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Update

Captive to cover property loss from Texaco refinery explosion

WILMINGTON, Calif.—Reinsurers could face property damage claims totaling hundreds of millions of dollars as a result of an explosion last week at a Texaco Inc. oil refinery near Los Angeles.

Texaco's Bermuda captive, Heddington Insurance Ltd., covers the property risk and has extensive reinsurance. But the oil company does not have business interruption coverage, said Daniel Grogan, assistant general manager-risk management for Texaco.

Texaco carries a $10 million self-insured

Continued on next page

Antitrust showdown set

Industry defendants elated that high court will review case

By JUDY GREENWALD

WASHINGTON—Insurance industry defendants are jubilant that the U.S. Supreme Court is going to hear the massive insurance antitrust litigation.

But they acknowledge there is no guarantee they will ultimately prevail.

Insurance industry defendants want the high court to overturn a 9th U.S. Circuit Court of Appeals ruling that reinstated the antitrust action after it had been dismissed by U.S. District Judge William Schwarzer (*BI*, June 24, 1991).

Last week, the Supreme Court agreed to consider three issues in the case. Two involve the McCarran-Ferguson Act, which gives insurers a limited exemption from federal antitrust laws, and one involves comity, a mutual respect for foreign law. Oral arguments are expected to take place early next year.

Supreme Court to hear ERISA cases but won't review pollution disputes
Page 49

Attorneys note that the suit would only be dismissed if the Supreme Court rules in favor of the defendants on both of the antitrust issues. A ruling in their favor on the comity issue is likely to lead only to the dismissal of some of the foreign defendants.

If the Supreme Court rules against the defendants on either of the antitrust issues, the case would then be returned to U.S. District Court for discovery and either a summary judgment or trial. During the initial stages of the litigation, both the trial court and the appeals court rulings were based on the assumption the factual allegations made by the states bringing the action are true.

Last week's decision is "a very good sign," said Stephen M. Shapiro of Mayer, Brown & Platt in Chicago, which prepared the review petition filed by most of the U.S. defendants.

Two of three cases the court reviews are reversed, he noted.

By taking the case, the justices were indicating "they think something is very

Continued on page 48

AP/Wide World Photo

Mr. Perot favors a health benefit tax.

Perot offers low-key health care reform plan

By CHRISTINE WOOLSEY

DALLAS—Presidential candidate H. Ross Perot wants to corral runaway health care costs by, among other things, taxing employees on their health benefits.

The Texas billionaire's health care proposal is vague, but not that controversial. It mainly calls for short- and long-term strategies that stress cost containment and preventive health programs.

One probable source of friction, though, would be his call for "changing federal rules to allow states the necessary flexibility to conduct pilot (health reform) programs." While he provides few specifics, many observers think this refers to waiving Employee Retirement Income Security Act pre-emption rules—a move that would not sit well with multistate employers.

In addition, Mr. Perot would push for an increase—to 35% from 25%—in the Medicare Part B premium, and he would remove the $130,000 ceiling on the 1.45% portion of the FICA tax that covers Medicare Part A.

The independent candidate also wants to trim pension benefit in-

Continued on page 51

• • • Employee • • •
Benefits
Communication
• • • Awards • • •
Page 3

Aviation rate reversal?

El Al crash may trigger price hikes

By ALINE SULLIVAN

AMSTERDAM—Hull and liability claims from the Oct. 4 crash of an El Al Israel Airlines in an Amsterdam suburb may reach $200 million, which could shock the aviation insurance market into raising rates.

The crash of the El Al Boeing 747-200 comes one week after a Pakistan International Airlines Airbus A-300 crashed in Nepal. Insurers face hull claims of $35 million and an undetermined amount of liability claims from the PIA crash (*BI*, Oct. 5).

While some market observers think the losses will force increases in aviation rates, others say there still is too much capacity and competition among underwriters for rates to increase.

The El Al crash killed an estimated 250 people on the ground, three crew members and one passenger and destroyed two 10-story apartment buildings. The airline has $750 million in liability insurance and $62 million in coverage for the hull. The coverage was placed by Alexander Howden Ltd.

The hull and liability coverage was underwritten by a pool of five Israeli insurers: Clal (Israel) Ltd., Hamgan, Hassneh Insurance Co. of Israel Ltd., Israeli Phoenix Insurance Co. Ltd. and Migdal Insurance Co. Ltd.

Almost all of the pool's exposure was reinsured outside of Israel, with the bulk placed in London, according

Continued on page 50

Rescue workers shuffle through the remains of the Dutch apartment complex destroyed in the crash.

