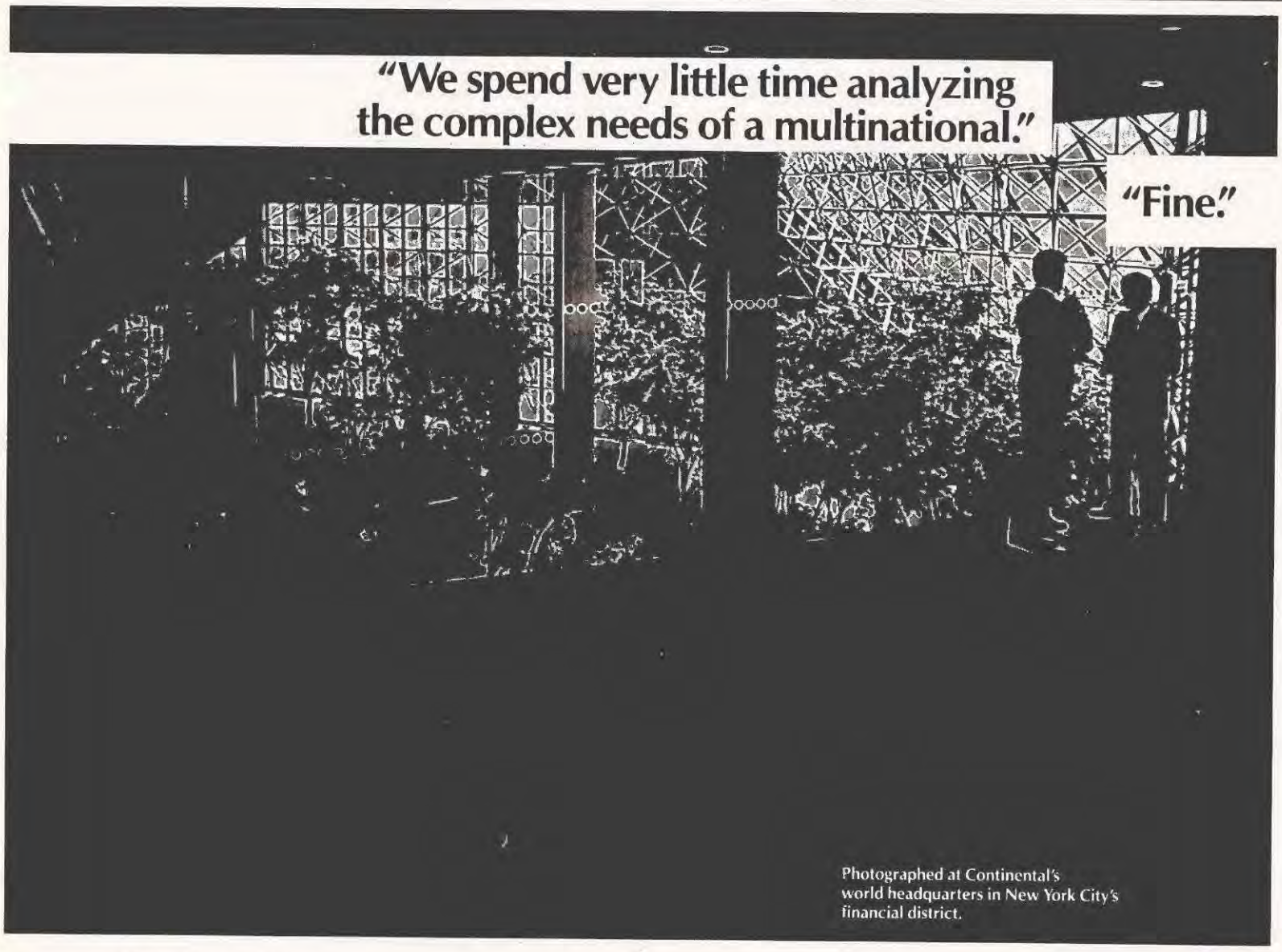

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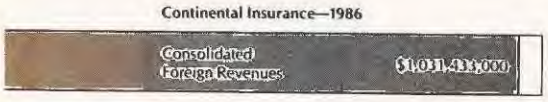

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Continued from previous page

linder warned.

However, he does not see a totally bright future for risk retention groups.

Mr. Bolinder said that these groups could accelerate the softening of the current market for liability insurance.

"If this happens, risk retention groups and purchasing groups may become less attractive," Mr. Bolinder stressed.

If state insurance commissioners want to impose administrative laws and similar controls on risk retention groups as are placed on insurers, they could "very well hinder the ability of risk retention groups to form and operate," he added.

And both risk retention and purchasing groups may also be "hampered by a difficulty or inability to secure adequate reinsurance," Mr. Bolinder speculated.

"In the end, the purchasing groups may have more resilience to survive the ups and downs of the insurance cycle than do risk retention groups."

And, Mr. Bolinder emphasized that while he "totally supports" the concept of risk retention groups, "risk retention groups must be subject to the same regulation as insurance companies."

"With consistent regulation, not only would both entities be dealing on the same plane, but individual members of the risk retention groups would be protected by the same financial safeguards as the insurance companies' policyholders," he continued.

Mr. Bolinder suggests that insurance companies find ways to work with risk retention or purchasing groups in those industries where they prove to be the best risk management alternative, by providing them with:

- Underwriting expertise.
- Unbundled services.
- Reinsurance.

The insurance industry might find that "ultimately, the expansion of risk retention groups will likely free surplus in the regular insurance marketplace for true insurance for the majority of commercial risks," Mr. Bolinder added.

Zurich-American's Mr. Bolinder does not see a totally bright future for risk retention groups.

But "before joining forces with those forming risk retention groups," insurers should first determine why they are being formed and why the group is being forced away from the conventional insurance marketplace.

Insurers may find a way to modify their business efforts and better meet the needs of the group, he said.

If so, the insurers could design target marketing efforts to meet those needs. ■

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Case management

Continued from page 3

programs, he said.

"The arrangements we make to pay for health care have dramatically changed. We now have preferred provider organizations and prospective payments. The result is that providers have incentives to control utilization," Dr. Rosenbloom explained.

Before implementing a case management program, employers need to carefully consider their needs and then choose a program that best meets those needs, he advised.

"It's very important to think about the cost of actually performing the case management and how much the program will save on the treatment of an illness," Dr. Rosenbloom suggested.

"In a case management program, you are going to pay attention to the most complex cases. Remember that 3% of the people covered spend 50% of the health care dollars," Dr. Rosenbloom added.

When evaluating the programs available from case management vendors, "employers should look for a clear definition of what you'll get, what types of cases will be included."

"You need a program that takes into account medical technological advances and a program that keeps up with advances in case management," he noted.

However, "employers need to know that there is nothing easy about case management," he warned.

"You must be willing to wait several months to see results."

Employers also can evaluate the cost effectiveness of case management programs once they are implemented, he added.

In evaluating the programs, employers can look at the ratio of the cost of the program to the savings achieved per case, the overall dollar savings achieved by the program and the effect the program has on the rate of decrease or of increase in total health care expenses, he explained.

"In the final analysis, the proof will be in the claims," Dr. Rosenbloom noted.

To effectively evaluate the cost-to-savings ratio of the program, employers must look at the program's differential impact on health care costs.

For example, the total cost and savings of the program can be broken down to look at the effect of case management on employee groups with low health care costs and utilization, employees with high cost illnesses and its overall effect on health care costs and utilization of the entire employee population, Dr. Rosenbloom explained.

Because the effectiveness of many other cost containment measures is decreasing, "we need to look carefully at case management so that we don't get discouraged too quickly.

"Some intervention programs are more effective than others. Employers need to understand how these various programs fit in" to manage costs under their benefit plans. "You need to recognize the content of the programs, not just the buzzwords," he advised.

"Employers, better than most others, know that the pace of change in health care has been rapid. With that pace, we see an enormous amount of innovation, but costs still are quickly rising," Dr. Rosenbloom noted.

"We have to realize that the total cost that we face in health care is the product of the units of service we use and the cost of those units. It's not just utilization control, and it's not just price," he cautioned.

"Also, we need to be reminded that each of our cost containment and quality enhancement measures ought to be part of a multiyear, overall plan," he added. ■

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Association alters name, elects board

By DONNA DiBLASE

SAN DIEGO—The National Assn. of Employers on Health Care Alternatives has a new name and a new board of directors.

The association will retain the NAEHCA acronym, but is now known as the National Assn. of Employers on Health Care Action.

The name change was announced at the group's annual meeting, which was held May 14-15 at the historic Hotel del Coronado and attracted 175 registrants and 50 exhibitors.

NAEHCA, which has more than 100 members, was formed in the 1970s to help employers understand and work with health maintenance organizations. It was then known as the National Assn. of Employers on Health Maintenance Organizations.

When other alternative delivery systems were introduced into the health care marketplace, the group changed its name to the National Assn. of Employers on Health Care Alternatives.

Now, in addition to educating employers about alternative delivery systems, NAEHCA's mission is to serve the needs of employers in the management of health risks, health care delivery, health care costs and quality assurance.

The association is now known as the National Assn. of Employers on Health Care Action.

