Confronting the future

PPOs tout cost savings

FASB pension rules worry employers
Page 3

MAY 30, 1983

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update

Benefits not to be considered in comp award formula: Court

WASHINGTON—Employee benefits are not to be considered as wages in calculating a workers compensation award, the Supreme Court said last week.

In a case involving the federal Longshoremen's and Harbor Workers' Compensation Act, the high court said in an 8-1 decision: "There is no evidence in the legislative history indicating that Congress seriously con-

Continued on next page

Multiemployer law unconstitutional: Court

By JERRY GEISEL

SAN FRANCISCO—Employers that left multiemployer pension plans before President Carter signed the 1980 Multiemployer Amendments Act cannot be slapped with withdrawal liability charges under the act, an appellate court says.

The 9th U.S. Circuit Court of Appeals is the first appellate court to strike down as unconstitutional a retroactive provision in the law. That provision gives multiemployer pension plans the power to demand huge payments from employers that left the plans during a five-month period between the law's effective date and the date it was actually signed.

The retroactive provision "operates to the severe detriment of the employers," the court said in its May 20 decision. "We hold that retroactive application. . .violated the employers' rights to due process as guaranteed by the Fifth Amendment," the court added.

The court noted that the interests of employers, who could not have been expected to understand the impact of the act before it became law, to be protected from claims that threatened their solvency outweighed the interests of the plans.

"The decision is a recognition by the court that this kind of liability can cripple or bankrupt an employer," said George Knopfler of the Los Angeles law firm of Acret & Perrochet.

The decision, expected to be appealed to the U.S. Supreme Court by multiemployer plans and the federal government, applies to the hundreds of employers that withdrew from multiemployer plans between April 29, 1980,—the law's effective date—and Sept. 26,

Continued on page 59

Home builders go to court over risk retention group

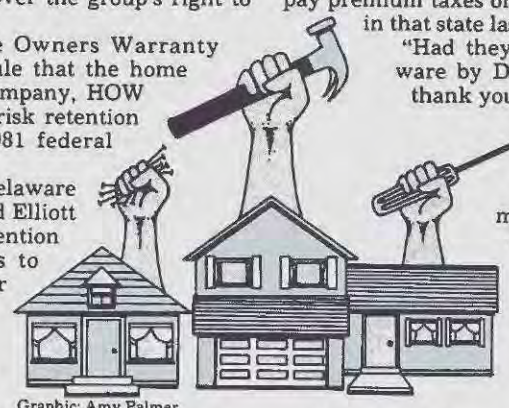
By JERRY GEISEL

WILMINGTON, Del.—A national home builders' association is fighting Delaware's insurance commissioner in U.S. District Court over the group's right to operate a risk retention group.

The 11,000-member Home Owners Warranty Corp. hopes the court will rule that the home builders' captive insurance company, HOW Insurance Co., is a bona fide risk retention group authorized under a 1981 federal law.

Such a ruling would force Delaware Insurance Commissioner David Elliott to recognize HOW as a risk retention group and remove obstacles to HOW's operations in other states that Mr. Elliott's position has produced.

The Delaware regulator's stance against HOW has created a cloud over its operations that needs to be lifted, said HOW Washington counsel Terence Cooke.



Graphic: Amy Palmer

"Other states were taking the lead from Delaware on this issue," Mr. Cooke said. A court decision would act as a signal to other states that HOW has clearly demonstrated its eligibility to operate as a risk retention group, he added.

For example, on March 17, the Texas government returned a check of $146,642.63 that HOW had sent to pay premium taxes on policies it sold to home builders in that state last year.

"Had they (HOW) been certified in Delaware by Dave Elliott, we would have said thank you and accepted their money," said Lyndon Olson Jr., a member of the Texas State Board of Insurance.

And in Georgia, Insurance Commissioner Johnnie Caldwell issued a cease-and-desist order to stop HOW from selling insurance policies in the state. The department considered HOW an unauthorized insurer since it had not been certified as a risk retention group in Delaware, its home state.

HOW, though, won an injunction in U.S. District Court in Atlanta that stays Mr. Caldwell's order. The court said HOW had complied with the federal Risk Retention Act, enabling it to operate as a risk retention

Continued on page 60

Small-firm risk managers assume varied duties

Risk managers' responsibilities*
(By company sales)

Duty	Less than $200 million	$200 million-$1 billion	$1 billion-$4 billion	More than $4 billion
Risk financing	56.5%	72.5%	85.2%	93.1%
Claims handling and settlement	72.7	71.1	52.5	44.6
Safety and fire prevention	47.8	42.6	28.7	24.8
Security	20.0	10.0	5.3	5.0
Benefits administration	38.8	21.3	10.7	1.0
Pension/profit-sharing	18.7	12.5	7.4	1.0

* Risk managers reporting "hands-on" responsibility.

Source: Logic Personnel Associates Inc.

By JAMES M. BURCKE

Risk managers at smaller companies wear many hats, a new survey confirms.

In addition to responsibilities for property/casualty insurance and claims handling, risk managers at smaller firms also may be directly in charge of benefit administration, safety and fire loss prevention, security and even their companies' pension and profit-sharing plans, the survey notes.

For example, 38.8% of the risk managers at companies with less than $200 million in annual sales reported they have "hands-on" responsibility for benefit administration.

Risk managers at large companies seldom have this responsibility. Only 10.7% of the risk managers at companies with $1 billion to $4 billion in revenues and just 1% of those at firms with more than $4 billion in sales are directly responsible for benefit administration.

However, risk managers at larger companies are granted much more responsibility in the important area of risk financing than those at small employers, according to the survey by Logic Personnel Associates Inc., a New York-based recruiting firm specializing in risk and safety management.

More than 93% of the risk managers surveyed at companies with more than $4 billion in sales say they have hands-on responsibility for risk financing, compared with only 56.5% of the risk managers at companies with less than $200 million in annual revenues.

"When you get to the large companies with $2 billion to $4 billion in sales, the financial ability of the risk managers becomes more relevant," says Logic's Richard Meyers, who is one of the authors of the survey.

The study of risk managers' responsibilities is contained in Logic's annual survey of compensation in the risk management profession (*BI*, May 23).

Logic received responses from 962 risk managers at companies of all sizes, a 42% response rate. The survey was mailed last fall to risk managers based on a mailing list compiled by Logic from a sample of *Business Insurance* subscribers. The results were tabulated this spring.

Benefit administration was just one of the added jobs that risk managers at many small companies take on.

Continued on page 63

INSIDE:

update

Benefits not part of comp award

Continued from previous page
sidered the possibility that fringe benefits should be taken into account in determining compensation under the act."

The high court decision overturns a ruling by the U.S. Court of Appeals for the District of Columbia involving survivors' benefits due the family of a construction worker employed by Morrison-Knudsen Co. of Boise, Idaho, who was killed in a 1974 accident during the construction of the Washington, D.C., subway system (*BI*, Feb. 8, 1982).

Nevada allows comp insurers

CARSON CITY, Nev.—Beginning July 1, 1984, Nevada employers will be able to purchase workers compensation insurance from commercial insurers.

S.B. 136, adopted by the Nevada Legislature in the final hours of its session May 22, changes the 70-year-old exclusive state fund into a competitive state fund. Nevada was one of only six states with an exclusive fund.

Swiss bank sues Posgates

LONDON—The Banque du Rhone et de la Tamise, the Swiss bank formerly controlled by several ex-officials at Alexander Howden Group P.L.C., is suing former Howden undewriter Ian R. Posgate and his wife Margaret in London's High Court to recover more than 1.4 million pounds (about $2.2 million) it says the Posgates owe the bank.

According to a suit filed by Howden's parent Alexander & Alexander Services Inc. against Mr. Posgate and four other former Howden officials, the ex-Howden officials secretly bought the Swiss bank with funds allegedly misappropriated from Howden (*BI*, Sept. 27, 1982). A&A assumed control of the bank last fall after the suit was filed.

Mr. Posgate's attorneys could not be reached for comment.

Older worker rules OK'd

WASHINGTON—Employers will have to give workers between the ages of 65 and 69 a choice of enrolling in corporate group health insurance plans or sticking with Medicare as their primary insurer, according to interim rules approved last week by the Equal Employment Opportunity Commission (*BI*, April 18).

The rules now go to the Office of Management and Budget for approval. The rules will be published next month in the Federal Register.

End to punitive claims sought

NEW ORLEANS, La.—Major defendants in the Pan American World Airways crash here last July 9 are offering not to contest their liability if plaintiffs will drop claims for punitive damages.

The offer was made by the airline, the federal government and by Pan Am's insurer, United States Aircraft Insurance Group. The government is involved through the Federal Aviation Administration, which provides weather advisories to pilots at the New Orleans airport (*BI*, Sept. 6, 1982).

In London, insurance sources said underwriters have established a reserve of $64 million to pay expected claims from the Pan Am crash.

Asbestos bill introduced again

WASHINGTON—For the second consecutive year, Rep. George Miller, D-Calif., has introduced legislation in the House of Representatives to compensate victims of asbestos diseases.

The bill, introduced May 26, sets up a single administrative mechanism under the U.S. Department of Labor for delivering benefits and creates a special task force within the department to expedite processing of asbestos claims.

The system would be the exclusive remedy for workers. However, if the compensation claim can't be processed under the system within 18 months, the worker could proceed with the lawsuit.

Industry would fund the system without contributions from the federal government.

Manville gets 30-day extension

NEW YORK—Parties to Manville Corp.'s reorganization proceedings report progress on a consensual plan that would satisfy Manville's creditors, including thousands of asbestos litigaints.

The progress was reported at a hearing May 23 in U.S. Bankruptcy Court in New York at which Manville was granted an extra 30 days to file a formal reorganization plan.

index

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Punitive damages allowed in Hilton hotel fire deaths

By STEPHEN TARNOFF

LAS VEGAS, Nev.—A state court judge's ruling paves the way for the estates of those who died in the February 1981 Las Vegas Hilton Hotel fire to press punitive damage claims.

At a May 20 hearing, Judge Paul S. Goldman of the state's 8th Judicial District Court interpreted Nevada law to permit punitive damages in wrongful death cases.

James L. Fetterly, a plaintiff's attorney in the litigation, says the ruling makes it easier for plaintiffs to pursue punitive damage claims, but that other evidentiary issues must still be decided before the issue can go before a jury.

But if punitive damage claims do go to trial, plaintiffs in the Hilton litigation have a stronger case than the plaintiffs in the MGM Grand Hotel fire litigation since the Hilton fire followed the blaze at the MGM, says Mr. Fetterly of the Minneapolis firm of Maslon, Edelman, Borman & Brand.

"It's a better case for punitive damages than MGM," he said.

Both the Hilton and MGM Grand hotels were designed by the same architects and had the same potential fire and safety problems, Mr. Fetterly added. "There was no clearer warning than what occurred three months before (at the MGM)."

But an attorney for the defendants in the litigation, other than Hilton, said that he thought it was unlikely that punitive damages would ever be assessed in the case.

"Personally, I believe that because the fire was due to a convicted arsonist, that will in the eyes and minds of most jurors mitigate the award of punitive damages against anyone," said Gene Backus of the Las Vegas firm of Thorndal,

Continued on page 64

Hyatt legal fees challenged

By BILL DENSMORE

KANSAS CITY, Mo.—Insurer-hired attorneys for Hyatt Corp. and Crown Center Redevelopment Corp. are asking a federal judge to reconsider his award of more than $2 million to plaintiffs' lawyers in the skywalks collapse litigation.

At the same time, a Park Ridge, Ill., law firm representing two victims of the July 17, 1981, collapse has appealed the federal court class-action settlement of claims arising from the disaster and the attorneys' fee order. The firm, which participated in the federal court proceedings, is not among those that will share in the attorneys' fees set by the court.

The two actions, filed earlier this month, at least temporarily upset the gradual winding down in the litigation triggered by the Hyatt tragedy, which killed 113 people.

On May 4, U.S. District Judge Scott O. Wright approved more than $2.2 million in fees and expenses to victims' lawyers in a federal class action that was settled prior to trial (*BI*, May 9).

Judge Wright issued the order after receiving statements from plaintiffs' attorneys detailing the time and expenses incurred in preparing the federal class action for trial. The work included review-

Continued on page 63

Minnesota approves comp reform

By CAROL CAIN

ST. PAUL., Minn.—The way is clear for revamping Minnesota's workers compensation system.

In the final hours of the legislative session May 23, lawmakers approved two bills that will:

- Accelerate the beginning of an open rating system to Jan. 1. The 1981 law that established open rating for the state wasn't due to go into effect until Jan. 1, 1986.
- Change the benefit structure, particularly permanent partial benefits.
- Establish a competitive state fund, allowing the state to sell workers compensation insurance.

Gov. Rudy Perpich is expected to sign the measures as soon as the final forms reach his desk. He campaigned on a workers compensation reform platform, as did many other candidates from the Democratic Farm Labor party.

The effect of the new laws on worker compensation rates won't be that drastic, according to attorneys and lobbyists, but it is hoped

Continued on page 61

Malpractice pool stops payments on claims

By BILL DENSMORE

TALLAHASSEE, Fla.—A Florida medical malpractice pool is suspending claims payments, threatening to stick the state's hospitals, doctors or taxpayers with millions of dollars in unpaid claims.

The Florida Patient's Compensation Fund, a state-chartered excess liability coverage pool, said last week it would no longer negotiate payment of any malpractice claims pending a decision by the Florida Supreme Court in a bitter dispute among doctors and hospitals over their respective share of retroactive premium assessments.

The state's highest court set oral arguments for June 6. But it could take much longer to issue a decision affirming or overturning a unanimous May 17 decision by a three-judge panel of the state 1st District Court of Appeals in Tallahassee that it is unconstitutional to place higher assessments on hospitals than doctors.

"It could be many months before they rule," says William A. Bell, general counsel of the Florida Hospital Assn. "Does it mean the claimants are going to have to eat it? Or will they take their claims to the Legislature or to hospitals directly?"

The appeals court declared unconstitutional a provision of the PCF's enabling statute that forbids the pool to tap doctor members for more than 100% of their original premium to cover deficiencies in loss reserves for past policy years. At the same time, the statute places no limit on assessments that can be levied on hospitals.

A group of hospitals filed suit last year after they were mailed assessments totaling $11.5 million—or twice what they originally paid in plan fees—to cover claims for 1978 and 1979. At the time of the assessment, losses attributed to the hospitals totaled only about $8.8 million (*BI*, March 8, 1982).

On the other hand, doctors as a group were asked to pay $2.4 million in assessments after contributing $2.9 million in premium. That compares

Continued on page 60

Regulators consider sale of BMF

By BILL DENSMORE

State insurance regulators may force a sale of broker Bayly, Martin & Fay to generate cash for the financial revival of Baldwin-United Corp.

Regulators overseeing the insurance operations of Baldwin-United are now evaluating the worth of Bayly, Martin & Fay, says Emil J. Molin, Indiana's deputy insurance commissioner and chairman of a six-member task force of the National Assn. of Insurance Commissioners trying to assure the solvency of Baldwin-United Corp.'s insurance companies.

The value of BMF is important not only in a sale, but also to the finances of one of Baldwin's insurers that financed BMF's sale to BMF management last year.

"Brokerage companies are going for a premium now and if Bayly Martin & Fay doesn't get too much bad publicity it is a valuable asset," says Mr. Molin .

Not everyone, however, would agree brokers are selling at a premium. Generally, prices paid for brokerage firms have been falling as the growth in brokers' revenues has slowed with cheaper insurance rates.

Mr. Molin said he understands that BMF's management/owners have been in contact with potential buyers for BMF.

BMF Senior Vp Samuel Alcorn responded that BMF "has not been out seeking a buyer" and added that the brokerage's management did not acquire the company from Baldwin-United Dec. 30 "with the idea of turning around and selling it again."

Until Dec. 30, Baldwin-United owned all of the stock of Bayly Martin & Fay International Inc., through a subsidiary. Baldwin's subsidiaries now hold approximately $92 million in debt issued by the managers/owners of the Newport Beach, Calif.-based brokerage.

Continued on page 62

Benefits: Confronting the future

PPOs: The new buzzword to learn

By RHONDA L. RUNDLE

There is a new buzzword on the lips of corporate benefit managers, although few of them had heard of a "PPO" a year ago.

At least 160 preferred provider organizations in California alone are knocking on the doors of major corporations, hoping to nail them to a contract with the PPO's panel of health care providers.

PPOs also are popping up in Colorado, Florida, Illinois, Michigan, Minnesota, Ohio, Virginia and other states.

State employer groups—led by employer health care coalitions—support the PPO concept and hail it as a new tool in the employer's arsenal of weapons to combat the escalating costs of health care benefits.

Hospitals and insurance companies also are promoting PPOs as an alternative health care delivery system to rival health maintenance organizations and traditional fee-for-service indemnity plans.

The response of physicians ranges from avid enthusiasm to outright opposition.

Illustration: Roger Schmierstroh

One of the most aggressive PPOs in California is headed by Edward Zalta, chairman of the board of trustees of the Los Angeles County Medical Assn. Yet, the statewide doctors' group, the California Medical Assn., is sponsoring legislation in Sacramento that would severely hamper PPO formation.

In a recent speech delivered at the Risk & Insurance Management Society's annual conference in Los Angeles, the president of the American Medical Assn. warned that PPOs threaten the quality of medical care in this country. The best physicians and hospitals may not participate, said William Rial.

PPOs take many different forms, but can be described as a group of health care providers that contracts with employers, insurance companies or other third-party payers to deliver health care services to an employee group at a reduced fee.

The employee is not obligated to use the preferred providers under contract with his or her company or group health insurer, but is offered a financial incentive to do so. This incentive may take the form of additional benefits, such as well care, or may entail reduced or eliminated deductibles or co-payments.

The employee's decision to use a preferred provider—or someone else—is made each time the need for medical care arises. This dual choice aspect of PPOs is the key feature that distinguishes them from health maintenance organizations, which typically require annual enrollment.

Hospitals and physicians who enter into PPO arrangements expect to increase—or at least preserve—their share of the health care market. They also benefit from speedier payment and fewer bad debts than they might experience through private patients.

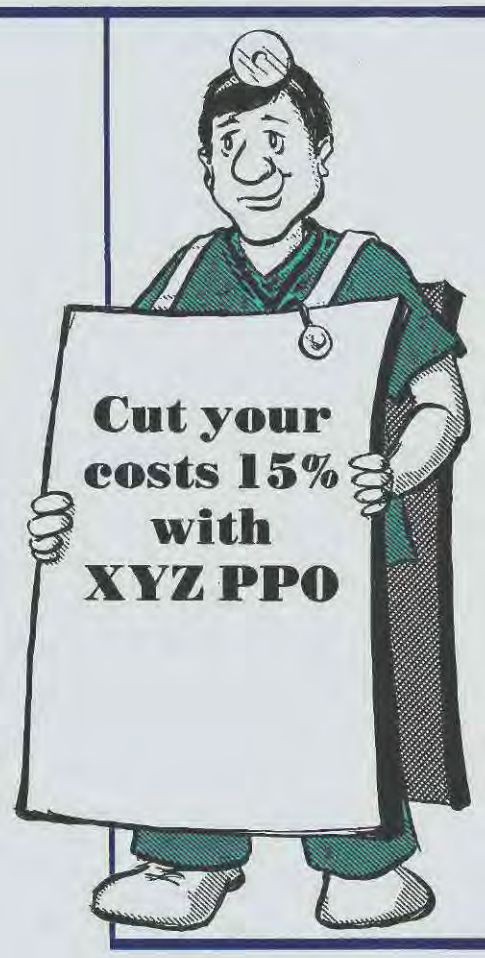
Employers that contract with PPOs are looking for both discounted fees and utilization review mechanisms with enough teeth to assure that providers won't make up in quantity of services what they are losing through the reduced fees.

"We believe that PPOs are going to be an important health care delivery alternative for three reasons," says William C. Deans, manager of health care benefits and employee relations for E.I. du Pont de Nemours & Co. and current president of the National Assn. of Employers on Health Care Alternatives.

They offer a managed system of health care, with the potential for enhanced efficiency. They retain the fee-for-service concept, which is less threatening to doctors than prepaid plans. And, they are not a mandated second choice like HMOs, so they may be more attractive to employees, he explains.

If the concept of a preferred provider organization doesn't sound terribly revolutionary, that's probably because it isn't. In a sense, Blue Shield's panel of physicians is a PPO limited to doctors. And PPOs like Mountain Medical Affiliates in Denver and the Lutheran Hospital Society of Southern California have been around the since the mid-1970s.

But now, some insurance companies and major employers are becoming active in PPO formation in a big way. These are powerful third-party payers capable of wringing meaningful concessions from hospitals and medical groups that want to hang onto or attract a large volume of patients to their facilities.



Legal obstacles have stood in the path of insurance company marketing of preferred provider plans in some states.

Continued on next page

San Diego employers behind push for local PPO

By RHONDA L. RUNDLE

SAN DIEGO—When the chairman and president of two jumbo corporations participate in a meeting to discuss a community-wide health care cost containment proposal, people listen.

Listening one day last January at such a meeting of San Diego employers, insurance companies, labor unions, hospitals and physicians were representatives of the largest health care foundation in the world—the Robert Wood Johnson Foundation.

The conferees, catalyzed by local employer members of the San Diego Health Care Coalition, were presenting their proposal for a community health network—a preferred provider organization.

The San Diegans had applied for one of 12 planning grants of $100,000 to be awarded by the foundation to local communities to fund innovative health care cost containment programs. Ten of the 12 communities will receive up to $1.5 million each to implement their plans.

The Robert Wood Johnson Foundation, endowed by one of the founding brothers of the Johnson & Johnson company, will give away $16.5 million through its grant program, called The Community Programs for Affordable Health Care.

During the last decade the foundation has awarded $500 million to various programs designed to improve the health care system, reports Robert Sigmond, director of the community programs grants.

To meet the foundation's application requirements, San Diego's employer coalition formed a broad-based community group called the Committee for Affordable Health Care that includes representatives of six employers, four hospitals, four third-party payers, four labor unions, two physicians groups and two medical research institutions.

An elaborate application document submitted by the committee was one of 140 received by the foundation.

"We survived the first hurdle and were chosen for a site visit," recounts Robert M. Colasanto, director of insurance and employee benefits for Pacific Southwest Airlines and immediate past chairman of the

Continued on page 12

Pension experts criticize FASB proposals

By DOUGLAS McLEOD

NEW YORK—Pension accounting rules proposed by the Financial Accounting Standards Board will produce expensive problems for corporations but not necessarily consistent and understandable accounting practices, pension experts warn.

Accounting and benefits consulting firms say the FASB proposals, which would move the unfunded liabilities of defined benefit pension plans to corporate balance sheets, could do damage in a number of areas, including corporate net equity and tax deductions.

Many companies already have concluded that the proposals would bring "wild" changes to their pension accounting procedures and balance sheets. In some cases, the rules could produce changes of hundreds of millions of dollars in companies' shareholders equity.

Many say the rules would impose a pointless burden.

"It would be a revolution in accounting, and an unnecessary one," said Eugene H. Flegm, deputy assistant comptroller for General Motors Corp. He added that rather than clarifying certain issues in pension accounting, the proposed rules would "disrupt the reliability of financial data."

FASB's proposals were first laid out last November in a report entitled "Preliminary Views on Employers' Accounting for Pensions and Other Postemployment Benefits."

The accounting changes proposed in Preliminary Views would apply only to a specific category of pension plans: U.S.-based, single-employer, non-contributory defined benefit plans that aren't funded by insurance contracts.

Last month, however, FASB issued a discussion memorandum that addressed the applicability of similar rules for defined contribution plans, multiemployer plans, foreign plans and plans funded by insurance contracts.

FASB is now accepting comments on both the Preliminary Views and the discussion memorandum and is expected to issue an exposure draft of final rules in 1984.

Under the Preliminary Views, companies would have to make the following changes in accounting for defined benefit plans:

- A net pension liability (or asset) would have to be recognized on the balance sheet. This net liability would consist of the pension benefit obligation—the value of benefits currently attributable to employee service—less the net plan assets available to cover the benefits.

For final pay or career average plans, the pension benefit obligation would have to include an estimate of future salary increases. This estimate, not required under current accounting rules, is expected to dramatically increase the pension obligation of many companies, especially those with final pay plans.

A third element in determining the net liability would be a so-called "measurement valuation allowance," an amount to be added or subtracted to offset actuarial gains or losses in the plan assets or obligation.

For example, if actuaries underestimate future salary increases for a final pay plan, resulting in a higher-than-expected pension obligation, a measurement valuation allowance would be subtracted to offset the increased obligation.

The allowance would not be recognized in full right away, but would be amortized over the average remaining service lives of active employees, which ranges between eight and 16 years for many companies.

The allowance is intended to reduce fluctuations in net liability caused by shifts in actuarial assumptions.

Under current accounting rules, companies must show a pension liability on the balance sheet only if the amount of accumulated pension expense charged to income exceeds the contributions the company makes to the plan. Accumulated benefits, plan assets and pension expense are shown only in footnotes to the financial statement. Future salaries are not included in calculations for pay-related plans, and actuarial gains and losses are spread out or amortized over periods of up to 40 years.

Continued on page 32

Bill would clear way for formation of PPOs

Continued from previous page

Laws that bar price discrimination, for example, may prohibit insurers from varying payments to providers. Also, many states' insurance codes contain so-called freedom of choice rules that prevent insurers from influencing through economic incentives a patient's choice of a provider.

Only California and Virginia have state laws that explicitly sanction preferred provider organizations, reports Rick Lee, director of public policy issues at the Washington Business Group on Health. Legislation to achieve the same end was recently introduced in Minnesota and defeated in Utah, he added.

Hoping to supersede this arduous state-by-state legislative process, U.S. Rep. Ron Wyden, D-Oregon, introduced H.R. 2955 in Congress on May 9 to open the door to PPO formation nationwide.

"So far no one has told us they oppose the bill," reports Lois Davis, administrative assistant to Rep. Wyden. The Washington Business Group on Health, Aetna Life & Casualty Group, The Travelers Insurance Co. and CIGNA Corp. all have indicated their support.

No one is sure where the first PPO got started, but many people point to Denver as the first community to develop PPOs in a big way. That's no accident. Like other hotbeds of PPO activity, Denver has an oversupply of both hospitals and physicians, a young and relatively mobile population and a high proportion of employers that self-fund health care benefits.

"There are at least five PPOs operating in the Denver area," reports Gary Jenkins, account executive for consultant Martin Segal & Co. Inc., which has been active in PPOs for about four years on behalf of a number of Denver health and welfare plans and other corporate clients.

The claims trends indicate that PPOs do reduce health care costs, but none of the Denver PPOs yet has really credible data, observes Mr. Jenkins. Developing effective utilization review systems is an evolutionary process that takes time. It is getting better, he believes.

But, employers risk very little to give PPOs a try, he suggests. The best way to find out if they work is to enter into an agreement, ask your claims-paying agency to keep separate claims experience by diagnosis on PPO vs. non-PPO charges and at the end of the year compare the results.

The real test of PFOs will be in California, where the concept is taking the state by storm.

It all started last summer when the California Legislature enacted a law to let the state contract directly with hospitals to treat Medi-Cal patients at reduced fees. Beginning last January, patients who wished to receive Medi-Cal benefits were obliged to seek treatment at designated hospitals that had signed contracts with the state.

While the Medi-Cal legislation was being debated, insurance companies complained that they would be placed at an unfair advantage if one of the state's largest third-party payers could negotiate reduced fee contracts, but they could not.

Assembly Bill 3480 was introduced to extend the same contractual opportunities to insurance companies and employers. On what has been described as a legislative fluke, the bill passed. The new contracts may be signed with hospitals and medical groups after July 1.

Employer coalitions, physicians, hospitals, insurance companies, claims administrators and other entrepreneurial firms all are now competing to form PPOs and to offer them to the biggest group purchasers of health care. The Department of Corporations lists more than 160 PPOs in the state.

The diversity of PPO offerings in California is evidence that the concept can take different forms. Some PPOs are really EPOs—exclusive provider organizations—which do not offer employees the dual choice advantage. Some are doctor groups that offer fee discounts with little promise of utilization review. And, some PPOs may be fancy marketing schemes to attract new business to hospitals plagued with empty beds.

Fifty-four percent of the 286 hospitals that responded to a recent survey conducted by the California Hospital Assn. are currently contracting with a PPO or in the process of developing one, reports Allen Toon, CHA publications editor. The association membership includes 520 of the 550 acute care hospitals in California.

Orange County, Los Angeles and San Francisco are the most active areas of California PPO activity, according to the survey.

Sixty-three percent of the respondents said they are involved with a hospital-sponsored PPO; 32% said the PPO was physician group-sponsored; 12% health maintenance organization-sponsored; 16% third-party administrator-sponsored; and 2% are sponsored by independent investors. (The total exceeds 100% because hospitals may contract with more than one PPO.)

"I don't think the medical care delivery system will ever be the same," says Ronald F. Zachary, vp and division manager of Safeway Stores Inc. "Employers in California are on the move," he noted at the end of a discussion on PPOs at a recent regional meeting of the National Assn. of Employers for Health Care Alternatives.

"I believe that PPOs and the competitive model they represent are the last hope of the health care system before massive federal regulation," believes Robert M. Colasanto, director of insurance and employee benefits at Pacific Southwest Airlines in San Diego.

The San Diego Health Care coalition that includes PSA and more than 50 other companies is the catalyst for a proposed communitywide PPO (see story, page 3).

Security Pacific Corp., which owns the state's second largest bank, expects to finalize a PPO arrangement in September with Admar Corp., which owns the Med Network based in Orange County but is expected to start operating statewide (see story, page 16).

A Los Angeles-based insurance company is contracting with Benefit Panel Services to offer a PPO option to its employees, reports James Garrison, BPS director of marketing.

Other highly visible PPOs in California include: California Pre-

Continued on page 6

WAUSAU WORKS.℠

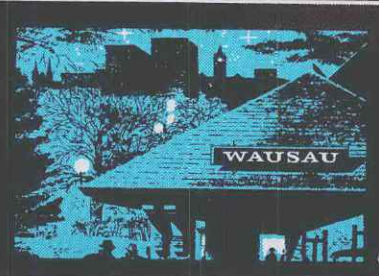
A premier restorer reviews Wausau's performance.

Conrad Schmitt Studios is a restoration and decoration firm in Milwaukee whose projects include restoring theatres to grand-opening condition. Its Chairman, Bernard O. Gruenke, and Bernard E. Gruenke, President, describe a study prepared for each prospective client. "It includes a history of the structure, a report on its present state and potential uses, and, always, a certificate of insurance from Wausau. We've found that the prospect appreciates our thoroughness and insistence on quality.

"We feel no matter *what's* accomplished, it should be done with quality. That's what a client has the right to expect. And he sees it in our decorating, in the mouth-blown glass we install, and in the insurance we carry.

"We've been with Wausau for over forty years and now have six lines of business insurance with them. That's because the Wausau people take a personal interest. They're like a part of our firm. And we respect that."

Valued comments, from a firm we respect, on one of the longer runs in business insurance.



WAUSAU INSURANCE COMPANIES
Wausau, Wisconsin 54401

Shown: Paramount Arts Centre, Aurora, Illinois.

Some are skeptical about merits of PPOs

Continued from page 4
ferred Professionals Inc., headed by the Los Angeles County Medical Assn.'s Edward Zalta; Universal Health Network offered by the Lutheran Hospital Society of Southern California; Unified Preferred Providers Inc.; California Health Network; and United PPO Inc., a statewide PPO formed through contracts with the 22 Foundations for Medical Care.

Despite California's enabling legislation, some legal observers are concerned that PPOs violate federal antitrust laws because they practice price fixing and restraint of trade. "Many East Coast insurance companies are leery of PPOs for this reason," acknowledged one PPO administrator.

There also are concerns about professional liability. A PPO might be dragged into a medical malpractice lawsuit if one of its providers is sued. Some insurance company-sponsored PPO contracts contain clauses that ask the provider to indemnify the PPO.

Physicians who sign such agreements don't realize that their medical malpractice insurers will not accept this risk, said an attorney who has studied the issue.

"I am skeptical that PPOs will be the salvation that everyone thinks they are," cautions Chuck Stewart, executive vp of Blue Shield of California.

Many of the same claims being made about PPOs were made about HMOs in the late 1960s and early 1970s, he points out.

He predicts that PPOs will cause a short-term adjustment of costs because of fee discounts and the limits that PPOs put on access to medical care. But, in the long run, PPOs do not address the fundamental causes of increasing medical costs.

Medical technology, an aging population and our high expectations for medical care—these are the real pressures on health care costs, says Mr. Stewart.

PPOs will not change our expectations or attitudes, nor can they reverse demographic population trends, he notes.

They may help a little with the technology problem because hospitals may have to curb their purchase of new equipment to become more price competitive.

"In the long run, I think lifestyle changes such as smoking cessation and fitness programs will achieve more," he says.

Mr. Stewart also worries that PPOs offer enormous potential for abuse of small employers.

"We could see a repeat of the multiple employer trust situation," he fears. Many small California companies have been stuck with unpaid health care claims after some multiple employer trusts, which offer group health insurance for relatively low premiums, have gone out of business.

PPOs—like METs—function in a regulatory vacuum, notes Mr. Stewart. Therefore, he warns, employers should approach PPOs with care—especially if they are going to be handling claims payments.

Blue Shield and the California Medical Assn. are sponsoring legislation—S.B. 907—that they say would add certain protections against PPO abuses for employers and patients. California's health care coalitions contend that the true objective of S.B. 907 is to squash the state's budding health care competition.

"The bill makes PPOs unworkable," argues PSA's Mr. Colasanto.