AP/Wide World Photo

New RJR Nabisco pension plan called more equitable, attractive

By JERRY GEISEL

NEW YORK—RJR Nabisco Inc. is launching a bold new defined benefit pension program that retains many of the strengths of traditional plans while avoiding many of their weaknesses.

The new plan is designed to provide a relatively steady accrual of benefits so that individuals who serve with the company for a shorter period of time can earn a much more substantial benefit than under a traditional plan.

And because the RJR Nabisco plan is partly based on a participant's final average pay, it can offer richer benefits to mid-career hires than defined contribution or cash balance plans, which require longer service to generate bigger benefits.

At the same time, the RJR Nabisco plan includes many of the features that have made defined contribution plans a hit among employees, including highly visible, relatively easy-to-understand benefits and benefit portability.

For each year worked under the new plan, employees will be credited with a specific percentage that will be used to calculate their pension. The percentage that employees earn increases with age. For example, an employee will earn 4% for each year of employment under age 30, rising to 13% annually starting at age 60.

When employees leave the company or retire, they will receive a benefit equal to the sum of the percentages earned multiplied by final average pay. Employees can take the lump sum as cash, convert it to an annuity or roll it over into an individual retirement account or another employer's pension plan (see story, page 40.)

The plan, which takes effect Jan. 1, will replace a $1 billion cash balance pension plan at the company's Nabisco Foods Group unit and a $1.5 billion traditional defined benefit plan at its R.J. Reynolds Tobacco Co. unit.

Continued on page 38

Update

Texaco covered for L.A. blast

Continued from previous page
retention for property risks, he said. Texaco then purchases an unknown amount of property coverage from Heddington.

Heddington retains $20 million of the risk and buys about $700 million of quota-share reinsurance, said Heddington Senior Vp John Turner. The captive's reinsurance program is placed by Willis Faber & Dumas in London, Mr. Turner confirmed.

The program is structured in several layers with various leading reinsurers. Lloyd's of London syndicate 190, managed by Cater Allen Syndicate Management Ltd., is the lead reinsurer of the first layer, as well as several other layers, Mr. Turner said.

"I doubt whether the whole value of the refinery exceeds $700 million, but claims could get into hundreds of millions of dollars," Mr. Grogan said.

About 16 workers suffered minor injuries when the refinery, located about 15 miles south of Los Angeles, exploded Thursday night. There were no deaths. The fire was under control by Friday.

Mr. Grogan said that "all of the automatic shut-off valves worked, so all of the good things that were supposed to happen did."

The explosion blew out windows in buildings near the refinery, and 200 families in the area were evacuated after the explosion. Heddington also writes Texaco's liability coverage.

Gooda review clears Lloyd's

LONDON—A loss review committee has cleared Lloyd's of London of any negligence in connection with the massive losses incurred by members of defunct syndicates formerly managed by the Gooda Walker group of agencies.

Lloyd's "properly administered the relevant regulatory requirements related to the Gooda group," the committee said.

The report also clears the underwriters and directors of the Gooda Walker companies of "impropriety of a dishonest nature."

But, the report identified "deficiencies" in managing agencies Gooda Walker Ltd. and Gooda & Partners Ltd. that contributed to the huge syndicate losses, including "inadequate" planning and control of underwriting and a failure to give "all relevant information" to members. Were it not for those deficiencies, member losses "might have been avoided or mitigated," the report concludes.

To date, members on all seven Gooda Walker syndicates have been asked to pay 682.2 million pounds ($1.17 billion) (*BI*, Aug. 31).

The committee also said the syndicates lacked adequate reinsurance to protect against the London market excess-of-loss reinsurance spiral, which was exacerbated by catastrophe claims from 1987 to 1990.

The report also suggests several possible regulatory changes, such as limiting the use of time-and-distance policies and adopting a risk-based system to limit syndicates' exposures.

AIG eyes new excess facility

HAMILTON, Bermuda—American International Group Inc. is proposing to set up an excess liability insurer in Bermuda to compete with established facilities like X.L. Insurance Co. Ltd. and ACE Insurance Co. Ltd.

AIG is seeking to raise preliminary capital of $100 million for the new insurer, tentatively called Global Excess Liability Insurance Co., according to a draft prospectus.

Plans call for Global Excess to write umbrella excess liability limits of $100 million excess of a minimum of $50 million. The company also is expected to offer up to $50 million of directors and officers liability coverage excess of $50 million.