NAEHCA services include:

- Assisting employers in establishing health risk management systems.
- Assisting employers in negotiating and purchasing health care services at competitive prices.
- Providing information on cost containment techniques.
- Assisting in the development of quality assurance programs based on performance outcomes.
- Providing education and being active in legislative matters to support the association's objectives in the management of health risks, health care delivery, costs and quality assurance.

The newly elected officers of NAEHCA are:

- Bynom E. Tudor, corporate vp of employee benefits for RJR Nabisco Inc. in Winston-Salem, N.C., re-elected chairman emeritus.
- Patricia Nazemetz, manager of benefits development for Stamford, Conn.-based Xerox Corp., elected chairman of the board.
- Ruth H. Stack, executive director of NAEHCA of Key Biscayne, Fla., elected president.
- Douglas M. Bartlett, director of U.S. employee benefits for Dayton, Ohio-based NCR Corp., re-elected treasurer.

Other directors are:

- Terrence C. Burke, vp of group corporate for Prudential Life Insurance Co. of America in New York.
- Thomas E. Burns, manager of employee benefits for Fairfield, Conn.-based General Electric Co.
- Jeanne Kardos, director of employee benefits at Southern New England Telephone Co. in New Haven, Conn.
- Elmer A. Kindt, manager of benefit analysis for Dow Chemical Co.
- William S. Rice, manager benefits policy and planning, Hoechst-Celanese Corp. in New York. ■

Mental health case management options

By DONNA DiBLASE

SAN DIEGO—Case management of mental health care has the potential not only to improve the delivery of mental health services but also to organize the way mental health care is delivered, according to one mental health expert.

However, examination of the current mental health care delivery system and the types of case management currently used is a necessary prerequisite to any change.

"While it is clear from existing research that good mental health care is well-managed care, it is to be seen whether the particular case management models used currently or yet to be developed will prove useful as cost containment or quality assurance strategies," said Sharon A. Shueman, a Ph.D. and vp of National Psych Reviews in Manhattan Beach, Calif.

"In the meantime, we need to use our knowledge of mental health service delivery and our experiences with case management in other settings as the basis for asking pointed questions about the characteristics and potential effects of case management on mental health care," she added.

Ms. Shueman discussed the current uses of case management of mental health care, as well as its implications for the future, at the annual conference of the National Assn. of Employers on Health Care Action. The conference, which focused on case management, was held May 14-15 in San Diego.

Although there are many types of case management, there are two primary models, she explained.

Supportive case management is the "traditional case management process" used mainly by the public social service system,t she said. Under this model, the case manager acts as the patient's advocate, ensuring that the patient has access to medical care and other types of assistance, such as food stamps and housing.

"Since clients served by the public sector are often chronically disabled—either because of the nature of their dysfunctions or because the system is unwilling or unable to invest the resources necessary to habilitate or rehabilitate them—the relationship between the case manager and the client under this model is likely to be permanent," she noted.

The rehabilitation model of case management is the model most often applied to corporate benefit plans, she said. Under this model, "the case manager identifies and obtains services which, in his or her judgment, have the greatest probability of returning the patient to an adequate level of functioning in the shortest period of time," Ms. Shueman explained.

The case manager not only assesses the patient's needs and then arranges the appropriate care, but also monitors the patient's progress, she said. "The monitoring process includes ongoing communication with service providers, the patient and his family. This may involve a reassessment and a change or termination of services."

One of the most important implications of case management of mental health services is that it may help to create an organized mental health system in the private sector, she said.

"What is euphemistically referred to in the private sector as the mental health system is, in reality, a loosely connected network of individual and institutional providers operating under the long-standing tradition of independent practice," Ms. Shueman explained.

"This is a network shaped by the cost-reimbursement system which has traditionally provided little incentive for individual providers to act as members of a comprehensive mental health system," she added.

Independent providers who are reimbursed for the cost of the services they provide "have been rewarded for relying primarily on their own resources. . .sometimes with little regard for the potential range of treatment possibilities," she explained.

For example, mental health providers may not direct patients to a day treatment program or crisis home as an alternative to inpatient treatment, or they may not refer patients to specialists, she said.

"It is the case manager's responsibility to create a system where none exists," she said.

The case manager must also work with the employer or the insurer of the employer's benefit plan to arrange for coverage of services that may not be included under the plan.

"Too often, these plans cover a narrow range of traditional services, which may not be the most cost-effective alternatives for seriously dysfunctional individuals. For example, many plans cover acute inpatient care but not partial hospitalization or day treatment programs," she said.

Case management programs, if properly executed, can "ensure the effectiveness of services provided to patients and decrease the amount of money spent on ineffective or unnecessary care," Ms. Shueman explained.

But, to accomplish these goals, "the case manager must know the patient, the services and the individual providers and must use this information to gain control over a system lacking in appropriate accountability mechanisms," she added.

Case management of mental health services is difficult because it requires one person who possesses broad clinical knowledge and can coordinate services, handling conflicting interests, while not having complete control of the resources, she said.

To effectively perform case management, the case manager must be clinically sophisticated and experienced with the range of mental health problems and services available to treat these problems. These capabilities are important in ensuring that the case manager has credibility with the patient and mental health providers, she noted.

Along with these qualities, a case manager also must have interpersonal skills to help the patient feel the case manager is an advocate, as opposed to an adversary.

The ideal case management process would be "conducted by a tribunal, or a multiprofessional group that would collectively represent a broad range of experience with problem types and treatment options," she noted. The group could be made up of a psychiatrist, psychologist and a clinical social worker.

A good case management program should possess three main components, she said. These include a system for identifying and performing the initial evaluation of mental health providers that will make up the network; a criteria for selecting the cases that would best benefit from case management; and a system for evaluating the outcomes of treatments. ■

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San Diego' historic Hotel del Coronado was the site of the National Assn. of Employers on Health Care Action's annual meeting. The hotel, which opened in 1888, was named a national landmark in 1977.

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Utilization review hinges on info: Expert

By DONNA DiBLASE

SAN DIEGO—Information is essential to determining whether a utilization review program is needed and how to operate a utilization review and case management program, according to one managed care expert.

"Information about costs, utilization, providers and patterns of care for your employee population and their dependents" is necessary to effectively implement the most appropriate managed care programs, said Ron Z. Goetzel, director of marketing for New Haven, Conn.-based Corporate Health Strategies Inc. The firm provides cost control services such as utilization review and employee benefit information systems.

Mr. Goetzel explained the use of health care cost and utilization information in analyzing health care problems and taking action to correct problems at the annual meeting of the National Assn. of Employers on Health Care Action in San Diego on May 14-15.

"Information determines a need, identifies solutions and monitors results," he added.

Employers can collect health care data from many sources.

For example, health insurers process claims data that identifies charges and utilization of hospitals and individual physicians.

And, utilization review systems collect clinical data such as severity of illness information, complication rates and questionable admissions.

Health maintenance organizations are beginning to collect and make available data on their patients, he noted.

In addition, employers collect health data through employee surveys and demographic data through payroll systems, he explained.

But, merely collecting data isn't enough to be able to make good decisions. Employers must transform the data into useful information, he said.

'Good, well-organized information becomes the basis for intelligent decision-making. This is a move away from the dart board approach,' Mr. Goetzel says.

For example, to produce useful information, employers can link quality and cost efficiency data and compare HMO costs and experience to indemnity experience, he added.

"Good, well-organized information becomes the basis for intelligent decision-making. This is a move away from the dart board approach," Mr. Goetzel noted.

"Next, take action based on the information," he said.

Employers can use health information to redesign benefit plans, set up an effective utilization review program, implement preferred provider arrangements, select HMOs or introduce substance abuse rehabilitation programs, he explained.

"The selection of the right solution requires knowledge of the problem."

Employers should use information when selecting utilization review and case management programs to determine how their experience compares to norms.

Information also can be used to determine specific locations, diseases or employee groups that are the most problematic, he said.

And, employers can use information to identify outliers, or cases that fall outside the normal average for a diagnosis. An example of an outlier is a normal delivery in which the mother is hospitalized for more than nine days, he said.

"These cases usually represent about 1% to 2% of the patient population," he said.

High outliers account for 2% to 5% of hospital admissions, 15% to 20% of hospital charges and 20% to 25% of hospital days. These patients have an average length of stay of 40 days and an average charge of $40,000.

Information also can be used to project savings as a result of implementing a specific cost control program.

"You also can use information to monitor the results of these programs. Then, you can add, delete or fine-tune programs that fall short of expectations," he noted.

Once an employer has identified specific health care cost and utilization problems and has decided to implement a utilization review and case management program, there are several things to consider in selecting a program, Mr. Goetzel said.

In an effective system, "alarms and sirens should go off when a potential high outlier enters the system, such as a spinal cord injury, an AIDS patient, a premature infant or a substance abuse patient," he said. This "early warning device" should automatically identify these cases as good candidates for case management.

The case management process "reduces an employer's costs since people are moved from acute care settings to alternative treatment programs, which include rehabilitation facilities, hospices, home health care or skilled nursing home care."