The last section is the most objectionable, he explains. It says that any physician who is willing to meet the terms and conditions of a contract that a PPO has with another physician must be permitted to join the PPO.

"It's nonsense, just a reinvention of Blue Shield," says Mr. Colasanto. "What other business can you think of in which a vendor can come along and say, 'You've got to do business with me on the same terms that you do business with someone else?'"

The bill isn't all bad, some employers concede. But they say the coalitions didn't want to support 10% of the bill when the other 90% is "garbage." That would be a strategic disaster, they believe.

"The coalitions have taken the position that they just refuse to discuss any amendments—we were just dumbfounded by their attitude," says David Willet, an attorney who represents both the California Medical Assn. and Blue Shield.

Physicians are not out to kill PPOs, says Mr. Willet. They opposed them at the outset, but they accept them as a fact of life now.

Physicians are fearful that giving control over quality and access of medical care to insurance company-sponsored PPOs with a financial stake in the process may not be in the best interests of patients or employers, he explained. ■

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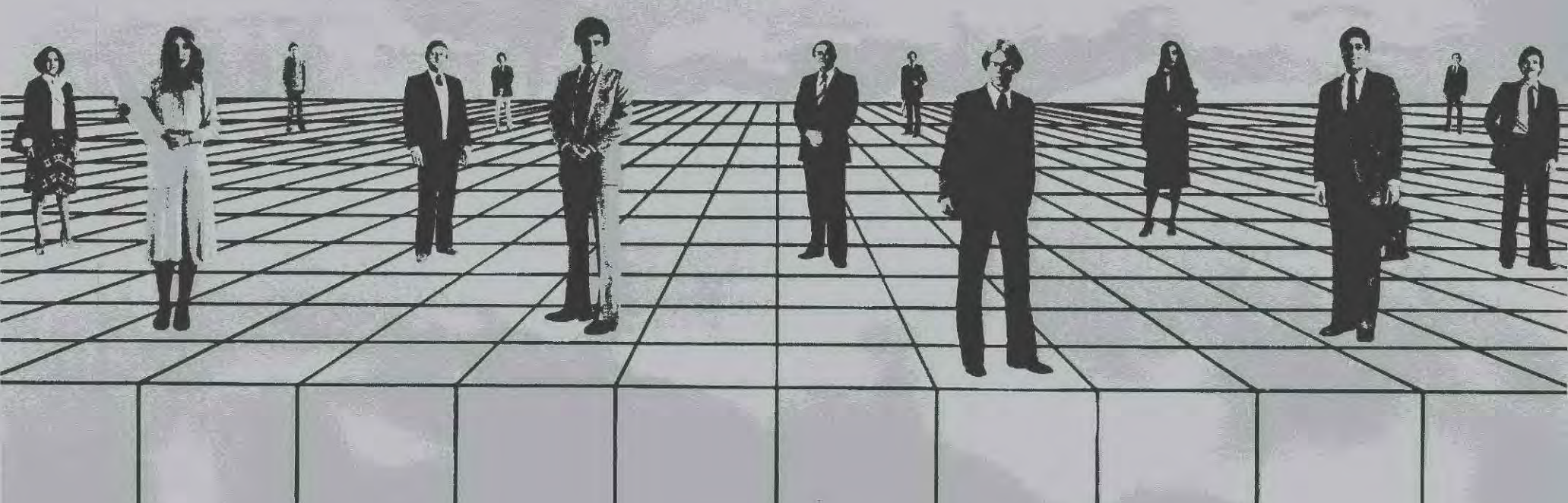

opinions

A new weapon in the costs war

PREFERRED PROVIDER organizations—or PPOs as they are called—could turn out to be a powerful weapon in an employer's arsenal in the war against rising health care costs.

PPOs corral many of the long-touted methods of changing the way health care professionals deliver service and the way consumers use the health care system. In addition, the PPO system of giving employees a choice as to whether to use the PPO at any given time should attract more employees to this alternative health care delivery system than have been attracted to health maintenance organizations that require members to receive all their care through the HMO.

PPOs will control health care costs, however, only if employers get involved in them, by contracting with them and by monitoring their performance.

As the report in this week's issue by Los Angeles Bureau Chief Rhonda L. Rundle explains, PPOs are alliances of health care professionals who contract with employers to provide health care to employees. Unlike HMOs, however, they are not prepaid health care delivery systems. PPOs provide service for a fee—a fee that is discounted.

The discount in and of itself, however, should not be the feature that attracts employers to PPOs. First, employers must compare the discounted rates to rates charged by other health care providers. A 10% discount off rates that are 20% higher that those charged by the neighboring hospital or clinic is no bargain. Second, employers should be more concerned with the utilization review conducted by PPOs than the initial discount. Without effective utilization review that stops overuse, health care costs will continue to rise.

Employers contracting with the PPO must ask to receive the utilization review reports to analyze them for abuse of the system and pinpoint problem areas that could be corrected. The PPO must show that its policies on mandatory second opinions on elective surgery, outpatient testing and no weekend admission for non-emergencies are enforced. Enforcing these changes in health care use is vital to success.

And yet, these changes don't have to be foisted upon employees. Eliminating deductibles or co-payments when treatment is sought from a PPO will entice employees into trying these preferred providers. We also envision employees trying out the PPO on their own sometime when they can't get an appointment with a favorite doctor. If the service is good, you can bet they will go back for the extra coverage often offered by PPOs.

Employers should investigate the availability of a PPO in their area—organized by insurers, hospitals, medical groups, claims administrators or other entrepreneurs. They also should consider creating a PPO as the employers are doing in San Diego.

PPOs offer another opportunity to introduce more competition into the health care system, which is the only force we think is strong enough to control rising prices. Employers should want to do all they can to foster competition before states begin implementing the kind of price controls Associate Editor Carol Cain describes in her series of article this week.

Contracting with a PPO is one more way for employers to demonstrate to the health care community that they want changes in the medical care system that will stop the rising cost of health care. It's another way to keep the problem in focus and the pressure on for solutions from the health care providers. And, a PPO rewards with more patients those providers who are trying to solve the problem.

letters

Compare claims services wisely

To the editor: With some interest, and I must say also some disappointment, we felt it necessary after reading the Perspective, "The claims of work comp" by Jack Love (*BI*, May 2), to comment to you.

We feel that Mr. Love has missed the point in trying to compare third-party administrators to insurers. It has been our experience that price always seems to be a controlling factor.

The problem we have as an industry is that we are not exactly explaining to our policyholder or self-insured client what it is that the claims department is supposed to do and how to measure their results. We at Fremont are very proud that we have developed a measuring stick that we think can be used by either insurers or third-party administrators. That measuring stick is "What is your incurred loss ratio average over a five-year period when compared to other companies or self-insured programs in the insurance industry?"

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I don't think it'll ever surprise me that someone accepts price only in selecting someone to administer if the whole story isn't communicated.

In respect to Mr. Love's comments about the deterioration of claims staffs with the advent of more women than men, all I can say is, "Bah, humbug." I'm afraid he's a little out of touch with the real world.

David L. McIntyre
President
Fremont Indemnity Co.
Los Angeles

Publishing accounts drove captives away

To the editor: There is one historical inaccuracy regarding the captive insurance business in the Bahamas I would like to correct (*BI*, April 25).

The imposition of the premium tax was not a reason for the exodus of the early captives from this country.

In point of fact, the premium tax had nothing whatsoever to do with this "exodus," as it was not created until 1975. It was, of course, primarily the requirement of having to publish accounts that drove captives from here at a time when the whole movement was in a fledgling stage and its main motivation was tax avoidance.

The premium tax, when introduced in 1975, also applied only to indigenous insurance. It was never intended to apply to captives operating here. The 1978 Regulations clarifying that the premium tax would not apply to non-resident insurers became necessary only because there was rumor going around that the premium tax would inhibit captives from considering the Bahamas as a domicile.

C.T. Fernie
Managing director
J.S. Johnson & Co. Ltd.
Nassau, Bahamas

A company's obligation

To the editor: Dr. William Rial's comments in "Beware of cost-containment danger" (*BI*, May 2) beg a response.

Surely it is no secret that health benefits are no longer an incidental cost of doing business (they are currently 10% of the Gross National Product). Therefore, any company that intends to stand behind its commitment to provide health care to its employees has an obligation to those employees to devise a strategy for managing costs now. Without such strategy, it may find itself unable to afford health coverage at all by the year 2000.

Benign neglect of the problem is not a healthy attitude, either on the part of industry or the medical community.

Gloria Gomes
Corporate manager-employee benefits
Litton Industries
Beverly Hills, Calif.

Bringing back memories

To the editor: The story "Coverage keeps hydro project afloat" on insurance for hydroelectric projects (*BI*, May 2) brought back memories. In 1960, I believe, when I was an inland marine underwriter for Fireman's Fund, that company wrote an "insufficiency of water" policy for the Oroville Irrigation District, part of the California Water Project.

As I remember, the district had a contract with a public utility to deliver hydro power. The concern was that in a low-rainfall year there would be insufficient water to generate the required power.

J.J. Launie
Professor of insurance
California State University
Northridge, Calif.

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How The Hartford improves cash flow for groups of 100 or more.

"If you're still paying standard premiums, you're losing money."

Ray Drury, Vice President, Group Sales, tells benefit plan managers how The Hartford's full range of cash flow options can cut insurance costs.

Q. How did your Minimum Funding Group Life Insurance slash premium payments by almost 90% for a large Southwestern city?

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Thanks to this arrangement, the city's fixed monthly premium was reduced from $135,000—the estimated standard premium that would have been due—to less than $15,000. And the city has the use of the funds without any dilution of coverage or insurance safeguards.

Q. If losses become higher than normal, will the city pay more than the standard premium?

A. Absolutely not. Our Minimum Funding plan caps total monthly premiums—fixed and variable combined—so that they never exceed what would be due under a standard-premium plan.

Q. Can cash flow advantages be realized by small groups?

A. Definitely. While our Minimum Funding Group Life and cash flow LTD plans are designed for larger groups, we also have a full spectrum of options for groups of 100 or more. They include Minimum Premium Plan, Administrative Services Only, and Excess Risk Insurance.

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Q. How great a cash flow improvement can a small group realize by self-funding?

A. The improvement can be dramatic. For example, a West Coast electrical equipment manufacturer with 300 employees completely self-funded its medical benefits, while The Hartford provided Stop Loss coverage. As a result, the company reduced its fixed monthly cost from over $100 per family in standard premiums to under $10 per family—including third-party administration.

Q. What ways do you have to improve cash flow with your fully insured plans? And what kind of impact can they have?

A. We have Deferred Premium plans and Retrospective Rating Agreements which are available with our full range of group Life/Health coverages. Using both those options, a Midwest food processor with some 4,000 employees improved its cash flow by more than $1 million in a conventionally insured Hartford group plan. And that's not an isolated example.

To sum up, we have a full spectrum of cash flow options. And we'll work closely with you—and your broker, agent or Hartford-approved third-party administrator—to determine which options can best improve your bottom line results.

Q. How can I get a brochure describing The Hartford's full range of cash flow options?

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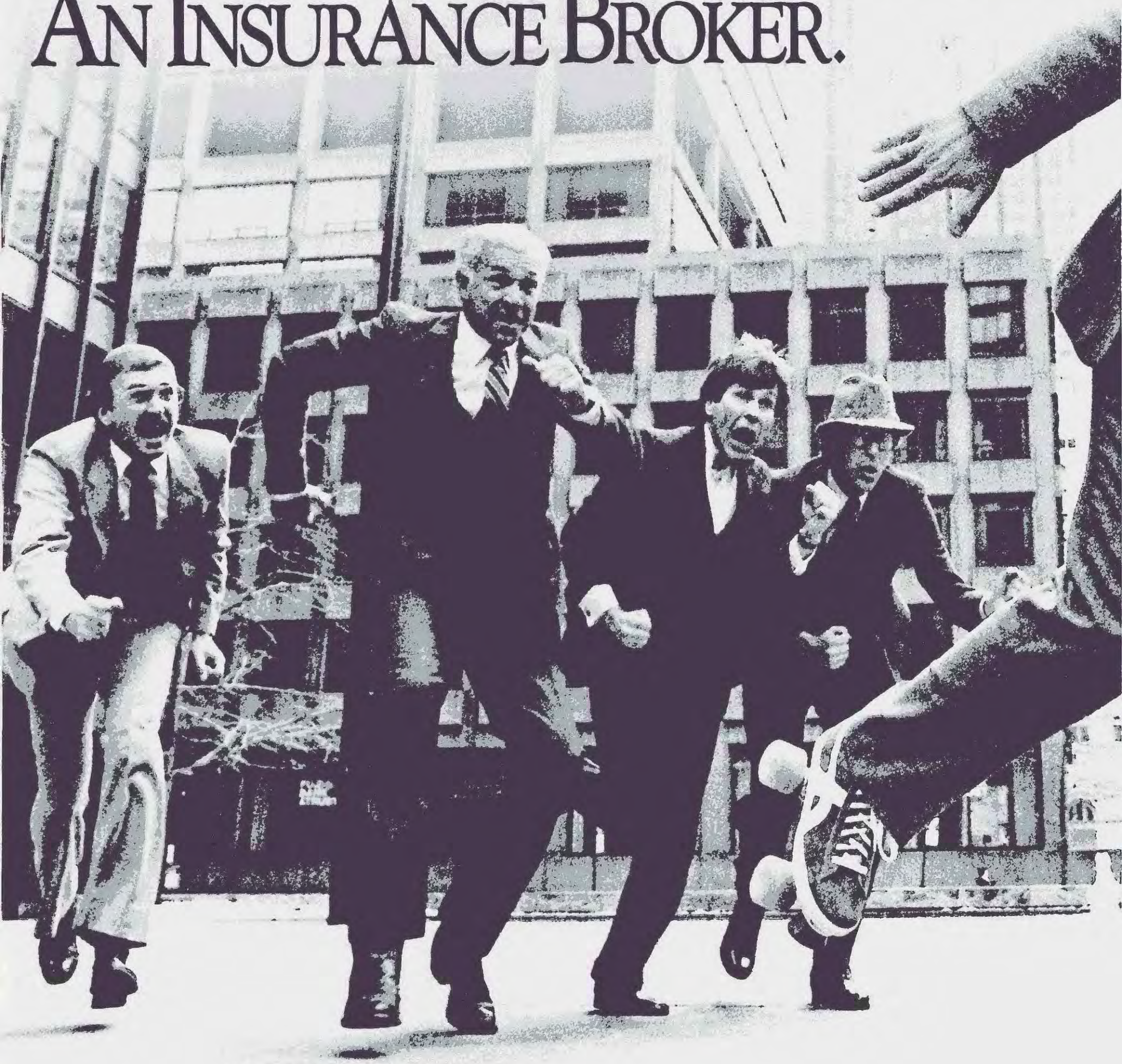

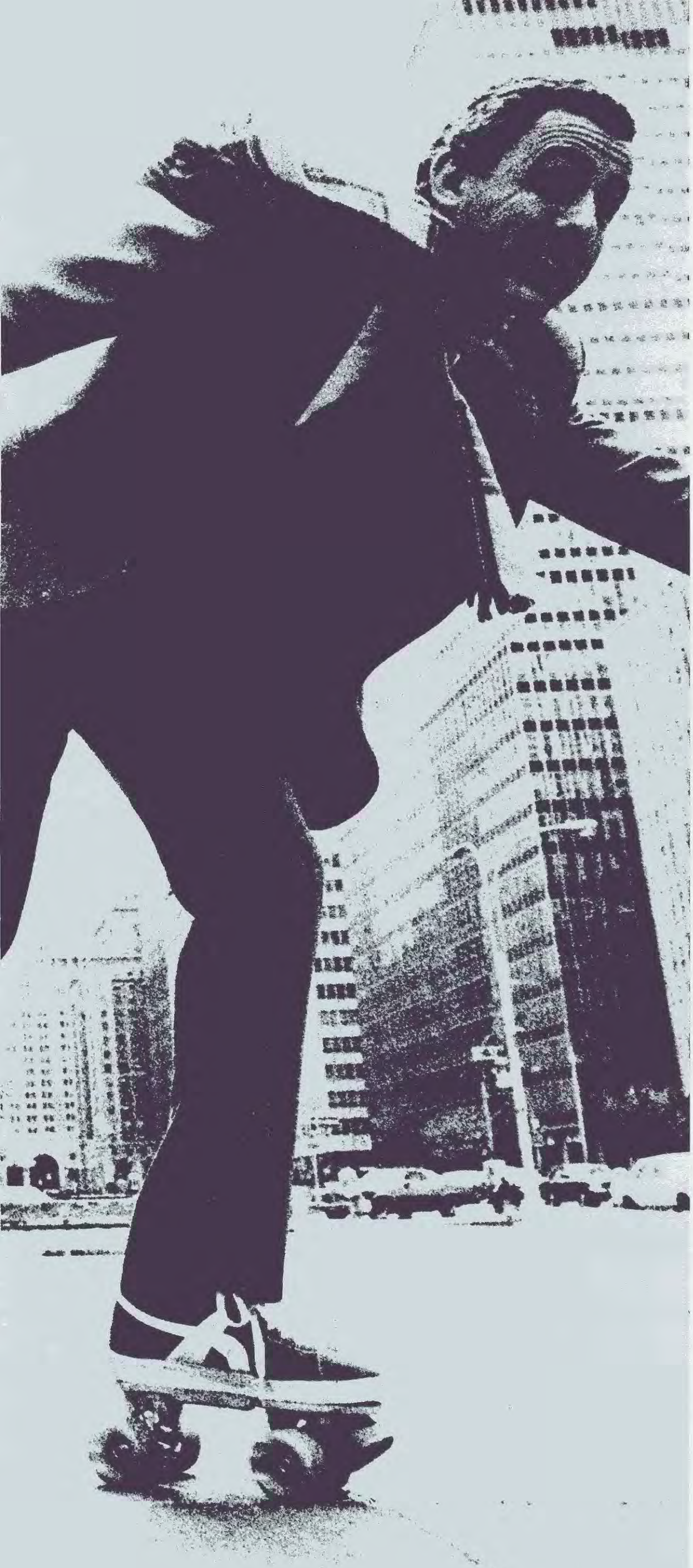

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San Diego businesses form their own PPO

Continued from page 3
San Diego business coalition.

Participating in the site visit last January were Harry Todd, chairman of the board of Rohr Industries Inc.; Paul C. Barkley, president and chief operating officer of PSA; and a host of other committee members.

San Diegans have high hopes their application will be in the winner's circle when the foundation's board of directors makes its decision at the end of May. Nobody wants to pre-empt the board's formal decision, but all signals point to a happy outcome for the city's health care innovators.

Even if the committee is not awarded a grant, it plans to go ahead with its proposed health network because "what we're doing here is so critical it needs to be done," says Mr. Colasanto.

Besides PSA and Rohr Industries, other employer sponsors of the committee are Cubic Corp., San Diego Trust & Savings Bank, M/A-Com Linkabit Corp. and the San Diego Community College District. The chairman of the San Diego Health Care Coalition also sits on the committee as the representative of the other coalition companies.

The committee's centerpiece project is formation of a preferred provider organization of selected hospitals and physicians who will contract with the committee to deliver health care services to participating employees of San Diego companies. The committee's PPO will differ from others in the state because the catalyst is employers, not hospitals or doctors.

However, the proposed community health network enjoys the support of many hospital and physician groups in the San Diego area.

"We're adding our medical expertise to the proposal and are supporting the concept of a local plan put together by local people," says Michael Busch, president of the San Diego County Medical Society and a physician member of the Committee for Affordable Health Care.

The committee is a joint effort, he points out. "Providers, employees and employers all will have to bend a bit to make it work."

San Diego employers want to take a hand in organizing a communitywide PPO because they are skeptical of the genuine cost containment prospects of provider-sponsored PPOs.

"Those that I've seen don't go far enough in having a significant impact upon the system itself," explains Mr. Colasanto. They tend to be marketing schemes to conserve the provider's share of local business, he believes.

For example, hospitals may offer PPO contractors a 10% to 15% discount off billed services. But if they don't plan substantial changes in their utilization review mechanisms, such discounts are "a waste of time," says Mr. Colasanto.

"Hospitals can finagle their pricing very easily and a 15% discount at one hospital may be the going rate two miles away. So, there's nothing really new or exciting in those kinds of (discount) arrangements. They don't make meaningful changes in the system."

The San Diego community health network is still in the planning stages and probably a year away from implementation. However, it will include:

- A prospective payment financing system authorized by recent California legislation, which permits employers to contract with physicians and hospitals.
- Aggressive utilization review independent of the provider organization.
- Communitywide participation with no exclusivity to any insurance company or other third-party payer such as a claims administrator.
- Significant patient volume generated by the participation of large and small employers.

"What we're really talking about is competition—pure and simple," stresses Mr. Colasanto. If one group goes out and contracts with designated providers at a given rate and begins to direct patients to efficient providers, then other providers will have to meet this competition, he explains.

The PPO reimbursement system would eventually begin to have an impact on the non-PPO reimbursement system, generating some savings for non-participants. That's what the committee envisions.

However, critics do not believe the benefits of such contractual arrangements will extend to small employers and individuals who do not have access to a PPO. They charge that PPOs will worsen the cost shift of medical care from government and PPO patients to a shrinking population of non-PPO patients.

But the San Diego committee plans to make the PPO accessible to everyone, counters Mr. Colasanto. "We have no provincial attitudes about keeping out small employers or insurance companies. Prudential, Metropolitan, Aetna, Pacific Mutual—they're all welcome to take their clients and bring them into our system."

Eventually, the committee wants to offer help to small employers who need advice on how to integrate PPOs into their benefit plans.

Indeed, a huge patient volume is crucial to the PPO's success.

"If you have a whole bunch of PPOs with just a few people in them, the providers can't make any concessions because you aren't guaranteeing them volume," says Mr. Colasanto.

"We know that we cannot go to a hospital and say 'Give us an attractive price, and by the way, we're going to send you 25 patients.' "

The 53 private and public employer members of the San Diego Health Care Coalition provide health care benefits to more than 200,000 employees and dependents out of about 2 million people who live in San Diego County.

One of the major planning considerations in a PPO is structuring of the provider reimbursement system. The San Diego committee's objective is to design the system in such a way that hospitals begin to share both the risks and the rewards of the health care system.

"We currently operate in a system where the payer of health care services assumes most of the risk," points out Mr. Colasanto. In this system, a hospital or physician can administer tests, X-rays and any other service regardless of necessity and be reimbursed by an employer, insurance company or individual.

The reimbursement system should be designed to make the provider efficient, explains Mr. Colasanto. He favors a per diem reim-

Continued on page 16

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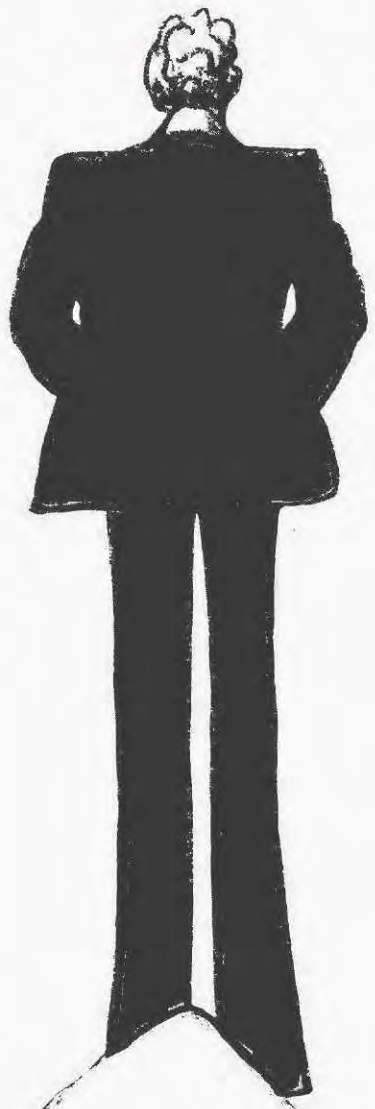

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San Diego employer coalition plans its own PPO

Continued from page 12
bursement system because the hospital knows ahead of time what it will be paid for a given patient, regardless of the tests, drugs or treatments that are administered.

Separate per diem payments might be set for intensive care, cardiac care and other special care.

But, the hospital is only the care facility. Physicians call the shots in the health care system. Physician reimbursement is another issue the San Diego committee must consider: How do you design a payment system to create an incentive for physicians to practice efficient as well as quality medicine?

The San Diego committee is considering a discounted fee-for-service system based on flat fee schedules—with a twist. It is looking at the possibility of creating a bonus pool. At the end of a contract period, certain utilization criteria would be reviewed. The most efficient physicians would take home a bonus.

It's a novel idea. Exactly how it would be implemented is a question. "But we think it is feasible," notes Mr. Colasanto.

Would allied medical practitioners such as podiatrists, dermatologists and chiropractors be part of the PPO? Probably. But that's another question that the committee is still mulling.

Committee attorneys also are studying the best legal structure for the PPO. The PPO contracts probably will be signed by the selected providers and the Committee for Affordable Health Care, a non-profit research organization—rather than directly with participating employers.

Some employers and others who have studied PPOs are concerned that they may present participating companies with unwanted liabilities. They fear that a company might be sued for medical malpractice by an employee who claims that as a PPO contractor the company is part of the health care delivery system.

Because of the excess supply of hospitals and physicians in the San Diego area and the strength of community cooperation there, Mr. Colsanto believes that the committee has a unique opportunity to develop an effective competitive model for health care delivery.

Security Pacific hopes for large cost savings

By RHONDA L. RUNDLE

LOS ANGELES—Security Pacific Corp., a diversified financial corporation that owns California's second biggest bank, believes that a preferred provider organization will reduce its massive health care bill.

Over a 12-month period, Security Pacific calculates that a PPO attracting 40% of its health care business will shave about $806,000 from its self-funded, $25 million-a-year medical and dental benefits expense.

This conservative estimate takes into account $280,000 in PPO administrative charges, plus about $327,000 worth of enriched benefits available only to employees who use the PPO.

"Security Pacific Corp. does feel (PPOs) will work and we look forward to implementing one in the near future," summed up Alan M. Jeffery, vp of employee benefits in a speech at a recent California regional meeting of the National Assn. of Employers on Health Care Alternatives.

Although many California companies have been studying the PPO concept since state legislation was enacted last year to permit their formation, Security Pacific is among the first to attempt a quantitative financial analysis of a PPO's impact on health care costs.

Based on its forecast savings, Security Pacific intends to enter into an agreement with Admar Corp. in Santa Ana, Calif., to use that company's Med Network preferred provider system. Although many details remain to be worked out, both parties hope to finalize the agreement by September.


Mr. Jeffery

PPOs can take many different forms, but a typical configuration is a group of doctors and hospitals providing services by contract with an employer or third-party payer at a reduced fee to a specified group of employees. Although employees are not obligated to use these providers, they have a financial incentive to do so.

"Utilization review is a very integral part of any PPO. I can't stress that enough," he said.

Security Pacific was concerned that the PPO might encourage higher utilization of services that could potentially offset reduced service fees. The bottom line result would be no savings at all.

To protect against this risk, Security Pacific decided that its PPO plan must have a number of cost-containment mechanisms. In addition to a strong utilization review program, it wanted the PPO to offer pre-certification of elective hospitalization, second opinion elective surgery procedures and concurrent hospital review.

At the outset of planning, Security Pacific decided that it would not set up its own PPO, but would contract with an existing organization. This decision was based to a large degree on the geographic dispersity of the company's nearly 25,000 employee population.

There are about 650 Security Pacific National Bank branches and other offices throughout California. Some of these are very small offices with small staffs. As a potential PPO contractor, Security Pacific would not have much patient volume bargaining power in most of its locations.

So, the company went shopping for a PPO with a good track record of cost containment and the potential to serve most, if not all, of its employees throughout the state.

Security Pacific identified three broad types of PPOs: provider-based networks set up by a hospital or physician group; purchaser-based organizations set up by an insurance company; and entrepreneurial-type networks established by businesses independent of both providers and purchasers.

"We felt the entrepreneurial PPO was the best way to go," says Mr. Jeffery.

Since the independent PPO would have no allegiance to any particular group, its business would

Continued on page 18

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Bank corporation considers PPO

Continued from page 16

depend upon its ability to contract with quality providers who also were efficient. If the entrepreneur could not do this, the PPO would not survive.

"We also felt there had to be incentives for each group involved with a PPO—and we listed those incentives," continued Mr. Jeffery.

For example, providers who participate get an increased patient load and a guarantee of rapid payment.

Employers who participate in a PPO look forward to a reduced cost of providing health care benefits to their workforces.

"As a self-administered firm, we also could have better control over these costs through pre-hospital certification and utilization review," says Mr. Jeffery.

Last year, Security Pacific processed more than 150,000 medical and dental claims for 20,000 employees and dependents covered under its self-funded indemnity plan. About 4,500 workers are enrolled in health maintenance organizations.

Employees who use Security Pacific's PPO will enjoy a higher benefit level. They will not be required to pay a deductible for medical services and doctor charges for illness or accident will be 100% paid following a $10 per visit office charge.

And employees enjoy the swing plan or dual-choice option in the Security Pacific plan. That means they may opt to use a preferred provider or any other provider each time they need medical services. However, Security Pacific's comprehensive fee-for-service plan provides only 80% coverage instead of the 100% coverage available through the PPO.

"In addition, we thought it would be necessary to throw in some benefits not available under the indemnity plan to entice the employee a little more to go to one of the PPO providers," says Mr. Jeffery. Therefore, the company decided to offer the following well care benefits at no cost to employees through the PPO:

- Annual gynecological examinations.
- Well baby care to age 1.
- Childhood immunizations to age 2.

After sketching this basic outline of its proposed PPO, Security Pacific's next step was to develop a projected savings estimate.

To make its analysis, the company assumed that 40% of its claims would be coming from the PPO within 12 months—a percentage that seemed conservative based on discussions with other employers who have applied the PPO concept.

Security Pacific also reasoned that there would be increased costs in office visits and lab and X-ray procedures due to elimination of the deductible and co-payment features of the traditional fee-for-service plan.

"We threw in a 25% increase for those two items," said Mr. Jeffery.

Based on a reasonable and customary fixed fee schedule, Security Pacific assumed the following reductions in service costs through the PPO:

- 10% for hospitalization.
- 30% for surgery.
- 25% for maternity.
- 30% for office visits.
- 14% for hospital doctor visits.
- 5% for outpatient hospitalization.
- 15% for X-ray and lab.

Based on a projected 40% utilization rate, actual 1982 claims costs by specific services rendered and the above assumed reductions for those services, Security Pacific calculated a gross medical claim cost reduction of $1,412,710.

However, this gross savings had to be reduced by the projected 25% utilization increase in office visits, including those for the additional benefits provided only to PPO users, and lab and X-ray procedures plus the PPO administrative charges.

Security Pacific estimated that increased utilization would add $327,079 to plan costs and administrative charges would be about $280,000. Therefore, the estimated net savings to Security Pacific through use of a PPO is $805,631.

The company actually expects savings to be 5% to 10% higher due to other non-quantifiable factors such as second opinion programs, use of generic drugs by PPO physicians and prior authorization of all elective hospitalizations.

Also, total costs will be reduced because the PPO point of entry for the patient is a primary care center and not the high-priced medical specialist. ■

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Before you sign PPO contract, do homework

By RHONDA L. RUNDLE

Benefit managers anxious to board the preferred provider organization bandwagon may get bushwhacked by bad PPO schemes if they don't do their homework.

There are a lot of planning issues to be resolved before a company is ready to sign a PPO contract with health care providers.

"Don't lock yourself into a contract until you have a good grasp of what PPOs are all about," warns Ed Myatt, consultant for benefits planning and compliance at Los Angeles-based Atlantic Richfield Co.

ARCO is investigating the PPO option for its employees and has asked its two group insurers—Aetna Life & Casualty and Metropolitan Life Insurance Co.—to review two PPOs in the Los Angeles area.

Unfortunately, employers' most burning questions about PPOs, including their potential for cost containment, will not be fully answered until there is more real world experience to evaluate.

However, employers, consultants, insurers and PPO developers offer the following mixed bag of dos and don'ts for companies exploring PPO proposals.

"I think the first thing you would want to do is to assess the quality of the PPO based on the hospital and physicians it is affiliated with," suggests Gary Jenkins, account executive with consultant Martin E. Segal Co. Inc., which has been active in developing PPOs in the Denver area.

Although definitions of PPOs vary, they are typically arrangements in which health care providers contract with employers, insurers or third-party administrators to provide medical services to employees at reduced fees.

"Assuming that you are dealing with quality providers, the next thing I would look for is whether the PPO is promoting discount medicine or utilization review," continues Mr. Jenkins.

Ask the PPO for a description of the utilization review mechanism, he urges. Does it make sense? How many cases have been referred? What was the action on those cases and what was the final outcome? What statistical reports will be provided to show that the review program is working?

PPO developers agree that fee-for-service discounts—although attractive to employers going into a contract—have limited long-term potential for reducing health care costs.

Unless the PPO is committed to aggressive utilization review, providers may deliver more services to make up their reduced revenues from fee discounts.

But, evaluating the effectiveness of that utilization review may be the toughest step for employers. PPO developers and health care specialists disagree about who should perform this oversight function.

Should the review be conducted by hospital medical staffs, a peer review committee or an independent contractor? Should review be retrospective, concurrent or prospective of services rendered?

"My feeling is that the most successful PPO packages will be those initiated and controlled by an alliance of hospital-medical staff joint ventures," declares Roberta Shapiro, senior consultant for InterQual Inc., a Chicago-based health care consulting company involved in PPO seminars and development.

She argues that medical care users and purchasers can demand accountability, but that meaningful review mechanisms will only work if they are supported by the hospital medical staff.

But, many employers are skeptical of utilization review programs by in-house medical staff.