According to the prospectus, Global Excess will provide additional capacity for companies that have been looking to increase their liability limits. The proposed insurer also is seen as an effort to exploit the contraction in capacity in the London market.

AIG is understood to be prepared to put up 20% of the initial capital.

Global Excess would compete directly with X.L., which offers $100 million of liability coverage excess of $25 million, and ACE, which writes $50 million of D&O coverage excess of $25 million.

City unions win retiree benefits

PHILADELPHIA—About 15,000 Philadelphia employees are back to work after a 36-hour strike over wages and health benefits.

Members of Local District Council 33, which represents 12,000 blue-collar workers, and Council 47, which represents 3,000 white-collar workers, returned to work Wednesday under a new four-year agreement that guarantees them retiree medical benefits at no cost and retains the unions' right to administer group health plans.

Mayor Edward G. Rendell had proposed cutting retiree medical benefits and taking over the administration of group health insurance plans from the union locals representing city workers, including fire and police unions (*BI*, Sept. 28). The fire and police unions are currently in arbitration.

Total health care costs for the city are estimated at $175 million for the fiscal year ending June 30.

Updates continued on page 50

Errors & omissions

• Robert B. Angle, vp of national marketing and regional vp at Montgomery & Collins Inc. in Glastonbury, Conn., was elected president of the National Assn. of Professional Surplus Lines Offices Ltd. David R. Hartoch, chief operating officer and president of Sherwood Insurance Services in San Francisco, will serve as vp of NAPSLO, not president as incorrectly reported in an Oct. 5 article.

Insurers, agents hope for a season of change

By JAMES M. BURCKE

NACSA/NACSE CONFERENCE
The Greenbrier

WHITE SULPHUR SPRINGS, W.Va.—The rolling hills that surround The Greenbrier were unusually green for the first week of October as top U.S. property/casualty insurance industry executives assembled for their annual gathering at the posh resort.

While the lack of fall colors may have been a disappointment for some, the agents, brokers and insurers at this year's joint meeting of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives generally would not mind seeing a bit more green—the color of money.

Five years of falling rates and an unprecedented run of catastrophes—climaxed by Hurricane Andrew, the most costly disaster in history and whose toll still is climbing—are prompting calls for insurers and intermediaries to change the way they do business. The options are many, from the adoption of total quality management programs to new strategies to further consolidation, especially among agents and brokers.

Even after weeks of bad news in the wake of hurricanes Andrew and Iniki, few insurers and intermediaries can say with any certainty that the market will turn by year end. Some executives predict a slow, gradual turn that will be in full effect by the

Continued on page 44

Andrew's toll still climbing

Allstate's estimated $1.73 billion in claims could be a record

By SARA J. HARTY

Claims from Hurricane Andrew continue to mount, with Allstate Insurance Group now reporting what is thought to be the largest gross loss ever reported by a U.S. insurer for a single event: $1.73 billion.

Other insurers last week also increased their hurricane-related loss estimates, and State Farm Group said it will pump $2 billion into its property/casualty unit's surplus because of the large hit the unit will take.

Hurricane Andrew, the costliest storm ever, roared through the Bahamas, Florida and Louisiana in late August (*BI*, Sept. 7; Aug. 31). The Property Claim Services division of the American Insurance Services Group initially estimated insured losses in the United States at $7.8 billion. And insured losses not counted by the group, like marine losses and losses in the Bahamas, add about $800 million to that total.

But claims advices from Hurricane Andrew indicate that the loss to insurers and reinsurers will total $10 billion to $12.5 billion, said George Lloyd-Roberts, chairman of Lloyd's Non-Marine Underwriters' Assn.

Most of the claims coming into London will be on catastrophe reinsurance policies, he said.

Insurers over the past few

Continued on page 49

Harvard offers supplemental plan for health workers

AIDS benefit questioned

By SALLY ROBERTS

CAMBRIDGE, Mass.—It is unlikely that many health care institutions will follow the lead of Harvard University and offer a lump-sum $100,000 benefit to any hospital or clinic employee who contracts the AIDS virus on the job.

Benefit consultants are raising several questions about, among other things, the value and fairness of the Harvard benefit.

The benefit will be paid in addition to workers compensation and health insurance benefits to doctors, nurses, medical students and other workers who contract the human immunodeficiency virus through a work-related incident.

Controlled Risk Insurance Co. Ltd., Harvard's Cayman Islands captive, will fund the new benefit.