"Case management also increases the quality of care by helping the patient and the family take the fullest advantage of the full range of treatment programs. Further, the patient is weaned away from providers who have a history of inade-

Continued on page 44

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Business Insurance Circulation Breakdown*
Commercial Consumers

Administrative:	
CEO's Presidents and Owners	2,426
Vice-Presidents, General Managers and Other Administrative Personnel	3,136
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,683
Secretaries, Treasurers, controllers and other Financial Personnel	4,888
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	8,144
Sub-total	**21,277**
Associations	506
Government, Unions and Educational Institutions	1,400
Commercial Consumers	
Sub-total	**23,183**
Insurance Agents and Brokers	11,009
Insurance Companies	7,111
Financial Institutions	989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants	5,560
Others Allied to the Field	1,442
TOTAL	**49,294**

* Source Business/Occupational breakdown of qualified circulation, November 24, 1986 issue, as submitted to BPA for December 1986 BPA Publisher's Statement.

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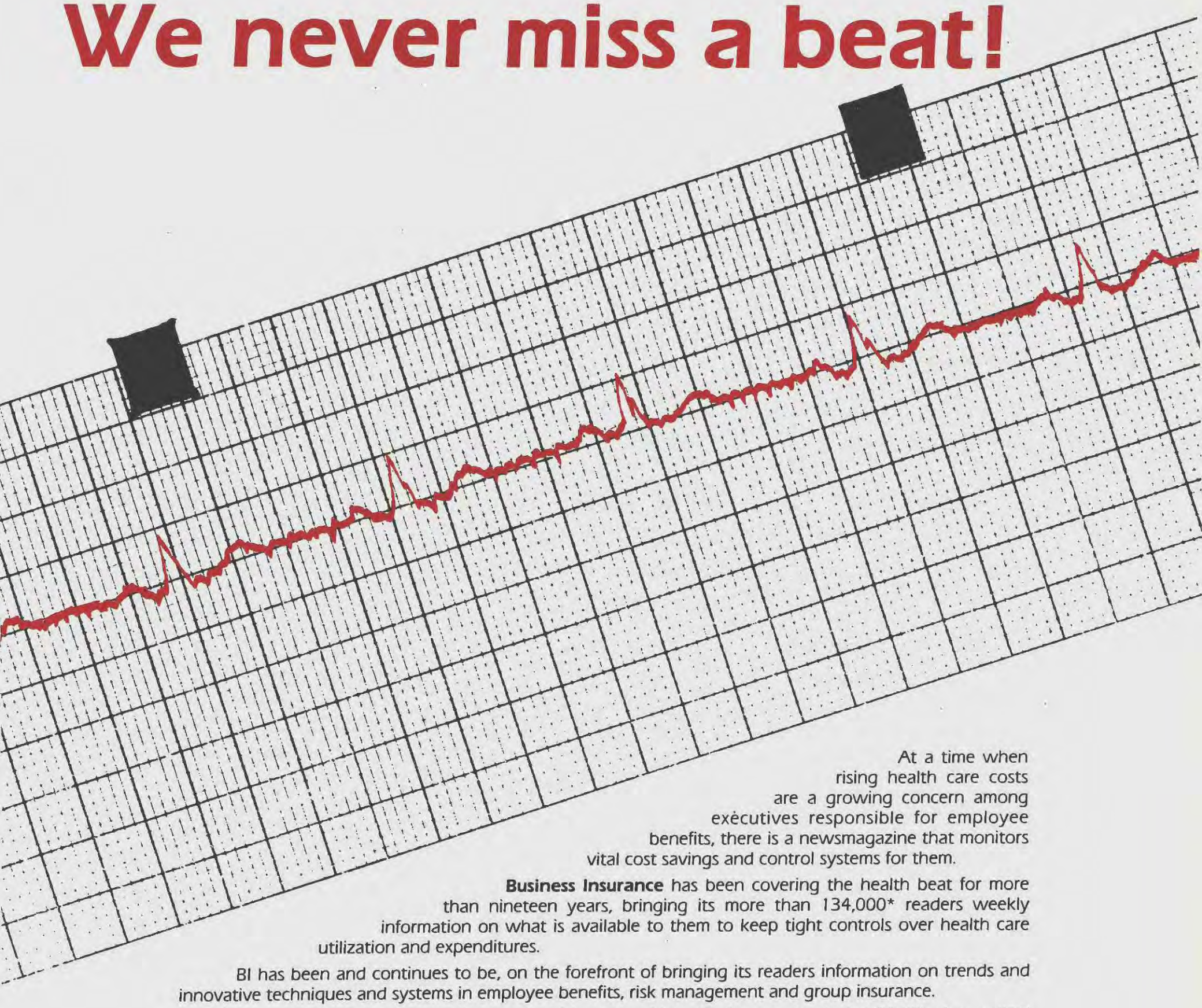

At a time when rising health care costs are a growing concern among exécutives responsible for employee benefits, there is a newsmagazine that monitors vital cost savings and control systems for them.

Business Insurance has been covering the health beat for more than nineteen years, bringing its more than 134,000* readers weekly information on what is available to them to keep tight controls over health care utilization and expenditures.

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Information

Continued from page 42

quate care," Mr. Goetzel explained.

And, case management is a team approach to managing a patient's health care. "The physician is no longer calling all of the shots. Now, the family, the patient, the employer and the medical case manager are all working together to ensure high quality care," he noted.

In addition to identifying high outliers, an effective utilization review system also should screen and identify questionable hospital admissions.

And, if a hospital admission is required, the system should control the length of stay. For example, Corporate Health Strategies uses Medicare's Diagnostic Related Groups to determine appropriate lengths of stay for particular illnesses, he said.

The system also should be linked to the medical claims system on the "front end," where it can check the patient's benefits eligibility and check the cost and utilization profile of the provider before the patient receives care, he explained.

The system also should be linked to the claims system at the "back end," so that at the end of the patient's care, the claim can be compared to the utilization review record. Also, utilization review data can be linked to claim data files to add quality indicators to provider records, he said.

Making HMOs work for the elderly

By DONNA DiBLASE

SAN DIEGO—While health maintenance organizations can provide greater benefits to Medicare beneficiaries, certain problems must be solved to make HMOs appropriate health care providers for the elderly, experts say.

And, employers should play an active role in solving these problems, they add.

"The federal government and HMOs must work together to work out problems and improve quality," said Cynthia L. Polich, executive vp and director of the Center for Aging and Long-Term Care, a division of Interstudy, an HMO research group in Excelsior, Minn.

"Some HMOs do an excellent job at managing costs. Others are lucky because they've gotten better Medicare risks," or Medicare enrollees that do not have serious, expensive chronic illnesses, explained Christine Boesz, senior policy analyst for the federal Health Care Financing Administration's Office of Policy, Planning & Liaison.

She continued: "Some HMOs are still learning and some have had financial difficulties.

"The challenge of the future is how we can use collective buying power. The federal government and employers have a common interest—purchasing the best kind of benefits for the elderly."

The appropriateness of HMOs as providers of health care to the elderly was discussed at the annual conference of the National Assn. of Employers on Health Care Action held earlier this month in San Diego.

The HCFA first contracted with an HMO to provide coverage Medicare beneficiaries in April 1985. The HCFA now has 152 such contracts in 34 states.

And, there are 35 applications for contracts pending, Ms. Boesz said.

The average monthly payment by the HCFA to Medicare-contracting HMOs is about $189 million for about 915,000 Medicare enrollees—an average of $213 per month per Medicare enrollee.

A total of about 30 million people are eligible for Medicare, she said.

'Most HMOs fall short of providing long-term care coverage,' which is the single largest expense for elderly people, Ms. Polich says.

"HMOs are able to offer impressive benefits to Medicare beneficiaries," she noted.

For example, 89% of the 152 Medicare HMOs offer coverage for extended hospital days; 87% offer preventive care; 75% offer eye care coverage; 41% offer extended coverage of skilled nursing home expenses; 19% offer dental coverage; and 4% offer mental health care coverage.

"These are benefits that are above the benefits provided by Medicare coverage," she said, referring to traditional Medicare indemnity coverage.

However, most HMOs do not provide the one benefit many Medicare recipients need the most —coverage of long-term care expenses.

"Most HMOs fall short of providing long-term care coverage," which is the single largest expense for elderly people, Ms. Polich of Interstudy said.

In 1982, the total expenditure for long-term care in the United States was $27.3 billion, 91% of which was spent on institutional care. The remaining 9%, or $2.5 billion, was spent on home health care, she said.

"Most elderly people have multiple chronic conditions—about three conditions. And, about 50% of the elderly are limited in daily activities because of chronic conditions," Ms. Polich added.

However, "HMOs have the potential to meet the needs of the elderly. The federal government is advocating the use of HMOs to contain Medicare costs. But, controlling costs is not the only issue. The government is under pressure to provide a wide range of services and benefits to the elderly," she said.

Ms. Polich noted that HMOs can be appropriate health care providers for the elderly because:

- All of the patient's health care is coordinated in one system.

This makes receiving medical care easier for the elderly because they don't have to submit claims forms for every service they receive. And, costs are controlled through the utilization and cost controls used by HMOs.

- HMOs provide benefits above those covered by the traditional Medicare plan.
- The out-of-pocket expenses required of elderly patients are lower in an HMO.

According to Ms. Polich, the reasons that HMOs have not reached their full potential as health care providers to the elderly include:

- HMOs fear that an uncontrolled risk and increased cost would result if they provided a long-term care benefit.