"It's like sending a wolf to guard the chickens," says Robert M. Colasanto, director of employee benefits and insurance for Pacific Southwest Airlines in San Diego.

Mr. Colsanto believes hospital or physician-based PPOs "may turn out to be fancy marketing schemes to preserve or capture a portion of the health care marketplace." For this reason, he and other employers in the San Diego area are spearheading development of a community-wide PPO in their area (see related story, page 3).

An employer also will want to know the scope of services available through the organization.

Does the PPO include both primary care and specialty physicians? Do the PPO hospitals offer a full range of surgical and ancillary services? What about home health care? Skilled nursing care? Chiropractic and psychiatric services?

Some companies may decide to offer additional benefits to employees as a way to entice them into using a PPO provider.

Obviously, employees are not likely to use the PPO if its facilities are not geographically convenient to where they live and work.

So, the benefits manager should determine whether the PPO's providers are local, regional or statewide, points out Christine W. Roberts, director of employee benefits for National Medical Enterprises Inc. in Los Angeles. NME is interested in PPOs both as a consumer of health care services for its employees and as a service provider through its worldwide network of hospitals.

Another question to ask is whether the PPO requires employees to make a choice between the PPO plan and the standard comprehensive medical plan at the beginning of the contract period. If so, the arrangement closely resembles a health maintenance organization.

The key difference between a PPO and an HMO is the swing plan or dual choice feature of PPOs, which permit patients to decide each time they need medical care whether to use a PPO or any other provider of their choice.

What will be the financial incentive for the employee and his or her dependents to use the preferred providers?

Most proposed plans eliminate deductibles and co-payments under the PPO option. But, if the employer's plan deductible is only $50 or $100 and the co-payment is 20%, will the incentive be sufficient to get a patient to give up the family doctor?

"If I were a major California employer I would give PPOs a try—but not statewide," advises Chuck Stewart, executive vp of Blue Shield of California. "Go cautiously in one area where you can best measure the PPO's effectiveness."

He thinks employers would be wise to select a PPO offered by their group health insurer because it will be easier to compare costs. ■

States considering ways to cap health costs

By CAROL CAIN

Hospital costs, escalating to a fever pitch and plaguing employers like a nagging pain, are attracting the attention of state lawmakers.

Legislatures from coast to coast are considering a variety of proposals to help bring health costs back in line with other expenses.

Among the array of options, the ones receiving the most consideration appear to be hospital rate-setting boards and preferred provider organizations. PPOs usually specify the providers that a group of subscribers to health care insurance should use. In some states, legislation is needed to form PPOs because of laws that prohibit insurers from discriminating against providers.

But other cost-containment movements like mandatory coinsurance levels and deductibles in health insurance plans (see story, page 30) as well as consumer education are also being studied.

Although the proposals vary from state to state, common theories are held in almost every capital.

Almost everyone agrees that the continuing rise in hospital costs is a problem created by several factions. Solving it will take the efforts of not only hospitals, but also physicians, the government, insurers, employers and consumers.

And, changing the way health care is delivered and purchased is a key to any viable, long-term solution, say employers, legislators and hospital administrators alike.

Some states, like Pennsylvania, have developed proposed legislation that it hopes ultimately will lead to a competitive health care marketplace. But, to get to that point, hospitals first must disclose their costs for services and consumers must understand how to compare and use these costs, a governor's task force reports (see story, page 30).

Pennsylvania, as well as several other states, are also considering the establishment of boards that would limit how much hospitals can charge. Six states—Maryland, New Jersey, New York, Washington, Connecticut and Massachusetts—already have boards or commissions that have the authority to approve hospital budgets and rates, and West Virginia earlier this year passed a law setting up a panel, though the law is being challenged in court (see story, page 31).

In several states, like New Jersey, what a hospital can charge is determined by diagnosis-related groups or DRGs—categories created to include all the patients who are about the same age, have similar diagnoses, require similiar medical procedures and have similar discharge status (*BI*, Feb. 14).

Legislative committees in other states, like Wisconsin and Florida, are studying similar proposals.

Hospitals generally favor a more organized method of billing, but they believe the solution of government regulation and rate-setting commissions is too narrow of an approach to cost containment. In some states, strong hospital lobbies have come out against legislation that would control their charges, saying rate limits ultimately will result in less service.

Proponents of rate setting, though, say it results in lower rates.

An November 1981 article in *The New England Journal of Medicine* said rate setting through mandatory prospective reimbursement appears to slow the growth of hospital expenditures and seems to be the only regulatory tool that has been effective.

But, the article's author, Dr. William B. Schwartz, a professor at the Tufts University School of Medicine in Boston, concludes: "Prospective reimbursement has been used in only a handful of states and it cannot be concluded that the program would be equally effective in the rest of the country."

"I think regulation is the answer in some states," said Michael Schiffer, director of government and industrial relations for CIGNA Corp. in Hartford, Conn.

"I think that you'll find in the older industrial states, where there are more Democrats than Republicans—the more liberal states—that the idea of regulation is accepted. But it's not a universal answer."

It apparently was the answer for only a short time in Colorado. A hospital commission was set up in Colorado in 1977 to control both how much revenues a hospital could make and what rates it could charge, but the commission was dissolved in 1980.

The Legislature created the commission in response to threats by the federal government that it would start regulating health costs, said Donald Rice, associate director of the Colorado Department of Health.

But once the commission came into existence, it became a bureaucracy run amok, said Tom Sangster, government relations special-

Continued on next page

States consider hospital rate commissions

Continued from page 21
ist for the Colorado Hospital Assn.

The commission's rules and regulations made it difficult for hospitals to function, observers said.

"The commission became insensitive to the (hospitals) and lost sight of its goal," Mr. Sangster said. "It became a personality problem."

Two years later, the legislators listened to the strong hospital lobbyists and voted to have the commission dissolved in 1980, after the federal regulation threat had subsided, Mr. Rice said.

Some political voices, particularly Democrats, opposed the commission's demise. A few hospitals also were in favor of keeping some type of regulatory arm in control since it was the only data collection base for hospital records in the state.

But the commission appears to have met its goal of holding down cost hikes. Colorado hospital costs were below the national average before the commission, appeared to decrease during its tenure and rise again after its dissolution, Mr. Rice said.

Even though costs have gone up, there is next to no noise to establish a commission again, he said.

The specter of federal regulation also was the main reason why the Washington Legislature created a commission in 1973, said Maurice Click, executive director of the Washington State Hospital Commission.

"Because we were way out here, the state decided that if we're going to be regulated we would rather be at the state rather than national level," Mr. Click said.

The Washington commission currently reviews and approves budgets and rates annually for the state's 111 hospitals.

However, "sunset" legislation passed by the state four years ago requires that all state commissions, boards and agencies justify their existence to a special legislative committee according to a timetable, or cease to exist. That committee has been studying the hospital commission since January 1982 and will issue its preliminary findings in June.

Maryland's Health Services Cost Review Commission, which was established in 1971 and started regulating in 1974, was not started because of federal pressure, said Dennis Phelps, the commission's acting assistant chief for audit and compliance.

Hospital costs were skyrocketing at the time, he said, adding that its formation was also prompted by solvency questions about some inner-city hospitals.

The Maryland commission requires hospitals to submit a number of reports quarterly and annually. These reports must include the hospital's revenues, volume of service, expended costs by department, audited statements and discharge tapes of diagnoses.

Although it requires annual reports, the commission only performed in-depth reviews of hospitals during its first three years of existence. Since then, hospital rates have been changed by an "inflation adjustment factor."

The burden is on the hospitals to apply for an increase in rates or an inflation adjustment, Mr. Phelps said. In order to win this adjustment, the hospital must demonstrate through its records that its charges are in line with a computated average cost of similar diagnoses in similar hospitals.

Hospitals are aware of this process and usually don't apply for the inflation adjustment unless they believe they will meet the test, Mr. Phelps said.

A recent commission report stated that 1982 was the seventh year in a row that the cost of a day of hospital care in the state was lower than the national average.

"In the last five to six years, we've beat the rate of increase in the nation by 2% to 4% in hospital cost per day and hospital cost per admission," Mr. Phelps said.

Some people, however, don't believe that rate setting is the right answer to the current problem and may in fact lead to new problems.

Ron Krause, president of the Arizona Hospital Assn. believes that rate setting ultimately will mean fewer hospitals and less care.

He compared the future of medical care in the United States to Sweden, where medical care is regulated and rationed.

"Certain procedures are not available there after a certain age. We have to decide if we want that as a society," Mr. Krause said.

"Rate setting is nothing new," adds Dr. Winfield Dunn, senior vp for government affairs with the Hospital Corp. of America, in Nashville, Tenn.

The corporation owns and operates 365 hospitals in eight different countries and very few of them are in states where rates are regulated, he said. "We find it more desirable (to operate) in states where there is less regulation."

The new interest in rate setting, he explains, has come from a feeling of frustration because of the high medical costs.

"But rate setting is like treating the symptom rather than the cause of the disease. And the hospitals of America have been sick for a long time," he said.

He says the problem behind high health care costs lies in utilization and the cure is to educate consumers in using medical care.

Some states, like Virginia, are opting for plans that fall short of actual rate setting. That state's rate commission, created in 1978, requires mandatory reporting of hospital budgets, audits and proposed rate increases, but its recommendations are not binding.

"The leverage we have is public disclosure," said Sheryl Paul, executive director of the state Health Services Cost Review Commission.

In still other states, like Utah, the majority think market competition is enough to hold the line on rates.

"In Utah there's a climate of less regulation and more along the lines of a competitive mode," said Sue Ross of the Utah Hospital Assn. "We're really not like a lot of states in the East that are trying rate review commissions."

However, Utah has some characteristics that set it apart from the other 49 states when discussing health care costs, noted Michael Stapley, deputy director for the Utah Department of Health.

Health care costs in Utah are 20% to 30% lower than national averages, he said. "And they should be. Utah has the youngest population in the United States."

But, even with those characteristics, Utah is experiencing the same average 16% annual rate of medical cost increases as the rest of the country. ■

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B-5/30

Arizona employers leading health cost battle

By CAROL CAIN

PHOENIX, Ariz.—Double-digit health care inflation means big bucks to Arizona employers, and they're leading the fight to corral these costs.

They've formed a health care cost-containment coalition that has already successfully pushed one cost-control bill through the Legislature, and they're fighting for more.

Health care costs rose 19% in Arizona last year, even though the overall inflation rate climbed only 3.8% statewide.

If Arizona health care costs jump another 19% this year, it would cost four of the state's largest employers —Honeywell Inc., Sperry Corp., Motorola Inc. and Garrett Corp.— another $9.5 million on top of the $50 million the companies estimate they already spend on health benefits for their Arizona employees.

The four companies realized they had to do something to control these costs, says Frank Connell, manager of human resources and environmental services at Honeywell's Large Computer Products Division in Phoenix.

Representatives from the four employers began meeting weekly several years ago, then two and three times a week until their gatherings spawned the Arizona Coalition for Cost Effective Quality Health Care.

The coalition, which now boasts more than 1,000 members, has already won one big victory: A bill recently signed by Gov. Bruce Babbitt that will require hospitals to use a uniform billing system based on diagnostic-related groups (DRGs) by Feb. 1 (*BI*, Feb. 14).

Although the specifics of the DRG system have not yet been worked out, the bill is intended to make hospitals use standardized billing forms so that employers can compare what different hospitals charge for the same procedure.

Besides uniform billing, hospitals also will have to report to the state Department of Health Services such statistical data as the number of hospital confinements, the average length of stay, the average charge per day and the average charge per confinement for each attending physician.

This information will be published by the department semiannually and distributed to the public.

After the DRG system is in place, consumers, including employers, will be able to compare costs from one hospital to the next, said Charles T. Stevens, the coalition's legal and legislative counsel.

"It will give industry and business the opportunity to redesign their health care packages. . .so they can make intelligent judgments. Right now they're only guessing (on the cost of services)," he said.

However, the DRG measure was the only piece of legislation from a package of four separate bills put together by the coalition after a year of study and introduced in the state Legislature earlier this year by Rep. Burton S. Barr, R-Phoenix.

Although they were not passed this year, the employer coalition and the state's hospitals are now attempting to negotiate compromises on the other three coalition proposals: a moratorium on hospital construction, the creation of a rate-setting commission and a cap on rates.

The governor has said that if the coalition and hospitals can agree on further health care cost-containment legislation that can win support from legislators, he will call a special session of the Legislature this fall.

However, if the Legislature does not meet, the coalition, which represents employers with more than 125,000 workers, is prepared to start gathering petitions in the fall for a ballot initiative asking for a halt to capital expansion of hospitals and some type of rate review mechanism, Honeywell's Mr. Connell said.

If the coalition decides on a ballot proposal, the vote could be held in November 1984.

"We want a better planning process and we want adherence to a plan," he said. "The only thing that will stop the initiative is if we get legislation that will stop the problem. . . .Voluntary compliance won't work."

The Arizona Hospital Assn. is gearing up to fight a drive for a ballot initiative, while still hoping to negotiate a solution to high health care costs with employers. The group represents a majority of the state's 65 hospitals that are not run by the federal government as military or Indian hospitals.

Critics of the hospital association say the group did not take the employers' coalition seriously until just recently. "The legislation (proposed this year) was used as a big stick to get them to start talking," said Donald Jansen, legal counsel to Rep. Barr.

But a spokesman for the state's hospitals says he doesn't think that the coalition's proposals will solve the health care inflation problem.

"We have said from the beginning that a package of legislation aimed at hospitals solely was a quick-fix bandage approach," said Ron Krause, president of the hospital association.

Other parties, besides the hospitals, have contributed to today's health care inflation, including employers, labor unions, insurers and the federal government, Mr. Krause says.

"Until a mechanism or mechanisms are developed that involve all those players, there won't be a true solution," he says.

Part of the problem behind the high cost of health care, he explains, is the way medical care has been provided in the past 20 years. "We've operated in this country that whatever the best that technology has ought to be offered immediately. . .as a right, irrespective of (anyone's) ability to pay, and without standing in line.

"That's a very expensive way to do things," Mr. Krause said.

But the coalition says many of the factors behind the health care price spiral are primarily the hospitals' doing.

One main complaint, for example, is the excess of hospital beds that currently exist in Arizona and the hospitals' requests to build more.

A study published last year by the coalition noted that there are enough beds now in Maricopa County, Arizona's largest with about 55% of the state's population, to handle its needs through 1986, the coalition's Mr. Stevens says.

At the same time, he adds, there are requests pending by the hospitals to build an additional 1,000

Continued on page 26

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Arizona employers lead battle against cost hikes

Continued from page 24
beds in the county.

Hospital utilization compounds the situation, according to a position paper issued this month by the coalition. The average annual hospital occupancy in Arizona dropped to 64% in 1981 from 67% in 1979, it says.

Mr. Krause of the hospital association admits there may well be too many beds in one area, but that's because the state's population is shifting. He also notes that there is a lack of hospital beds in other areas in the state.

He also explains that hospital utilization increases over annual averages during peak winter periods when many of the state's tourists use the hospitals.

But the coalition rebuts this argument, saying that in Maricopa County, for example, only 76% of the beds are occupied even during peak periods.

The coalition also charges that cost overruns from hospital construction are contributing greatly to health care inflation.

Mr. Stevens cites various individual hospital construction overruns in the state, ranging from $2.6 million to $13 million per site, that are passed on to patients in the form of higher room rates.

For instance, Good Samaritan Hospital in Phoenix charges $168 per day, of which $89 goes toward debt service, according to coalition estimates. At Tempe's St. Luke's Hospital, $110 of the $189 per-day charge goes toward debt service, Mr. Stevens says.

But, Mr. Krause says, "The real problem, if there is one, lies in the definition of terms" and the source of the figures.

He says that much of the blame can be put on inflation. When a hospital decides to build an addition or an entirely new hospital, he notes, it files a "letter of intent" with the state that cites estimated costs. Although this is the amount the hospital uses to budget the construction, it often differs from final costs.

"There should be room for inflation (in the higher figures) if nothing else," he said.

"Is there cost overrun? I'm sure there is. Is there waste in hospitals? I'm sure there is," Mr. Krause explains, but he quickly adds that the overruns and waste are not so great as to be singled out as the culprit for soaring health care costs.

Mr. Krause explains that a moratorium on new hospital construction, as the coalition proposes, will not stop hospitals from raising their rates, increases that, according to the coalition, ranged from 6.7% to 35.3% last year.

Instead, Mr. Krause says that "all the players" must look at the issue together and develop a plan to hold the line on increases that includes all parties, not just hospitals.

The coalition also claims Arizona hospitals should be put under additional regulation because they make serious billing errors. In some cases patients were charged for procedures that were never performed, Honeywell's Mr. Connell said.

But, Mr. Krause replies, the state's hospitals are bound to make mistakes since they handle 4 million outpatient and 400,000 inpatient admissions annually.

Although the DRG system of uniform billing will help employers monitor overcharges at various hospitals, the president of the Arizona Chamber of Commerce says the system is not a cure for health care inflation.

"It probably has merits: disclosure, awareness, education value, maybe even in the competitive sense," says the chamber's William Jacquin. "But it doesn't do much really when you talk about hospital costs or cost accounting."

He, like many others, says the key across the country is to change the way health care is provided so that consumers have more of a say in the delivery of medical services. ■

Pennsylvania willing to try competition before regulation

By CAROL CAIN

HARRISBURG, Pa.—Business and government leaders in Pennsylvania believe there are two ways to cap soaring hospital costs, which rose 15% in the state last year: increase market competition and regulate hospital rates.

The industrial state is energetically considering both methods after a governor's task force on health care cost containment issued a report in March that listed recommendations and proposed legislation.

But, according to the report, the state should see if hospitals can hold costs down through competition and self-regulation before the state steps in and sets rates.

Among the panel's recommendations was the establishment of a state cost-containment commission to develop incentives for the efficient use of hospital services, and if that fails, to regulate hospital cost increases.

"The lack of marketplace incentives is the principal cause of health care inflation," state Insurance Commissioner Michael L. Browne said recently.

"In the health care industry, the incentives in place actually work to escalate costs rather than reduce them. Nowhere is this more evident than in the case of hospitals, whose budgets traditionally expand to cover whatever costs they incur," Mr. Browne said.

The members of the task force—business executives and representatives of the insurance and health care industries—cited building a competitive health care market as the ideal way to harness health costs.

"The task force believes that a solution which puts hospitals on a budget and also minimizes the degree of governmental regulatory intrusion into the health care system is preferable to one in which government plays a more pervasive role," the report reads.

The task force report advises that the state should not set hospital rates if hospitals can limit their cost increases in fiscal 1983-84 through changes in the way health care is delivered. But, if the hospitals can't meet this goal, the panel says the proposed commission should set rates for hospitals in advance.

However, hospitals that are able to trim big cost increases and also provide consumers with incentives to hold down health costs should be entitled to an exemption from direct regulation, the task force recommended.

The development of alternative health care delivery systems like health maintenance organizations to encourage price competition, incentives for efficiency and consumer choice is also recommended in the report.

In addition, the report also advocated a curb on state government expenditures for medical services to discourage overutilization of health care and hospital services.

"We don't see this (proposal) as price control," said Don Mazziotti, executive director of the Business Council of Pennsylvania, a coalition of 39 corporate chief executive officers whose companies employ 1.5 million workers.

The coalition's own report on health care cost containment, which came out earlier this month, parallels in many ways the task force's recommendations.

In addition, the council recommends the establishment of preferred provider organizations (see story, page 3).

Mr. Mazziotti says that other business coalitions, besides the Business Council of Pennsylvania, have been formed in Pennsylvania to curb health cost hikes. "The average per-worker cost for benefits is $2,000 and it's increasing at 15% per year. This is affecting the bottom-line profitability for employ-

Continued on next page

Pennsylvania willing to try self-regulation

Continued from previous page
ers," he said.

The group is hoping that a package of cost-containment proposals, including a bill to establish the cost-containment commission proposed by the governor's task force, will be introduced in the Legislature when it meets in the fall.

Others agree that a voluntary approach to cost containment would be best, but they also point out that cost-control efforts shouldn't be limited to hospitals.

"There's no question that hospital costs here have gone up a whole lot faster than other costs, but that's not unique to Pennsylvania," said James Neely, president of Health Alternatives Development Inc., a recently formed corporation that is applying for a license to write health insurance in Pennsylvania.

But the blame for the rising costs should not just be placed on the hospitals but also on physicians, employers and health care consumers stressed Mr. Neely, who was formerly president of the Hospital Assn. of Pennsylvania.

"Physicians did the ordering (of services), patients are the ones who do the demanding and employers gave the store away with benefits," he said, adding that government entitlement programs, like Medicare and Medicaid, also increase health care utilization andcosts.

"The governor's task force says there's no solution unless all the people who created the problem work together,' said Mr. Neely, who was a member of the panel. "I hope we'll see significant changes in the way health care is purchased within the next five years, but only if we all work together."

Hospitals can no longer be paid on a retrospective basis, he maintains, adding that doctors cannot be paid as a reward for providing more services, as they are now. Employees must be taught how to buy efficient health care and employers will have to change their benefit plans by adding higher coinsurance levels and deductibles to put an end to unnecessary health expenditures, he said.

The task force report agrees with this concept, noting there is a lack of useful information about health care, how it is delivered and billed. The report recommends that the cost-containment commission should gather and disseminate comparative information about the costs charged by hospitals and other providers.

It also recommends that employers, as well as labor unions and insurers, develop programs to encourage preventive health care.

Philidelphia-based Bell Telephone Co. of Pennsylvania is one employer that's doing some of those things right now.

"We're making videotapes on what our benefits are and the way our benefits work," said Ted Hibberd, Bell's district staff manager of employee services and activities. The tapes will be shown to employees to explain how to use the cost-containment features in the company's health plan, like second surgical opinions and pre-admission testing, he said.

Employees also will be given a wallet-sized card with a phone number to call for the name of a physician who can give a second opinion.

"We also do our best to educate our employees on health maintenance organizations—how they work and can be used," he said, adding that the company offers membership to eight HMOs.

Bell's health plan, underwritten by Pennsylvania Blue Shield and Blue Cross of Greater Philadelphia, pays the full cost of a semiprivate room for 120 days after a deductible equal to 1% of annual salary, not exceeding $150.

A maximum of three deductibles must be paid for any one family.

In an attempt to track physicians' costs, the company also will pay 95% of the doctor's bill if the employee uses a doctor participating in a Blue Shield cost-containment program, Mr. Hibberd said. Employees who use other doctors receive a lesser reimbursement for doctors' fees.

"We have asked our employees to tell us if these doctors charge more than the Blue Shield contract says," Mr. Hibberd said, adding that, so far, 50 doctors who overcharge have been identified.

"Employers ought to be looking at their benefit plan design to build into it elements that will cause employees to understand the system and use appropriate levels of care and reward appropriate levels of care," Mr. Hibberd said.

"Right now the system is a mystery to everybody. The providers are not inclined to make it more understandable," he said. "I feel the veil of secrecy, the shroud, has got to be removed from the process so people know how the system works, how the doctors are paid, the morbidity rate and the mortality rate.

"It's (health care) taking 10% of our gross national product and we don't even measure (medical services)," Mr. Hibberd said, adding that something "as silly as a baseball team" is measured backward and forward for averages, runs batted in and other statistics.

This whole educational process will be difficult, "and the health care providers will fight us," Mr. Hibberd said, "but it's the only reasonable manner to inform consumers so they can make informed choices."

One group representing the providers, the Hospital Assn. of Pennsylvania, supports the idea of marketplace incentives to control health costs and has issued its own report on that subject.

"The (governor's task force) report strongly supports a marketplace incentive approach to control health care costs and this association's board endorsed that as our policy about a year and a half ago," said a hospital association official.

He agreed that costs in Pennsylvania's 250 hospitals went up about 15% last year, but added: "We're committed to working as hard as we can to keep those forces under control."

But, he says, hospitals have no control over some of the factors influencing health care pricing, like the state of the economy and the reimbursement system.

"We think that Pennsylvania is at a crucial point at convergence of a lot of forces to bring about some change, and we count ourselves as among the leaders," the hospital official said.

The hospital association's members have recently been sent copies of the governor's task force report and are expected to meet in July to draft a response. Until then, the association will not comment on specific recommendations in the report. ■

Prescription Drug Coverage -- PCS vs Major Medical?

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Cost Controls			
Employee Cost Sharing	Deductible per prescription (varies by plan)		Deductible, co-insurance (varies by plan)
Cost of Drug	Wholesale price		Retail price
Pharmacy Dispensing Fee	Set by client		Retail fee set by pharmacy
Claims Payment Control	19 Computerized Edits on every claim		Few controls (varies by plan)
Post-Payment Audit	Yes, in-house and field auditors		Rarely
Utilization Review	Computerized Activity Reports		Rarely
Claims Processing Costs	Less than 71¢ per claim		From $5.00 to $10.00 per claim
Visibility	Personalized plastic "Credit Card"		Minimal
Popularity	"The last benefit they would give up."		Minimal - hassle of reimbursement procedure
Cost-Containment Effectiveness*	Optimal		Minimal

* The proper use of prescription drugs is one of the most effective methods of health care cost-containment. Studies indicate that **proper drug therapy can actually lower employee benefit costs.**

When a PCS program is adopted, some feel the resulting "first dollar" benefit will increase costs. However, good drug therapy has been proven to reduce hospital/surgical expenses and employee absenteeism.

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Florida looking at several ways to cut costs

By CAROL CAIN

TALLAHASSEE, Fla.— High health care costs may be a bigger problem in the Sunshine State than elsewhere in the nation because of the large number of senior citizens living here.

Some 17.7% of Florida's residents are age 65 or older, compared with the national average of 11.3%, "and generally, the elderly use health care services more," says Del Lawrence, executive director of the Florida Task Force on Competition and Consumer Choices in Health Care, a panel set up by the Legislature to investigate rising health costs.

Although that task force isn't expected to issue a report until next year, the state is already considering a variety of measures to limit increases in hospital costs, which have jumped 36% in Florida in the last two years.

Many state legislators predict health costs will continue to rise in Florida, especially because of a change in the federal Medicare programs that will affect almost all of the state's senior citizens. Starting this fall, the federal government will phase in advance rate setting for Medicare-funded procedures, and many say that some of these costs not covered by Medicare will be shifted onto employers (*BI*, March 14).

The Legislature, which is scheduled to adjourn next week, is considering a variety of bills that would mandate health care cost-containment measures.

The legislation was triggered by employers facing rising health care budgets and Insurance Commissioner Bill Gunter, whose department issued a list of legislative proposals in late February in a "case for a new approach to hospital cost containment."

Among the bills pending in the Legislature or proposed committee bills (PCBs) are:

- S.B.988. This bill, one of Mr. Gunter's proposals, would give the state's Hospital Cost Containment Board the power to approve budgets for those hospitals whose increase in expenditures exceed the Consumer Price Index by 7%.

The board, established in 1979, has the power to review rates, but not set them. A proposal to allow it to set rates failed in 1979.

The current proposal was approved 5-3 on May 18 by the state Senate's Health and Rehabilitative Services Committee and is scheduled to go before the Senate Commerce Committee.

A similar bill in the House, H.B. 880, has been sent to that chamber's Health and Rehabilitative Services Committee for a vote.

- H.B. 1182. This bill, awaiting action in the House, would mandate that every group health insurance policy sold or delivered in Florida contain a coinsurance provision. The bill would require employees to pay at least 20% of their health care costs, up to a minimum $500 out-of-pocket limit for individuals and a $750 limit for families.

"What we've aimed the bill at is affecting the incentives that are built into third-party payments so that consumers become aware of health care costs," said Bill Quattlebaum, counsel to the House Commerce Committee.

The proposal also incorporates most of the provisions of another proposal, H.B. 209, which mandates coordination of all health insurance benefits so that no one can be reimbursed for more than 100% of medical costs.

It also requires mandatory outpatient coverage for any procedures that are covered on an inpatient basis, as well as mandatory second surgical-opinion programs.

The bill also would clarify existing state laws to allow insurers to package services that specify which providers are to be used, so-called preferred provider organizations (see story, page 3). Unlike most insurance policies, the choice of providers would be limited, in exchange for a discounted or fixed rate.

A similar bill to set up PPOs—S.B. 132—is pending in the Senate.

- S.B. 1118. This proposal is similar to H.B. 1182, except it would mandate deductibles for employees instead of coinsurance. The bill proposes minimum annual deductibles of $200 for individual coverage and $350 for family coverage.

"We think either approach (mandatory deductibles or coninsurance) will work," said Lester Abberger, executive assistant to Mr. Gunter.

- PCB 9. This bill would make physicians pay hospitals a fee of up to $500 per year for hospital staff privileges, plus an assessment of 2% of all hospital charges they order. The money would be used to reduce hospital room rates.

Supporters of the bill say that physicians now can order any number of tests without having to pay for them or know how much they cost.

The proposal is still in a cost-containment subcommittee of the House Health and Rehabilitative Services Committee.

Some observers in Tallahassee say that some legislation will be passed this session, though no single bill will be approved in its original form.

Others believe, however, that the Legislature will hold off on any action until it receives the report from its task force next year.

"We have made some preliminary observations (on the proposed legislation), none of which supports or opposes it," said the task force's Mr. Lawrence.

The panel represents a cross-section of philosophies, he said.

"...Now we are leaning toward the setting of some guidelines to let market forces operate better," he said, an approach similar to one taken by a similar task force in Pennsylvania (see story, page 27).

The state's hospital association has already made its position clear: It's against rate setting.

"We don't think that Florida needs rate setting. When we compare with states that have rate setting, we compare favorably, even though we are a growing state," said Earl Tredway, vp of government relations with the Florida Hospital Assn.

"Really, the only thing to lower costs is reductions in services," he said. "The only costs hospitals have control over are prudent purchasing and good management. We don't admit patients; we don't order what (services and tests) patient's are getting; we don't discharge patients." ■

West Virginia sets up rate commission

By CAROL CAIN

CHARLESTON, W.Va.—While many other states are still discussing how they can hold down health care cost increases, West Virginia has taken action.

The state Legislature earlier this year approved a bill that establishes a hospital rate-setting commission.

The move should mean reduced health cost increases for employers that pay for their employees' medical coverage, supporters of the system say. But, some critics of the new law say it may mean poorer service in the long run and are challenging the law in court.

"Of course our rate of (hospital cost) increase has been significant, but part of that is a statistical phenomenon. Our base was lower than other states," said Bruce Carter, president of the West Virginia Hospital Assn.

According to Mr. Carter, West Virginia hospitals ranked 40th in the nation in cost per patient day and 41st in cost per patient stay.

The law took effect March 25, but a federal judge issued a temporary restraining order and then a preliminary injunction against its implementation earlier this month after four hospitals challenged two provisions in the law. The state is expected to appeal.

The first provision freezes hospital rates retroactively to Feb. 1 of this year until July 1, 1984. The second caps increases in hospitals' gross revenues each year at 12% over the previous year.

Hospitals argued that capping the amount by which they can increase their gross revenues is unfair because revenue increases can reflect volume increases, not just rate increases, Mr. Carter said.

The two provisions, if upheld by the courts, could cost the hospitals $50 million next year, John H. Brown Jr., director of community affairs for the Charleston Area Medical Center, a 934-bed multihospital teaching facility and member of the association said.

Other provisions in the law that are not being challenged include:

- The measure will apply to all hospitals, except those operated by the federal government.
- Hospitals must provide all information necessary for the commissions to set rates on an individual basis.
- Rate setting will be based on review and investigation of previous rates, future trends, cost efficiency and the solvency of the hospital.
- Rate setting will begin July 1, 1984.

The new law is modeled after Maryland's (see story, page 22), but Mr. Carter said that West Virginia hospital costs are already lower than that state's.

"I think its a drastic and simplistic approach to dealing with hospital costs. We don't see any evidence in those states that have been experimenting with (rate commissions) of lower rates," he said.

The new law is referred to as a cost-containment measure, but Mr. Carter believes that's a misnomer. "It really only controls hospital revenues," he said.

"The rest of the country is going with prospective payments with Medicare and diagnostic-related groups. We think West Virginia is out of sync with what's going on nationally," said Mr. Brown.

Current hospital costs in West Virginia are lower than in the six states that regulate rates, Mr. Brown said. "We're really at a loss to explain the true justification for this regulation," he said.

"I think there's a lot of confusion about the new law," said Richard Walker, chairman of Cecil I. Walker Machinery Co., which sells and services heavy mining equipment from its Charleston plant.

"I've got mixed emotions about the law," Mr. Carter says, though he adds that he believes hospitals need more cost accountability. Another West Virginia employer is trying to curb health cost hikes on its own.

"We're trying to work with the doctors, and a doctors' coalition is being formed," says Arnold Werner, superintendent of safety and health for FMC Corp. in Nitro, one of two FMC plants in the state.

"In our own company we're encouraging second opinions, which are required of all salaried employees," he explained. The program cannot be required for hourly employees because it's not a contracted item, he explained.

"It seems there is no real incentive on the part of the people that are receiving the service to keep costs down. And that includes insurance companies that set rates on an experience level," he says.

Charleston National Bank is another employer that began looking into its own cost-containment plan. Moses Scaff, vp and director of human resources, says that according to the premium increase he received from its health insurer, Connecticut General Insurance Co., the bank's hospital costs are rising at a 20% clip.

"We're going to take a real hard look at our coverage. We're looking at cost containment, ways to redesign the plan and also at our experience rating to see what areas are really important to employees and what areas are not being used. And we're shopping around," he said.

The 366 employees at the bank must pay a $500 deductible for their major medical coverage, Mr. Scaff said. The company only pays a percentage of hospital charges, which differ based on the service. ■

Firms question pension accounting proposal

Continued from page 3

Whether calculations with the proposed rules result in a net liability or a net asset, FASB proposes to offset the balance sheet effects by including another new item on the assets side.