The captive also writes medical malpractice liability coverage for the university's hospitals and doctors. Claims will be administered by the Harvard Risk Management Foundation.

The benefit is "a starting point," said Jack McCarthy, executive vp with the foundation, a management agency for affiliated Harvard medical institutions in Cambridge, Mass.

Continued on page 47

Final 404(c) rules to aid employers

By JERRY GEISEL

WASHINGTON—Final Labor Department rules will make it easier for employers sponsoring defined contribution plans to avoid fiduciary liability for employee investment decisions.

The rules also contain relaxed compliance requirements for employers that offer company stock as an investment option.

But the final rules—to be published this week in the Federal Register—will increase the amount of financial information employers must disclose to plan participants about investment options to qualify for an exemption under Section 404(c) of the Employee Retirement Income Security Act of 1974.

That section relieves employers of fiduciary liability for losses from a participant's investment decisions.

The final rules, though, retain the core of earlier versions: Employers must offer participants at least three diversified categories, each with materially different risk and return characteristics (*BI*, Dec. 24, 1990).

In addition, an investment alternative offered to participants,

Continued on page 50

Inside

Departments

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.... TOTAL BENEFITS PROGRAM ....

Best of Show
New York Life Insurance Co.

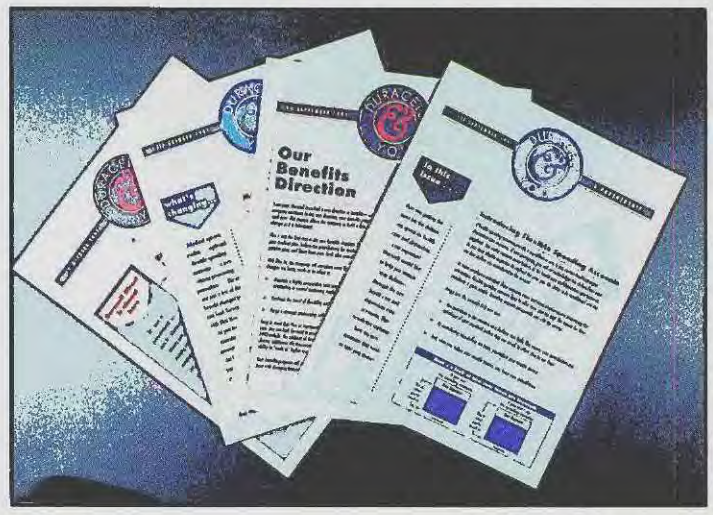
Award of Excellence
St. Luke's Hospital
MAPCO Inc.
American Telephone & Telegraph Co.

.... MULTI-SUBJECT BOOKLET ....

Best of Show
PepsiCo Inc.

Award of Excellence
Intermountain Health Care

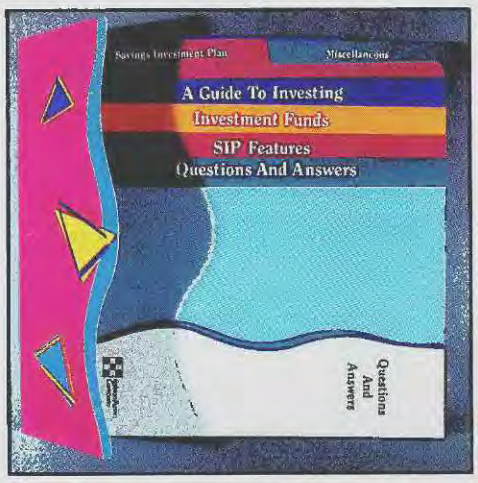
.... BENEFITS NEWSLETTER ....



Best of Show
Duracell International Inc.

Award of Excellence
Duquesne Light Co.

.... MULTI-MEDIA PROGRAM ....



Best of Show
Ralston Purina Co.

.....Employee..... Benefits Communication .....Awards.....

The 20th annual *Business Insurance* Employee Benefits Communication Awards competition recognizes oustanding efforts by 18 employers to effectively communicate their benefit programs to employees.

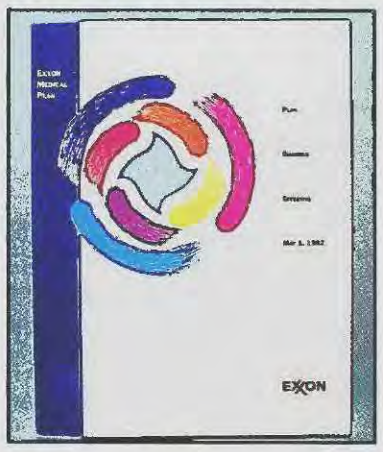
The 1992 competition attracted 177 entries from 139 companies.