"This includes a fear of adverse selection," that could result if only those patients needing long-term care coverage enrolled in the HMO, Ms. Polich noted.

- HMOs lack knowledge of the specific needs of the elderly.

This includes understanding the needs of patients with multiple chronic illnesses.

- HMOs lack an adequate financing mechanism to manage the costs and experience related to accepting Medicare enrollees.

An appropriate health system for the elderly requires a trained staff that includes geriatricians and geriatric nurse practitioners, Ms. Polich said.

The system also should be able to assess each elderly enrollee's needs and then coordinate and monitor the appropriate care, she added.

And, the system should provide enrollees with access to a full range of health and long-term care coverage, she noted.

Medicare HMOs also should include health education and promotion for elderly enrollees.

And, "HMOs should clearly explain to the elderly the advantages and disadvantages of enrolling in an HMO," she asserted. ■

In Focus:

Gene Rak, Chicago

Sherwood Insurance Services, continuing to expand its commitment to the Midwest insurance market, has signed on Gene R. Rak as Property Manager in Chicago. "Gene's addition underscores our desire to bring a high level of expertise, matched with strong local understanding, to our latest branch office," stated Don Sherwood, President.

Rak, a native of Illinois, is a 15-year insurance veteran in Chicago, the last 11 years as a property underwriting manager. "While my strength is in property, I'll also be looking for opportunities in the casualty field for Sherwood," explained Rak. "I know I have the Sherwood Network to lean on for expert help." Rak was referring to Sherwood's 70 professionals located in San Francisco and Los Angeles who have a market reputation for active interoffice communication on markets, trends, service updates, etc.

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info

- Coopers & Lybrand's Actuarial, Benefits & Compensation Group has prepared a booklet titled, "Employer Health Care, A System in Transition," which addresses **employer health care cost containment.** The booklet explains why health care costs are rising drastically and the economics behind health care delivery. In addition, it features five specific steps employers can take to effectively control health care costs. Free copies are available from Renee Smith, Coopers & Lybrand, 1800 M St. N.W., Washington, D.C. 20036.

- "Determinants of HMO Success" is a 264-page softbound book that documents the practices of eight exemplary **health maintenance organizations**. The book details corporate practices and innovations as well as cost management techniques. It includes four case studies chosen for examples of specific management principles, an overview of areas that are of concern to these HMOs and documentation of those qualities the authors believe will remain critical to HMOs success in the future. To order a copy, at $23 plus $3 postage and handling, contact The Foundation of the American College of Healthcare Executives, Order Processing Center, 1951 Cornell Ave., Melrose Park, Ill. 60170; 312-450-1101.

- For those who would like to check their knowledge of benefit-related subjects, **"The Quizzical Administrator: Employee Benefit Trivia,"** should fit the bill. Published by the International Foundation of Employee Benefit Plans, the collection of 211 questions and answers was compiled by Irving Baldinger, senior vp of American Benefit Plan Administrators Inc. of Los Angeles. Topics include: ERISA, COBRA, the Tax Reform Act of 1986, pension benefits, Medicare and Social Security. Copies are $4.95 for IFEBP members and $7.95 for others, with discounts for orders over 100. Contact the International Foundation of Employee Benefit Plans, Publications Department, P.O. Box 69, Brookfield, Wis. 53008-0069.

- **"The High Price of Mental Health Services"** is the title of a mental health research study written by Dr. John C. Brady II, president of Psychology Systems. The study focuses on the five principal reasons for the rise in psychiatric and substance abuse and dependence care costs: the reduced stigma of patient status; new categories of patients created by psychiatric treatment; the absence of psychiatric peer review; too many mental health workers; and inattention to pricing. The study concludes that a system of managed psychiatric care must be developed. For a copy of this study, write Psychology Systems, H-P, 615 S. Main St., Milpitas, Calif. 95035.

- A new brochure is available from Self Insurance Exchange Inc. to organizations that are self-insured or are considering self-insurance. In the brochure, "SIEX—National Clearinghouse of Self-Insurance Experts and Services," SIEX provides a complete **guide to services a self-insured organization should consider** and an explanation of how the clearinghouse can help organizations with their self-insurance needs. For a free copy of the brochure, write Self Insurance Exchange Inc., P.O. Box 8104, Newport Beach, Calif. 92658-8104.

- "Leveraged ESOPs—A Financing Technique for Savings Plans" is the subject of a recent Kwasha Lipton newsletter. In it, the benefit consultants explain how a corporation that offers its employees a savings plan can, using an **employee stock ownership plan** approach, "prefund" the savings plan and reduce its after-tax costs by using borrowed funds to buy shares of its stock in advance for the company's future matching contributions, and taking a tax deduction for the dividends on ESOP stock that are paid to plan participants. Free copies of the newsletter can be obtained by writing Kwasha Lipton, Marketing Department, P.O. Box 1400, Fort Lee, N.J. 07024.

- Persons involved in litigation can compute valid **predictions of the actuarial value of any injury claim** by using a revised evaluation form developed by Jury Verdict Research Inc. The revised form, compiled with the assistance of attorneys and insurance claim vps, features a checklist format that makes it simpler to fill out and also allows inclusion of all secondary adjustment factors pertinent to the case. The evaluator can adjust proposed settlements for collateral payments that must be taken into account in determining ultimate damages. This procedure is explained in the "How to Use" manual, which contains a table based on analysis of 8,086 verdicts. Copies of the new form and manual are available at no charge from Jury Verdict Research Inc., 5325 Naiman Parkway, Suite B, Solon, Ohio 44139-1065.

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Asbestos claims

Continued from page 1

When Manville Corp., the largest asbestos producer, filed for reorganization in 1982, it projected 32,000 new lawsuits would be filed in addition to the approximately 16,500 claims it faced at the time.

Asbestos defendant Raymark Corp. has projected that 90,000 claims will be filed against it.

But, based on current filings and projections, as many as 24,000 to 48,000 new claims will be filed in one year alone.

Reinsurers, too, know more claims are being filed.

Leonard Minches, vp-claims for Gerling Global Reinsurance Co., said reinsurers are concerned about the increase, but they don't know yet whether the increased claims are an acceleration of anticipated claims or were unexpected.

"We know the amounts being reported to us have increased more in the past six months than ever before," said Carl Patek, vp-finance for Allstate's Business Insurance Group, which includes its reinsurance department.

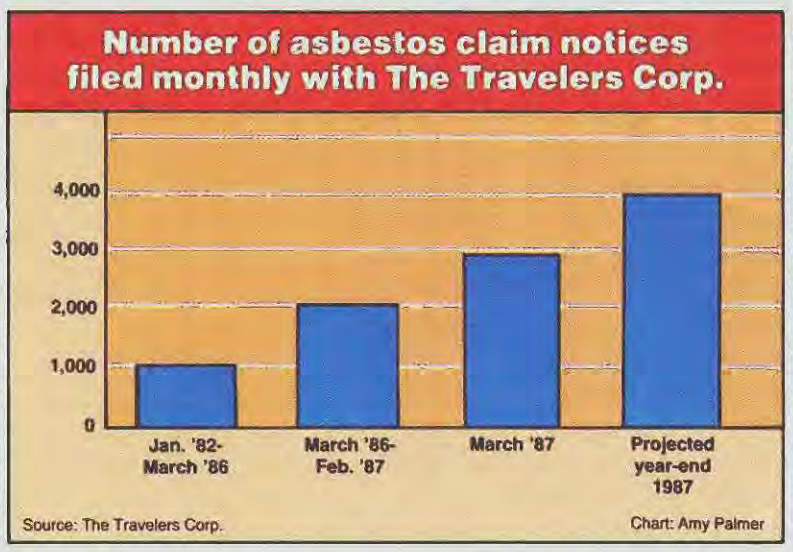
"There's not any question there is an increase in the numbers of cases being filed," says Albert Parnell, an attorney who has long been involved in defending asbestos cases. "Primarily the cases I see stem from large lawyer or union screenings."

Mr. Parnell of the Atlanta firm of Freeman & Hawkins said unions often bring in members for X-rays and retain doctors who liberally read them so that asbestos-related diseases are diagnosed.

Plaintiffs' lawyers also have organized screenings on their own with similar results, he notes.

An increase in unemployment among steelworkers and tire workers has contributed to the increase in lawsuits from these workers claiming bodily injury from asbestos, said a general counsel for an asbestos producer who asked not to be identified.

While asbestos producers had expected new claims from workers other than insulation and shipyard workers, they did not foresee the "traveling entrepreneurial roadshow" that some plaintiffs' attorneys have instituted, the attorney said.



Many of the new cases "didn't come out of the doctor's office, they came out of the lawyer's office," he quipped.

Fortunately, however, his company only is being hit with 1,200 to 1,500 new cases per month, a smaller jump in the past two to six months compared with what some other asbestos producers are experiencing.

Plaintiffs' attorneys and union personnel defend the screening programs, contending that many workers are unknowingly suffering from asbestos-related diseases.

San Diego plaintiffs' attorney Richard F. Gerry says his firm has helped screen approximately 25,000 tire workers during the past year and about 5,000 of them have shown some evidence of asbestos-related diseases. Plaintiffs allege that the talc used in the manufacture of tires is contaminated with asbestos.