If a company shows a net pension liability, it would be offset completely or partially by an "intangible asset," representing an expected future benefit to the employer of maintaining and improving the pension plan. If the company shows a net pension asset, the asset side of the balance sheet would include a deferred credit to offset it.

In Preliminary Views, FASB offers companies two options for making the transition from current accounting practice to the new rules.

Under the "prospective" approach, the company would recognize the net liability and an equal intangible asset that would be amortized over the average remaining service lives of the employees. The effect of this option would be an increase in yearly pension expense.

Under the "retroactive" approach, the company would recognize the net liability and an unamortized intangible asset not necessarily equal to the liability. The difference between the liability and asset would be charged or credited to equity, though FASB hasn't decided whether the effect should be shown in net income or directly in the company's retained earnings.

Under this option, the impact of the change would be borne mainly by corporate equity rather than showing up as increased pension expense.

- Companies would be required to use the same actuarial method for calculating pension expense and other balance sheet entries. Use of the so-called "projected unit credit" method by all companies would improve "comparability and understandability" of financial reporting among companies, FASB concludes.

If use of this method is mandated, many companies would have to switch from several methods acceptable under current rules. According to a 1981 survey of 428 companies conducted by Coopers & Lybrand for the Financial Executives Research Foundation, only 13% of the companies used the unit credit approach.

- Companies would be required to accrue costs for employees' post-employment health care and life insurance benefits during the service lives of the employees who will receive the benefits. Most companies now provide for these benefits on a pay-as-you-go basis. (See related story, page 44.)

Overall, FASB feels the rule changes would provide readers of financial statements with a clearer idea of a company's long-term obligations and would make it easier to compare the pension data of various companies.

A number of accounting and benefits consulting firms are quarreling with FASB over the proposed rules, though.

One argument involves the effect of the rules on a company's debt-to-equity ratio and thus on its financial well-being. In an analysis of the Preliminary Views, Coopers & Lybrand notes that in cases where companies recognize a net pension liability, debt-to-equity ratios could be "adversely affected," especially if financial analysts and creditors recognize the liability but treat the offsetting intangible asset as "soft" or "funny."

A company with a mounting debt-to-equity ratio could find itself in technical default on long-term debt covenants that specify minimum ratios, the study warns.

Not all pension experts express this fear, however. Many feel that sophisticated financial analysts already know what companies' long-term pension obligations are and won't be surprised by what may appear on the balance sheet.

"It's totally a matter of cosmetics," said Manuel Castells, a partner with consultant Kwasha Lipton in Fort Lee, N.J. "Many companies believe this has been discounted totally already by financial analysts."

"Balance sheet or footnotes should not make much difference to a sophisticated analyst," said Larry B. Wiltse, a consulting actuary with Buck Consultants Inc. of New York.

Another problem cited is the potential for erratic changes in yearly pension expense brought on by a proposed rule on pension asset valuation. Under the Preliminary Views, a company's pension assets would be calculated at fair value at the time of the financial statement, rather then actuarial value, making the asset valuation more vulnerable to volatile swings of the stock and bond markets.

Pension expense of 10% a year is all right, but "it shouldn't cost me 10% one year, 5% the next year and 14% the next year because of fluctuations in the stock market," Mr. Castells said.

Presumably, some of these fluctuations would be accounted for by the measurement valuation allowance, but in looking at "field tests" of the proposed rules performed at several companies, FASB has found more volatility than is possible under present accounting standards.

"The smoothing achieved by the valuation allowance isn't as great as the smoothing achieved by methods being used now," said Timothy S. Lucas, FASB project manager.

Still, FASB feels that over the long run the dips and peaks of yearly valuation will even out.

Some consultants also fear that for some companies a switch to the projected unit credit method of determining pension expense will result in expense figures that are lower than the amounts the companies should contribute to be sure the pension plan is properly funded.

"One of the things we worry about is management not understanding the difference between expensing and funding," said Mr. Wiltse. "They may say, 'If this number is good enough for FASB (for expensing), it's good enough for funding.'"

But in some cases it may not be good enough, and the result could be an underfunded pension plan, Mr. Wiltse said.

One further problem, Mr. Wiltse added, is the boosting of corporate pension expenses that might result from the amortization requirements set out in the Preliminary Views.

When a plan is amended to improve benefits, those improvements are often applied not only to employees' future service but also

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retroactively to prior service. Under the Employee Retirement Income Security Act of 1974, these unfunded prior service costs can be amortized over periods of up to 30 years. Under the Preliminary Views, however, the costs must be amortized over the average remaining service lives of active employees, which may range up to a maximum of only 16 years for many companies, Mr. Wiltse said.

The shorter amortization period means that a company would be forced to swallow larger chunks of prior service costs each year. The net effect would be an increase in the company's pension expenses for the first 10 years or so after an amendment, Mr. Wiltse said.

A related problem involves the tax deductibility of pension expenses, he added. Maximum deductible contributions to pension funds can now be amortized in equal amounts over 10 years. But the larger chunks of prior service costs amortized over shorter periods under the Preliminary Views may amount to more than a company can legally deduct, Mr. Wiltse pointed out.

"I would envision the amounts some companies would have to expense would be in excess of what's deductible," he explained.

For these reasons and others, many companies are not in favor of the FASB accounting proposals.

In the 1981 Coopers & Lybrand survey, 29% of the 428 companies surveyed agreed that pension obligations should be recorded in some form on a company's balance sheet. About 61% disagreed and 10% either didn't know, didn't answer or were neutral.

Pension obligation for the purposes of the survey question meant the actuarial present value of benefits payable in the future for past service and did not include any estimate of future salaries as would be required under Preliminary Views.

Only 16% agreed that obligations should be recorded in total with the plan assets reflected as assets of the company. About 75% disagreed, and 9% either didn't know, didn't answer or were neutral.

A majority—62%—felt that a recorded pension liability should be handled as a deferred charge with subsequent amortization. Only 11% thought the liability should be charged to current income, and 13% thought it should be charged to retained earnings.

On the question of actuarial method used to calculate pension expense, only 15% agreed that one actuarial method should be prescribed. About 73% disagreed, and 12% either didn't know, didn't answer or were neutral.

Several companies contacted by *Business Insurance* have already assessed the impact of the proposed rules as part of a field test sponsored by the Financial Executives Institute for FASB. All are unhappy with the results.

E.I. du Pont de Nemours & Co. Inc. of Wilmington, Del., tested its parent company plan, a final pay plan covering 70,000 hourly and salaried employees and accounting for two-thirds of the company's yearly pension expense, according to Con Noland, Du Pont's assistant comptroller.

Pension expense for all of Du Pont's plans—including those of its Conoco, Consolidated Coal and foreign subsidiaries—totaled $537 million in 1982. Assets available for benefits amounted to $7.64 billion, while the actuarial value of accumulated benefits totaled $4.88 billion.

Mr. Noland estimated that the immediate effect of including future salary increases in expense calculations would be to boost accumulated benefits for the parent plan alone by $2 billion. The effect on shareholders' equity varies "quite substantially"—by about $1.5 billion—depending on which transition method, prospective or retroactive, Du Pont uses, Mr. Noland said. Most of the variance is on the side of reduced equity, he added.

Du Pont's yearly pension expense for the parent plan would increase by a minimum of 10% and a maximum of 70%, again depending on which transition method is used, according to Mr. Noland.

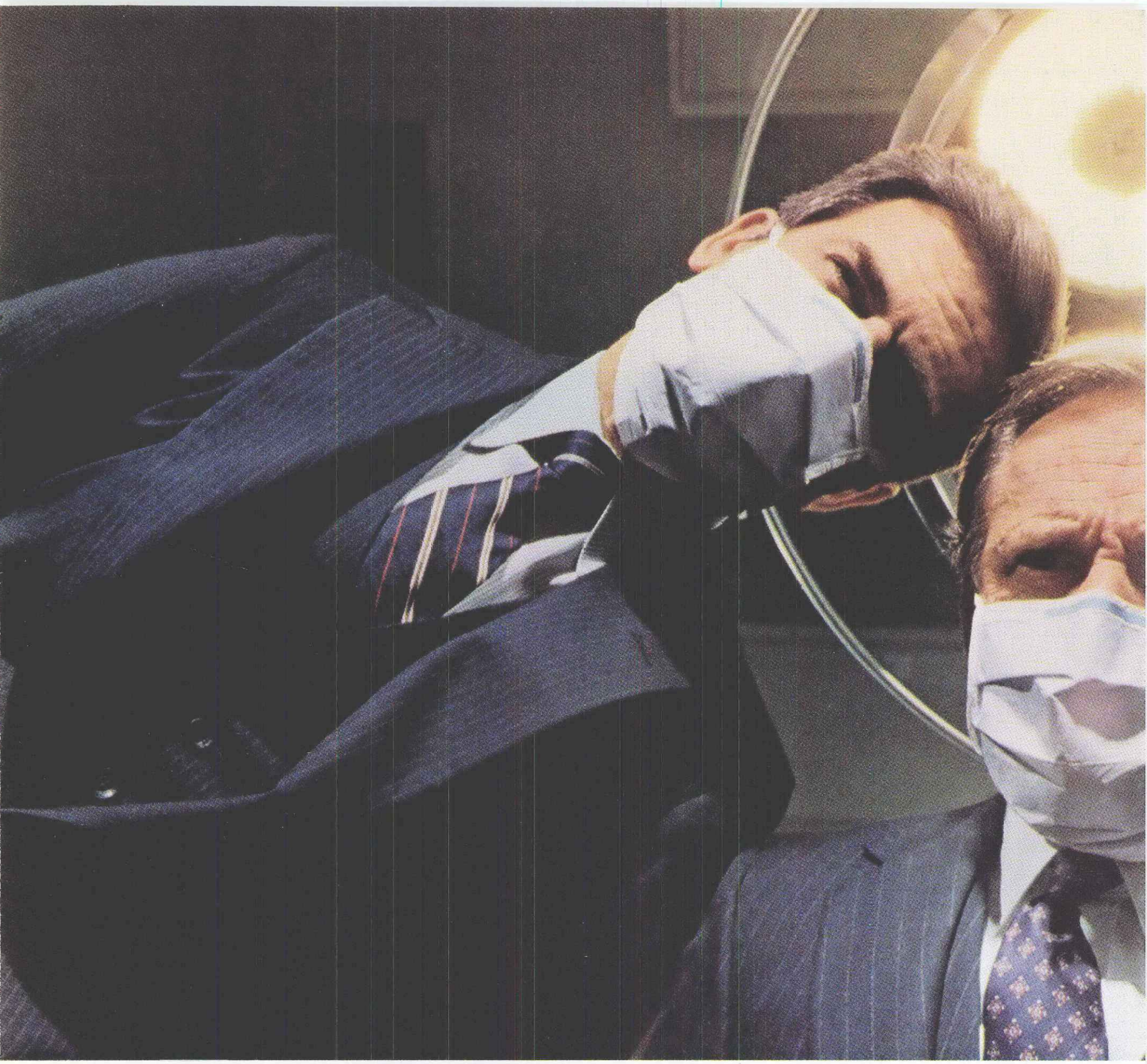
"It's just mind-boggling," he said.

In addition to objecting to the concept of defining future salary increases as an accounting liability, Mr. Noland pointed out that the range of transition methods available probably won't produce the uniformity in pension accounting that FASB is looking for.

"The very wide range of alternative results (in Du Pont's case) indicates that it would be counterproductive," he said. "Rather than resulting in greater comparability, it would result in a higher degree of disparity."

Cummins Engine Co. Inc. of Columbus, Ind., tested one of its two union plans, a flat benefit program covering about 7,000 domestic employees and accounting for about a quarter of the total yearly expense of the company's three separate plans, according to Roland L.

Continued on page 42



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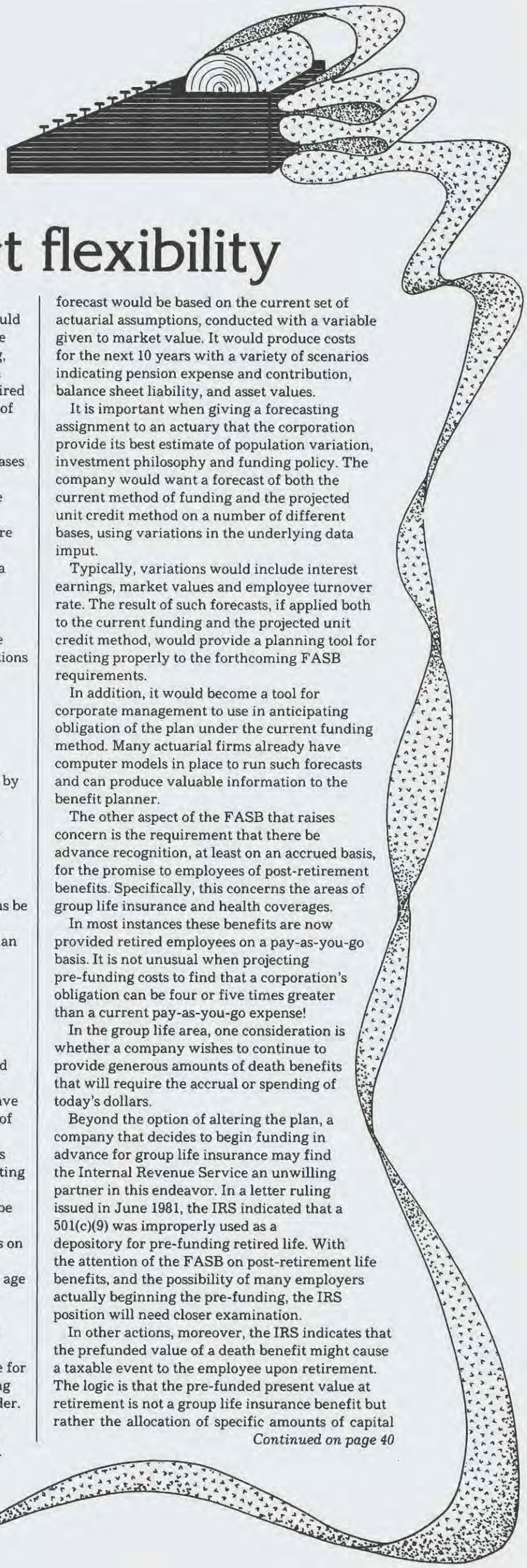
perspective

ACCOUNTING FOR PENSIONS



FASB plans would restrict flexibility

By Bernard Schoen

THE FINANCIAL ACCOUNTING Standards Board has issued "preliminary views" on accounting for both pension and other post-retirement benefits in an effort to standardize a common measure of the net assets or liabilities of defined benefit retirement plans.

The document proposes that a corporation's financial statement should reflect the net asset (or net liability) value of the retirement plan on the balance sheet. All corporations would use a common actuarial cost method—the projected unit credit method—and this method would reflect anticipated increases to future compensation.

Further, balance sheet accrual of post-employment benefits, such as retirement life insurance and retirement medical benefits, would be required.

If the changes expressed in the preliminary views are ultimately incorporated as an accounting standard, the net effect to a corporation could be either a plus or a minus. However, the retirement plan financial condition would change the balance sheet debt/equity ratio and other indications of the financial position of the company.

The corporation could continue to use its preferred funding method in the actual amortization of its liability. But for financial statement purposes, the FASB proposes one standard funding method and amortization schedule.

The net effect of the FASB action will vary from one corporation to another. For some, this accounting requirement and the resulting net liability or asset will have an insignificant effect.

For many others, the adverse effect could be so severe as to cause reconsideration of the benefit levels provided, or even elimination of a pay-related defined benefit plan. Most certainly, any corporation now considering a merger or acquisition, or perhaps planning a benefit improvement, should examine the FASB preliminary views closely in order to project the results of plans and any contemplated changes.

It would appear that the FASB's major objective is to narrow the flexibility now employed in both the funding and the accounting of a pension plan—at least from the accounting point of view—so that the balance sheet ultimately reflects a corporation's pension obligations in a standard format that is understandable to the reader. However, in developing a comprehensible and comparable measure of pension obligation, other problems emerge.

There are many valid reasons for a corporation to choose one funding method over another. The actuary's choice permits a company to utilize a method that can relate directly to the covered employees and the long-term capital needs and financial status of the corporation.

In addition, traditional methods allow flexibility in the amortization of past service liability, permitting acceleration in some years and deferment in others, depending on the company's financial situation and the plan's cash needs.

The practical application of this flexibility could lead to potential separation between the balance sheet-funding methods and actual plan funding, and this could create even greater confusion. In each such instance, corporations would be required to produce two valuations: One for the purpose of accounting and accrual and one that actually affects cost.

Pension plans have been successful even in cases where benefits were not funded as they were earned. Within the standards established by the Employee Retirement Income Security Act, justification can be made either for funding more rapidly or more slowly.

The net result for many corporations will be a decision to provide a funding standard that duplicates the financial standard. In the corporation's attempt to eliminate confusion, it loses the flexibility and the autonomy it and the actuarial profession are now granted. The questions now being asked by benefit planners for each specific plan include:

- The relationship between the present liabilities and the FASB balance sheet entry amounts.
- The relationship between the unit credit method as proposed and the method being used by the company presently.
- The differences between the PBGC legal liability requirements and the liability amounts that will result from the FASB requirements.

These differences and their effects should be known by corporate management today.

Just how severe will the financial implications be to the corporation? Are they so severe that corporate planning should consider changing plan design or emphasis from an existing defined benefit plan to a defined contribution plan? Investment managers should be advised on the potential impact the requirement can have on current asset allocation methods.

Further, the levels of post-retirement life insurance and health plans must be re-examined after projections of pre-funding expenses have been developed. Possibly, those benefits may have to be adjusted, based on financial requirements of the corporation rather than on employee need.

If, indeed, the substance of a retirement plan's benefit formula is going to be shaped by accounting considerations, the loser in this transaction may well be the covered employee. Employers may be unwilling to promise benefits because of the potential effect (when accrued) of those benefits on the balance sheet.

The nature of each company's workforce, the age of the plan, the frequency with which plan improvements were made and the company's policy in the past toward funding, will vary the outcome of the retirement plan. Because of the implications in the future, a forecasting exercise for both the corporation's current method of funding and the proposed FASB method would be in order.

A forecast can be a valuable tool to financial management. Studies indicate that as much as a 50% difference in pension expense increasing or decreasing is not uncommon. Typically, the forecast would be based on the current set of actuarial assumptions, conducted with a variable given to market value. It would produce costs for the next 10 years with a variety of scenarios indicating pension expense and contribution, balance sheet liability, and asset values.

It is important when giving a forecasting assignment to an actuary that the corporation provide its best estimate of population variation, investment philosophy and funding policy. The company would want a forecast of both the current method of funding and the projected unit credit method on a number of different bases, using variations in the underlying data imput.

Typically, variations would include interest earnings, market values and employee turnover rate. The result of such forecasts, if applied both to the current funding and the projected unit credit method, would provide a planning tool for reacting properly to the forthcoming FASB requirements.

In addition, it would become a tool for corporate management to use in anticipating obligation of the plan under the current funding method. Many actuarial firms already have computer models in place to run such forecasts and can produce valuable information to the benefit planner.

The other aspect of the FASB that raises concern is the requirement that there be advance recognition, at least on an accrued basis, for the promise to employees of post-retirement benefits. Specifically, this concerns the areas of group life insurance and health coverages.

In most instances these benefits are now provided retired employees on a pay-as-you-go basis. It is not unusual when projecting pre-funding costs to find that a corporation's obligation can be four or five times greater than a current pay-as-you-go expense!

In the group life area, one consideration is whether a company wishes to continue to provide generous amounts of death benefits that will require the accrual or spending of today's dollars.

Beyond the option of altering the plan, a company that decides to begin funding in advance for group life insurance may find the Internal Revenue Service an unwilling partner in this endeavor. In a letter ruling issued in June 1981, the IRS indicated that a 501(c)(9) was improperly used as a depository for pre-funding retired life. With the attention of the FASB on post-retirement life benefits, and the possibility of many employers actually beginning the pre-funding, the IRS position will need closer examination.

In other actions, moreover, the IRS indicates that the prefunded value of a death benefit might cause a taxable event to the employee upon retirement. The logic is that the pre-funded present value at retirement is not a group life insurance benefit but rather the allocation of specific amounts of capital

Continued on page 40

Bernard Schoen is a vp with Johnson & Higgins in New York.

ENDING THE SILENCE

How one ERISA amendment is giving states the power to regulate self-funded METs

By David J. Brummond

ALTHOUGH UNNECESSARILY complex and long overdue, the Erlenborn-Burton Amendment to section 514 of the Employee Retirement Income Security Act passed in December 1982 is a positive step in clarifying the jurisdictional boundary between ERISA and state insurance laws.

By enacting a complex, narrow amendment to the text of the ERISA pre-emption provision, Congress ended its eight-year silence on the federal-state jurisdictional controversy surrounding self-funded multiple employer trusts. The amendment itself is less than lucid and its adoption came after little or no public exposition. Yet its provisions provide considerable assistance to states in their battle to establish regulatory jurisdiction over METs.

Representatives of the insurance regulatory community have complained on many occasions that the broad pre-emption language of ERISA's section 514 exerted a chilling effect on their efforts to enforce certain state insurance laws. That section states that ERISA pre-empts, or supersedes, "any and all state laws that relate to an employee benefit plan."

The chilling effect of section 514 was particularly burdensome, state officials asserted, on their efforts to identify and regulate entities that engage in insurance activities without state authorization or licensing. Generically labeled self-funded multiple employer trusts, such entities often collected premiums and promised to pay health insurance benefits to participating employers under the guise of being employee welfare benefit plans under ERISA.

Since the regulatory standards of ERISA governing employee welfare benefit plans deal primarily with reporting and disclosure requirements, pre-emption of more rigorous state laws left little or no governmental oversight of the financial affairs of such entities. State efforts to assert jurisdiction over self-funded METs as unauthorized insurers were often met with loud cries of federal pre-emption by MET operators.

The years immediately following ERISA enactment in 1974 witnessed an alarming growth of self-funded METs. Rising health care costs of small employers, combined with the superficial appearance of ERISA legitimacy, made self-funded METs an attractive financing mechanism for employers to provide employees with health care benefits. Moreover, the absence of governmental oversight and taxation gave self-funded METs a competitive advantage over licensed insurers.

Soon the lack of financial controls began to be felt, however, as several self-funded METs encountered fiscal difficulties. When actual MET insolvencies occurred, state insurance departments were faced with millions of dollars of unpaid health care claims. In providing assistance to the victims of self-funded MET schemes, state insurance departments became more aggressive in challenging the pre-emption assertions of MET operators.

By the late 1970s, courts were issuing rulings rejecting arguments of federal pre-emption by those METs and upholding the authority of state insurance departments to regulate them as unauthorized insurers. Even to this date, not a single judicial decision can be found which holds that a self-funded MET or similar entity engaged in insuring is exempt from state insurance laws because of ERISA's pre-emption language.

Despite unqualified success against self-insured METs in the courts, state insurance departments still confronted MET insolvencies and unpaid claims in the early 1980s. By this time, the jurisdictional battleground surrounding self-funded METs had moved from the courtroom to the street, however.

The major difficulty of state insurance departments was no longer their legal authority to regulate METs, but rather the practical problem of discovering a self-funded MET before it became insolvent and a backlog of unpaid claims developed. Since there were no registration or filing requirements for self-funded METs, it was not uncommon for state insurance departments to first learn about an MET months, or even years, after its operation began.

Thus, despite success in the courts, insurance regulators always seemed a step behind MET entrepreneurs. Regulators were continually rectifying the adverse consequences of self-funding rather than preventing their occurrence.

It was this problem of discovering the self-funded METs prior to their insolvency that precipitated a movement in Congress in 1982 to amend the ERISA pre-emption provision to deal with METs.

Following a major exposition of a fraudulent MET scheme in Chicago by WBBM-TV, Rep. John Erlenborn, R-Ill., of the House Committee on Education and Labor held hearings on the MET problem in March 1982. Apparently impressed by the testimony of fraudulent MET victims and state insurance regulators, Congressman Erlenborn soon co-sponsored legislation with the late Rep. Philip Burton, D-Calif., to amend the section 514 pre-emption language to deal with the METs.

The so-called Erlenborn-Burton bill was subsequently endorsed by the National Assn. of Insurance Commissioners and made a high-priority item on its 1982 legislative agenda. After a substantial lobbying effort by the NAIC and individual insurance regulators, the Erlenborn-Burton Amendment to ERISA was passed by Congress on Dec. 21, 1982.

Although drafted with the best of legislative intentions, the text of the Erlenborn-Burton Amendment is a maze of legal concepts and technical terms.

The addition of its language to the existing provisions of section 514 of ERISA results in a statutory scheme that can only be described as Byzantine. Therefore, this effort to summarize the meaning of the Erlenborn-Burton Amendment must be accompanied by more than the usual caveats and qualifications.

The Erlenborn-Burton Amendment is comprised of two major sections: a definitional and an operative section.

The definitional section identifies the types of entities that are subject to the amendment's operative language. It establishes a new definition in section three of ERISA for a multiple employer welfare arrangement, defined as:

"An employee welfare benefit plan, or any other arrangement (other than an employer welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained:

(i) under or pursuant to one or more agreements which the Secretary (of Labor) finds to be collective bargaining arrangements, or

(ii) by a rural electric cooperative."

It appears that a MEWA thus defined is roughly equivalent to an MET, although important differences exist.

For example, an MET connotes the existence of a trust document, while a MEWA can be any "arrangement" offering or providing welfare benefits to employees. Moreover, any plan or arrangement that otherwise meets the definition of a MEWA but is found by the Secretary of Labor be established or maintained pursuant to a collective bargaining agreement is specifically excluded from the definition of a MEWA.

Aside from these distinctions, the term multiple employer welfare arrangement in the amendment is a device for generally identifying the class of entities that comprise the self-funded MET problem.

The substantive treatment of MEWAs in the Erlenborn-Burton Amendment depends on whether the MEWA is fully insured, exempt or non-exempt. A MEWA is considered "fully insured" if the secretary of labor determines that all of the employee benefits it provides are guaranteed under insurance contracts issued by insurers "qualified to conduct business in a state." Any MEWA that is not fully insured is either exempt or non-exempt MEWA.

An exempt MEWA is one which has been determined by the secretary of labor to be not fully insured, and an employee welfare benefit plan under ERISA. A non-exempt MEWA is "any other" MEWA.

In the case of MEWAs that are fully insured or exempt, state insurance laws may apply to them if they are laws "requiring the maintenance of specified levels of reserves and specified levels of contributions" to ensure the MEWAs will "pay benefits in full when due." Although imprecise insurance terminology, this phrase appears to include state laws governing claim reserves for health insurance policies as well as laws governing health insurance rates.

In addition to claim reserve and rating laws, the amendment further provides that state provisions "to enforce such standards" apply to fully insured and exempt MEWAs. Thus, even if a multiple employer welfare arrangement is funded through an insurance policy or exempted by the secretary of labor as a bona fide employee welfare benefit plan, the amendment directs that certain state laws can be applied to such MEWAs.

In the event an entity meets the definition of a MEWA but is not fully insured or exempted by the secretary of labor, the Erlenborn-Burton Amendment permits a broader application of state law. In the case of non-exempt MEWAs, "any law of any state which regulates insurance may apply to the extent not inconsistent" with ERISA provisions.

Since ERISA's requirements for employee welfare benefit plans primarily involve reporting and disclosure standards, there would be few state insurance laws that would be inconsistent with ERISA. Consequently, nearly every state law regulating insurance could be applied to a non-exempt MEWA without violating the amendment's mandates.

Enactment of the Erlenborn-Burton Amendment in December 1982 represented a milestone in the ongoing ERISA pre-emption debate. The amendment was the first major congressional modification to section 514 of ERISA since its enactment in September 1974. After eight years' experience with the language, Congress apparently developed some doubt about the desirability of a broad pre-emption policy, at least with respect to METs.

The jurisdictional controversy surrounding self-funded METs previously centered on two specific legal issues: whether the MET entity was an employee welfare benefit plan within the meaning of ERISA and whether the activities of the MET constituted transacting the business of insurance.

Virtually every judicial ruling involving a self-funded MET has focused on the question of whether the MET satisfies the definitional elements of an employee welfare benefit plan pursuant to ERISA section 3(1). While no decisions can be found holding that a particular MET is an employee welfare benefit plan, the absence of detailed guidelines on what constitutes a welfare benefit plan continues to generate litigation over the status of particular METs.

Continued on page 40

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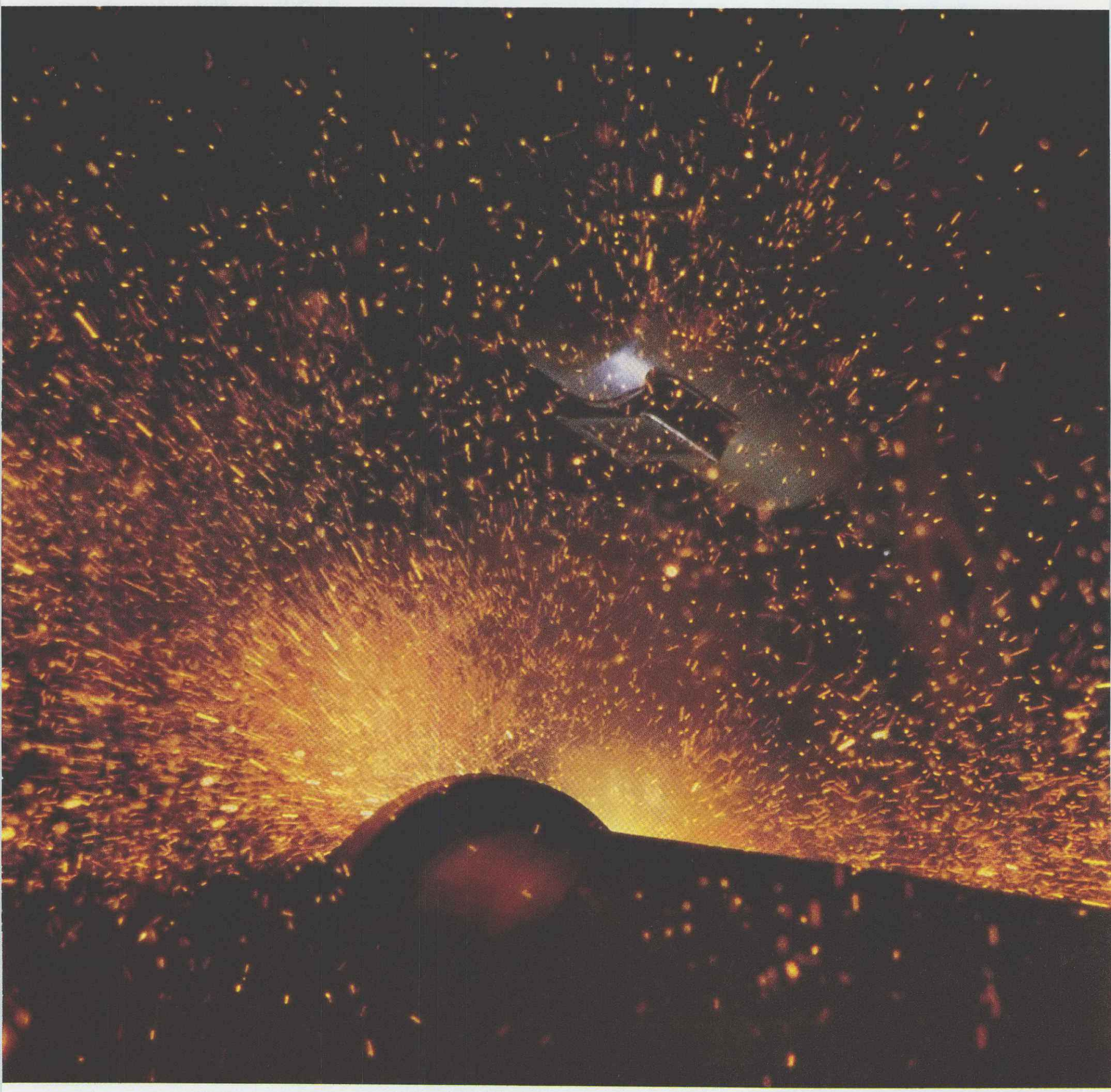

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perspective

THE SOMBER SIDE OF 83-3

IRS ruling may lessen the sheen of tax leveraging

By James E. Roberts

ALTHOUGH NOT DIRECTLY addressed to tax-leveraged employee death benefit plans, Internal Revenue Service Ruling 83-3 sets forth principles that would destroy the plans' tax leverage and, therefore, their attractiveness in the corporate marketplace if applied to them.

The ruling dealt with three facts in which income, properly excludable from gross income, was utilized to pay expenses that were otherwise properly deductible for federal income tax purposes. The ruling stated that expenses that were otherwise deductible, but were related to excludable income, were non-deductible pursuant to Section 265(1) of the Internal Revenue Code.

That section provides that "No deduction shall be allowed for. . .any amount otherwise allowable as a deduction which is allocable to. . .classes of income. . .exempt from taxes. . ." for federal income tax purposes. The regulations define income exempt from taxes as any class of income excluded from gross income under any provision of the federal tax law (Treasury Regulation 1.265-1(b)(1)(c)).

Obviously, life insurance proceeds excluded from gross income under section 101(a) would fall within that definition.

An example of the type of plan that could be affected by the ruling is found in Private Letter Ruling 7910064, issued Dec. 11, 1978. In that case, the employer maintained a "cost-plus" group term life insurance plan.

Under that plan, the employer would pay the insurer each month an amount equal to the actual claims paid the preceding month plus an administrative fee.