Twenty-two of the entries—and one of the winning programs (see story, page 16)—were prepared in-house by employers; the remaining 155 programs were developed with the assistance of benefit consultants.

The entries were judged by 19 experts—up from 11 last year—in the fields of employee benefits, communications and marketing, design and production. The entries were scored based on how well they fulfilled each of five basic criteria, including the program's objectives, strategy, content, presentation and effectiveness.

Profiles of the winners begin on page 6.

... SINGLE SUBJECT BOOKLET ...



Best of Show
Exxon Corp.

Award of Excellence
Kaiser Permanente Medical Care Program
The Equitable Life Assurance Society of the United States

PERSONALIZED .... CORRESPONDENCE ....

Best of Show
The Coca-Cola Co.

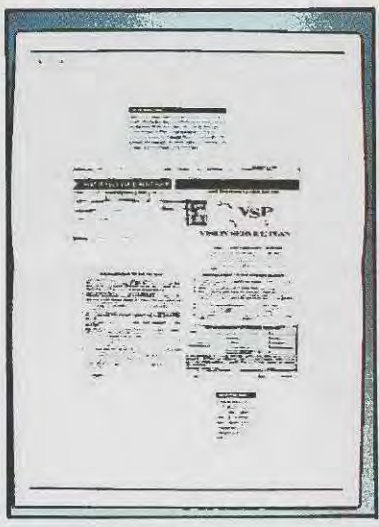
Award of Excellence
QSP Inc.

.... AUDIO-VISUAL PRESENTATION ....

Best of Show
Los Angeles County Employees Retirement Assn.

Award of Excellence
PepsiCo Inc.

.... SPECIAL PROJECT ....



Best of Show
Tenneco Inc.

Award of Excellence
International Business Machines Inc
Public Service Electric & Gas Co.

Benefits communication at the touch of a button

By SALLY ROBERTS

Alexander Graham Bell would be amazed at how far technology has taken his 1876 invention.

Advances in telephone voice response systems and other technologies have not only increased employee understanding of benefit options and increased enrollment, but also reduce the amount of paper used, the chance of errors, and the time spent on routine inquiries and transactions.

And now that interactive technology is less expensive to install and has shown positive results, more employers are investing in these systems.

"Today, it is more widely accepted that interactive benefit communication is cost-effective for administration," said Jay Marchant, principal at William M. Mercer Inc. in Deerfield, Ill.

Telephone systems are the most popular interactive technology—well ahead of interactive personal computers—and their use has "skyrocketed" over the past couple of years, said Gilbert Jacobs, a consultant with The Wyatt Co. in Washington.

More employers are leaning toward using telephones to convey and receive benefits information because they are easy to use and there is almost universal access, agreed Tim Stentiford, a consultant with Hewitt Associates in Walnut Creek, Calif.

"Not everyone has access to a personal computer," he pointed out.

Two years ago, the most popular use of telephone voice response systems was to communicate routine benefit information to employees and to answer common questions (*BI* April 2, 1990).

Although that is still its primary use, the technology has evolved some since then.

Now, in addition to obtaining information and answers to workers' questions at any hour of the day, some employers are using the telephone to enroll employees in retirement plans, savings

Continued on next page

Interactive systems

Continued from previous page

plans and flexible spending accounts.

Additionally, through a touch-tone phone, employees can transfer funds in their 401(k) plan between different investment options.

The next wave in interactive telephone systems could well be voice recognition systems.

Currently, interactive phone systems are limited to touch-tone telephones, but the voice recognition technology is very promising, said Mr. Jacobs.

Voice recognition systems are able to understand the numbers zero through nine from human voices. And while the technology is still new, there is a 97% accuracy rate, Mr. Jacobs said.

Voice recognition systems eventually will be able to recognize the spoken alphabet with similar accuracy, he said.

Currently, voice recognition systems are able to understand such words as "help" and "operator" quite well, he added.

The advantages to employers that use voice response systems include greater participation, less paper used, fewer errors and less time spent answering questions and entering data.

And the costs of such a system has become more attractive, as well.

Initial set-up for a voice response system now costs anywhere from $10,000 to $70,000 or more, said Shelley Ochab, a consultant for Hewitt Associates in Lincolnshire, Ill. The cost depends on the complexity of the voice response system, she explained.