Cases involving about one-half of these individuals have been filed in the past year, says Mr. Gerry, who is with the firm of Casey, Gerry, Casey, Westbrook, Reed & Hughes.

Tire workers alone eventually could bring 20,000 claims, Mr. Gerry predicts.

In addition to tire workers, sheet metal workers also are being screened as part of various medical studies, including one by Dr. Irving Selikoff of Mount Sinai School of Medicine in New York.

Approximately 5,000 workers have been screened, and many have been found to have asbestos injuries, such as asbestosis, a scarring of the lung; lung cancer; or mesothelioma, a cancer of the lining of the lung, says James Golden, the Asbestos Project Coordinator for the International Assn. of Sheet Metal Workers.

"Many are filing lawsuits," said Mr. Golden, noting that union members, widows of union members, and other survivors have entered into more than 1,000 contracts with the South Carolina law firm of Blatt & Fales to represent them in asbestos litigation.

Of 33,000 sheet metal workers eligible to be screened, about half will be screened, Mr. Golden estimates. "We anticipate a good number will file lawsuits," he said.

Noting that some screening programs are really legal programs, Mr. Golden said, "ours is a medical program." All of the screenings are paid for by health plans and not by attorneys, he asserts.

Plaintiffs attorneys also are involved in the screening of thousands of steelworkers, merchant seamen, and railroad workers.

But Mr. Gerry contends that the increased lawsuits stem not from plaintiffs' attorneys but a growing awareness by union leaders of the dangers of toxic substances.

No one knows yet how much this new onslaught of claims will cost asbestos producers, insurers and reinsurers. Previously, the cost of asbestos bodily injury claims has been estimated anywhere from $4 billion to more than $100 billion.

The new wave of lawsuits not only names the major asbestos producers but also many additional small and large manufacturers that used asbestos in their products, such as Pfizer Inc. in New York and Union Carbide Corp. in Danbury, Conn.

Because the workers now suing have been in industries where they have been exposed to many products in addition to asbestos, insurers will have to conduct more investigations to determine whether there is an asbestos-related injury and whether it was caused by a policyholder's product, notes Mr. Knowlton of Travelers.

As a result, legal and administrative costs could be very significant, he says.

However, the indemnity payments in these cases may not be as large as for shipyard workers, Mr. Knowlton added. Some speculate that the injuries of those currently suing are not as serious as those of plaintiffs that have already sued.

These new plaintiffs are probably not as ill as plaintiffs that worked in shipyards or as insulators, although it is still early in the litigation, said the claims facility's Mr. Fitzpatrick.

"By and large, the more recent cases are less heavily diseased, lightly diseased or not diseased at all," said the general counsel for the asbestos defendant who asked not to be identified.

But some say that there has not been enough discovery in the new cases to make definitive statements about how ill the new plaintiffs are.

Plaintiffs' attorneys and union representatives, however, argue that these cases are just as serious as earlier cases and that significant evidence of asbestos-related diseases is being found.

If there is minimal impairment in the new cases, producers and insurers likely will vigorously defend the cases and settle fewer of them.

"If they are non-meritorious, producers will have to defend them to a conclusion," says Mr. Fitzpatrick of the claims facility. "It will probably result in more asbestos trials."

Whether the claims have merit or not, they will prevent the facility from disposing of the current backlog of claims as had been hoped, Mr. Fitzpatrick noted.

Even before this wave of new claims, more bankruptcies of asbestos producers had been expected, and the insurance industry's ability to fund asbestos claims had been questioned.

Already, a half-dozen asbestos producers, including Manville, formerly the largest asbestos producer, have filed for reorganization under federal bankruptcy laws because of overwhelming asbestos litigation. And, most recently, Nicolet Inc. of Ambler, Pa., stopped paying claims because it ran out of insurance, according to its national counsel, Byron L. Milner, with Bennett, Bricklin & Saltzburg in Philadelphia.

William E. Bailey, a longtime asbestos litigation observer and former senior vp of Commercial Union Insurance Co. of Boston, contends that even under the broadest insurance coverage interpretations there is not enough insurance to cover all the asbestos claims that will be filed.

"I still maintain the problem is a national health problem," said Mr. Bailey, adding that he considers asbestos-related diseases to be as serious as the spread of acquired immune deficiency syndrome.

With billions of dollars to be paid to claimants, some producers will exhaust their insurance and could be forced to seek Chapter 11, Mr. Bailey says. He suggests that now is the time to seek federal government intervention.

But, Mr. Fitzpatrick of the claims facility says he does not think more companies will have to file for Chapter 11.

One asbestos producer not seeing a large increase in new claims is Raymark, now called Raytech Corp. Claims are still averaging about 1,000 per month this year as they did in 1986, said Vp and General Counsel LeGrande L. Young.

Because of financial and insurance problems, Raytech has recently negotiated group settlements with thousands of plaintiffs, averaging between $1,000 and $2,000 per case.

Mr. Young speculated that the company's problems may have discouraged plaintiffs from suing or that plaintiffs bringing the new filings were not exposed to Raytech products. ■

update

Fraud probe results in arrests

Continued from page 2

The arrests followed an investigation by the Florida Department of Insurance's division of insurance fraud that found Transportation Services was paid $35,000 between September 1986 and January of this year by Jack D. Bailey for the coverage that was never arranged, according to a department spokeswoman.

She said Transportation Services had issued certificates of insurance that listed CNA Insurance Cos. and Wilshire Insurance Co. in Raleigh, N.C., as insurers of Mr. Bailey's fleet when in fact they were not providing coverage.

The spokeswoman said officials at Transportation Services had arranged for Mr. Bailey to lease his trucks to another company that they said would add the fleet to its insurance policy. "The investigation determined that no coverage was ever in place" for Mr. Bailey's trucks, according to the spokeswoman.

Prior to the arrests, Mr. Beck appeared before a grand jury in Pensacola, Fla., to answer charges that the company illegally acted as an insurer or an insurance agent (*BI*, April 27).

Liability for collapse sought

BRIDGEPORT, Conn.—A hearing in Connecticut Superior Court is scheduled here today to discuss "bill of discovery" lawsuits filed by four plaintiffs to uncover information needed to determine liability for the apartment project collapse that killed 28 workers in late April (*BI*, May 4).

In addition, one of the subcontractors on the project, Lift Frame Builders, based in Elmsford, N.Y., has filed a $1 million suit in federal district court in New Haven against the city of Bridgeport in connection with the accident, according to city attorney Lawrence J. Merly.

Mr. Merly said he believes the purpose of the suit is to establish a jurisdiction for litigation in connection with the case. Lift Frame's attorney, Arnold J. Bai, could not be contacted.

It will take several months before the cause of the collapse is determined, according to a spokesman for the Royal Insurance Group. TPM International, one of the project's general contractors, is covered by a $15 million builders risk policy with Royal.

The project's developer, L'Ambiance Partnership Ltd., has a liability insurance policy for an undisclosed amount with The Hartford Insurance Group.

Royal Insurance Group had agreed following an April 30 meeting led by Connecticut Insurance Commissioner Peter W. Gillies to establish a $2 million trust fund for the rescue and cleanup effort. The agreement stipulated Royal did not admit any liability in connection with the accident. Half of the amount will be returned to Royal if it is determined that another party not insured by Royal is found to share liability for the accident.

MBIA to make stock offering

WHITE PLAINS, N.Y.—Shareholders of MBIA, the holding company of the Municipal Bond Investors Assurance Corp., expect to raise up to $137.5 million by selling a 15% interest in the company in an initial public offering in July.

The shareholders are Aetna Life & Casualty Co.; Fireman's Fund Insurance Co.; a CIGNA Corp. company; the Continental Insurance Co.; and some affiliates of those companies.

The registration statement filed with the Securities & Exchange Commission said 5.5 million shares are expected to be sold in the common stock offering, of which 4.5 million will be offered in the United States and Canada and 1 million internationally.

The offering price is expected to range between $22 and $25 a share. MBIA plans to apply for a New York Stock Exchange listing. As of March 31, the net par value of MBIA municipal securities insured totaled $28.4 billion and MBIA had $61.1 billion net insurance in force.

Bus crash settled for $5 million

SAN FRANCISCO—Industrial Indemnity Co. has paid $5 million on behalf of California's assigned risk plan to settle claims against Starline Sightseeing Tours stemming from a May 1986 accident that killed 21 people.

The settlement was reached May 1 with 40 claimants.

The settlement prohibits the plaintiffs from pursuing other claims against the tour bus company or the driver of the vehicle, says the San Francisco-based insurer, a Crum & Forster unit.

The claimants, who will receive amounts ranging from $30,000 to $500,000, include injured passengers and families of those killed.

Industrial Indemnity insured Starline for $5 million under the state's assigned risk auto insurance pool, the California Commercial Auto Insurance Plan. Industrial Indemnity therefore will be reimbursed for the entire settlement by the pool.