In addition, the employer purchased, and was the beneficiary of, ordinary life insurance contracts on the lives of its key executives. It intended to use the proceeds of the ordinary life policies to pay the insurance premiums due under the group term life insurance policy upon the deaths of its key employees.

Upon an employee's death, the employer would receive the proceeds from the ordinary life policy tax-free under section 101(a) and would deduct the amounts paid to the insurer under the group term life insurance plan as a result of the employee's death. Obviously, this would provide the employer with substantial tax leverage.

Although in 1978 the IRS approved of this taxing pattern under the principles set forth in Revenue Ruling 83-3, an employer sponsoring such a plan would not be able to deduct the amounts paid to the group insurer, which were related to the insurance proceeds under the ordinary life policy.

Another type of plan that could be affected by Revenue Ruling 83-3 involves tax-leveraged employee death benefit plans in which the employer promises to provide a death benefit to the employee's beneficiary upon the employee's death.

The employer's obligation under these plans is funded with life insurance owned by and made payable to the employer. Upon the employee's death, the employer receives the proceeds of the life insurance policy on the employee's life tax-free under section 101(a) and, as envisioned by such plans, deducts the amounts payable to the employee's beneficiary.

Because of the tax leverage of such plans, in other words, deducting amounts paid with amounts which were not includable in gross income, they are usually sold as a no-cost feature of such plans.

Prior to the issuance of Revenue Ruling 83-3, the IRS was reconsidering its position presented in the private letter ruling, as well as its position on cost-plus group term life insurance plans.

Currently, these issues are before the IRS Interpretive Division. In view of the position set forth in Revenue Ruling 83-3, one would expect the IRS to revoke private letter rulings issued in connection with such plans.

Because of the possible impact on tax-leveraged employee death benefit plans, employers maintaining or considering such plans, as well as companies marketing them, should carefully review the ruling and its authority. In addition, employers should be aware of the basis for the prior administrative position stated in the letter ruling 7910064 and be prepared to rebut the apparent change found in Revenue Ruling 83-3. ■

James E. Roberts is a partner in the law firm DeCarion, Roberts & Martin in Miami.

Amendment lets states regulate METs

Continued from page 38

Although the ambiguity surrounding the definition of an employee welfare benefit plan could be effectively addressed through regulations by the Department of Labor, it has so far shown no willingness to promulgate such regulations.

A close review of the text of the Erlenborn-Burton Amendment fails to reveal any clarification of the phrase employee welfare benefit plan. The phrase itself is used throughout the operative provisions of the amendment and is one of the distinguishing features between an exempt and a non-exempt MEWA.

Thus, rather than clarifying the definitional ambiguities of what constitutes an employee welfare benefit plan, the Erlenborn-Burton Amendment simply adds another layer of statutory interpretation to the MET jurisdictional controversy. Courts reviewing the amendment in litigation challenging the status of an MET entity under ERISA must still determine whether the entity meets the prerequisites of an employee welfare benefit plan under ERISA.

In this respect, the Erlenborn-Burton Amendment offers little assistance to states in their efforts to assert jurisdiction over MET entities.

Even though the amendment provides little guidance to the courts and state insurance departments in determining what is an employee welfare benefit plan, the language of the amendment nevertheless provides very practical assistance to states in asserting jurisdiction over self-funded METs.

Once it is established that an entity falls within the definition of a multiple employer welfare arrangement under section 302(a) of the amendment, state insurance departments should have little difficulty in obtaining preliminary jurisdictional authority from the federal courts.

Since even employee welfare benefit plans that meet the definition of a MEWA are subject to claim reserve and rating laws of state insurance codes, the argument of MET operators that state insurance laws are pre-empted by ERISA is no longer viable. Moreover, the burden of proving that an MET is a multiple employer welfare arrangement under the amendment is significantly easier than proving that an MET is not an employee welfare benefit plan.

Thus, the practical effect of the Erlenborn-Burton Amendment is to reduce the burden of proof of state insurance departments. Even though the issue of whether the MET is an employee welfare benefit plan must still be decided, its outcome will not prevent the states from asserting jurisdiction over a self-funded MET.

Having to meet a lower standard of proof in establishing the existence of a multiple employer welfare arrangement is not the only assistance offered to the states by the Erlenborn-Burton Amendment.

One of the major difficulties encountered by state insurance departments has been the problem of discovering the existence of self-funded MET before it is too late to take action. While the NAIC and individual states have urged Congress to redress this problem by enacting registration or prefiling requirements, no such provisions are contained in the amendment.

However, the amendment clearly implies that the states themselves may promulgate registration requirements for MEWAs. Such requirements would clearly be "provisions to enforce" claim reserve and rating standards that apply to MEWAs under the Erlenborn-Burton amendement. Thus, its language appears to authorize the states to require METs to register with the state insurance commissioner before conducting business. This authorization, more than any other amendment aspect, offers the greatest hope for financally resolving the MET problem.

The amendment's failure to refine standards for what constitutes an employee welfare benefit plan is its major shortcoming and reflective of a continuing lack of appreciation by Congress of the legal issues underlying the MET debate.

Nevertheless, taken as a whole, the amendment greatly improves the ability of state insurance departments to obtain preliminary authority over self-funded METs. More importantly, the amendment appears to offer states exactly what they requested as the best enforcement tool against illicit MET operations: pre-registration requirements. Armed with these regulatory weapons, states should be able to establish proper governmental controls over self-funded METs.

Accounting for retirement benefits

Continued from page 37

to the retired employee. All of this currently discourages group life prefunding.

Determining the accrual of the ultimate expense of a retired employee's health coverages is difficult as well. We cannot even be certain as to the level of benefits that will be provided to the retired employee. With the constant erosion of Medicare benefits, particularly in the deductible and coinsurance area, the benefit provided by the employer will vary.

This is because most retired health plans coordinate or supplement the medical benefits provided. Thus, we have uncertain benefits at the outset. In addition, the multiple caused by compounding the inflation rate at which medical care costs increase distorts projections.

Currently with our nation's economy at a 5% to 7% inflation rate and anticipated medical inflation at 18% to 20%, an attempt to project ultimate health plan costs and "save" for them can be financially prohibitive.

Certainly, the intent of the FASB was not to have a company curtail benefits. However, uncertainties in projections and the differential in the value of the dollar expensed today to the dollar expended in the future on a pay-as-you-go basis can differ so greatly that a corporation may have no alternative.

It is possible with both retired life and medical insurance to have an actuary forecast liabilities and expenses. Every company should investigate both the present and future costs using FASB criteria.

The FASB's preliminary views come at a difficult time. With current economic conditions, some corporations are struggling for survival. Continued existence depends upon the availability of capital and potential to borrow.

For these struggling corporations, the additional requirements imposed by a new FASB standard could make the difference in retirement plans. It may even mean altering or terminating a promised retirement benefit. Yet, if the company decides the future benefit must be ended, the employee becomes the ultimate loser. ■

The Perspective section is compiled and edited by Assistant Copy Editor Claudette Dampier. She can be reached at 312-649-5282.

FASB proposal could hike pension costs

Continued from page 33
Laing, assistant corporate comptroller.

Pension expense for the union plan was $4.9 million in 1982. Plan assets amount to about $110 million, while the actuarial value of accumulated benefits total about $107 million, Mr. Laing said.

Cummins' results would also vary widely depending on what sort of transition method is used. Under one set of circumstances, Cummins would post a $50 million net liability, offset with an intangible asset of $38 million for a net decline in shareholders' equity of about $12 million, Mr. Laing said.

In another case, a net liability of only $300,000 would be booked while the same $38 million intangible asset is recognized, resulting in a substantial increase in shareholders' equity, he said.

"We were dumbfounded by the range of numbers," Mr. Laing said. "Unless the board puts some limitation on (transition methods), there's going to be a lot of gamesmanship."

He added that he doesn't think the intangible asset constitutes any real enhancement of a balance sheet, and that the accounting rules proposed in Preliminary Views are not "very relevant or useful."

Kimberly-Clark Corp. of Neenah, Wis., tested two final-pay plans covering 22,500 hourly and salaried workers, active and retired, according to David W. Dusendschon, a staff vp. The plans generated expenses of $38.1 million for the year ended Jan. 1, 1982, and had assets of $387 million and accumulated benefits of $416 million, he said.

The transition approach the company chose would have left it with a net pension liability of more than $200 million last year, most of which would have been produced by the inclusion of future salary increases, Mr. Dusendschon said.

He expressed doubt as to whether future salaries qualify as true accounting liabilities which, by current definition, must result from "past transactions or events," and noted that final pay plans will bear an especially heavy burden if future salaries are including in the calculations.

"A company with a final pay plan is going to end up with a much larger net liability than the others do," even though it may be providing the same benefits, he said. "You could have companies that are identical (in other respects) and come out with wildly different pension liabilities."

He also added that the wide latitude granted in transition methods will "reduce the credibility of financial reporting," and that in cases where a particular transition method produces a smaller pension expense, some companies may end up underfunding their plans

FASB indicates that it isn't necessarily tied to either of the transition methods it has proposed. "It is not impossible that we would decide we should the same transition method (for all companies)," said FASB's Mr. Lucas.

Mr. Lucas added that if one transition method is chosen it would probably be the prospective method because it involves less administrative work for companies.

Mr. Flegm of General Motors gave no estimation of the impact of the proposed rules on his company other than to say the effects on the auto industry as a whole would be "quite dramatic."

GM's U.S. plan, a career average plan covering about 400,000 hourly and salaried workers, has accumulated vested and nonvested benefits of about $18 billion, and plan assets available for benefits of about $14.4 billion, Mr. Flegm said. Pension expense for the plan in 1982 was $1.6 billion.

GM objects to the accelerated amortization required under Preliminary Views as well as the inclusion of future salaries, he said. Pension plans are "executory contracts," in which each side has an obligation to the other, and liability for future services should arise only as the services are performed, he explained.

He also noted that the pension fund is an irrevocable trust to which GM has no access, and that it wouldn't be accurate to treat the trust fund assets as assets of the corporation. Both the net liability and the intangible asset generated under the proposed FASB rules would be "extremely soft," he said. ■

Firms could alter plans to lessen impact

By DOUGLAS McLEOD

NEW YORK—Employers could change their pension plans in several ways to mitigate the effects of pension accounting changes proposed by the Financial Accounting Standards Board, pension experts say.

But many companies report that they haven't even begun to think about making plan changes.

FASB, the rule-making body of the accounting profession, has proposed that for U.S.-based, single-employer, non-contributory defined benefit pension plans, unfunded liabilities—including liabilities for future salary increases—should be moved from the footnotes of a financial statement to the the balance sheet.

The proposals were published last November as "Preliminary Views on Employers' Accounting for Pensions and Other Postemployment Benefits." Similar views affecting defined contribution, multiemployer and foreign plans may follow.

FASB is now accepting comments on the Preliminary Views and on a discussion memorandum on the defined contribution, multiemployer and foreign plans and is expected to issue an exposure draft of final rules in 1984. A final Statement of Financial Accounting Standards is expected in 1985. Accountants and benefits consultants say that the proposed rules for defined benefit plans could produce major disruptions of corporate finances.

To minimize these effects, employers could change their benefit plans in a number of ways, notes Lawrence N. Margel, vp and chief actuary for consultant Towers, Perrin, Forster & Crosby in Washington.

Possible changes include:

- Eliminating the defined benefit plan altogether and switching to a defined contribution plan. However, the may not do much good if FASB applies similar accounting procedures to defined contribution plans at a later date.
- Switching from a final pay plan to a career average plan, where the impact of including future salary increases in calculating pension expense would be less severe. Benefits under a career average plan could be made equivalent to those for final pay if the plan is periodically updated to account for salary increases, Mr. Margel noted.

A danger of reduced benefits could exist in some cases, though, if a company either stops updating the plan or doesn't update frequently enough, he added.

- Amending a final pay plan so that salary increases after a certain date are not included in calculating pension expense. That date could then be pushed back periodically to allow for fresh salary increase projections to prevent a reduction of benefit levels.

For example, Mr. Margel said, a plan could be amended so that no salary increases after 1988 are considered for expensing purposes. Then, in 1987, the plan could be amended again so that no salary increases after 1992 are considered. Benefits are increased and the company has firmer control over the liabilities it would otherwise have under the proposed FASB rules.

Continued on page 43

Plan changes suggested

Continued from page 42

• Adopting a so-called "target" benefit plan, which looks like a final pay plan but is really a form of defined contribution plan, according to Mr. Margel.

Under a target plan, an employer would first project the working lifetime of an employee and his or her future earnings to arrive at a career-long lump sum pension benefit. The employer would then divide that lump sum by the number of working years the employee has left, and pay a flat amount into the pension fund for that employee each year.

"It's not as simple as that because you have to account for the (experience) gains and losses. But that can be done," Mr. Margel said.

Once again, the employer would have a greater degree of control over the liabilities that would otherwise be imposed by the FASB proposals.

One further option for employers would be to freeze further improvements of their defined benefit plans and move the savings into defined contribution plans, says Larry B. Wiltse, a consulting actuary with Buck Consultants Inc. in New York.

For example, instead of increasing a defined pension benefit from a "substandard" 1.25% of final pay to 1.5%, employers might freeze the final pay benefit at 1.25% and make the 0.25% difference an employer contribution to a defined contribution plan, Mr. Wiltse explained.

Some consultants say the FASB Preliminary Views by themselves will not prompt many companies to make any plan changes.

"I think the plans of sizable companies will be defined benefit for the foreseeable future," said Manuel Castells, a partner with consultant Kwasha-Lipton of Fort Lee, N.J.

But adoption of the Preliminary Views as an accounting standard may contribute to what other consultants say is an already-growing movement away from defined benefit plans, which are seen as increasingly burdened by regulatory and other problems.

"You take your choice as to which is the last straw," Mr. Margel said, suggesting that for some companies, adoption of the FASB proposals would be the last straw.

Still, the consultants say their clients have yet to examine plan changes. Most of the employers contacted by *Business Insurance* say it's still too early to think about changes, although some say that passage of the Preliminary Views might prompt them to change their minds.

"We're proceeding on the assumption that there will be substantial changes in the FASB Preliminary Views," said Con Noland, assistant comptroller for E.I. du Pont de Nemours & Co., Inc. Du Pont is not now considering any changes to the final pay plan covering 70,000 of its hourly and salaried employees, Mr. Noland said.

Honeywell, Inc., of Minneapolis, has not considered any changes to the final pay plan that covers 56,000 of its salaried employees. But adoption of the Preliminary Views might affect future plan improvements, according to Wendell G. Sprang, director of finance and accounting.

"Companies, unless they are sitting in a very good position, would be reluctant to take that additional liability," Mr. Sprang said.

One Northeastern manufacturing company has not considered plan changes, but only because other business has been more pressing, according to its pension manager, who asked that the company not be named.

One of the company's plans is a final pay plan covering 17,650 active, inactive and retired salaried employees, and accounting for two-thirds of the company's total pension assets of $165 million. The actuarial value of total accumulated benefits is $255 million, and the 1982 pension expense was $31.2 million.

The pension manager said adoption of the Preliminary Views would mean an increase of $126 million in the company's pension liability and a $1.5 million reduction in shareholders' equity, based on 1981 figures.

If this came to pass, the company would consider dropping the final pay plan, among other options, the pension manager said.

"Obviously, we would have to think hard about it if it became a done deal," he explained. ■

Retirement benefits changes could have significant impact

By DOUGLAS McLEOD

NEW YORK—Many companies may suddenly become aware of the high cost of providing certain retirement benefits if a proposed rule on accounting for the benefits becomes final, pension experts say.

Some corporate pension managers speculate that passage of the proposed rule could lead to reductions of retirement benefits now offered by companies.

The rule change, proposed by the Financial Accounting Standards Board, would require employers to accrue the costs of postemployment medical care and life insurance benefits over the working lives of the employees who will receive the benefits.

Most companies provide retirement life insurace benefits and the majority of the Fortune 1,000 companies provide retirement medical benefits.

Currently, most companies provide for these benefits on a "pay-as-you-go" basis, recognizing the costs only when the benefits are actually paid.

A smaller number of companies use the "terminal funding" method, under which companies start funding for the costs of an employee's postemployment benefits only after the employee has retired.

Under the proposals by FASB, the rule-making body of the accounting profession, these two methods would no longer be considered appropriate.

In a November 1982 publication, "Preliminary Views on Employers' Accounting for Pensions and Other Postemployment Benefits," FASB says that postemployment benefits constitute a form of deferred compensation and should be accounted for during the years employees provide services.

FASB would therefore require use of the "accrual" method, under which companies start recognizing the cost of the benefits immediately and continue accruing the costs over each employee's working lifetime based on actuarial estimates of what the ultimate value of the benefits will be.

The yearly cost of the benefits under the accrual method would have to be funded completely by the employer, or the difference would show up as a liability on the corporate balance sheet, notes Lawrence N. Margel, vp and chief actuary with consultant Towers, Perrin, Forster & Crosby in Washington, D.C.

"There's a huge liability there that's going to keep building up" if it's not funded, he said.

The yearly expense of postemployment medical benefits at the average company could actually equal the expense of the company's pension plan, he added. While pension benefits could cost between 4% and 8% of payroll, postemployment benefits could cost 6% of payroll if the company has been funding on a pay-as-you-go basis, he said.

"Relative to pensions, which everyone considers such an expensive animal, postemployment medical benefits are pretty close," he said.

"We're talking about big bucks," said Manuel Castells, a partner with consultant Kwasha Lipton in Fort Lee, N.J.

Mr. Castells estimated that for the typical company, the expense of postemployment benefits could total a third of pension expenses.

The problem of the high cost of postemployment benefits relative to pensions is aggravated by a number of factors.

One is the high rate of medical cost inflation compared with more broadly based inflation rates.

Another is the fact that while pension expenses are based in part on years of service, postemployment medical benefits are not: the same benefits are provided a retiree with five years of service as one with 30 years of service.

Thus, a company that hires a high proportion of older employees may have relatively low pension costs but relatively high postemployment benefit costs.

Since pension benefits have been accrued and funded over many years, pension funds have accumulated investment income to provide a further cushion against the impact of the pension's ultimate cost, Mr. Margel said. But since the majority of companies today do not accrue or fund postemployment benefits , no investment income is available to provide a similar cushion.

For all these reasons, the proposed FASB rule on postemployment benefits could have a proportionately greater impact than the proposal to move unfunded pension liabilities to the balance sheet.

"(Many companies) could be moving from a very, very small current cost to a significantly larger one," Mr. Margel said.

Employers' opinions on which accounting method is most appropriate for postemployment benefits appears to be divided, though many companies seem to oppose required use of the accrual method.

A 1981 survey of 428 companies conducted by the accounting firm of Coopers & Lybrand found that only 28% of those surveyed agreed that the accrual method should be required, while 43% disagreed. About 29% either didn't know, didn't answer the question or were neutral.

About 41% favored required use of the pay-as-you-go method, while 35% were against it and 24% didn't know, didn't answer or were neutral.

Only 3% of those surveyed favored required use of the terminal funding method.

Asked whether there should be a required method at all, 51% of those surveyed said there should not. About 24% said there should be some requirement, and 25% either didn't know, didn't answer or were neutral.

The majority of those surveyed —60%—were against including some measure of the present value of the postemployment benefits as a liability on the balance sheet. Only about 23% were in favor of including the liability.

Despite the favorable response of some companies to the accrual method, most do not really know what their liability would be if the FASB rule changes were to be finalized.

"Most companies don't have a feel for what these benefits are going to cost them," Mr. Margel said. "We have an obligation to wrestle with," said David W. Dusendschon, a staff vp with Kimberly-Clark Corp. of Neenah, Wis., which is on the pay-as-you-go method. He added, though, that since there are no prescribed formulas for figuring what the obligation would be, the company isn't sure how big a liability it is facing.

"The industry isn't aware of the tremendous liability" for postemployment benefits, which for many companies could be in excess of the liability for pensions, said Robert Orben, vp and comptroller for Cummins Engine Co. Inc. of Columbus, Ind.

Cummins hasn't measured what its liability might be.

"There are very significant problems in quantifying the amounts involved there," said Con Noland, assistant comptroller for E.I. du Pont de Nemours & Co. of Wilmington, Del., which also uses pay-as-you-go.

Mr. Noland added that postemployment benefits could suffer if companies are faced with increased liabilities in switching to the accrual method.

"There would be no liberalization of retirement benefits," he said. "Companies would back off of what they are already offering."

Many companies argue that since postemployment benefits do not represent as firm a commitment as pensions, they could curtail the benefits at any time and should, therefore, not be required to fund for them using an accrual method, Mr. Margel noted.

But cutting back the benefits may be easier said than done, he said.

"Morally, they may have problems, from an employee relations standpoint they may have problems and in cases of negotiated (union) contracts they may have problems," he explained. ■

CU promotes Anthony Brend to president

Anthony L. Brend has been named president of Commercial Union Insurance Cos. in Boston.

Mr. Brend, currently managing director of National Commercial Union Ltd. of Australia, will succeed **Howard H. Ward,** who has been elected chairman of the U.S. company. He is also the company's chief executive officer.

Mr. Ward

Mr. Ward replaces **Lawson L. Swearingen** who is retiring.

In December 1983, Mr. Ward will retire as chairman and chief executive officer of CU. He will be succeeded by Mr. Brend.

Also, **Kenneth J. Duffy** elected senior executive vp of Commercial Union in the United States. He had been a senior executive at Commercial Union Assurance P.L.C. in both the United States and Great Britain.

Commercial Union Assurance is the parent of both the U.S. and Australian operations.

Other insurer changes:

E.R. DeRosa, president and chief executive officer of Mission Insurance Group, will retire by Jan. 31, 1984, or earlier if a replacement is named. Mr. DeRosa has held both of the posts at Mission since 1964.

Michael I.D. Morrison named vice chairman of American Home Assurance Co. and AIG Energy Inc. in New York. Mr. Morrison is an AIG senior vp for domestic general insurance brokerage. He was previously president and chief operating officer of American Home. **Dennis A. Busti** succeeds Mr. Morrison as president of American Home. He was an executive vp of American Home and National Union. **Charles N. Force** also succeeds Mr. Morrison as president of AIG Energy. He had been an executive vp of AIG Energy. American Home, National Union and AIG Energy are all member companies of American International Group Inc.

Mr. Pasqualetto

John Pasqualetto joined Pacific Compensation Insurance Co. in San Francisco as executive vp. He is responsible for all division operations, office marketing, underwriting and loss-control functions in this newly created position. Mr. Pasqualetto was previously senior vp in charge of Western operations for Argonaut Insurance Co.

Richard B. Kushner named director of program development for Good Weather Inc., a rain and adverse weather insurer in Jericho, N.Y. Good Weather is a member company of American International Group Inc.

John J. Hoefs promoted senior vp of HMO Minnesota, an affiliate of Blue Cross & Blue Shield of Minnesota, in St. Paul. Mr. Hoefs had been vp at HMO Minnesota.

William Jenison elected vp of claims for Blue Cross & Blue Shield of Minnesota in St. Paul. He was most recently claims director at BC/BS of Minnesota.

Reinsurers

Michael J. Tyrell named director of the facultative property department of Prudential Reinsurance Co. in Newark, N.J. **Steven A. Mestman** replaces Mr. Tyrell as regional director of the New York facultative branch office of Prudential Re. Mr. Mestman had been facultative casualty director in the Newark, N.J., corporate headquarters.

Excess/surplus

Milton E. Fletcher and **James R. Graves** named vps in the marine/energy department of RISC Inc. in Houston. Mr. Fletcher previously was with Emett & Chandler as energy/marine manager. Mr. Graves had been assistant vp with Terramar Insurance Managers Inc. RISC Inc. was formerly known as Terramar Insurance Managers Inc. in Houston and Dub Martin & Co. in Dallas.

R.W. Winters joined Burt & Scheld Specialty Underwriters Inc. in Ormond Beach, Fla., as vp. Mr. Winters was previously a branch manager of American Excess Insurance Co. Burt & Scheld is a unit of the Ormond Reinsurance Corp.

Other suppliers

Robert R. Baker Jr. named managing vp of Benefacts Inc., the employee benefits communication unit of Alexander & Alexander, in Baltimore, Md. He was most recently a senior vp at Benefacts.

Ira L. Sharenow joined Pharmaceutical Card System Inc., in Phoenix, Ariz., as vp and general manager of Pharmaceutical Card's system product lines. He was formerly president of Health Care Resources, a physician and institutional supply company.

William E. Yanovitch joined Pilko & Associates Inc. in Houston as a consultant. He will consult on hazardous waste management, environmental risk assessment and community relations. Mr. Yanovitch previously was environmental supervisor for Allied Corp.'s Houston office.

J.M. Elwell promoted to Chicago office director for Toplis & Harding Inc. adjusters and surveyors. **D.H. Malvern** was named director of the Los Angeles office and **J. Roger Parry** was named vp in the Jacksonville, Fla., office.

Agents/brokers

James E. Stone named senior vp and national manager for employee benefits for Reed Stenhouse Inc., with responsibilities for directing the broker's nationwide employee benefits consulting efforts.

Mr. Stone previously was vp and manager for employee benefits for the Houston office of Reed Stenhouse.

Paul K. Zdon elected vp of Reed Stenhouse Inc. of Illinois in Chicago. He previously was an account executive in Reed Stenhouse's Chicago office.

Harvey Knoll appointed vp and manager of the property and casualty division of the Boise office of Fred S. James & Co. of Idaho. He previously was an account executive. ■

comings & goings: industry

datebook

JUNE 26-30. International Insurance seminar in Singapore, sponsored by International Insurance Seminars Inc.; $650. Dr. John S. Bickley, P.O. Box J, The University of Alabama, University, Ala. 35486; 212-570-2338.

JUNE 27-29. Safety for the Oilfield seminar in San Francisco, sponsored by the International Safety Academy; $395. ISA, 10575 Katy Freeway, P.O. Box 19600, Houston, Texas 77224; 713-932-9400.

JUNE 27-JULY 1. Occupational Safety Management course in Chicago, sponsored by the National Safety Council; $495 for members; $620 for non-members. Also **July 11-15** and **Sept. 13-17** in Chicago. NSC, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800, ext. 283.

JULY 11-15. Fundamental of Modern Safety Management course in Seattle, Wash., sponsored by the International Loss Control Institute; $625. ILCI, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

JULY 11-15. Total Loss-Control Management seminar in Houston, sponsored by the International Safety Academy; $585. ISA, 10575 Katy Freeway, P.O. Box 19600, Houston, Texas 77224; 713-932-9400

JULY 18-19. Computer Security workshop in New York, sponsored by the Computer Security Institute; $495. Computer Security Institute, Dept. IP, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

JULY 18-20. Safety for the Oilfield seminar in Houston, sponsored by the International Safety Academy; $395. ISA, 10575 Katy Freeway, P.O. Box 19600, Houston, Texas 77224; 713-932-9400.

JULY 18-22. Basic Safety Management seminar in Chicago, sponsored by the International Safety Academy; $570. ISA, 10575 Katy Freeway, P.O. Box 19600, Houston, Texas 77224; 713-932-9400.

JULY 18-22. Safety Training Methods course in Chicago, sponsored by the National Safety Council; $495 for members; $620 for non-members. Also **Sept. 20-24** in Chicago. NSC, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800, ext. 283.

JULY 18-22. Safety Evaluation for Single Location Personnel conference in Seattle. Wash., sponsored by the International Loss Control Institute; $625. ILCI, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

JULY 21-23. Labor-Management Trustees and Administrators institute in Toronto, sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

JULY 25-28. An Ergonomics Approach to Materials Handling seminar in Houston, sponsored by the International Safety Council; $575. ISA, 10575 Katy Freeway, P.O. Box 19600, Houston, Texas 77224; 713-932-9400.

JULY 27-29. Risk Management in Environmental Health & Protection summer institute in New York, sponsored by New York University; $400. Summer Institute in Risk Management in Environmental Health & Protection, Graduate School of Public Administration, New York University, 4 Washington Square N., New York, N.Y. 10003; 212-598-3133.

JULY 27-30. Corporate Benefits Management conference in Monterey, Calif., sponsored by the International Foundation of Employee Benefit Plans; $470 for members; $545 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

JULY 28-30. Florida Surplus Lines Assn. annual convention in Boca Raton, Fla.; $125 for members and associate members; $150 for non-members. Philip R. Cree, FSLA, Box 343800, Coral Gables, Fla. 33114; 305-448-2211.

AUG. 3-6. Public Employees conference in Seattle, sponsored by the International Foundation of Employee Benefit Plans; $390. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

AUG. 4-6. Public Sector Pension and Health and Welfare Benefit Plans conference in Seattle, Wash., sponsored by the International Foundation of Employee Benefit Plans; $390. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

AUG. 8-12. Basic Safety Management seminar in Houston, sponsored by the International Safety Academy; $570. ISA, 10575 Katy Freeway, P.O. Box 19600, Houston, Texas 77224; 713-932-9400.

AUG. 8-12. Loss Control Management course in Atlanta, sponsored by the International Loss Control Institute; $625. ILCI, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

AUG. 9-12. Employee Assistance Programming fifth biennial Canadian conference in Toronto, sponsored by Humber College; $100 per day or $235 for entire conference. Input '83 Headquarters, Professional and Management Development, Humber College, Box 1900, Rexdale, Ontario, Canada M9W 5L7; 416-675-7420.

AUG. 15-19. Professional Consulting in Safety and Loss Control course in Atlanta, sponsored by the International Loss Control Institute; $625. ILCI, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

SEPT. 11-14. Society of Chartered Property and Casualty Underwriters 39th annual meeting in New York; $225. Society of CPCU, Kahler Hall, Providence Road, CB #9, Malvern, Pa 19355; 215-648-0440.

SEPT. 12-14. Techniques of Risk Management conference in Chicago, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 21-23. Reinsurance Concepts conference in Chicago, sponsored by the Risk & Insurance Management Society; $445 for members; $545 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 21-24. International Benefits seminar in San Francisco, sponsored by the International Foundation of Employee Benefit Plans; $470 for members; $545 for non-members. IFEBP, Box 69, 18700 W. Bluemound Road, Brookfield, Wis. 53005; 414-786-6700.

SEPT. 25-28. International Assn. of Industrial Accident Boards & Commissions 69th annual convention in Atlanta, sponsored by the association; $160 for members; $220 for non-members. James C. Pullin, IAIABC Convention-83, c/o Georgia Workers Compensation Building, 100 S. Omni International, Atlanta, Ga. 30335; 404-656-2048.

SEPT. 25-29. National Association of Life Underwriters annual convention in Chicago, sponsored by the association; $125; $105 before Aug. 1. NALU Convention Registration, 1922 F St. N.W., Washington, D.C. 20006; 517-372-5148.

SEPT. 26-28. Valuation seminar in Long Grove, Ill., sponsored by the Kemper Group; $300. W.P. Thomas Jr., NID (HPR) A-1; Long Grove, Ill. 60049; 312-540-3380.

SEPT. 27-OCT. 1. Safety Management Techniques course in Chicago, sponsored by the National Safety Council; $545 for members; $680 for non-members. NSC, 444 N. Michigan Ave., Chicago, Ill. 60611; 312-527-4800, ext. 283.

SEPT. 29-OCT. 1. Sixteenth Annual Canadian Conference in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members; optional preconference programs offered at an additional charge. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

OCT. 3-5. Techniques of Loss Control conference in Chicago, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 3-7. Property Conservation course for property owners in Long Grove, Ill., sponsored by Kemper Group; $400. Also **Nov. 7-11** in Long Grove, Ill. W.P. Thomas Jr., (HPR), A-1, Long Grove, Ill. 60049; 312-540-3380.

OCT. 9-12. EDP Institute in Palm Springs, Calif., sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

OCT. 17-19. Fundamentals of Insurance conference in Toronto, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 17-21. Advanced Property Conservation course in Long Grove, Ill., sponsored by Kemper Group; $400. W.P. Thomas Jr., NID (HPR) A-1, Long Grove, Ill. 60049; 312-540-3380.

OCT. 23-26. Health Care Cost-Containment seminar in San Francisco, Calif., sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

OCT. 31-NOV. 1. Communicating Employee Benefits conference in Chicago, sponsored by *Business Insurance* $95; 10% discount for additional participants from the same company. Ann Vazquez, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

NOV. 11-16. Design for the Future 29th annual educational conference in New Orleans, sponsored by the International Foundation of Employee Benefit Plans; $450; $390 before Nov. 10; $130 extra for each preconference institute selected. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

NOV. 14-18. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $425. John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

NOV. 19-21. Fundamentals of Industrial Exhaust Ventilation course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; $350. John Garis, Manager, Industrial Hygiene, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

NOV. 27-30. Benefits Processing institute in Hollywood, Fla., sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

NOV. 28-DEC. 1. Hemispheric Insurance 19th biennial conference in San Francisco, sponsored by the International Insurance Advisory Council; $400 for delegates; $700 for observers. Gordon Cloney, International Insurance Advisory Council, U.S. Chamber of Commerce, 1615 H St. N.W., Washington, D.C. 20062; 202-463-5480. ■

It's now time to enter *BI* EBC competition

Redesigning a benefit plan can be a tough job. Not only are the benefits themselves changed, but employees must be given clear, detailed information on the new benefit programs.

Business Insurance wants to reward such efforts. Employee benefit managers and their staffs who took on that task in the past year—and those who did not change their plans but think they have top-notch employee benefit comunications—are invited to submit their communications programs to the annual *Business Insurance* Employee Benefits Communications Awards competition.

Entries for this year's contest are now being accepted. The entry deadline is June 30.

Various forms of communications can be submitted to the competition.

The benefits communications vehicles are divided into five categories: Booklets, personalized correspondence, audiovisual presentation, special projects and total communication program.

Companies may enter materials in more than one category.