But that is significantly lower than the $300,000 to $400,000 average cost of early systems developed in the mid-1980s, consultants say.

Voice response systems currently are predominant among the biggest companies, which initially were the only companies that could afford the technology.

There is probably not a Fortune 500 company that is not using voice response systems in benefit administration, said The Wyatt Co.'s Mr. Jacobs.

The only question now is whether the systems will catch on with companies that have 2,000 or fewer employees, Mr. Jacobs said.

One such company using an interactive phone system is MNX Inc., a transportation firm in St. Joseph, Mo.

Through its phone system, MNX's nearly 2,000 employees—mostly on-the-road truck drivers—can get information, enroll in various benefits programs and change benefits options.

"The interactive telephone system is made for the trucking industry," observed Michele Wohl, a William M. Mercer Inc. associate in Kansas City, Mo.

Because the trucking industry has a mostly transient workforce, MNX needed a non-traditional way to explain and promote its benefit programs to employees, said Ms. Wohl, who worked with MNX.

MNX employees are now able to call a toll-free number from any touch-tone phone at any time of the day to get information about their benefits.

By pressing "1," employees hear general information about the company's 401(k) plan, health care spending account or dependent care spending account. By hitting "2," they can enroll in any of these programs, change participation or change investment options in the 401(k) plan.

Ms. Wohl would not say how much the voice response system cost. She noted, however, that it has resulted in a 42% increase in 401(k) participation.

Although interactive telephone systems are regarded as an excellent way to cut administrative costs, some consultants say personal computers are a better way for employers to better promote and more fully explain benefit plans.

Computers can do sophisticated modeling of employees' elections well beyond what interactive phone systems can do. Employees can project, for instance, how much will be in their 401(k) savings plan when they retire based on a particular contribution level.

Currently, most computer systems are not set up to automate enrollment, leaving that function in the hands of benefit administrators.

First Chicago Corp.'s "HR Connection" system lets employees review information ranging from confidential salary data to general company benefit policies.

HR Connection is housed in a computer kiosk—resembling an automatic teller machine—with a touch screen for executing commands.

It provides more than 400 pieces of current information about the bank's benefits and human resources programs, but does not provide enrollment options, said Sal Campagna, a vp with the Chicago financial institution.

Although enrollment is still done manually, First Chicago's ultimate goal is to eventually create a paperless human resources department, he said.

Because employees can use the system to make address changes or add a beneficiary to their life insurance policy, less paperwork has to be done. And, by making employees more aware their benefit options, the system has reduced calls to human resource representatives for purely factual information, said Mr. Campagna.

Two kiosks have been placed in high-traffic areas at First Chicago's headquarters and more will be installed.

The initial system development cost nearly $50,000, Mr. Campagna said. Each additional touch screen kiosk costs another $3,000, he added.

Interactive computer kiosks are very sophisticated systems—incorporating touch screens, full-motion videos, animation, color and sound—but they have "not become very popular" because of their high costs, according to Wyatt's Mr. Jacobs.

The hardware itself is expensive and the cost of printers and cabinetry also need to be included, he noted.

The cost of an interactive computer system can range from as low as $10,000 to as high as $100,000 or more, said Mr. Jacobs. But, over the past five years, prices of such systems have dropped 50%, he projected.

A computerized alternative to kiosks that costs significantly less is making benefit software available to employees.

Computer diskettes can be distributed to employees who can run the programs on their office or home PCs.

One example is Towers Perrin's FlexPlanner software, which is designed to give employees information about their flex plan options and choices. At a total cost of $10,000 to $15,000, the software helps employees choose among benefit options found in a company's flexible benefit programs, including medical, dental, disability and life insurance, said Peter Breslin, a consultant at Towers Perrin in Stamford, Conn.

For example, FlexPlanner can assist employees to compare the finan-

Continued on page 6

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... Employee Benefits Communication Awards ...

Tenneco booklet offers one-stop claims assistance

By EILEEN P. GUNN

.... SPECIAL PROJECT ....

HOUSTON—People seldom look more perplexed than when trying to decipher their medical claims forms, and even small changes in benefit programs can add wrinkles to an already-furrowed brow.

So Tenneco Inc. had good reason to expect some chaos and confusion when it radically altered its benefit programs for 1992. Among other things, it dropped five insurance companies that had provided medical benefits and introduced a new flexible benefits plan provided by a single insurer.