Briefly noted

John Hancock Mutual Life Insurance Co. has put up for sale its Health Plans Inc. subsidiary, which owns and operates six health maintenance organizations in Atlanta, Chicago, Philadelphia, Jacksonville, Fla., Connecticut and Kentucky. . . . **RIMS-NET**, the Risk & Insurance Management Society's information and communication network service, will provide insurance companies ratings from Standard & Poor's Corp. beginning July 1 (*BI*, May 18). . . .**The American Bankers Assn.** has extended its deadline to Sept. 30 from May 15 for U.S. banks to apply for directors and officers liability insurance and bankers blanket bonds from its new Bermuda captive, The American Bankers Professional & Fidelity Insurance Co. Ltd. . . .**Morton Thiokol Inc.** of Chicago, manufacturer of the rocket boosters on the space shuttle Challenger, settled a liability suit filed by the family of Challenger astronaut Ronald McNair. The terms of the settlement are being kept confidential.

Kennedy bill

Continued from page 1
of the premium.

The legislation also contains several provisions that would reduce the impact of the health insurance mandate on small employers.

Employers that are less than two years old and have fewer than 10 employees would have to provide only catastrophic health care coverage. Those employers would have to provide a plan that covers health care expenses exceeding $3,000 annually.

In addition, the self-employed would be allowed to deduct as a business expense 100% of their health insurance premiums. Currently, only 25% is deductible.

At the same time, insurers and other providers would be asked to bid on pools through which small employers could buy a standard minimum plan.

Sen. Kennedy believes small employers could cut their health insurance costs by between 20% and 25% by purchasing coverage through the pools compared with the cost of each employer negotiating coverage individually.

And, in a provision that would cut costs for nearly all employers, the Kennedy legislation would pre-empt the hundreds of state laws requiring companies with plans to offer certain benefits.

These state benefit laws not only raise health care costs, but also make it difficult for employers operating nationwide to offer a uniform benefit package.

"Uniformity is very important to our members who may operate in a couple dozen states," said Willis Goldbeck, president of the Washington Business Group on Health.

Sen. Kennedy tried to make the legislation more palatable to the business community.

"There is genuine interest on the part of Sen. Kennedy and his staff to develop employer support for his proposal. Therefore, they have been willing to make some changes to win business support," said Frank McArdle, director of education and communications at the Employee Benefit Research Institute, a Washington-based benefits think-tank.

"Sen. Kennedy understands the problem is how to find coverage for the uninsured. . .not with existing employer plans," said Mr. Goldbeck of the WBGH.

"We did not want to disturb employers already providing coverage," said David Nexon, a Kennedy aide who drafted the legislation.

Despite the changes in the legislation, several business organizations issued news releases denouncing the proposal.

For example, the U.S. Chamber of Commerce described the legislation as national health insurance financed by business.

"It is ridiculous to believe that every company in the nation can afford to provide such a generous array of health care benefits. For many firms, especially smaller companies, a mandate to provide health coverage to all employees and their families will mean failing to hire additional workers, cutting back on pay and other benefits, reducing investment or, in some cases, going out of business," asserted James Klein, the Chamber's manager of pension and employee benefits.

"Enactment of this legislation would disrupt existing employer health plans, significantly increase corporate health costs and diminish industry's competitive position," said Alexander Trowbridge, president of the National Assn. of Manufacturers.

The opposition by some business groups to the plan is not surprising, benefit experts say.

"Some groups will oppose a federal health plan mandate because of ideological reasons," regardless of its merits, Mr. Goldbeck said.

But Mr. Goldbeck predicted that opposition will decline as more employers realize that a health care mandate may be far less onerous than other proposals under consideration, such as employer-subsidized pools to provide coverage to uninsured individuals.

In addition, employer opposition will wane as companies with health care plans realize they now are indirectly subsidizing employees of companies without health care benefits, some experts say.

This subsidy occurs because hospital administrators shift the costs of the uninsured onto patients with health care coverage.

"It is an education process. Employers don't realize that they are paying for other firms' health care costs," said Karen Ignagni, assistant director of the AFL-CIO's department of Occupational Safety and Health Administration in Washington.

But this educational process apparently has begun. American Airlines this month endorsed the concept of universal health coverage for what its top executive called sound, pragmatic business reasons.

"American Airlines does not object to paying its fair share of the health care costs of low-income individuals and senior citizens. But we do object to paying for the health care costs of individuals employed by or retired from other businesses, some of whom may even be our competitors. And that is precisely what is happening today. It is absolutely inequitable to allow businesses to shift these costs to others," said American Airlines Chairman and President Robert Crandall in testimony before the House Ways and Means Health Subcommittee.

And, several other major employers are preparing a letter endorsing mandatory employer-provided health insurance, a business lobbyist said.

The cost of the benefit mandate would be significant.

Sen. Kennedy estimates his bill will force businesses and employees to spend $25 billion more than they do now on health care plans: employers not now offering coverage or offering insufficient coverage would pay $20 billion and employees would pay $5 billion.

But Sen. Kennedy says this added cost for some businesses would be partially offset by reduced hospital cost-shifting to employers with health plans. And, small employers would be able to minimize costs by purchasing coverage through pools, he added.

Requiring employers to offer health insurance coverage would make a huge dent in the number of people without coverage, according to Sen. Kennedy. He says an employer mandate would provide coverage to 24 million employees and dependents. The current number of the uninsured is estimated at about 37 million.

Sen. Kennedy predicted that the Labor and Human Resources Committee will approve the legislation by July. ■

Superfund rules

Continued from page 3
tor the market for pollution liability insurance and continue to seek and secure such insurance coverage (however limited) from commercial insurance carriers or through alternative risk transfer mechanisms."

The interim guidelines would limit indemnification to contractors working on Superfund sites—those dump sites identified by the federal government or state governments as being among the worst in the nation. Contractors cleaning up non-Superfund dump sites would not be eligible for federal indemnification.

Further, the proposed guidelines state that indemnification is primarily available for contractors working for states or the federal government. Contractors working for private parties are eligible for indemnification, but the requirements are much more strict.

"In general," the guidelines state, "the agency expects to use this (indemnification) provision in cases where (the private parties) are small firms."

The proposed guidelines also state that in determining whether to indemnify a contractor working for a private party, the EPA will take into account the total net assets of the private party.

In addition, the proposed guidelines call for retroactive indemnification for all work done by contractors for the government. But it does not apply to contractors working for private parties on Superfund sites.

Mr. Mason noted that with the change in the liability standard for cleanup contractors and the softening of the insurance market, EPA officials are optimistic that an adequate market for this coverage will develop.

"Our view is that this is more legitimately a function of the private sector," Mr. Mason noted.

"Frankly, before Superfund was reauthorized, most, if not all, of the people in the insurance industry were saying 'there is no way we will ever write this kind of risk,' " Mr. Mason noted.

Now, several insurers have contacted the agency about covering cleanup contractors. But he added, "clearly we're not there yet."

For that reason, the EPA likely will allow contractors to piggyback federal indemnification on top of whatever pollution liability insurance they can buy, Mr. Mason explained.

Mr. Mason says the agency also is developing regulations that will supersede these interim guidelines.

While the indemnification outlined by the interim guidelines is extremely broad in scope, Mr. Mason says the indemnification task force is researching indemnification limits, covered risks, deductibles, and eligible policyholders under the permanent program.

"We want it to be a risk-based approach," Mr. Mason pointed out.

He said part of the reason for this approach is to "aid the insurance industry in the future to better understand the risks associated with this work."

The proposed regulations are expected to be published in the fall and will be available for public comment, he said. The permanent regulations probably will not go into effect for at least two years.

Meanwhile, one program for cleanup contractors already is being marketed by Corroon & Black and underwritten by American International Group Inc.

Mr. Mason noted that the EPA views the Corroon & Black program "with optimism."

It is the only insurance program he is aware of for hazardous waste cleanup contractors.

The program, which requires a $100,000 self-insured retention, includes general liability coverage, with limits of $1 million; automobile liability, with limits of $1 million; and pollution liability, with limits of $1 million per occurrence/$2 million annual aggregate.

The package features blanket coverage for all job sites and completed operations, according to David J. Dybdahl, an account executive with Corroon & Black of Milwaukee.

Typically, environmental liability insurance is site-specific and excludes alienated premises, which makes such policies useless for waste cleanup contractors, Mr. Dybdahl explained.

In three states, New Jersey, Illinois and Missouri, the coverage is available for contractors working on both Superfund and non-Superfund sites. However, in the rest of the nation, only contractors working on non-Superfund sites are eligible for coverage.

The legislatures in those three states have passed laws that define the cleanup contractors' liability, but in most states it is not clear what standard of liability will be applied to these contractors, Mr. Dybdahl said.

While the federal Superfund law changed contractors' liability for cleanup from a strict to a negligence standard, it does not pre-empt state laws that might be stricter. Mr. Dybdahl says Corroon & Black is reviewing the laws of the other states and plans to expand the program in the near future.

The minimum premium for the program is $25,000, Mr. Dybdahl said. Corroon & Black also is working with AIG to raise the available limits. "We are confident we can do so in the near future," he said. ■

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Shareholder suit

Continued from page 2

ACIC last month, the Delaware Insurance Department also required Beneficial to contribute $200 million to the insurer's reserves. The reserve contribution followed a $260 million pretax reserve increase Beneficial announced last year.

The sale of the insurance units to the management group represented one phase of a plan by Beneficial to divest units unrelated to its core consumer lending business. The divestitures followed the failure of a previous plan to sell the entire company.