The entries are judged by a panel consisting of corporate communications, advertising, graphic arts and benefit communication professionals and executives.

First-, second- and third-place awards are presented in each of the five categories.

The conference recognizes the excellence of the benefits communication effort itself, not the benefits involved.

Competition winners will receive their awards at the *Business Insurance* Communicating Employee Benefits Conference at the Knickerbocker Hotel in Chicago Oct. 31 and Nov. 1. The award-winning communications programs will be on display at the conference.

Besides the awards presentation, the conference offers sessions and workshops to give participants the chance to learn about new developments and designs for effective, timely communications of employee benefits.

Business Insurance will offer reduced hotel and airline rates to conference registration.

The registration fee for the conference is $495, with a 10% discount offered to the second participant from the same company.

A variety of companies earned recognition for their communications in the 1982 contest (*BI*, Nov. 15, 1982).

The Aluminum Co. of America in Pittsburgh won the first place award in the total program category for its total compensation communication program. Alcoa's consultant on the award-winning package was Hewitt Associates.

Borg-Warner Corp. in Chicago won first place for its pre-retirement program in the special projects category. Frame One Inc. and Meidinger Inc. helped put the presentation together.

Boise Cascade Corp. in Boise, Idaho, took first place in the booklets category.

Taking first place for personal correspondence was Equibank of Pittsburgh. Towers, Perrin, Forster & Crosby was Equibank's consultant on the project.

In the audiovisual category, Loews Corp., along with its consultant, Hewitt Associates, won first place for its audiovisual program on flexible benefits.

The second place winners were: Johnson Controls in Milwaukee for total programs; Canterra Energy Ltd., in Calgary, Alberta, for special projects; Smith Barney, Harris, Upham & Co. Inc. in New York for booklets; Texas Utilities Services Inc. in Dallas for personalized correspondence; and General Host Corp. in Stamford, Conn., for audiovisual presentations.

The companies awarded third-place awards were: Jockey International in Kenosha, Wis., for total programs; Bissell Inc. in Grand Rapids, Mich., for special projects; Interlake Inc. in Oak Brook, Ill., for booklets; Morgan Stanley & Co. in New York for correspondence; and Aluminum Co. of America in Pittsburgh, audiovisual presentations.

To obtain contest rules and entry forms contact Ann Vazquez, Communications Services Department, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137. She also will provide conference registration information. ■

Sedgwick forms Dallas commercial brokerage

Sedgwick Group P.L.C., Britain's largest insurance brokerage company, is opening a Dallas-based wholesale brokerage to be called MacLean, Oddy & Associates Inc.

The wholesale brokerage will be headed by Roy B. Oddy, who recently resigned as president of Swett & Crawford, the surplus lines brokerage unit of Continental Corp. that was ranked last year by *Business Insurance* as the third-largest excess/surplus lines marketer in the nation.

Mr. Oddy also served as president of the National Assn. of Professional Surplus Lines Offices.

The new Sedgwick unit will "provide insurance services to retail brokers and agencies in the U.S.," said Reg Bowers, chairman of Sedgwick North America Ltd.

"We're delighted to have Roy. He fits the Sedgwick mold," Mr. Bowers said.

markets

Reorganization

AIG Entertainment Risks Inc., the year-old managing general agency of American International Group Inc. specializing in entertainment risks, has been reorganized under Joseph P. DeAlessandro as president.

"We are now going out to solicit all phases of entertainment insurance business," says Mr. DeAlessandro, who is based in AIG's New York headquarters. AIG Entertainment is interested in insuring "motion pictures, stage, cable, video, special events types of coverage, including weather insurance (and will consider rain insurance on outdoor events), concerts—indoors and outdoors, circuses, tent shows."

AIG Entertainment can offer an international package of coverage, using AIG insurance companies American Home Assurance Co., National Union Fire Insurance Co. of Pittsburgh, Pa., and American International Underwriters. Mr. DeAlessandro also is president of National Union.

AIG Entertainment has written more than $2 million in premiums so far in 1983, compared with $2.7 million in all of 1981. Among the risks it has written are this year's Academy Awards presentation and the Broadway musical hit "Cats."

MGA formed

A new managing general agency, Southern Underwriting Managers Inc., has been formed to offer underwriting management services for specialty insurance programs. The firm's home offices are at 2415 Ave. J, Suite 100, P.O. Box 5284, Arlington, Texas; 817-640-9901.

A branch office, Southern Underwriting Managers of Florida Inc., is located at Interstate Plaza, Suite 100, 1499 W. Palmetto Park Road, P.O. Box 3015, Boca Raton, Fla. 33431; 305-363-1144.

Bermuda opening

Cologne Reinsurance of West Germany is opening an office in Bermuda in July. The company plans to use its 2-year-old Bermuda subsidiary, Colonial Reinsurance Co. (Bermuda) Ltd., which has been managed by Trenwick Ltd.

Cologne Reinsurance has recruited former Walton Insurance Ltd. underwriting manager Graham Puta, who has been appointed vp. Mr. Puta lost his job at Walton when Walton's owner, Phillip's Petroleum, decided Walton should stop underwriting unrelated risks and run off its international reinsurance business (*BI*, April 25).

Acquisitions

Monumental Corp., the holding company for **Monumental Life Insurance Co.**, has agreed to acquire **First Federated Life Insurance Co.** of Baltimore for $18.8 million. The acquisition must receive regulatory approval.

The Statesman Group Inc., a financial services holding company based in Des Moines, Iowa, has acquired two Iowa insurance agencies. They are **Grodt-Moore-Gregson Insurance** and **Grodt Moore Life Inc.**

New offices

Tillinghast, Nelson & Warren Inc. is moving its St. Louis office to 34 N. Meramec St., St. Louis, Mo. 63105. The telephone number remains 314-862-7611.

Hunter & Associates of Louisiana, a specialty risk underwriting manager, has opened new offices at 201 Evans Road, Suite 103, Harahan, La., 70123.

Health Corp. of America, an administrator of self-funded employee benefit plans, has moved to new quarters at 650 E. Swedesford Ave., Wayne, Pa. 19087. The telephone number remains 215-687-8680.

Orion Group Inc., underwriting managers for EBI Cos. and Security Insurance Group, has opened new offices at 2621 E. Camelback Road, Suite D 128, Phoenix, Ariz. 85016. ■

PAYSOPs attract interest: Survey

NEW YORK—Payroll-Based Stock Ownership Plans are catching the interest of many companies, even though the plans got off to a slow start when they were created in 1981, according to a consultant study.

By the end of 1983, 60% of the 268 large companies surveyed expect to have a PAYSOP in place, according to a study from benefit consultant Towers, Perrin, Forster & Crosby.

PAYSOPs, which were created by the Economic Recovery Tax Act, enable a company to establish a tax-qualified plan investing in its own securities. The plan is paid for through a payroll-based tax credit and employees can participate in ownership of the company.

The PAYSOP tax credit can equal as much as 0.5% of an eligible employee's pay in 1983 and 1984. This will rise to 0.75% in 1985. Using these credits, a company can reduce its federal tax liability.

Of the companies that expect to start a PAYSOP, nearly 75% have determined how they will allocate the tax credit among eligible employees:

- Sixty-five percent will distribute it according to an employee's pay, up to $100,000, the maximum allowed by law.
- Eight percent will allocate it according to an employee's pay up to a stated amount lower than the $100,000 limit.
- Twenty-seven percent will allocate it in equal dollar amounts to all employees. ■

Canadians have two health benefit sources

LINCOLNSHIRE, Ill.—Canada's provincial health insurance programs aren't the only plans providing health care benefits to employees.

A survey of 110 major Canadian companies by Hewitt Associates, a Lincolnshire, Ill., consulting firm, found that all of the employers provide supplemental health care benefits to salaried employees.

For example, 95% of surveyed Canadian employers, mainly companies based in Ontario, offer a dental insurance plan. By contrast, 89% of American companies offer dental plans, according to a similar survey Hewitt conducted among U.S. firms (*BI*, May 9).

Furthermore, U.S. employers are much more likely to require their salaried employees to pick up at least some of the dental insurance premium than their Canadian counterparts. While 34% of U.S. companies with dental plans require employee premium contributions, only 17% of Canadian companies require salaried employees to pay part of the premium, according to the survey.

All of the surveyed companies provide coverage for semiprivate or private room hospital charges above ward rates.

Because the provincial government's health care plans provide basic benefits, deductibles for supplemental benefits offered by employers, like private room care, are low. Some 95% of the surveyed plans impose deductibles of $25 or less. In the United States, many large companies require their employees to pay at least the first $100 of health care costs.

Some 77% of the Canadian employers surveyed pay all premium costs for supplemental health care benefits for employees. In the United States, 39% of companies pay all premium costs for medical and hospital care for salaried employees.

Other popular benefits offered by Canadian companies include prescription drug coverage, provided by 100% of the surveyed firms; vision care, offered by 28%; and hearing care, 25%.

Pension plans also have become almost universal among major Canadian employers, with 95% of the surveyed companies reporting that they offer a plan to their salaried employees.

Some 64% of the plans require an employee to work for 10 years before he is entitled to a pension, while 6% of the plans offer 100% vesting after five years of service. Some 13% of plans provide 100% vesting after an employee turns 45 and has 10 years' service.

Some 63% of Canadian companies offer pension plans in which the benefit is based on average salary over the last five years of employment. Some 20% of plans base benefits on average salary over the final three years of employment.

By contrast, Hewitt Associates found that 76% of U.S. companies based pension benefits on the final five years of salary, while 10% based benefits on the last three years of salary.

In addition, 49% of the surveyed Canadian companies recognize bonuses when computing an employee's retirement benefit, compared with 50% in the states.

Some 11% of the surveyed Canadian companies allow an employee with 30 years of service to retire at age 55, while 21% allow 30-year veterans to retire at 60 and 30% at 62. Some 34% of the surveyed companies require employees with 30 years of service to stay on the job until 65 before they can retire with a full benefit.

Canadian employees, though, are much more likely to pay for at least part of the cost of their pension benefit than their U.S. counterparts. For example, 31% of the Canadian companies require employee contributions to their pension programs, compared with 15% of the surveyed U.S. companies.

Furthermore, Canadian companies are much less likely to offer capital accumulation plans, like thrift or savings plans.

About 44% of Canadian companies offer thrift/savings plans to their salaried employees, compared with 76% of U.S. companies.

About half of the surveyed Canadian companies don't offer any kind of capital accumulation plan; just 5% of major U.S. companies don't provide a capital accumulation plan to salaried employees.

Life insurance benefits provided by Canadian and American companies are comparable. A majority of Canadian and U.S. companies provide life insurance for salaried employees that equal between 2 and 3.9 times annual salary.

Long-term disability benefit programs also are similar. For example, 46% of Canadian companies require employees to pay at least some of the LTD premium, compared with 44% of U.S. companies.

LTD plans offered by major Canadian and U.S. employers typically are designed to replace between 60% and 64% of an injured or disabled employee's salary. Some 13% of Canadian companies offer LTD plans that replace at least 70% of an employee's salary, compared with only 5% of U.S. firms.

Of the Canadian companies, 96% pay LTD benefits until a sick or disabled employee reaches age 65; the remaining 4% pay benefits until the employee dies.

In the United States, 88% of companies offer LTD benefits to employees until age 65, while the remaining 12% have a varied schedules.

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Copies of "Salaried Employee Benefits Provided by Major Canadian Employers" are available from Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60015; 312-295-5000. The cost is $25 per copy.

Rep. Erlenborn will try again for public pension plan reform

By JERRY GEISEL

washington

WASHINGTON—Rep. John Erlenborn, R-Ill., wants to make another attempt at public pension plan reform.

Mr. Erlenborn, Congress's top pension expert, says he soon will introduce legislation that would set federal reporting, disclosure and fiduciary standards for the nation's 7,000 state and local government pension plans.

"I firmly believe that it is the primary responsibility of state and local governments to set their own houses in order in the area of public pensions," Rep. Erlenborn said before the Washington Legislative Update conference sponsored by the International Foundation of Employee Benefit Plans.

Under the Public Employee Pension Plan Reporting and Accountability Act, or PEPRA, public plans would have to disclose their unfunded liabilities.

Plan participants would have to be supplied with a description of plan provisions and, upon request, other information on benefits and vesting.

Taxpayers, plan participants and other interested parties would have to be given access to financial statements, plan asset holdings and other plan documents.

The federal reporting and disclosure standards would not apply to plans in states where the governor certifies that state law contains substantially equivalent provisions.

However, unlike the Employee Retirement Income Security Act, the 1974 federal law governing private pension plans, PEPRA would not set funding, vesting or participation standards for public plans.

Mr. Erlenborn believes such requirements probably would be unconstitutional.

A similar bill previously introduced by Rep. Erlenborn died on the House floor last year.

Retiree taxes

Sen. Alfonse D'Amato, R-N.Y., wants to repeal a new requirement that interest from tax-exempt bonds should be included in calculating whether retirees have enough income to be taxed on their Social Security benefits.

Under the Social Security reform legislation signed last month by President Reagan, individuals whose adjusted gross income exceeds $25,000 and couples whose adjusted gross incomes exceed $32,000 will be taxed on 50% of Social Security benefits received (*BI*, April 4). The tax would go into effect for the 1984 tax year.

Income from tax-exempt bonds would be included in determining whether a retiree is over the tax threshold.

But Sen. D'Amato says the provision will discourage retirees from investing in tax-exempt state and municipal bonds.

"This amounts to a tax on tax-exempt income," Sen. D'Amato said. "As it stands now, there exists a tremendous incentive for the middle class to sell their municipal or state bonds and buy higher yielding taxable securities," he added.

His proposal, S. 1113, would allow retirees to exclude interest from tax-exempt bonds in calculating their adjusted gross income from Social Security benefit purposes.

Trucking coverage

The Department of Transportation plans to issue final regulations soon to implement a congressionally ordered delay in the effective date of higher liability insurance requirements for truckers.

Congress, on the last day of last year's session, agreed to delay to Jan. 1, 1985, the higher insurance limits for motor carriers that were to go into effect July 1 (*BI*, Jan. 3).

That 18-month reprieve delays the second stage of insurance requirements in the Motor Carrier Act of 1980.

Under that federal law, which deregulated the trucking industry, motor carriers that haul non-hazardous cargoes, like furniture, and hazardous cargo had to have $500,000 of liability insurance by July 1, 1981, and carriers of very hazardous cargo, like liquified compressed gas, had to have $1 million in insurance.

Then by July 1 of this year, carriers of non-hazardous cargo were to have $750,000 in coverage, carriers of hazardous substances were to buy $1 million and carriers of very hazardous substances were to have $5 million.

PBGC penalty

The Pension Benefit Guaranty Corp. on July 1 will lower to 11% from 16% the interest rate the agency charges employers who don't pay their termination insurance premiums on time.

The PBGC is required by law to charge interest on unpaid premiums at the interest rate set by the Internal Revenue Service.

The Tax Equity and Fiscal Responsibility Act of 1982 requires that the IRS interest rate be adjusted semi-annually based on the average prime rate during that period. Accordingly, the IRS recently announced that the interest rate for the period July 1-Dec. 1, 1983, will be 11%.

Currently, employers with pension plans pay the PBGC an annual premium of $2.60 per plan participant. However, Congress is now considering legislation, S. 1227, introduced by Sen. Don Nickles, R-Okla., chairman of the Senate Labor subcommittee, that would raise the annual premium to $6.

More premium revenue is needed to help pay off the PBGC's growing deficit, which now exceeds $300 million.

Tort reform hearings

It still isn't clear whether the Senate Commerce Consumer subcommittee will hold another day of hearings on federal product liability legislation, S. 44, introduced by Sen Robert Kasten, R-Wis.

Two hearings have been held on the bill this year to give backers and opponents an opportunity to discuss the measure. But some members of the Commerce Committee say a third hearing is needed to give accident victims a chance to discuss the measure, according to sources.

The Kasten bill would pre-empt state product liability laws with a uniform federal law. Many business groups and insurers say a federal law is needed to reduce legal uncertainties, a factor in high product liability insurance rates.

But legal, labor and consumer groups say the Kasten measure will take away the rights of accident victims. The bill, among other things, would bar product liability suits involving capital goods products that are more than 25 years old.

There are also doubts about the bill within the Reagan administration. Some members of the White House policy staff, for example, are skeptical about the need for a federal law in an area that traditionally has been handled at the state level, according to Commerce Department internal memos (*BI*, May 23).

Social Security taxes

Social Security taxes may have to be increased 200% to 300% from current levels to prevent the program from going broke, the system's former chief actuary says.

Future scheduled increases that will gradually raise the FICA tax to 7.65% from 6.7% by 1990 "will be grossly inadequate to sustain the system in the long run," according to A. Haeworth Robertson. The FICA tax rate may exceed 14% after the turn of the century, he says.

Mr. Robertson, now a managing director in the Washington office of William M. Mercer Inc., a benefit consulting firm, says the present Social Security system is not financially viable.

"We have promised more than we will be able to deliver. Anyone who thinks there are no significant financial problems ahead...is engaging in wishful thinking and has a very dangerous false sense of security," he said.

These looming tax increases, needed to pay benefits to a rapidly expanded pool of retirees, may erode support for the program from the working population, Mr. Robertson says. ■

British candidates buy election coverage

By STACY SHAPIRO

LONDON—Now that the British general election campaign is in full swing, some politicians are purchasing insurance to protect themselves against being wrongly accused of violating election laws.

They are buying a new legal expense insurance policy that covers candidates and their campaign workers for up to 50,000 pounds (about $77,950) in defense costs if they are wrongly brought before the election court.

The election policy costs only 55 pounds (about $86) for up to 24 months of coverage.

The policy, underwritten by Lloyd's of London through broker Sedgwick Associated Risks Ltd., has been endorsed by the ruling Conservative Party and the Social Democratic Party. The Liberals and the Labor Party have not yet endorsed the coverage.

In Britain, a candidate and his or her campaign organization must abide by the strict election rules contained in a law passed by Parliament earlier this year. Candidates are limited in how much they can spend, they must follow a code of conduct and must abide by rules that restrict how a campaign can be run.

An opponent or any voter can bring a candidate before a special election court if the candidate is alleged to have broken the British election law.

If a candidate realizes he has broken the law after an infringement, he can apply for a waiver from the election court.

"Our policy covers that candidate (and his supporters) if he inadvertently overspends on the election budget or he made another mistake and has to go to court," a Sedgwick spokesman explained.

The policy will reimburse the candidate for legal expense only if he is found innocent. "If he is guilty of clear, intentional misconduct or criminal activity, we will not pay," the spokesman said.

"But the rules are so tight that the size of his billboards or the cost of printing posters can be challenged even if he is innocent," he added.

The insurance fills a need since the legal costs of defending oneself before an election court can be high. During a recent local election, a Liberal Party candidate was accused of 15 violations by his Conservative opponent. The Liberal candidate had only exceeded the allowable budget by less than a pound, but his defense costs totaled more than 50,000 pounds.

It is very unusual, however, for a candidate in a general parliamentary election, like the one to be held June 9, to be accused of a violation. "It has not happened since 1952," the Sedgwick spokesman said.

Shergar claims

Lloyd's of London underwriters are telling the owners of Shergar, the prized breeding stallion that was kidnapped from an Irish horse farm in February, that claims must be filed soon.

The bloodstock insurance covering the thoroughbred, valued at $18 million, contains a clause that claims must be filed within 90 days of the horse's disappearance.

"Since the horse has not reappeared, those people with insurance have been advised to present claims to their insurers," said Roger Barklam, managing director of Hughes Gibb & Co. Ltd., the Lloyd's broker that placed the coverage. "People are now presenting claims."

However, underwriters are not currently paying those claims in hopes that Shergar will be returned by his abductors. Mr. Barklam said he did not know when claims would be paid.

It is also unlikely that the stallion's full value will be recovered if he is not returned since only some of the bloodstock insurance purchased by members of the syndicate that owns the horse contained theft coverage (*BI*, Feb. 14).

london line

Sasse liabilities

The Corp. of Lloyd's still has liabilities of more than 8.7 million pounds from the defunct Sasse Syndicate, according to Lloyd's 1982-83 annual report.

It's not known if this figure includes the recent out-of-court settlement of litigation among Lloyd's, former members of the syndicate, syndicate member Sasse & Turnbull Ltd. and Lloyd's broker Brentnall Beard International Ltd. (*BI*, May 9). The details of that settlement have not been released, but Lloyd's Chairman Peter Green says he will explain the settlement at Lloyd's annual general meeting on June 22.

No matter what is announced, it is unlikely that Lloyd's members will be asked to foot any more of the bill from the syndicate's collapse, sources at Lloyd's say, because reinsurance and contribution already made by the membership will probably cover the loss.

The Sasse syndicate was forced to close in 1978 by Lloyd's after an avalanche of claims, far exceeding premiums, poured into the syndicate from substandard New York property risks it underwrote in 1976 (*BI*, Feb. 6, 1978).

In 1980, Lloyd's agreed to indemnify 1,100 Sasse names for some of the $41 million in claims they had to pay. Lloyd's entire membership was then asked to foot the bill through annual contributions.

Policy cancellation

An insurance buyer is bound to an insurance contract in Britain as soon as it is signed by the underwriter accepting the risk, the Court of Appeal ruled recently.

The policyholder cannot cancel the underwriting contract once underwriters sign the slip binding them to the insurance, the court ruled.

The court overturned a 1981 Commercial Court decision that said the option existed—as custom or practice in both the London company market and at Lloyd's—to cancel contracts even after they are signed.

The case heard by the Court of Appeal—General Reinsurance Corp. vs. Forsakringsaktiebolaget Fennia Patria, an insurer based in Helsinki, Finland—concerned reinsurance for a major fire loss in Antwerp, Belgium.

The court ruled that the Finnish underwriter's purported cancellation of a retrospective amendment slip for reinsurance by General Re was invalid. ■

Buyers to face rate hikes soon, reinsurers predict

By STACY SHAPIRO

HARROGATE, England—Insurance buyers will probably pay more for their insurance during 1984 renewals, members of the Reinsurance Offices Assn. predict.

For example, Lloyd's of London underwriters will probably charge higher premiums to cover increased expenses triggered by the new accounting procedures they will have to abide by, says R.J. Kiln of the Lloyd's underwriting agency of R.J. Kiln & Co. Ltd.

"Lloyd's is facing an explosion in the expense cost field," Mr. Kiln said at the ROA's conference last month.

"Lloyd's will find it difficult to compete with other insurers because its expense ratios to follow regulations will pull them down."

Other insurers, though, will also seek higher premium rates because reinsurance capacity is tightening, forcing them to reduce the amount of risk they cede to other underwriters.

"The insurance buyer does not like to hear that, to a large extent, he will pay more," said Dr. Walter Diehl, chairman of Swiss Reinsurance Co. in Zurich.

"He (the buyer) will not be able to avoid an increase because he has not paid enough before," Dr. Diehl said.

Since the 1970s, he explained, insurance companies have been able to rely on an enormous reinsurance capacity to fund risk. The more risk the underwriters could cheaply cede to reinsurers, the more cheaply they could write increased amounts of direct business.


Dr. Diehl

However, the word "overcapacity" is becoming a thing of the past, conference participants said.

Many reinsurers are refusing to underwrite some risks at what they consider to be inadequate rates in light of dwindling—or sometimes non-existent—profits.

"We must communicate the problem and make it clear to the markets what is going on every day," said H.K. Jannott, chairman of the board of management at Munich Reinsurance Co. "We must try not to underwrite business which is not technically sound.

"The main thing is to get the right net premium to cover the risk. But, the direct insurer deals with the (buyer) and it is up to them to put their house in order. The reinsurer has no direct (contact) with the client."

The overall mood of this year's ROA conference, which attracted about 300 people, was gloomier than last year's. In the past 12 months, reinsurers have been struggling to stay in the black amid mounting loss ratios and declining investment yields.

Also, the industry in some cases has been stuck with unpaid claims after reinsurers became insolvent or refused to pay claims because of problems with intermediaries.

In fact, the reinsurers admitted, one of the market's greatest concerns is whether reinsurers will still be around to pay claims if a disaster strikes.

"How are we risk managers supposed to know about reinsurance?"

> 'The insurance buyer does not like to hear that he will pay more,' says Swiss Re's Dr. Diehl.

asked Hugh Loader, chairman of the Assn. of Insurance & Risk Managers in Industry & Commerce, who represented insurance buyers at the reinsurance conference.

"Security is one of the main things that concerns us as direct buyers," Mr. Loader explained.

"The direct insurance market is alleged to stay soft, but these people at this conference will decide when the market turns. This is where the market is going to start hardening," he said.

The market probably has begun to turn, reinsurers at the conference said. They have already taken action to improve their security and, in the process, increased their rates.

Reinsurers in the London market have already decided they are losing money on reinsurance treaties and have reduced the amount of a risk they will accept (*BI*, March 21).


Mr. Loader

The conference held by the ROA, a group whose goal is cooperation among reinsurers, attracted representatives of reinsurance companies from all over the world. But despite their diverse backgrounds, most of the conference participants had the same thing in mind.

The talk over tea, at the formal conference dinners and in the cocktail lounges was about how reinsurers are refusing to underwrite many risks because rates are inadequate.

"I am afraid that we will go back to our desks after the conference, though, and we will accept commercially unsound business," one reinsurer told Munich Re's Mr. Jannott.

"Isn't it about time we said no more often?"

"Indeed, this is the center point of our problem," Mr. Jannott responded. "I would very much recommend (you) use the word 'no' more often, but also bring things forward in a positive sense.

"Explain to clients why we will not accept proposals, but (say) that under different conditions we would accept them—that is the right direction," he told the reinsurer.

Unfortunately, many reinsurers will not take these positive steps until they lose a lot of money, said Mr. Kiln, the Lloyd's of London underwriter.

"Things never get better until enough people get the boot," he explained. "But, we are seeing a toughening for the first time. For the first time in 1983, a lot of people did say no."

Many companies are still trying to offer competitive rates for the business they already have, but now is the time to give up that business if it means losing money, Mr. Kiln said.

"Management must decide to not accept business," he explained. ■

U.S. reinsurers cut capacity: Bunaes

HARROGATE, England—The U.S. reinsurance market will probably tighten by the end of this year, predicts the head of a large U.S. reinsurer.

Rising underwriting losses and concerns about reinsurer solvency will force U.S. reinsurers to limit the amount they underwrite and hike their rates, says B.E. Bunaes, chairman, president and chief executive officer of Constitution Reinsurance Co., a unit of Crum & Forster Inc.

Some reinsurers have watched their combined ratios climb as high as 117%, he noted, while interest rates continue to drop, reducing investment income.

"There has been one insolvency every month, reducing reinsurance capacity around the world, and if one fails, how many collapses will there be before it affects us all?" Mr. Bunaes asked at the Reinsurance Offices Assn. conference last month.

U.S. regulators are now cracking down on the security of insurance and reinsurance companies following the insolvency of Kenilworth Insurance Co. and others, he said (*BI*, May 23).

Mr. Bunaes

"We have reached a turning point in the cycle," Mr. Bunaes told the conference. "Now let's make sure that when we see a light at the end of the tunnel it is not a train coming at us 60 miles per hour."

If the market does begin to turn, there is at least one way for risk managers to combat increased premium rates, Mr. Bunaes pointed out. Some American facultative reinsurers will deal directly with risk managers at large companies. A licensed insurer can front the primary layer of the coverage and the reinsurer can accept the rest of the risk.

"While this does not automatically result in a lower premium level, it is quite doubtful that it results in a higher level," said Mr. Bunaes.

This may be one of the few techniques left for the risk manager, however, to hedge increased premiums by the end of the year, he said.

Already, American reinsurers are turning away business because it is no longer profitable to underwrite at bargain-basement rates and would only further increase the underwriters' already too-high loss ratios.

Constitution Re, for instance, cancelled $40 million of its reinsurance portfolio in the past six months because the business was "inadequately rated," Mr. Bunaes said. The company only regained $15 million of that business when the treaties were renegotiated, he said.

"But the time has come in this cycle to lose 25% to 30% of the business in order to sanitize the market," he explained.

Virtualy all U.S. insurers are now worried about their reinsurance security, forcing many U.S. regulators to closely monitor reinsurers' solvency and propose new regulations limiting the use of reinsurance.

"At the least, this trend will have a marked impact on the level of control of the reinsurance premium leaving the United States. Further consequences can only be guessed at. Over time, there could be a major reduction in the outflow of business from the United States," he said.

Some foreign reinsurers believe that standardized regulations and policy forms would help increase security and reduce the amount of mavericks in the reinsurance market today, but Mr. Bunaes disagrees.

"No regulation will ever be able to control the international reinsurance business if it is not strictly or expertly enforced, or if the players dedicate themselves to finding ways to circumvent the regulation," he said.

"POSA and Kenilworth could be repeated with different players, long before the authorities would become aware of and be able to enforce the regulation."

Mr. Bunaes said that a turn in the market and increased regulation could put the U.S. reinsurance industry in a stronger position worldwide.

The U.S. reinsurance market is growing faster than any other in the world, he pointed out, explaining there are now 125 U.S. reinsurers, compared with only 60 in 1975.

In 1981, he added, U.S. domestic reinsurers captured $7 billion of the $10 billion in reinsurance premiums that originated in the United States.

Mr. Bunaes also pointed out that U.S. reinsurance companies are starting to become part of larger organizations, which gives them added financial stability. For example, Constitution Re's parent, Crum & Forster, was recently acquired by Xerox Corp.

"This is certainly good, though very painful," said Mr. Bunaes. "The move leads to better management, underwriting and overall control." ■

Japanese market growing without insurance exchange

By STACY SHAPIRO

HARROGATE, England—Japan probably will not follow the United States' lead and create an insurance exchange soon, if ever, says Mokuji Kashiwagi, president of Toa Fire & Marine Reinsurance Co. Ltd. of Tokyo.

"The Japanese market is so reliant upon the London insurance market historically and Japanese clients very much rely on the long, historical treaties they have," Mr. Kashiwagi told other reinsurers attending last month's Reinsurance Offices Assn. conference.

Mr. Kashiwagi

"It would be hard to develop an exchange in Tokyo" like Lloyd's of London or the U.S. exchanges in New York, Chicago and Miami, he said. "We have no insurance brokers for our own market. The brokers in Tokyo cede our accounts abroad, so we are not ready to develop an insurance exchange in Tokyo."

Mr. Kashiwagi flew 8,000 miles to speak to ROA members about reinsurance in the Far East, a subject that is not easy to explain because of the many different markets involved.

However, he told the reinsurers that the Far East, particularly Japan, is fast becoming a major reinsurance market for risks around the world. For example, between 1966 and 1980, the Japanese market earned more than $1.1 billion in reinsurance premium, while the Japanese sent $1.6 billion of reinsurance overseas.

Besides Japan, there are at least two other Far Eastern nations that have the potential to become major reinsurance centers, Mr. Kashiwagi said. Singapore has already become a booming market, he pointed out, and China's sheer size and population give it the potential of becoming a dominant influence on the world reinsurance scene.

But, he added, it's hard for anyone to sort out what's happening in the Far East. "Even today, the state of things in the Far East is not even clear to me, with the radius and background differing from country to country," said Mr. Kashiwagi.

"The insurance markets are different in levels of development. But the East Asian countries are fast-growing markets.

"It is the sincere good hope that no water be thrown on Far East countries that are trying to develop their markets," he said.

Of all the growing markets, Japan is probably the oldest and most established, he said. After World War II, the Japanese Ministry of Finance allowed 16 domestic insurance companies to form and permitted 31 overseas insurance companies to start operations in the nation.

The number of players hasn't changed very much since then, he pointed out. Now, there are 22 domestic insurers and 41 licensed foreign companies doing business in Japan.

Many outsiders claim the Ministry of Finance strictly limits the number of foreign insurers that can do business in Japan, but that's not so, Mr. Kashiwagi said.

"The government is ready to invite newcomers if they want to underwrite in Tokyo," he said. "But I do not think it is too wise to start. Some companies have opened up offices but seen no profit."

Mr. Kashiwagi explained that foreign newcomers to the Japanese insurance arena may have a hard time making money because of the strong links between domestic insurers and their clients. Japanese companies usually buy their insurance from insurers that have stock interest in their firms (*BI*, Dec. 27).

However, Japanese companies usually spread their reinsurance business around, Mr. Kashiwagi said. Usually a Japanese company will offer a reinsurance treaty to bids from underwriters and several domestic and foreign reinsurers will end up participating on the coverage.

"Reinsurance is entirely free in Japan reinsurance market," he said. "The Ministry of Finance does not restrict it."

There's also no law against Japanese companies acquiring overseas reinsurers and some companies have done just that. "But the record shows that this is not fruitful," said Mr. Kashiwagi.

"I do not think Japanese companies have any ideas about extending their business abroad," he said. ■

Mental health benefits studied

SANTA MONICA, Calif.—Widespread coverage for mental health problems would only increase overall health care costs by a small amount, according to a new study by Rand Corp.

Researchers found that only 9% of the people who were offered full mental health coverage for up to 52 doctor's office visits a year sought such treatment. And only 5% of those underwent psychotherapy.

At the same time, according to the federally funded study, those who did receive the generous mental health benefits sought therapy twice as often as those whose plans required they pay all costs up to $1,000 before coverage began.

"These figures at first may seem contradictory," said Willard G. Manning Jr., an economist who conducted the study for Rand. "What they tell us is that generous coverage sharply increases the demand for mental health services.

"But, the fact remains that only a small percentage of those with such generous coverage draw upon it," Dr. Manning said.

According to the study, a full-coverage health care plan, which includes full mental health benefits, paid out only an average of $24 a year for mental health claims.

That was just 5% of the amount paid for all other health services by the plan.

However, the researchers emphasized that such low mental health plan utilization can only be anticipated where mental health coverage is widespread.