To help its 28,000 employees adjust to the change, the conglomerate developed a "Tips For Filing Claims" booklet to be included in its employee orientation program. The booklet was given a Best of Show award in the special projects category of the 1992 *Business Insurance* Employee Benefits Communication Awards competition.

"Our uniqueness was the massiveness of the change," said Kim R. Bacon, director of benefits planning at Tenneco in Houston. "Switching to one carrier was a big hurdle to jump."

"Every claim form people were used to filling out changed," explained Kevin R. Barris, a consultant with Towers Perrin in Houston, which helped develop the booklet. "Our goal was to make a confusing array of things a little simpler."

Even with the new plan and changes in paperwork, the number of claims being returned is much lower than Mr. Bacon and his colleagues anticipated. Even forms for programs employees never had before, like flexible spending accounts, are being filled out correctly.

Mr. Barris calls the booklet a "claims kit" that "brings all the pieces of claims together."

The booklet runs 24 pages and cost $36,000 to produce. It features full-sized reproductions of claims forms for medical coverage, two types of dental and vision coverage, several flexible spending accounts and other general filings.

The first page lists toll-free numbers for the medical, dental and vision claims and a mail-order prescription drug service.

Comic strip-style conversation balloons surround the claim form reproductions reminding employees to include information or giving explanations.

For example, at the bottom of the medical claim form, an arrow points to an employee signature box. A bubble reminds claimants

Continued on next page

Interactive systems

Continued from page 4

cial impact of various medical coverage choices, taking into account contribution amounts, reimbursement levels, anticipated claims and benefits under a spouse's plan, Mr. Breslin said.

In addition, the software can also help employees decide how much to set aside in a health care spending account to pay out-of-pocket expenses, based on estimated claims and the medical option selected.

"These are very difficult calculations, but they are easy on a PC," Mr. Breslin said.

Like First Chicago's interactive computer kiosks, FlexPlanner lacks an enrollment feature. Employees print out their options and send them to the employee benefit department to record and file.

Apple Computer Inc. has developed a system to simplify enrollment with its MacFlex software, a flex plan enrollment program for the Macintosh computer.

Last year, the computer company upgraded the software to add bar codes to the printouts of employees' selections. Using a special scanning device, a benefits administrator can scan the code on employees' enrollment printouts into the system, said Sally Gottlieb, benefits manager for Apple in Cupertino, Calif.

This eliminates data entry time, although it does not completely eliminate excess paper, she noted.

Ultimately, according to Hewitt's Mr. Stentiford, technological advancements in electronic mail systems could help automate enrollment.

Employees could use existing software products to make their benefit elections and changes, but instead of printing out their choices and sending the paper to the human resource department, they could send their enrollment data through E-mail systems.

This technology "wasn't practical to use before, because it couldn't send files back and forth"—only brief messages, Mr. Stentiford said.

Today, however, there are "newer systems that have file exchange capabilities," which can virtually eliminate excess data entry and paper use, he said.

Meanwhile, as interactive communication technologies have made benefit information more private for employees, "security is still an issue," although not to the extent it was two years ago, Wyatt's Mr. Jacobs said.

Benefit consultants agree that requiring employees to use personal identification numbers, Social Security numbers and/or passwords to open up personal files have decreased the threat of security problems in interactive systems. ■

Continued from previous page
that by signing they are telling the insurer "to pay any benefits directly to the provider. . .if you are paying the provider do not sign this section."

On the dental form another bubble points out that employees do not have to wait until after a treatment to find out how much of their bills will be covered. "If you want to know in advance how much you can be reimbursed for specific dental treatment, check this box. . .this can be helpful to you as you budget for the dental expense."

The bubbles are carefully targeted. They are meant to cut down on delays and frustration by drawing attention to areas that are often overlooked or filled out incorrectly.

"You can have all the benefits in the world, but if you don't know how to claim them, they aren't very useful," Mr. Barris said.

Tenneco had two goals for this booklet, the last stage in a multimedia information series about the new programs.

First, it was to soften the blow of cost-shifting. The company wanted to take one last opportunity to stress that although "it will cost the employee something, we will provide benefits," explained Mr. Bacon.

Tenneco also wanted to reduce the number of calls to its benefits managers from employees frustrated by new procedures or angry over processing delays brought on by incorrect information on forms.

"We anticipated a lot of problems," said Mr. Bacon. "The key is that front line"—the benefits managers in the offices—has to answer all the questions employees have. "We thought with this one package we could take off some of that pressure."

Now that they have a better grasp on procedures and their claims are being processed more efficiently, employees "appreciate their benefits more," said Mr. Barris.