The shareholder derivative suit was filed in U.S. District Court for the District of Delaware by Schumer Lonoff, executor for the estate of Miriam Lonoff, owner of 600 Beneficial common shares.

The suit names:

- Finn M.W. Caspersen, Beneficial's chairman and chief executive officer and 14 Beneficial directors.
- RCK Holdings, Beneficial International and First Delaware Holdings.
- Three in the management group buying the insurance units: Mr. Rothman; Andrew Kerstein, senior vp and chief actuary of Beneficial Insurance Group; and Nicholas Cooper, vp of Beneficial International.

The complaint charges that Beneficial's directors consistently covered up the magnitude of ACIC's reinsurance losses.

In an Aug. 1, 1986, letter to stockholders, Mr. Caspersen announced that Beneficial was considering merger, sale or divestiture of some of its operations.

The letter also said that Beneficial would add $260 million before taxes—about $150 million after taxes—to the loss reserves of its property/casualty units, principally ACIC. The letter said that contribution would bring reserves to a "high prudent" level.

This statement was reiterated in Beneficial's Form 8-K filed with the Securities and Exchange Commission on Aug. 28, 1986, the complaint says.

In addition, a Beneficial spokeswoman last December denied reports that Beneficial would have to contribute further to the insurance units' reserves.

However, in a Feb. 26 press release, Beneficial announced a $171.6 million net loss for the previous year, more than triple the $50 million loss prediction attributed to Mr. Caspersen in a December news report, the complaint says.

A Feb. 27 report in The Wall Street Journal also quoted a Beneficial executive saying that the company had pumped more money into the insurance units' reserves in the fourth quarter of 1986, in addition to the earlier $260 million pretax contribution, the complaint notes.

It was later learned that the Delaware Insurance Department, as a requirement of ACIC's sale, had told Beneficial to boost the reserves by another $200 million, based on worst-case loss development projections.

Beneficial's directors also fended off a possible takeover by Allegheny Corp., which had acquired 15% of Beneficial's stock in the summer of 1986, the suit says.

In reaching the agreement with the Rothman group, however, Beneficial's directors passed up what the suit describes as a better offer from Mr. Bentley, the former Georgia insurance commissioner.

The Bentley group originally proposed buying ACIC, Beneficial International and two Beneficial International subsidiaries.

However, First Boston Corp., acting as a consultant to Beneficial, told Mr. Bentley that the two subsidiaries were not available for sale, and Mr. Bentley then proposed buying only ACIC and Beneficial International.

In an initial meeting, a First Boston official asked Mr. Bentley for his views on ACIC's finances and future prospects, the suit says. Mr. Bentley said he did not have sufficient information to give a detailed answer, according to the suit, which alleges that the First Boston official declined to provide Mr. Bentley the information.

Mr. Bentley complained to Beneficial that he was being given "short shrift" even after signing a confidentiality agreement. Mr. Bentley received only public documents on file with the SEC and state insurance departments, the complaint says.

In late January, Mr. Bentley submitted his proposal for the acquisition of ACIC and Beneficial International, which offered no cash, but would provide a 10-year note entitling Beneficial to 50% of ACIC's assets or equity, whichever was permitted by state insurance law, the complaint says.

Mr. Bentley met with Beneficial executives to summarize his plan for ACIC and Beneficial International and projected that the two insurers would be worth $250 million to $300 million after 10 years, entitling Beneficial to about $140 million, the complaint says.

But Mr. Bentley's proposal was rejected as being "vague," the complaint says.

Mr. Bentley later learned that the Rothman group had been able to submit a detailed proposal because it had information that was denied Mr. Bentley, the suit says.

Mr. Bentley later submitted a proposal offering $13 million in cash for the insurance units, including $10 million from Beneficial International funds, a note with a face value of $65 million, and an option granting Beneficial the right to purchase at a nominal price 9.9% of the stock of two British-based Beneficial International subsidiaries.

The second proposal—to which Beneficial never responded—was worth "at least $3 million and possibly in excess of $100 million" more than the Rothman group's offer, the suit alleges.

Beneficial's 1986 Form 10-K, filed with the SEC on March 31, was false and misleading because it discussed the management group buyout but did not disclose the two Bentley proposals or that Beneficial directors "had failed to negotiate with the Bentley group in good faith," the complaint says. ■

HCA hospital sale

Continued from page 2

plan is expected in the next few weeks, after further discussions with involved parties and consideration of the financial, regulatory and legal issues, the spokeswoman said.

The sale of the hospitals would not have any effect on HCA's recent joint venture with New York-based Equitable Life Assurance Society of the United States, which created the managed care company Equicor, spokesmen said.

The restructuring plan could involve the sale of about 100 of HCA's acute-care general hospitals. This would leave HCA with a core group of about 80 acute-care general hospitals and 50 psychiatric hospitals, the HCA spokeswoman said.

In addition, HCA would retain its HCA Management Co. subsidiary, which provides management services to more than 215 non-HCA-owned acute care hospitals, she said. The company also would retain HCA International Co., a subsidiary that operates more than 40 hospitals worldwide.

About 20,000 to 25,000 employees would participate in the new employee-owned hospital company, which would be created through a leveraged ESOP, said another HCA spokesman. In addition, the ESOP would become the only retirement plan for employees of the new company, he said.

In the leveraged ESOP, the new company would arrange for a bank loan, which would be deposited into a trust fund. The company then would make tax-deductible contributions to the ESOP trust fund, which would be used to repay the bank loan. As the loan is repaid, shares of stock would be allocated to employees' accounts in the ESOP in a manner similar to profit-sharing plans.

Leveraged ESOPs offer savings to both employers and lending institutions. Lenders may exclude from their taxable income 50% of the interest they receive from loans made to ESOPs. And, the bank's savings can then be passed on to the new employee-owned company in the form of lower interest rates on the loans.'

While employees of the new company would own the majority of stock in the company, HCA would retain a minority interest in the new company, the spokeswoman said.

HCA would receive a significant cash payment from the sale of the hospitals, which would be used to reduce corporate debt and repurchase common stock. The company is not disclosing the amount of the sale.

And, while Mr. Frist would remain with HCA, certain other senior managers of HCA are expected to join the new company, she added.

HCA's profits declined 48% in 1986 to $174.6 million on revenues of $4.93 billion from a $338.6 million profit on revenues of $4.35 billion in 1985. However, "1985 income reflected a one-time after tax gain of $65.4 million from the termination of a merger agreement," the HCA spokeswoman explained.

And, "1986 was a year of restructuring. We decided to go ahead and follow the advice of some actuarial studies we had conducted. And, we used $61 million to increase our professional liability insurance reserves," she said.

HCA insures its professional liability risks with its Tennessee-based captive insurance company, Parthenon Insurance Co., which in turn reinsures with another HCA subsidiary, Parthenon Casualty Insurance Co.

The $61 million is being held by HCA and won't be released unless the insurers need it, the spokeswoman said.

She also noted that if the sale of the hospitals goes through, "there will be a ripple effect on all HCA operations, but it remains to be seen how it will affect Parthenon."

Parthenon wrote gross premiums of $75.1 million in 1986 and reported year-end capital and surplus of $57.9 million.

The sale of the hospitals would not affect Equicor, the joint venture between HCA and Equitable, said spokesmen.

"This transaction has no relationship to Equicor," said the Equicor spokesman in New York. "This will have no effect on Equicor's operations or future business plans."

Late last year, Equitable and HCA each contributed $90 million in cash to create Equicor, which was capitalized with more than $400 million, including the cash contributions and the assets of Equitable Group & Health—formerly Equitable's group health and life insurance division—and HCA's health insurance division, HCA Health Plans (*BI*, Aug. 11, 1986).

Equicor began a three-year plan to introduce a three-pronged group health insurance program in 200 markets, beginning with markets where both Equitable has group health clients and HCA has hospitals.

The program includes traditional indemnity insurance, health maintenance organizations and preferred provider organizations.

However, under the joint venture agreement, Equicor is not required to contract only with HCA hospitals for its managed care plans, and HCA hospitals don't have to contract solely with Equicor.