"Any employer or insurance company offering more generous mental health benefits than others in the community might find that those desiring mental health services would flock to those plans," Dr. Manning said.

Although those who received more generous metal health benefits than others increased their spending for mental health care, that in spending was about equal with the increase in spending on traditional health care services when people are given more generous medical care benefits, the survey noted. ■

Equitable to offer wellness program to all employees

By MARGARET LeROUX

CHARLOTTE, N.C.—An award-winning wellness program at the Equitable Life Assurance Society of the U.S. Southern Regional Service Center here is spawning a national program of health services soon to be available to all of the insurer's employees in the United States.

The wellness program will provide employees with incentives such as cash and gift certificates for athletic equipment for achieving and maintaining a healthy lifestyle.

The national program is based on a pilot project now in its third year at the Charlotte site where about a third of 322 employees are participating in nutrition, fitness, smoking cessation and stress-management efforts.

Earlier this year, Equitable received The North Carolina Governor's Award for Fitness and Health in Business and Industry for the Charlotte program.

The award is sponsored by Blue Cross & Blue Shield of North Carolina with the Governor's Council on Physical Fitness and Health. North Carolina is the only state in the nation to recognize employer-supported wellness programs with a governor's award.


Dr. Sherwood

The success of the wellness program in Charlotte has led to development of a nationwide health assurance program that Equitable plans to make available to all its employees within the year.

Data from the Charlotte program and wellness statistics from the company's five other regional service centers will eventually be used to market a package of health services to Equitable's group insurance clients, according to John R. DeLuca, vp and director of the medical department in the New York home office.

"Very few companies are systematically planning wellness programs and health services like we are," Mr. DeLuca said.

The Equitable approach to wellness is coordinated from New York, but will rely on consultants from outside the company for each of the regional service centers in Milford, Conn.; Columbus, Ohio; Des Moines, Iowa; Fresno, Calif.; and Colorado Springs, Colo.

"A lot of wellness programs needlessly increase their expenses by relying on 'big city' experts," noted Dr. Martha Sherwood, Equitable director of health services. "These New York City types aren't always accepted by local people, while someone from within the community would be," she said.

Additionally, there is the aspect of confidentiality. "We don't want to turn a program designed as a benefit into something perceived as Big Brother examining how employees lead their lives," Mr. DeLuca added.

"We found that using consultants who are not from Equitable inspires trust from employees," Ms. Sherwood said.

In Charlotte, the wellness program is under the direction of Dr. Linda Sloan Berne, an epidemiologist and professor of health education at the University of North Carolina.

Besides Dr. Berne, there is a nutritionist who offers classes plus a 24-hour binge-eating hotline and an exercise physiologist with the local YMCA who conducts health screenings, classes, workshops and seminars on health topics.

There are coed exercise classes and aerobic dancing, stress-management clinics and separate health classes for men and women. During the holidays there were seminars on how to keep holiday drinking enjoyable and safe.

The program in Charlotte has been closely monitored by Equitable headquarters.

"We're fine tuning the program as we go along so we can learn from our mistakes and make other regional wellness programs even better," Dr. Sherwood said.

The insurer has learned the importance of customizing the wellness program to meet the specific needs of different employee populations.

"We've found, for example, that the employees in Charlotte don't drink at the same rate as the staff in New York, but they drive more and wear their seat belts less than their counterparts in New York," Ms. Sherwood said.

Equitable's Charlotte employees are also more suspicious of biofeedback as a stress-management tool than New York employees.

"In New York, it's become a macho trend to be on biofeedback to help manage your stress," Ms. Sherwood noted, "while in Charlotte, people are very skeptical of its value."

The comparisons between employees at the two locations are based on data tabulated from personal risk profiles and questionnaires on health, behavior and environment. The questionnaires are used as the foundation of the company's wellness program.

To date, New York and Charlotte are the only two Equitable locations that have used the personal risk profile. It will be introduced to employees at the other service centers as the company's wellness effort goes national.

Individual responses to questions in the personal risk profiles are kept confidential and employees receive a customized profile that examines their lifestyle and suggests ways to maintain or modify it to achieve better health.

Some 257 Equitable employees (161 males and 96 females) who participated in health education and promotion programs in 1982 and were profiled ranked the following as risks to their health: weight problem (85% of the total group); not using seat belts (73.5%); elevated cholesterol (50%); high blood pressure (42.4%); smoking (30.7%); excessive use of alcohol (23.7%); and sedentary lifestyle (17.5%).

To combat these problems on an individual basis, Equitable employees who completed the personal risk profile met with Ms. Berne or her assistant to discuss the findings and set individual health goals.

Before the health counseling, employees are also screened for height, weight and blood pressure and are given a blood test to measure cholesterol and glucose levels.

In her discussions with Equitable employees, Ms. Berne helps them "prioritize their problems from the most to the least serious." For some, it's losing 20 pounds and stopping smoking.

"In a case like that, we'd recom-

Continued on next page

Equitable expands wellness program

Continued from previous page

mend working on weight loss first, then attacking the smoking problem," she added.

"We want people to set goals that are reasonable and achievable so they will succeed," Ms. Berne said.

During the first year of the pilot project in Charlotte, "we learned people tend to shoot too high and then they didn't have the satisfaction of achieving their goal.'

Once a goal is set, the consultants work with employees on an individual basis to decide how it will be achieved.

For a weight-loss program, participants keep a food intake diary for a few days to see where the problems originate. Employees are responsible for keeping a weekly weight chart and meet periodically with the head of the nutrition program to assess their progress.

Those employees who decide to participate in the wellness program sign a contract agreeing to achieve their goal. At the end of the year, all who fulfill their contract are given a certificate and are eligible for drawings for cash, athletic equipment and other prizes.

For the first year of the wellness program in Charlotte, a day of paid vacation was offered for each goal an employee achieved. "But by the second year, participation in the program was so high, it got to be too expensive an incentive," said Ms. Sherwood.

Surprisingly, when the drawing for cash and prizes was substituted for vacation time, there was no diminishing of interest and participation in the wellness progrm.

"I think once people get involved in something like this, they see the personal benefit," Ms. Berne noted. "Other incentives become just extras."

Last year, everyone in the wellness program in Charlotte got a shirt with a logo designed by one of their own staff. This year, sweat shirts are being considered.

Ms. White

The need to keep people involved in the program has forced Ms. Berne and Becky White, regional wellness coordinator for the Charlotte service center, to come up with imaginative motivators.

A tour of North Carolina and some East Coast cities by foot or bike was promoted during the holidays, a slump period for exercise and dieting. Employees who made their destination received buttons proclaiming "I made it to. . ."

The consultants and staff at Equitable headquarters are pleased with employee participation in the wellness program at Charlotte: 86% of the participants met their goals for 1982 and responses to a survey indicated that 82% are more health-conscious since participating; 71% feel healthier than before; 51% say that family and close friends are paying more attention to their health; and 76% have urged coworkers to participate.

For Ms. White, who sets an example with four achievement awards posted at her work station, the wellness program has led to "a better self-image. I've learned patience and assertiveness," she added. "I'm much better at verbalizing feelings."

Another Equitable employee in the Charlotte service center was galvanized to act when her personal risk profile "showed I was supposed to be dead."

Floya Bryant jokingly exaggerates the state of her health when she began a fitness class three months ago, but has become a believer in exercise since then.

Nutrition classes helped Alice Coryelle, another Equitable employee in Charlotte, "relearn things I knew all along but didn't pay attention to," she said. "I'm eating breakfast for the first time in 50 years and am losing weight by cutting out junk food."

Ms. Coryelle is also taking an exercise class "that I love," she added. "I never would have done it if the program wasn't available here at the office."

The wellness program has also won accolades from Ed Terrell, regional vp who handles the Charlotte service center. "I was very skeptical at first," Mr. Terrell said, "but I've seen measurable results: people are losing weight; they look healthier. We're more proud of the program than I thought we'd be," he said.

At the Equitable home office, Mr. DeLuca noted, "There are a lot of obstacles to a person making a lifestyle change that would benefit his or her health. If an employer can make it easier by making some of the necessary resources available, then it's a valid expenditure." ■

Stress management vital to successful programs

Stress management is the foundation of a successful wellness program, according to Dr. Martha Sherwood, director of health services for Equitable Life Assurance Society of the U.S.

Stress management is essential but harder to implement, she said. "It's more complicated than having a running program."

But stress control is "one of the hottest health issues of the decade," according to Ms. Sherwood.

"Countless experts have sprung up with programs claiming to help you conquer stress in one day.

"But stress management is not something that can be taught in a one-day workshop," Ms. Sherwood said. "To make an impact on peoples' lives, you need to provide an ongoing program," she said.

"Stress management sessions should be participatory," she added. "To make an impact, you've got to make people do more than read pretty brochures."

"Since stress is something that cuts across all lines, it's also important to have a heterogeneous group," Ms. Sherwood said. Having a good mix of managers, executives and clerical people makes them realize "they are not the only ones who get migraines," she said.

Another important consideration is the qualifications of the person running it, according to Dale Starcher, director of clinical services at the Center for Stress Control, Hightstown, N.J.

"If someone claims to be an expert in stress control, ask what is his or her background," Mr. Starcher advised. "Most people in the field have degrees in psychology, counseling or health education," he said.

"If biofeedback is used as part of the stress-management program, it may well be covered by an employer's group health insurance policy," Mr. Starcher pointed out.

Cost effectiveness, an important measure of a wellness program, isn't a valid yardstick this time, according to Ms. Sherwood. "There's no doubt that cost effectiveness is an important goal, but the field is so new, strong data is just not available yet," she said.

"I tend to be skeptical of most data that is available right now," she continued. "We're going to need another five or six years before we'll be able to see a clear effect of stress management on health care costs and benefit utilization." ■

Storm damage set at $17.7 million

NEW YORK—Insured property damage caused by wind, hail and tornadoes that swept through portions of Texas, Louisiana, Alabama, Georgia and Florida April 22-23 is estimated at $17.7 million by the American Insurance Assn.

The most extensive property damage done in the five states was in Georgia. Damages there amount to an estimated $9 million. Next hardest hit was Texas, which suffered $3.5 million in insured damages, and Alabama, which suffered about $2.6 million worth of damage in the storm.

The estimates do not include damages covered under the National Flood Insurance Program.

The storm was assigned Catastrophe No. 90 by the Insurance Services Office. ■

Multiemployer law not retroactive: Judge

Continued from page 1

1980,—the day President Carter signed the legislation.

"The case is of phenomenal importance. Hundreds of millions of dollars are on the line," said San Diego attorney Michael Merrill, who challenged the 1980 law on behalf of a small California construction firm that was slapped with a $687,387 withdrawal liability bill.

Another firm—Johnson Motor Lines Inc.—was hit with withdrawal liability bills of more than $20 million after the Charlotte, N.C., trucking firm went out of business and withdrew from four Teamsters' pension plans during the summer of 1980 (*BI*, April 5, 1982).

However, the ruling does not affect Johnson because it applies only to those companies filing suit within the 9th federal judicial circuit, which includes Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington and Guam.

The appellate court decision also won't provide any protection from withdrawal liability claims to firms that left the plans after Sept. 26, 1980, or are planning to withdraw.

The Multiemployer Amendments Act requires firms leaving multiemployer plans to pay a share of the plan's unfunded vested benefits.

Because employers' contributions to the plans, which cover about 8 million people, haven't always matched the benefits promised to participants, the unfunded liabilities can be enormous.

By making employers liable for the plan's promised—but unfunded—benefits, Congress wanted to discourage companies from leaving the nation's 2,000 multiemployer pension plans.

Prior to approval of the 1980 law, an employer could leave a multiemployer plan and not pay a single dollar promised to participants as long as the plan didn't fold within five years of the employer's withdrawal.

When the 1980 amendments were passed, Congress feared employers would leave multiemployer plans in droves because of the increased pension liability. To prevent this, Congress made the law retroactive.

Several dozen employers have challenged this retroactive provision in federal court.

The 9th U.S. Circuit Court of Appeals decision involved three challenges to the act by three small, privately-owned firms that withdrew from two carpenters' multiemployer plans: R.A. Gray & Co, a Tigard, Ore., general and commercial contractor that left the Oregon-Washington Carpenters Employers Pension Trust Fund in June 1980; G&R Roofing Co., a roofing contractor; and Shelter Framing Corp., a construction contractor.

Both G&R and Shelter belonged to the Carpenters Pension Trust for Southern California and withdrew from the plan in August 1980. G&R's withdrawal liability bill was $687,397, or 40% of its net worth, while Shelter Framing's bill came to $797,684, or 180% of that company's net worth.

In the R.A. Gray case, the 18-year-old, 65-employee company was told by the Oregon-Washington carpenters plan that its share of the plan's $27 million in unfunded vested benefits came to $201,359. The firm had the option of making quarterly payments of $16,000 instead of one large withdrawal liability payment.

R.A. Gray filed a suit against the plan questioning the act's constitutionality. But a federal judge dismissed the suit and told the company to arbitrate its differences with the plan (*BI*, Dec. 14, 1981).

However, in the G&R and Shelter Framing suits, U.S. District Court Judge Irving Hill in Los Angeles said the retroactive provision was unconstitutional. Judge Hill said he was not convinced that Congress had to apply the act retroactively to prevent employers from leaving the plans before the multiemployer bill became law (*BI*, April 5, 1982).

The three cases were consolidated before the appellate court, which upheld Judge Hill's ruling.

In upholding that decision, the appellate court said it rejected arguments that employers should have known when they left the plans in 1980 that Congress was considering legislation with a retroactive effect.

Before passing the bill, Congress changed the effective date four times. Those frequent changes would have made it "impossible for anyone to predict with accuracy the final outcome of the legislative process," the appellate court said.

Had the employers known about their potential exposures, they might have taken alternative actions, such as remaining in the plans, to avoid withdrawal liability, the court said.

But because the employers withdrew before the law was enacted, they "were not given the opportunity to make such an educated choice," the court said.

In balancing the interests of employers and the plans, the court said the withdrawal liability imposed on the three employers was relatively insignificant in terms of the plans' total unfunded liabilities.

"The trust fund and covered employees have not relied heavily on these employers' contributions," the court said. "The withdrawal liability imposed on the employers. . .may well be disproportionate to the specific needs of the pension trust funds."

By contrast, employers who withdrew from the plan were required "to pay a sum that seriously threatens their solvency, without a specific showing of the proportionate need on the part on the part of the pension trust funds. . .We conclude the equities weigh against the retroactive application of the Amendments Act," the court said.

In reaching its decision, the court stressed that it was only dealing with the retroactive provision of the act.

"It is a decision that is exclusive to the retroactive application of the law," said Baruch Fellner, associate general counsel of the Pension Benefit Guaranty Corp., the federal agency in Washington that guarantees workers benefits when their companies or pension plans collapse.

Mr. Fellner noted that the prospective application of the law has been unanimously upheld by federal courts, while an overwhelming majority of district court decisions has affirmed the retroactive provision.

Other pension experts like James Watson, an attorney with the Los Angeles law firm of Cox, Castle & Nicholson, which represents the Carpenters Pension Trust for Southern California, say it will take a Supreme Court decision to resolve whether the Multiemployer Amendments Act is constitutional.■

HOW fighting for risk retention group

Continued from page 1
group in Georgia.

HOW's dispute with Mr. Elliott centers on how the Risk Retention Act should be interpreted. That law, passed in 1981, allows businesses to band together to form captive insurance companies to insure their product liability exposures with minimal interference from state regulators.

The act permits companies that receive an insurance charter in Bermuda, the Cayman Islands or any state to operate as a risk retention group as long as they meet the insurance capitalization requirements of at least one domestic state.

As risk retention groups, these companies can serve members and sell policies in all states without being licensed in each state or having to use a fronting insurer to avoid run-ins with state regulators.

At issue in the dispute is whether a federal definition of product liability or differing state definitions should prevail when states regulate risk retention groups.

Mr. Elliott has said that the home warranty coverages that HOW writes are not product liability risks, which are the only exposures a risk retention group can write. He says the home builders' exposures for defective products are surety and property exposures under Delaware law (*BI*, June 28, 1982).

"The Risk Retention Act did not establish a federal definition of product liability insurance," said Delaware Deputy Attorney General Catherine Mulholland, adding that definition is based on state law.

Among other things, the HOW insurance program guarantees warranties provided by home builders for defects occurring during the two years after a new house is sold and insures against major structural defects that may occur between three and 10 years after a new house is sold.

Mr. Elliott argues that the two-year warranty guarantee is surety coverage and the eight-year structural defect policy is property insurance under Delaware's statute.

But in its filing with the U.S. District Court in Wilmington, HOW says its coverage is within the Risk Retention Act's definition of product liability, adding that the federal definition of product liability pre-empts any state definition.

Citing a House committee report, HOW said in its filing the Risk Retention Act "clearly adopts a federal definition of product liability which is to be employed in determining whether a group is a Risk Retention Group."

That federal definition of product liability, as contained in the Risk Retention Act, is much broader than many state laws.

The act says that product liability includes property damage arising out of the design or sale of a product. Under the act, product liability includes damage to a product itself rather than just damage caused by a product.

A Senate Commerce Committee report cited by HOW also notes that one of the act's purposes was to "permit home builders to establish a risk retention group. . .to insure against any potential product liability."

Congress' intent in having this broad federal definition pre-empt state definitions of product liability was clear, the complaint says.

"If the group's attempts to assume and spread the product liability risk exposure were limited by the product liability law of each jurisdiction, the purpose of the act would be frustrated in that the interstate operation of the group would be hindered.

"The act permits the group to insure against potential product liability damages of any type which may arise anywhere. This reflects the 'interstate nature of product liability' and the intent of Congress that risk retention groups not be subject to conflicting requirements of the various states in which they may operate," the papers note.

Mr. Elliott isn't the only one who believes that state law shall determine the exposures that can be insured by a risk retention group. The National Assn. of Insurance Commissioners last year adopted a model bill that would allow states to impose their own definitions of product liability on risk retention groups (*BI*, Dec. 6, 1982).

HOW is the only group that says it has formed a risk retention group.

From 1978 to March 1, 1982, the HOW program was fully insured through INA Corp. and generated $30 million in premiums annually. However, INA told HOW in late 1981 that because of adverse claims experience it would terminate its role lead underwriter.

At that time, HOW considered tapping the Risk Retention Act, which was then being considered by Congress.

"The HOW Corp. saw the act as an opportunity to continue the program by developing a less-costly insurance cooperative for its member-builders, permitting them to self-insure against all or a portion of their product liability exposures," the court papers say.

The home builders chose Delaware as the domicile for its new insurance company on the advice of INA, which thought there would be few regulatory problems there.

"We thought Delaware, as a pro-business state, would be receptive," said Mr. Cooke, HOW's counsel.

The new HOW Insurance Co., which is controlled by HOW Corp., a subsidiary of the Home Warranty Corp., was licensed as a commercial insurance company by the Delaware Insurance Department on July 27, 1981. HOW later decided to operate the insurer as a risk retention group after the federal law was passed two months later.

HOW, which is substantially reinsured, was started with capital and paid-in surplus of $1.5 million, double Delaware's $750,000 minimum requirement. HOW now has a surplus and capital of $8 million, up from $4.5 million in 1982. ■

Pool halts claims payments

Continued from page 2
with doctor-related losses at the time of the assessment of $14.4 million.

Following the $11.5 million assessment, the 120 participating hospitals filed their suit against the plan and pulled out of the fund, reverting to the purchase of excess liability coverage from private insurers or self-insurance (*BI*, July 26, 1982).

Now fund officials are worried that their coffers are running dry. If they do, claimants won't have anywhere to turn other than to the state or directly to hospitals and physicians.

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

"If the appeals court ruling is allowed to stand, many seriously injured claimants will be left with no apparent means for recovering payments for their legitimate claims," warns John W. Odem, the fund's general manager.

Mr. Odem says he is "optimistic" the state high court will see the awesome ramifications of the appeals ruling and will reverse it, "thus allowing the assessment process to continue to provide needed funds for paying claims."

Mr. Bell, the hospital association lawyer, says two groups of hospitals plan to argue before the Florida Supreme Court in June. The first group of about 40 hospitals plans to argue that the entire statute that created the PCF should be scrapped, he says.

Those hospitals, for the most part, did not incur any malpractice liabilities exceeding $100,000 in the years in dispute and so have nothing to lose if the PCF can no longer be their excess liability insurer.

A smaller group of about 15 hospitals face severe claims during the disputed years, adds Mr. Bell, and "are a little nervous about being held personally liable." They are arguing that the PCF assessment system simply needs to be interpreted differently, he says.

Insurance Commissioner Bill Gunter and the Legislature already have acted to fix the problems with the PCF, but the solutions aren't retroactive.

Mr. Gunter named a task force that recommended a complete overhaul of the state's medical malpractice system (*BI*, Feb. 28).

Effective this year, the Legislature increased from $100,000 to $150,000 the point at which the fund's excess coverage is triggered and placed a cap of $10 million on the PCF's previously unlimited liability for high-dollar claims.

"I seriously doubt that any legislative fix will be forthcoming (to solve the retroactive assessment problem)," says Robert B. Atkins Sr., president of All Risk Corp. of Florida, a service agent for the Florida Hospital Trust Fund, a primary-layer self-insurance pool.

Mr. Atkins says the problem is that hospitals will continue to refuse to pick up the tab for what they see as physicians' bad loss experience, doctors will argue that they can't be assessed above the 200% limit and lawmakers will refuse to let taxpayers bail out either party. ■

Work comp bills approved

Continued from page 2

that rates will decrease slightly.

Employers, however, may see a savings in workers compensation costs through lower legal charges because of fewer contested cases. Supporters believe the new benefit structure is more specific and will result in fewer legal battles.

The workers compensation system in Minnesota has been criticized for its high rates and liberal benefit structure.

Several bills were proposed during the recent session to reform the system. In the final few hours before a midnight recess May 23, bills were amended at the pace of a high speed drill to ensure that some type of workers comp reform would be aproved. Many observers and legislators alike walked away from that session not knowing which of the earlier bills or which provisions finally were approved.

Two bills made it through—H.F. 274 and H.F. 575—neither resembling their initial forms.

H.F. 274 accelerates the establishment of an open rating system and also changes the benefit structure within the system.

When Minnesota's open rating law was approved in 1981, it was the first of its type in the country. Since then, several states, including Oregon, Kentucky, Illinois and Michigan, have not only adopted open rating laws, but have put them into effect.

Open rating, also known as competitive rating, requires that insurers file their own rates, rather than use rates established by a rating bureau. In Minnesota, insurers will have to file their own rates and rating plans 15 days after their effective dates.

Because Minnesota was the first state to adopt an open rating law, legislators in 1981 were hesitant to rush the effective date. They built in a three-phase timetable that was suppose to culminate on Jan. 1, 1986.

But, the insurance industry and insurance buyers are no longer as concerned that open rating may not work, said Mark Markman, the state's former insurance commissioner who helped draft the law. He now is a senior underwriting officer with St. Paul Fire & Marine Insurance Co. in St. Paul, Minn.

"I don't know if open rating will collectively lower rates, but it will have the price come to its proper level," Mr. Markman said.

Others, like Brad Robinson, president of Robinson Rubber Products Co. Inc. in Minneapolis, believe the new law will have little effect on the market, which he says has seen competition since 1969. At that time, insurers were permitted to sell insurance at rates less than the manual rates set by the rating bureau.

In the past year alone, rates were discounted up to 30% according to Mr. Robinson.

The crux of H.F. 274 is really the changes in the benefits structure of the workers compensation system.

It's a departure from anything that exists in any other state, according to Steve Keefe, commissioner of the Department of Labor & Industry.

Under this bill, lump sum permanent partial awards will be lowered in most cases, but amounts have not been set.

The law will encourage injured workers to return to work sooner and employers to help these workers find a job.

Currently, injured workers receive a lump sum permanent partial payment at time of diagnosis, whether they go on disability or return to work.

Under the new law, injured workers are separated into two classes: those who return to work and those who don't.

Injured workers, who return to work, either by finding a job on their own or with the help of their employer, are entitled to a lump sum payment 30 days after they return to work. This payment will be smaller than the current award in almost all cases.

For those workers who do not find a job, or who refuse a job offer, benefits will be doled out on a weekly basis rather than as a lump sum. If the worker does ultimately return to work, he or she would receive the balance of the predetermined payment

Another section of H.F. 274 will cut out the stacking of benefits for permanent partial injuries, said John Lennes, general counsel with the Minnesota Assn. of Commerce & Industry, a private trade association of about 4,500 companies.

He explained that some injured workers were awarded more than the maximum single benefit if they had multiple injuries. For instance, if an employee who suffered partial loss of an arm received 60% of the permanent total benefits and then received 50% of the permanent total benefits for a partial loss of a leg, he would end up with more than the allowed maximum benefit.

The new law will use the "total body" concept and set maximums for injuries that will not exceed 100% of allowed benefits.

In still another provision of H.F. 274, death benefits will be paid on a weekly basis. Under the current law, these benefits are paid in a lump sum.

There also is some court reform included in this bill. Appeals will be limited to include only the legal issues in question, rather than a rehash of the entire case.

In another provision, attorneys will be able to request that certain judges not hear the case. Currently, there is no choice or denial of judges, some of whom have earned bad reputations, Mr. Lennes said.

In H.F. 575, legislators approved the establishment of a state fund by July 1, 1984. Eighteen states already have established funds to sell workers compensation insurance. In some of those states there are exclusive funds, giving the right to sell insurance to the state only. Such an exclusive fund was discussed earlier this session by Minnesota legislators (*BI*, March 7), but a competitive state fund was finally adopted.

The state fund "won't be bad, it won't be good; one more company (selling workers comp insurance) won't really matter. I don't think it will have an impact in the marketplace," Mr. Markman said.

Passage of the state fund was a political gift to labor, Mr. Robinson and others said. For years, organized labor in Minnesota argued that a state fund would solve all the ills of the workers compensation system. But during the past decade, many of the problems have been eliminated, making a state fund unnecessary, critics of the fund say.

Advocates of a state fund have said that it would hold down the cost of workers comp insurance because it wouldn't have to make a profit like commercial insurers do.

Others have said that a state fund would increase competition. "But there already is competition, and don't forget the open rating law," said Brian Fahey, director of research for the Minnesota Assn. of Commerce & Industry.

Critics believe that the state fund may become a bad risk pool for employers that can't purchase insurance from any other source. This could affect all taxpayers in the state.

The bill provides that the state fund receive from the state's budget a loan of $3 million in capital and $1.7 million for start-up costs, to be paid back over a 10-year period at 8% interest. ■

Regulators considering the sale of BMF

Continued from page 2

If BMF is not sold, NAIC's Securities Valuation Office in New York will be required to determine the value of the $92 million in debt held by Baldwin companies as part of the Dec. 30 sale to BMF management, Mr. Molin said.

The NAIC office already has collected copies of some of the BMF transaction documents and is seeking the rest.

"It's my feeling that what should happen is the sale of BMF, which would obviate the necessity of an SVO evaluation," said Mr. Molin. "The value is what the market will bring, probably. . .(but) we're not going to have a fire sale, we're not going to give it away to anybody."

Mr. Molin says that, in his view, BMF "is not an asset that is essential" to the revival of Baldwin-United.

An issue in a sale of BMF would have to be an employment discrimination suit filed by a fired former treasurer of BMF. The suit alleges the nation's seventh-largest brokerage "concentrated" premium trust funds in a California account and drew on that account to finance operations and acquisitions. BMF denies all the allegations in the former executive's suit (*BI*, May 23). It has not filed a response with the court yet.

Mr. Molin says he views the allegations contained in the former BMF treasurer's suit as "in a large part, those of a disgruntled employee.

"We're confident we can get the full asset value out of (BMF)," he adds.

The value of BMF is important to regulators because of the transaction between Baldwin-United and the brokerage's management on Dec. 30, 1982. On that day, a newly formed holding company, BMF Services Inc., acquired all the equity of the brokerage and its subsidiaries. BMF Services is controlled by BMF's senior management.

In exchange, BMF Services, through at least six subsidiaries, paid to two Baldwin companies a total of $92 million consisting of debentures and attached warrants. The warrants allow Baldwin to exchange the debentures for 79% of BMF stock on demand.

One of the Baldwin subsidiaries is National Equity Life Insurance Co. of Honolulu, Hawaii, which purchased $60 million of the notes in exchange for cash from its insurance portfolio. The regulators want to ensure the value of those $60 million in notes.

The other $32 million in debt issued by BMF was held by a Baldwin affiliate, National Business Services Inc. At one time, all of the stock of NBS Inc. was held by MGIC Investment Corp., parent of several Wisconsin-based property/casualty insurers. An MGIC spokesman said last week he wasn't sure whether NBS is currently in the insurers' portfolios.

In Honolulu, a state insurance regulator, Brian Miyagi, said Hawaii was conducting a routine examination of National Equity Life's finances, which would probably be finished during June. If Hawaii finds that NEL's assets are insufficient to guarantee liabilities to policyholders, Baldwin-United could be asked to add funds, he said.

Mr. Molin said NEL had recently been dissolved as a Hawaii corporation and reincorporated in Indiana.

Regulators are trying to determine the worth of the assets held in the portfolios of all Baldwin-United insurance subsidiaries, Mr. Molin said. The subsidiaries include at least three other major life insurers besides National Equity Life and MGIC. The three companies, two of which are based in Arkansas and the other in Indiana, sold or reinsured single premium deferred annuities.

Mr. Molin downplayed suggestions that Baldwin might try to sell MGIC. "I don't believe there's going to be any sale of MGIC," said Mr. Molin. "They just happen to have the unfortunate circumstance of having been bought by Baldwin-United." Mr. Molin said he regarded MGIC as the likely centerpiece of a Baldwin restructuring. ■

Group dental insurance grows

WASHINGTON—More than two-thirds of workers employed by companies with more than 100 employees are covered by group dental insurance plans, according to the U.S. Labor Department's Bureau of Labor Statistics.

Between 1979 and 1982, the percentage of workers covered by dental plans increased from less than 50% to 68%, the department found in a survey of 1,500 firms with more than 100 employees.

The survey also discovered that some 42% of pension plan participants must wait until they are 65 before they can retire with a full pension benefit, while 31% could retire between 60 and 64. In addition, 13% of participants were enrolled in plans that allow an employee with 30 years of service to retire at any age with a full benefit.

About two-thirds of workers were covered by retirement plans that base the final benefit on earnings, while 30% received benefits based on a specified dollar amount for each year of service.

Nearly all of the surveyed employers offered group health insurance plans. In most of the plans, the employee had to pay the first $100 of expenses and 20% of costs over that deductible.

However, 57% of employees were covered by group health insurance plans that paid all remaining costs once an employee's annual out-of-pocket expenses reached a certain amount—usually $1,000.

Complete findings from the Bureau of Labor Statistics survey will be published this summer in issues of the Monthly Labor Review. ■

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NOTICE: The State of Wisconsin Group Insurance Board is seeking Administrative-Services-Only (ASO) bid proposals on the Group Health Insurance Program for state employes.
The current contract is self-insured and renewed annually on Jan. 1. The plan covers approximately 48,000 active and retired employes plus 77,000 dependents. The plan includes: hospitalization, professional services and major medical. Proposals must be submitted for self-insured (ASO) claim processing services.
Companies determined to be capable of handling claims processing for an account of this size will be furnished copies of the specifications.
For further information write or call: Wis. Group Insurance Board, Room 171, 201 East Washington Ave., Madison, WI 53702. Telephone: 608-266-0207.
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Business Insurance Circulation Breakdown*
Commercial Consumers

Administrative Management: owners, presidents, vps, etc.	6,483
Financial Management: chief financial officers, vps of finance, secretaries, treasurers, etc.	10,138
Insurance Management: vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc.	5,299
Government, Associations, Unions, Educational Institutions	1,034
Commercial Consumers Sub-total	**22,954**
Insurance Agents & Brokers	9,771
Insurance Cos.	5,217
Financial Institutions	352
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,603
Others allied to the field	937
TOTAL	**41,834**

*Source Business/Occupational breakdown of qualified circulation, November 1, 1982 issue, as submitted to BPA for December 1982, BPA Publisher's Statement.

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At small firms, risk managers handle pensions

Continued from page 1

Some 18.7% of the risk managers at companies with less than $200 million in sales and 12.5% of those at companies whose sales range from $200 million to $1 billion annually are responsible for pension and profit-sharing plan administration, according to the survey.

Only 7.4% of the risk managers at companies with $1 billion to $4 billion in annual sales and just 1% of those at companies with more than $4 billion in revenues reported responsibility for pension and profit-sharing plans.

In addition, risk managers at smaller companies are more likely to be the firm's safety, fire-prevention and security managers than those at giant companies.

More than 47% of the surveyed risk managers at companies with less than $200 million in sales and 42.6% of those at firms with revenues between $200 million and $1 billion told Logic they were responsible for safety and fire prevention. Only 28.7% of the risk managers at companies with $1 billion to $4 billion in revenues and just less than a quarter of those at companies with more than $4 billion in sales reported such responsibility.

Likewise, 20% of those in the smallest category—less than $200 million in sales—said they were responsible for security at their companies, while just 5% in the largest category—companies with revenues in excess of $4 billion—had that duty.

Although risk managers at larger companies were not directly responsible for as many jobs as their colleagues at smaller firms, they often supervised others who had hands-on responsibility for those duties.

For example, 72.7% of risk managers at companies with less than $200 million in sales reported they had direct responsibility for claims handling and settlements, while only 44.6% of those at firms with more than $4 billion in sales reported such responsibility.

Only 12.9% of the risk managers in the smaller category reported they supervised another person who had responsibility for claims, while 48.5% of those in the larger classification supervised the person in charge of claims.