So, the proposed HCA transaction "will have no effect on Equicor because Equicor and HCA do not exclusively contract with each other," explained the HCA spokeswoman. "But, HCA will continue to own 50% of Equicor." ■

BI Industry Stock Report

May 21, 1987 5/15/87 thru 5/21/87

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	25.38	9.1	30.2	1.00	3.9	25.50	22.50*	1,743.3
Baldwin & Lyons Inc	OTC	18.00	-5.3	7.5	0.20	1.1	18.50	18.00*	0.6
Corroon & Black Corp	NYSE	27.50	-1.8	12.8	0.84	3.1	27.88	27.13*	189.5
Gallagher Arthur J & Co	OTC	20.75	0.0	16.0	0.40	1.9	20.75	20.00	154.1
Hall Frank B & Co Inc	NYSE	13.13	-3.7	0.0	0.00	0.0	13.25	12.63	209.1
Marsh & Mclennan Cos Inc	NYSE	59.75	1.7	16.3	1.90	3.2	59.75	57.50	2,361.7
Poe & Assoc Inc	OTC	12.50	-5.7	15.8	0.40	3.2	13.25	12.50	3.6
AGENTS/BROKERS	AVERAGE			14.7		2.9			
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0
Amsco Inc	NYSE	11.88	-3.1	0.0	0.00	0.0	12.50	11.75	1,671.9
Berkley W R Corp	OTC	25.50	-4.7	8.7	0.28	1.1	26.38	25.00	414.3
Berkshire Hathaway Inc Del	OTC	3380.00	-2.6	112.2	0.00	0.0	3460.00	3380.00	1.1
CIGNA Corp	NYSE	57.38	-5.0	8.2	2.80	4.9	59.00	57.25	1,313.2
CNA Finl Corp (CNA)	NYSE	49.38	-1.7	11.3	0.00	0.0	51.38	49.00	347.6
General Re Corp	NYSE	49.63	-2.7	15.2	1.00	2.0	50.00	49.00*	3,697.6
ITT (Hartford Group)	NYSE	51.88	-2.8	13.3	1.00	1.9	52.50	50.63	4,683.5
Sears Roebuck & Co. (Allstate)	NYSE	51.50	-4.6	13.4	2.00	3.9	52.50	50.50	4,775.5
Transamerica Corp (Occidental)	NYSE	32.38	-1.5	7.3	1.76	5.4	32.38	31.63*	2,333.4
CONGLOMERATES/HOLDING COS.	AVERAGE			59.4		0.2			
Insurers									
Aetna Life & Cas Co	NYSE	56.75	-2.2	8.7	2.76	4.9	57.13	56.25	1,648.3
American General Corp	NYSE	35.25	-5.4	9.5	1.25	3.5	36.50	35.25	1,892.6
Amern Heritage Life Invt Co	NYSE	46.00	-0.5	15.5	0.96	2.1	46.25	46.00	0.5
American Indty Finl Corp	OTC	14.13	-4.2	0.0	1.12	7.9	14.75	14.13*	22.3
American Intl Group Inc	NYSE	62.13	-2.9	13.7	0.25	0.4	63.50	60.88	1,961.4
Aneco Reins Ltd	OTC	3.00	-4.0	12.0	0.00	0.0	3.13	3.00	52.5
Avemco Corp	NYSE	43.38	-5.4	31.4	0.28	0.6	45.38	43.38	12.7
Business Mens Assurn Co Amer	OTC	26.75	-3.6	0.0	1.10	4.1	27.50	26.25	79.7
Chubb Corp	NYSE	57.13	-4.4	9.0	1.68	2.9	58.88	56.75	865.9
Combined Intl Corp	NYSE	47.13	0.0	8.6	2.40	5.1	47.13	47.13*	109.6
Continental Corp	NYSE	41.13	-3.8	9.3	2.60	6.3	41.63	40.50*	584.4
Crown Life Ins Co	OTC	310.00	0.0	10.7	6.40	2.1	310.00	310.00	0.5
Durham Corp	OTC	31.50	45.4	15.8	0.61	1.9	31.50	21.11*	4.5
Farmers Group Inc	OTC	40.38	-3.3	12.7	1.20	3.0	40.75	38.75	1,847.3
Fairmont Finl Inc	AMEX	17.63	-2.1	9.9	0.00	0.0	17.75	17.63	108.1
Fireman Fd Corp	NYSE	35.00	-2.8	12.0	0.40	1.1	35.75	34.13	763.5
Fremont Gen Corp	OTC	15.38	-6.1	0.0	0.60	3.9	16.25	15.25	361.8
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	0.00	0.00	0.0
Home Group Inc	AMEX	19.25	-3.1	4.9	0.20	1.0	19.88	19.00	486.2
Hanover Ins Co	OTC	30.00	-3.2	7.2	0.36	1.2	31.00	30.00*	151.3
Harleysville Group Inc	OTC	15.13	-2.4	4.7	0.40	2.6	15.75	14.63	117.1
Hartford Steam Boiler Insptn	OTC	28.50	-0.9	12.4	1.00	3.5	28.50	26.75*	154.1
Kans City Life Ins	OTC	27.50	0.0	10.6	0.96	3.5	27.50	27.50	15.4
Kemper Corp	OTC	28.50	-5.0	9.9	0.60	2.1	29.50	27.50	791.9
Liberty Corp S C	NYSE	38.25	-0.3	13.8	0.72	1.9	38.38	38.13	42.3
Lincoln Natl Corp Ind	NYSE	48.13	0.0	10.2	2.16	4.5	48.88	48.00	301.7
Mission Ins Group Inc	PAC	1.50	0.0	0.0	0.00	0.0	4.38	0.69	8.1
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	23.00	-8.9	30.3	0.00	0.0	23.75	23.00*	274.4
Nobel Ins Ltd	OTC	12.00	-5.9	9.0	0.37	3.1	12.75	12.00	158.7
Northwestern Natl Life Ins	OTC	24.50	-5.8	7.0	0.96	3.9	25.75	24.50	301.1
Ohio Cas Corp	OTC	41.50	0.0	11.8	1.68	4.0	41.75	41.25	307.8
Old Rep Intl Corp	OTC	26.63	-1.8	9.5	0.80	3.0	26.88	26.38	72.2
Orion Cap Corp	NYSE	21.00	-10.2	0.0	0.76	3.6	22.50	21.00*	40.1
Protective Corp	OTC	13.63	-5.2	11.1	0.70	5.1	14.00	13.63	151.5
Provident Life & Acc Ins Co	OTC	20.13	-7.5	11.1	0.84	4.2	21.00	20.00*	177.8
St Paul Cos Inc	OTC	42.75	-2.3	9.9	1.76	4.1	43.25	42.00	1,067.0
SAFECO Corp	OTC	54.75	-2.7	10.2	1.92	3.5	54.75	53.75	647.3
Scor U S Corp	OTC	11.25	-6.3	17.9	0.00	0.0	11.50	11.00	53.1
Seibels Bruce Group Inc	OTC	15.00	-1.6	93.7	0.80	5.3	15.25	14.25*	84.1
Selective Ins Group Inc	OTC	24.00	-6.8	9.3	0.92	3.8	25.50	24.00	94.7
Statesman Group Inc	OTC	5.00	0.0	0.0	0.06	1.1	5.13	4.75	130.8
Tokio Marine & Fire Ins Co	OTC	87.25	0.0	98.0	0.17	0.2	87.25	87.25	12.5
Torchmark Corp	NYSE	24.88	-6.6	8.9	1.20	4.8	26.00	24.25	817.2
Travelers Corp	NYSE	42.88	-4.7	9.2	2.28	5.3	44.25	41.75*	1,175.6
Trenwick Group Inc	OTC	15.25	-3.2	25.8	0.00	0.0	16.00	15.25	24.5
United Fire & Cas Co	OTC	28.25	0.0	9.0	0.80	2.8	29.25	28.25	12.9
United States Fid & Gty Co	NYSE	38.50	-1.0	9.3	2.48	6.4	38.63	37.75	1,662.8
Unum Corp	NYSE	22.13	-3.8	0.0	0.40	1.8	22.75	21.63	482.0
Uslife Corp	NYSE	35.00	-4.8	9.0	1.20	3.4	36.25	35.00*	266.5
Washington Natl Corp	NYSE	23.63	-5.5	12.2	1.08	4.6	24.63	23.63*	34.4
Zenith Natl Ins Corp	OTC	21.00	6.3	12.1	0.80	3.8	21.00	19.50	182.3
INSURANCE COMPANIES	AVERAGE			12.1		2.7			

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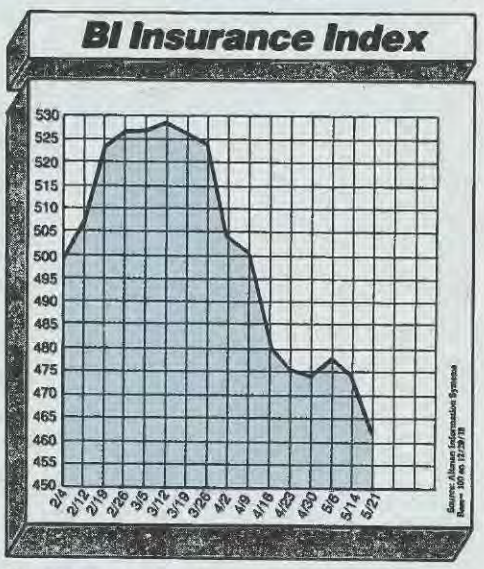
BI Insurance Index



The *Business Insurance* stock index tumbled last week, falling 10.5 points to 463.6 on May 21 from 474.0 on May 14. Forty-eight issues declined, four posted gains and 11 remained unchanged. The largest declines were posted by: Tokio Marine & Fire Insurance Ltd., down 10.4%; Orion Capital Corp., down 10.2%; and Nac Re Corp., down 8.9%. The largest increases were reported by: Durham Corp., up 45.4%; Alexander & Alexander Services Inc., up 9.1%; and Zenith National Insurance Corp., up 6.3%. During the period, the *BI* index fell slightly less than three major market averages. The *BI* index fell 2.2%, while the New York Stock Exchange composite fell 4.6%, the Standard and Poor's 500 average fell 4.8% and the Dow Jones 30 Industrials fell 4.3%.

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