Hence, 85.1% of the risk managers at the smaller companies had overall responsibility—either directly or indirectly—for claims handling and settlement, while 93.1% of those at the larger companies had direct or supervisory claims responsibility.

Much the same pattern holds true for overall responsibility for a company's liability insurance program.

Some 93.8% of the risk managers at companies with less than $200 million in sales said they were directly responsible for casualty insurance, while another 3.3% said they supervised the person in charge of this function.

At companies with more than $4 billion in revenues, only 70.3% said they had direct responsibility for casualty insurance programs, while the rest said they supervised the person who did.

Overall, 100% of the large-company risk managers had direct or indirect responsibility for casualty insurance, while only 97.1% of the small-company risk managers had such responsibility.

However, not all the duties performed by at least some risk managers fit this trend. For instance, 27.2% of the risk managers at the smaller companies reported direct or supervisory responsibility for corporate security, while only 7.9% of those at the largest companies said security was part of their department's duties.

Risk managers at larger companies can assign direct responsibility for duties like managing casualty insurance programs or handling claims to others because they have larger staffs.

According to the survey, companies with less than $200 million in annual revenues average fewer than two professionals on their risk management staffs. Larger companies, like those with between $2 billion and $4 billion in sales, averaged more than three professional risk management staffers, while the largest companies surveyed, those with more than $7 billion in revenues, had an average of slightly fewer than six risk management professionals on staff.

The size of a risk manager's clerical staff also varied with the size of the company. At the smallest of the companies surveyed, a risk management department averaged slightly fewer than two clerical workers, while the largest companies reported an average of slightly fewer than three clerical personnel.

Besides larger staffs, risk managers at large companies also can boast of a higher level of education than those at smaller companies, which could be one of the reasons large-company risk managers are entrusted with risk-financing duties far more often than their colleagues at small firms.

Logic devised a scale from one to four to rate the education level of risk managers. A score of one was assigned to a person with no college degree; a score of two was awarded to a person with a bachelor's degree; a score of three was given to someone with a master's in business administration or an equivalent; and a four signified a law degree.

Risk managers at the smallest firms—less than $200 million in revenues—average a score of 1.9, or slightly lower than bachelor-degree status. Educational scores increased as corporate size increased, with risk managers at companies with sales exceeding $7 billion reporting a score of 2.5.

The educational level of a company's professional risk management staff also increased with sales. For example 12% of the risk management professionals at companies with less than $200 million in revenues had received law degrees, while 15% had MBAs.

At companies with $1 billion to $2 billion in sales, 12% of the risk management professionals reported receiving law degrees and 31% had MBAs, while 25% of the surveyed professionals at firms with more than $7 billion in sales could boast law degrees and a whopping 72% had received an MBA.

Mr. Meyers at Logic said the large number of MBAs in large-company risk management departments is one of the reasons these departments are entrusted with risk-financing responsibilities more often than the departments at small companies.

Risk managers at larger firms are more likely to seek professional designations, the survey points out. Only 3% of the risk managers surveyed in the smallest classifications had received a Chartered Property/Casualty Underwriter designation, while 4% had attained the Associate in Risk Management designation. However, at companies with between $4 billion and $7 billion in annual sales, 12% are CPCUs and 10% have been awarded the A.R.M. designation.

Although risk managers at large companies can boast of bigger staffs and better education, risk managers at smaller firms are more likely to have direct links with the company's top management.

Twenty-one percent of the risk managers at companies with less than $200 million in revenues report directly to the company's chairman or president, while the remainder report to officers with lesser titles.

Only 4% of the risk managers at companies with more than $7 billion in revenues reported having this top-level access.

•

Copies of the "1982 Risk Management Compensation Survey" are available for $35 each, including postage and handling, from Logic Personnel Associates Inc., 170 Broadway, New York, N.Y. 10038; 212-227-8000.

At large firms, risk managers get more benefits

Risk managers at large firms are not only paid more than their colleagues at smaller companies (*BI*, May 23), but they also are more likely to receive some lucrative employee benefits.

For example, only 17% of risk managers at companies with less than $200 million in sales receive corporate stock options, according to a risk management compensation survey conducted by Logic Personnel Associates Inc., a New York-based recruiting firm.

As companies increase in size, the percentage of risk managers who are offered stock options increases. For instance, 29% of the surveyed risk managers in the next-largest category—companies with $200 million to $500 million in revenues—said they receive stock options.

Thirty-three percent of the risk managers at companies with sales ranging from $1 billion to $2 billion said they were offered stock options, while 61% of those in the largest category—more than $7 billion in sales—were offered options.

Risk managers at larger companies are also more likely to be covered by a corporate pension plan, the survey notes.

Only 78% of the respondents at companies with less than $200 million in sales said they were covered by a corporate pension plan, while 95% of those at companies with revenues ranging from $1 billion to $2 billion and 100% of the 73 surveyed risk managers at companies with $4 billion to $7 billion in sales were entitled to a company-paid pension.

In addition, large companies offer their risk managers more life insurance protection than small companies.

Risk managers at firms with more than $7 billion in sales receive life insurance protection that averages 2.6 times their average annual salary of $81,186, or total life insurance of $212,721.

Risk managers at companies with less than $200 million in sales—who, according to the survey, receive an average salary of $34,894—received an average of 1.8 times salary in life insurance, or an average of $62,809 in life insurance coverage.

However, the percentage of risk managers receiving one executive perk—a company car—did not necessarily increase with company size.

Twenty-three percent of the surveyed risk managers at companies with less than $200 million in sales said they received a company car, while only 16% of those at companies whose sales range from $1 to $2 million said they were entitled to one.

But, 29% of the risk managers at the largest firms—those whose sales exceed $7 billion—told Logic they received a company car.

Attorneys' fees challenged in Hyatt case

Continued from page 2

ing millions of documents and taking numerous depositions from defendants' employees.

Plaintiffs' attorneys say Judge Wright asked that they submit their time sheets to him only. In at least two instances, the sheets were filed with the clerk of the federal court in Kansas City in sealed envelopes, which the clerk will not open to public inspection without Judge Wright's approval. In a third case, the judge received the only copy of the attorneys' time sheets.

Hyatt and Crown Center, a subsidiary of Hallmark Cards Inc., argue that Judge Wright acted too soon in awarding the fees. They also say there should be a hearing, possibly public, at which the plaintiffs' attorneys would be required to discuss their time and billing in front of the defendants in the skywalk litigation.

Finally, they say the skywalk defendants, which will pay the $2.2 million to the attorneys, should reduce fee payments by whatever amount individual plaintiffs' lawyers receive in fees from their individual clients.

Meanwhile, in the 8th U.S. Circuit Court of Appeals in St. Louis, attorneys for collapse victims Joseph Vrabel and Brenda J. Abernathy, two members of the federal class action, filed notices of appeal of Judge Wright's class settlement order and fee order. No hearing date has been set.

The petitions were filed May 19 by the law firm of Stavros & Biasiello in Park Ridge, Ill.

In objections filed prior to Judge Wright's Jan. 31 class settlement order, the firm objected to the granting of settlement money to philanthropies. The Jan. 31 settlement provided a fund of $3.5 million to cover legal fees and damages to federal plainfiffs and an additional $6.5 million in long-term payments to Kansas City area charities.

"The proposed federal class settlement thunders an intent to award punitive damages to various charities," said the firm's objections filed Jan 19.

While plaintiffs applaud the defendants' flagrant display of philanthropy, plaintiffs suggest that the award has no basis in law or in fact.

The firm argued that only skywalk victims should benefit from the settlement money and concludes that its clients are being unfairly prejudiced as a result of the settlement.

The law firm also objects to Judge Wright's May 4 fee order for the federal class action lawyers.

According to Judge Wright's order, the $2.2 million is to be paid to attorneys who represented the class of victims that filed suit in federal court. However, the law firm of Stavros & Biasiello was not designated as class counsel by Judge Wright.

Plaintiffs' attorneys who filed suits in Jackson County Circuit Court that were later combined into a state court class action also are not covered by Judge Wright's May 4 order. They are being paid individual fees under a separate settlement.

Attorneys involved in the Hyatt litigation say that about $33 million was paid to about 220 victims prior to negotiation of the tandem state and federal class-action settlements late last year and in January 1983 (*BI*, Jan. 17). Attorneys' fees incurred for these pre-class settlements are not included in either of the class rulings.

Roughly another $28 million has been paid in the state class settlement to resolve suits filed in state court, and about $200,000 has been paid in the federal class settlement to resolve all but about six cases pending in federal court.

One plaintiffs' attorney estimates that the remaining six federal court cases involve injuries and damages worth approximately $200,000 to $300,000.

On that basis, total claims paid to federal court plaintiffs would be in the $500,000 range, compared with total claims payments of more than $60 million.

The $2.2 million in fees awarded May 4 by Judge Wright are for work done by attorneys representing the collective interests of all skywalk victims, the judge said in his order, even though those lawyers' clients will only receive compensation totaling approximately $500,000. ■

OSHA inspections increase

WASHINGTON—The Occupational Safety & Health Administration says it increased its total number of workplace inspections by nearly 15% in 1982.

The 63,914 OSHA inspections is the second highest total in the last six years, OSHA says.

"We have succeeded in not only raising the number of inspections above the average for the previous administration, but we have also been able to target these inspections on the most hazardous worksites," said Throne G. Auchter, an assistant secretary of labor and head of OSHA.

"This was accomplished despite a budget cut of 6.6% and a loss of 568 authorized positions, a 19.4% decrease from the previous year."

Of the 63,914 OSHA inspections last year, 31,012 were made at construction sites, which are considered by the agency as the nation's most hazardous workplaces.

OSHA says only 4% of its inspections were contested by employers last year, compared with 20% in 1980. ■

Punitive damages allowed in Hilton deaths

Continued from page 2
Backus & Maupin Ltd.

Eight persons died and 242 were injured in the Feb. 10, 1981, Hilton blaze, while the November 1980 fire at the MGM Grand killed 84 persons and injured more than 700 others.

Six wrongful death cases have not yet been settled in the Hilton fire litigation, Mr. Fetterly said, adding that 140 personal injury cases still remain.

According to an estimate by a plaintiffs' attorney, total liability in the Hilton fire, excluding punitive damages, could come to $25 million to $30 million. Hilton Hotels Inc., the owner of the hotel, had $200 million in liability insurance and $250 million in property insurance at the time of the fire (*BI*, Feb. 16, 1981).

Besides Hilton, approximately 70 other defendants have been named, including hotel suppliers, installers, local government agencies, construction companies and architects.

Nevada law is clear that punitive damages can be pressed in personal injury cases, but the defendants sought a ruling from Judge Goldman on whether Nevada's wrongful death statute prohibits punitive damage claims.

The wording in the statute was changed during the late 1970s when the state attempted to update its wrongful death, survival and other statutes, Mr. Fetterly explained. The words "punitive damages" were removed and "penalties" substituted.

The defendants argued that the word "penalties" did not include punitive damages.

Judge Goldman disagreed, however, stating that the statute was "clear and unambiguous.

"I suggest to you that in the context of the statutes the word 'penalties' clearly contemplates and includes punitive or exemplary damages," he said.

In his ruling, Judge Goldman described as "dark humor" the theory that he said can be applied in states that do not allow punitive claims in wrongful death cases. That theory is it is cheaper to kill a person than to injure him.

A Nevada court has never ruled on whether punitive damage awards assessed against a defendant are insurable.

No trial date in the case has been set. The parties are now attempting to put together a plan for orderly discovery, Mr. Fetterly said, adding they might be able to reach an agreement on discovery that could be submitted to the court for approval within two weeks.

Between 250 and 300 depositions may be required as part of the discovery process, said Mr. Backus, the defense attorney, adding that the number could increase. Attorneys probably won't start taking depositions until late summer or early fall, he added.

According to experts, states are split as to whether punitive damages can be awarded in wrongful death situations.

Marquette University Law Professor John J. Kircher, who has coauthored a book on punitive damages, says that it is a question of statutory interpretation among the states.

"There is a split of authority, not from a principled common law approach but rather on what the statute provides and whether it allows for punitive damages," Professor Kircher said.

A majority of the wrongful death statutes have been construed to not allow punitive damages, he added.

Defense attorney Victor B. Levit of the San Francisco firm of Long & Levit, who has authored articles on punitive damages, agrees that states are split on the issue.

"I don't think there is any trend," he said. "There is a lot of authority on both sides. It's fairly well split and evenly divided."

Mr. Fetterly added that though the same law firms represent both Hilton and MGM, attorneys for MGM never tried to bar punitive claims in wrongful death cases arising from the MGM fire.

All but a few of the 450 suits filed in the MGM litigation are included in a settlement with MGM Grand Hotels Inc. and a variety of other defendants. No punitive damages, either for personal injuries or wrongful death, have been awarded in the MGM case (*BI*, March 21). MGM's retroactive liability insurers, however, contend that punitive damages are part of the settlement.

Mr. Fetterly added that although there were fewer injuries in the Hilton fire than the MGM blaze, the injuries in the Hilton fire were "significantly more severe" than at the MGM.

That's due in part because the MGM fire occurred in the casino area, while the Hilton fire penetrated the hotel's sleeping quarters, trapping a number of persons and causing significant injuries from smoke and toxic byproducts, Mr. Fetterly noted. ■

Occidental consolidates pension plans

benefit beat

Occidental Petroleum Corp. is terminating four defined benefit pension plans affecting 23,000 salaried employees and will replace them with one defined contribution retirement program.

The plan consolidation, which was announced May 23 and filed with the Pension Benefit Guaranty Corp. the next day, will go into effect June 1. The four defined contribution plans are overfunded by more than $240 million, Occidental says.

Besides the new defined contribution plan, Occidental will also offer salaried employees a savings plan beginning Jan. 1.

Under the new defined contribution plan, Occidental will contribute a percentage of a worker's pay to individual accounts. The contribution formula for employees under 35 is 4% of base salary up to the Social Security wage base, plus 9% of the remainder. For employees 35 and older, the formula is 7% of base salary up to the Social Security base, plus 12% of the remainder.

The company's contributions to the retirement accounts will be invested in a guaranteed income contract with a major insurance company, an Occidental spokesman said.

Employees will be vested after 10 years of service or at age 40 after five years' service. No employee contributions are required.

Under the new employee savings plan, Occidental will match dollar-for-dollar employee contributions of up to 6% of pay. An employee vests 20% each year until he or she is fully vested after five years. Employees with less than a year of service are not entitled to any company contributions upon termination.

The four defined benefit plans being terminated by Occidental and three subsidiaries include 23,143 participants, of which 13,848 are vested and 2,696 are retirees.

Occidental says the plans, which have total combined assets of $726.5 million, are overfunded by $248 million.

The four plans to be terminated include:

- Occidental's own plan for salaried employees, which currently has 6,075 total participants, 2,304 vested participants and 198 retirees. The plan, which has $85.5 million in assets, is overfunded by $40 million, the company says.

The plan pays a benefit equal to years of service multiplied by the total of 1.2% of final average pay up to the average Social Security wage base, plus 1.7% of the excess.

The final average pay is based on an employee's five highest-paid years.

Employees become fully vested after 10 years of service or with five years of service at age 40. No employee contributions are required.

- The salaried employees plan at subsidiary Cities Service Co., which includes 909 retirees, 5,541 vested participants and 8,784 total participants. The total plan assets were $462 million, of which $150 million is overfunded, Occidental says.

The monthly benefit paid by the plan is based on the most lucrative of three different formulas: 1.5% of each year's pay up to the Social Security wage base, plus 2.25% of excess; $144 times years of credited service; 1.275% of final average pay up to the average Social Security wage base for the five years prior to retirement, plus 1.5% of excess salary, all multiplied by years of credited service.

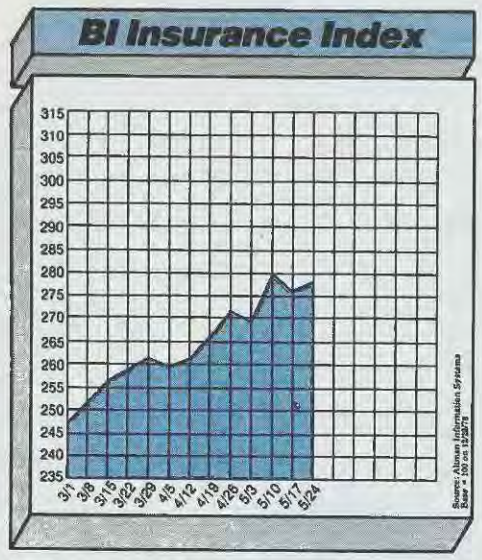
The Cities Service plan defines final average pay as the three highest-paid years of the last 10 years of service.

The plan, which requires no employee contributions, fully vests all participants after 10 years.

- Subsidiary Hooker Chemical Corp.'s salaried employee plan, which includes 338 retirees, 1,844 vested participants and 2,939 total participants. The plan has $49 million in assets, $23 million of which are excess, Occidental says.
- The Hooker Chemical & Plastics Co. salaried employee plan, which includes 1,251 retirees, 4,159 vested participants and 5,345 total participants. Occidental expects to receive $35 million of the plan's $130 million in total assets.

Details of the two Hooker plans were not available.

Salaried employees at two other Occidental subsidiaries, IBP Inc., a meat processor, and Island Creek Coal Co. are not affected. ■



The *Business Insurance* stock index continues to seesaw, rising 2.8 points to 278.6 during the week ending May 24. The index had dropped 3.5 points during the week ending May 17 after hitting a record high May 10. Twenty-nine insurance industry issues closed up, 13 were unchanged and 29 closed down. The leading gainers were Statesman Group Inc., 16.9%; Mission Insurance Group Inc., 14.7%; Hanover Insurance Co., 12.7%; Crawford & Co., 12.6%; and Integrated Resources Inc., 11.6%. The largest losses were posted by SAFECO Corp., 6.8%; Aneco Reinsurance Co. Ltd., 6.3%; Frank B. Hall & Co. Inc., 5.7%; Orion Capital, 5.7%; and St. Paul Cos. Inc., 5.7%. The *BI* index suffered a 1.03% decline, not as great as the 1.2% drop in the New York Stock Exchange composite over the same period.

British Issues

24 May Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	162	49.1	16.86	10.5	164—	161
Eagle Star	405	16.1	24.29	6.0	410—	405
Genl Accident	408	13.0	24.29	6.0	422—	407
Gdn Royal Exch	430	11.4	27.86	6.5	430—	422
Phoenix	332	18.1	25.00	7.5	334—	328
Royal	483	12.5	37.86	7.8	493—	482
Sun Alliance	1125	15.4	68.57	6.1	1200—	1125
Brokers						
CE Heath	308	8.4	21.07	6.8	315—	308
Hogg Robinson	113	8.7	8.57	7.6	115—	110
JH Minet	123	11.7	6.50	5.3	126—	120
Sedg Grp	213	12.2	10.00	4.7	218—	212
Stenhouse Hldg	113	10.6	7.86	7.0	120—	113
Stew Wrightson	246	8.9	20.43	8.3	267—	245
Willis Faber	528	13.9	25.00	4.7	527—	523

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

Insurers' first-quarter results do not reflect true situation

By MYRON M. PICOULT

Special to Business Insurance

THE BOOKS ARE now closed on the property/casualty insurers' first quarter, and as a general rule of thumb, operating earnings were in line with expectations. In fact, in many instances, the results exceeded estimates by a wide margin. Shortfalls were clearly the exception.

These better-than-expected results reflected improved underwriting results as the growth of the insurers' net investment income actually lagged projections. However, we do not view the underwriting experience and the operating results as true indications of the industry's present fundamental state. The underwriting cycle has not yet turned and property/casualty insurers' combined ratios will continue to worsen before they get better.

Mr. Picoult

Here are some observations from our survey, which includes companies that account for about 40% of the stock property/casualty insurance industry's premium volume:

- Net premiums written for the three months ended March 31 rose 3.1% and earned premiums edged up a similar amount. Of the 16 companies we track, the premium increase at nine was above the average, while the increase at seven was below.

Six underwriters actually recorded declines in written volume. While this shows a bit of a change in terms of companies' willingness to walk away from business, it still underscores the split within industry ranks with respect to market-share considerations. As has been the case for some time, the volume gains were almost exclusively tied to the personal lines segment of the business.

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- Pretax investment income from property/casualty operations continues to lumber along at a snail's pace. The companies surveyed showed a 3.2% investment income increase, with six companies above the average, nine companies below and one even with the average.

These results continue to reflect the impact of a reduction in cash flows and a decline in investment yields. This pattern will persist until there is a reversal in cash flow, which is the dominant variable.

- The average combined ratio (after policyholder dividends) for our group weighed in at 106.7%, compared with 107.7% last year. Only Geico Corp. and American International Group Inc. posted combined ratios less than 100%, with the ratios of the reporting companies ranging between 93.2% and 119.8%.

Although the average combined ratio improved, the expense ratio deteriorated about 1.1 percentage points, while the loss ratio improved 2.1 points, reflecting very favorable personal lines underwriting experience and a decline in catastrophe losses.

- Our loss reserve data is not complete. However, paid claims, mirroring the favorable level of catastrophes, expanded only slightly and the small increases in loss reserves—or lack of any additions—further buoyed the insurers' results.
- Finally, surveyed property/casualty insurers' operating earnings bounced up about 14.5%. There was a rather wide divergence between companies, with some posting as much as a 60% earnings increase, while others' earnings decreased by a similar amount.

The "Looney Tunes" cartoon that the industry has been projecting for the past few years may finally be coming to a conclusion. We suspect a turning point on pricing may be approaching as we come into the second half of 1983. We believe that the following have to be recognized:

- Cash flow from operations (excluding net investment income) has dried up. And, the paltry growth in net investment income, caused by the decline the yield curve, has further exacerbated the cash drought.
- Expense ratios are showing the strain of slow premium growth. Staff reductions vs. expansions are the benchmarks of this strain. Traditionally, management teams have not sought to shrink their companies.
- More underwriters seem to be approaching (or to have reached) the same tax bind that Aetna Life & Casualty Co. is in. As we noted earlier (*BI*, Feb. 23), the Securities and Exchange Commission has scotched all hopes of booking future tax credits.

Notwithstanding the first-quarter earnings results, we still expect industry earnings to decline in 1983. Book values, however, have shown some "apparent" growth reflective of stock- and bond-market gains. Thus, returns on equity figures, while not plummeting, are not going up, either.

Most important, however, is the beginning of some economic growth, which should manifest itself in some modest but nonetheless positive premium growth in various commercial lines in the second half of the year. We suspect that underwriters in the trenches will be more willing to attempt to secure some magnitude of rate relief from clients if there is some support in the form of premium growth. Hence, a total or partial rejection of a sought-after rate increase would not be as evident.

What does all of this mean? We believe that earnings projections that industry observers have made for 1984—and possibly 1983—are too high and some reductions in earnings will still be forthcoming. In addition, more company managements will have to bite the bullet and be more candid about the operating environment, as was done about two weeks ago by Continental Corp. Chairman John Mascotte (*BI*, May 23).

The longer the cartoon show runs, the more insidious becomes the industry's credibility about seriously reversing its current course. The industry is going to have to follow the lead of the well-known rotund little cartoon character who has been known to stammer: "...Tha', tha', tha' that's all, folks!" ■

BI Industry Stock Report

MAY 24, 1983 5/18/83 THRU 5/24/83

Insurance Cos.		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	42.13	0.6	7.4	2.64	6.3	42.13	41.75	784.2
American Bankers Ins Group	OTC	14.75	1.7	11.6	0.50	3.4	14.75	14.63	116.2
American Gen Ins Co	NYSE	23.00	0.0	8.8	0.80	3.5	23.00	22.75	506.5
American Indty Finl Corp	OTC	20.63	-0.6	15.3	1.12	5.4	20.75	20.50	7.8
American Intl Group Inc	OTC	75.00	2.0	12.9	0.44	0.6	76.00	74.50	302.6
American Natl Ins Co	OTC	19.25	0.0	8.0	0.84	4.4	19.50	18.88	95.0
American Sts Life Ins Co	OTC	31.00	6.9	8.6	0.88	2.8	31.00*	30.00	1.3
Aneco Reins Ltd	OTC	3.75	-6.2	125.0	0.00	0.0	4.00	3.75	30.9
Avemco Corp	AMEX	16.25	3.2	9.7	0.58	3.6	16.25	16.00	13.7
Banks Iowa Inc	OTC	44.00	3.5	11.6	1.52	3.5	44.00*	42.50	5.9
Bitco Corp	OTC	36.50	0.0	7.6	2.00	5.5	36.50	36.50	1.9
Carolina Cas Ins Co	OTC	8.25	0.0	10.9	0.32	3.9	8.25	8.25	0.7
Chubb Corp	OTC	55.00	-0.5	8.6	2.92	5.3	56.38	55.00	323.5
Combined Intl Corp	NYSE	34.00	-4.9	11.3	2.00	5.9	35.63	34.00	159.0
Continental Corp	NYSE	31.50	5.9	17.4	2.60	8.3	31.50	29.63	661.3
Crawford & Co	OTC	24.50	12.6	17.8	0.60	2.4	24.50*	23.75	100.8
Crown Life Ins Co	OTC	110.00	-4.3	7.2	3.10	2.8	115.00	110.00	0.2
Employers Cas Co	OTC	40.75	2.5	8.4	1.20	2.9	40.75*	39.75	7.5
Equifax Inc	NYSE	32.13	0.0	14.6	1.40	4.4	32.63	31.88	13.7
Excelsior Ins Co	OTC	12.00	0.0	0.0	0.70	5.8	12.00	12.00	6.4
Farmers Group Inc	OTC	41.50	-2.6	10.9	1.36	3.3	42.63	41.50	656.1
Foremost Corp Amer	OTC	53.25	-1.4	16.3	1.24	2.3	54.00	53.25	16.6
Fremont Gen Corp	OTC	29.50	4.0	983.3	0.48	1.6	29.63	28.50	261.7
Great West Life Assurn Co	OTC	199.00	0.5	10.8	10.00	5.0	199.00	198.00	0.0
Hanover Ins Co	OTC	64.25	12.7	8.0	0.88	1.4	64.25*	56.00	79.0
Hartford Steam Boiler Insptn	OTC	55.50	0.9	12.2	3.00	5.4	55.50*	55.50	9.7
Jefferson Natl Life Ins Co	OTC	47.50	3.3	14.9	0.76	1.6	48.00	46.50	17.7
Kemper Corp	OTC	49.25	-0.5	9.2	1.80	3.7	49.50	49.13	24.5
Lincoln Natl Corp Ind	NYSE	49.75	-1.0	9.1	3.00	6.0	50.75	49.75	160.1
Mission Ins Group Inc	NYSE	39.00	14.7	10.8	1.00	2.6	40.75*	33.50	662.2
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	DID NOT TRADE		
Northwestern Natl Life Ins	OTC	34.88	0.7	23.1	1.50	4.3	34.88	34.50	24.3
Ohio Cas Corp	OTC	53.13	-4.5	10.0	2.52	4.7	55.88	53.13	107.1
Old Rep Intl Corp	OTC	32.13	0.0	7.8	0.92*	2.9	32.13	32.00	75.8
Orion Cap Corp	NYSE	25.00	-5.7	12.6	0.66	2.6	26.00	24.50	198.6
Preferred Risk Life Ins Co	OTC	33.88	-1.1	9.3	1.00	3.0	34.00	33.88	4.3
Provident Life & Acc Ins Co	OTC	63.50	0.8	9.0	2.60	4.1	63.50	63.00	36.5
St Paul Cos Inc	OTC	62.63	-5.6	6.4	2.80	4.5	66.00	62.63	397.0
Safeco Corp	OTC	54.88	-6.8	11.4	2.40	4.4	58.13	54.88	136.8
Sri Corp	OTC	47.00	3.9	8.8	1.12	2.4	47.25	45.25	52.2
Seibels Bruce Group Inc	OTC	25.75	-3.7	14.1	0.80	3.1	27.38	25.75	42.4
Statesman Group Inc	OTC	13.00	16.9	8.7	0.15	1.2	13.13*	11.25	122.4
Tokio Marine & Fire Ins Co	OTC	103.75	-0.5	16.6	0.92	0.9	104.00	102.63	9.9

MAY 24, 1983 5/18/83 THRU 5/24/83

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Travelers Corp	NYSE	31.50	0.0	8.4	1.80	5.7	31.63	31.13	850.8
United Fire & Cas Co	OTC	33.50	1.5	9.9	0.88	2.6	33.50*	33.50	0.5
United States Fid & Gty Co	NYSE	55.50	4.0	13.0	3.84	6.9	55.50*	54.25	426.9
United Svcs Life Ins Co	OTC	24.00	-4.0	7.2	1.00	4.2	24.75	23.63	29.9
Uslife Corp	NYSE	24.88	-1.0	6.9	0.88	3.5	25.38	24.88	232.6
Washington Natl Corp	NYSE	33.50	-1.1	15.2	1.08	3.2	33.50	32.00	170.6
Zenith Natl Ins Corp	OTC	22.75	1.1	11.0	0.80	3.5	22.75	22.50	9.7
INSURANCE COMPANIES	AVERAGE			10.5		3.7			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	21.38	1.8	0.0	1.00	4.7	21.38	21.00	425.3
Baldwin & Lyons Inc	OTC	41.50	0.0	7.6	0.80	1.9	41.50	41.50	0.3
Corroon & Black Corp	NYSE	25.13	-1.5	13.4	1.80	7.2	25.50	25.13*	23.5
Crump E H Cos Inc	OTC	11.75	0.0	17.0	0.40	3.4	11.88	11.63	23.6
Emett & Chandler Cos Inc	OTC	10.38	0.0	0.0	0.00	0.0	10.38	10.38	1.2
Hall Frank B & Co Inc	NYSE	31.25	-5.7	17.8	1.70	5.4	32.25	31.25	133.8
Integrated Res Inc	AMEX	41.00	11.6	16.1	0.00	0.0	41.00	38.50	227.1
Marsh & Mclennan Cos Inc	NYSE	44.75	-3.8	13.0	2.20	4.9	46.75*	44.50	596.8
Poe & Assoc Inc	OTC	6.50	0.0	0.0	0.40	6.2	6.50	6.50	11.2
Reed Stenhouse Cos Ltd	OTC	17.00	4.6	17.0	0.60	3.5	17.00*	16.25	46.2
AGENTS/BROKERS	AVERAGE			17.0		3.6			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	69.75	3.5	14.5	1.92	2.8	69.75	66.50	1,485.9
Anderson Clayton(Ranger/PanAm)	NYSE	31.75	3.3	21.2	1.32	4.2	31.88	31.38	66.7
Armco Inc	NYSE	19.25	2.7	0.0	0.40	2.1	19.25	18.25	380.1
City Investing Co. (Home Ins.)	NYSE	34.50	-0.7	8.2	1.80	5.2	35.00	33.88	310.1
CNA Finl Corp (CNA)	NYSE	21.88	2.3	8.7	0.00	0.0	22.00*	21.63	22.8
Control Data (Comml. Credit)	NYSE	57.00	2.9	14.3	0.60	1.1	57.00*	53.50	1,179.0
General Re Corp	NYSE	62.13	0.2	13.1	1.28	2.1	62.75	60.00	518.9
Gulf Utd Corp	NYSE	27.88	-0.4	8.7	1.32	4.7	28.13	27.88	272.2
Cigna Corp	NYSE	49.00	3.4	7.1	2.48	5.1	49.00	47.25	1,132.9
ITT (Hartford Group)	NYSE	39.00	-2.5	8.4	2.76	7.1	39.75	39.00	908.5
Optimum Hldg Corp	OTC	8.13	1.6	13.3	0.00	0.0	8.13	8.00	21.5
Sears Roebuck & Co. (Allstate)	NYSE	40.25	-0.6	14.7	1.52	3.8	40.25	38.88	2,113.7
Baldwin Utd Corp	NYSE	11.13	-1.1	5.3	0.00	0.0	11.50	10.88	1,414.5
Teledyne Inc (Argonaut)	NYSE	150.38	4.8	13.0	0.00	0.0	151.25	143.75	539.1
Transamerica Corp (Occidental & Fred S. James)	NYSE	30.50	1.2	10.0	1.50	4.9	30.50	29.00	533.6
CONGLOMERATES/HOLDING COS.	AVERAGE			13.4		2.6			

*Record high/low since Jan. 1, 1983

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Financial briefs

Industry results

Commercial property/casualty premiums written by the U.S insurance industry increased just 0.37% in 1982 to $39.7 billion, according to final industry statistics compiled by A.M. Best Co. Inc.

According to Best, the industry—including both commercial and personal lines—suffered its worst underwriting year in history last year, as underwriting losses totaled $8.36 billion, almost double the $4.5 billion underwriting loss the industry posted in 1981.

The property/casualty industry's total net written premiums, including personal lines, increased 4.3% to $104.2 billion, Best says, while net investment income increased 12.7% to just more than $15 billion. That, however, compares with investment income increases exceeding 20% in each of the previous four years.

The insurers reported their total admitted assets increased 9.7% in 1982 to $251.2 billion and policyholders' surplus jumped 11.8% to $60.8 billion.

The Best survey includes 1,723 insurers that represent 98% of the U.S. property/casualty insurance market.

Lincoln National

Lincoln National Corp. has declared a quarterly cash dividend of 75 cents per share on both its common stock and its Series A Cumulative Convertible preferred shares.

The common stock dividend is payable Aug. 1 to shareholders of record July 8. The preferred dividend is payable Sept. 5 to shareholders of record Aug. 15.

Colonial Penn

Colonial Penn Group Inc. says its first-quarter earnings increased 74% to $10.7 million, or 66 cents per share, compared with $6.1 million or 38 cents per share in last year's first quarter.

Consolidated revenues for the three months ended March 31 rose 6.4% to $295.4 million from $277.9 million. ■

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