The booklet is meant to be an easy-to-read collection of tips rather than a how-to manual. The design created to meet this end was "a good example of when client and consultant work well together," Mr. Barris said.

Though they do not plan on releasing another guide soon, Mr. Bacon said Tenneco would use the same approach if it significantly changed benefits again. ■

EAP guide addresses workers' fears

ARMONK, N.Y.—Employee assistance programs can be difficult to develop and promote because most employees do not vocalize their impressions of EAPs, fearing it would advertise that they have personal problems that could interfere with work.

International Business Machines Inc. of Armonk, N.Y., hopes to override these concerns with an easy-to-read, colorful guide about its EAP that was mailed to 185,000 employees' and retirees' homes.

The guide runs crayon-colored drawings and composite "testimonials" alongside short sections of basic information about the EAP.

To prepare the composite testimonials, the writers compiled comments from surveyed participants and then combined many different comments on similar themes.

"We wanted to create a warm-looking document, and we wanted the information to be easy to find," said Barbara L. Bickerman, program administrator for personnel communications.

The drawings and testimonials were used to draw readers into the booklet by showing the range of people who benefit from an EAP.

Ms. Bickerman collaborated on the project—which won an Award of Excellence in the special projects category of *Business Insurance*'s 1992 Employee Benefits Communication Awards—with Cindy Drankowski, wellness programs administrator at IBM. The two women developed the text and concept for a 20-page booklet, which a design firm then put together.

IBM's entry, which cost $181,000 to produce, was the only one to win an award this year the did not require the help of a consultant.

IBM thought mailing the booklet to employees' homes would make it more personal. This tactic also ensured family members would see it and extended its "shelf life" as a resource guide, a spokesman said.

—By Eileen P. Gunn

Report compiles benefit changes

NEWARK, N.J.—Sometimes employees need a single document to tie together the flurry of health care and benefits information they receive throughout the year by way of newsletters, brochures and update reports.

To meet this need, Public Service Electric & Gas Co. in Newark, N.J., releases an annual report summarizing benefit changes that have already been made, previewing upcoming changes and illustrating company spending on benefits.

The annual report, which is produced for about $40,000 by Hewitt Associates in Bedminster, N.J., has a design similar to the company's newsletter: short blocks of information interspersed with pulled quotes, graphs and cartoons.

"Our objective is always to give employees a sense of the big picture of everything else we send out during the year," said Richard D. Quinn III, benefits planning manager for the utility.

The report, which won an Award of Excellence for special projects in the *Business Insurance* Employee Benefits Communication Awards, stresses personal involvement and individual responsibility by the employees.

"We'll give them the tools and help them, but they have to make the decisions," he said.

Since the utility issued its first annual report in 1990, enrollment in flexible spending accounts has gone up 50% and union workers' use of the employee savings plan has increased 20%. It has received "positive feedback" from union organizers and from workers.

"Our communication efforts have facilitated the unions' communication to their members," said Mr. Quinn.

—By Eileen P. Gunn

Opinions

Bite the bullet on reserves

IT IS TIME FOR more property/casualty insurers to "belly up to the bar," as one analyst puts it, and follow the lead of ITT Hartford Group Inc. by increasing inadequate loss reserves. No one would want to see insurers go "belly up" because of reserve inadequacy.

It has happened before. Mission Insurance Co. and Transit Casualty Co. are more than ghosts from the past; they also are reminders of how the mighty can fall.

It is no secret that many property/casualty insurers have been soft in setting reserve levels for years. The pressure to deliver profits to shareholders, combined with the difficulty in determining correct reserve levels for long-tail liability claims, has left reserves far short of the correct levels.

Some analysts have estimated that recognizing reserve inadequacy and unrecoverable reinsurance would reduce the U.S. property/casualty insurance industry's surplus by more than $30 billion, or about 20% of the $161 billion in surplus the industry reported as of June 30.

Even the Insurance Services Office Inc., which is funded by property/casualty insurers, agrees that the industry is probably underreserved. Loss reserves grew by only 6% in 1991, the smallest increase since 1962 (*BI*, June 29). ISO speculates that reserves last year grew "$10 billion less than would have been expected based on historical relationships."

Now is probably the perfect time for insurers to correct years of underreserving. Apparently convinced the market is ready to turn, investors are paying new attention to property/casualty insurance stocks. The hit to profits created by reserve strengthening may not hurt stock prices in the current environment. ITT Corp.'s stock actually rose the day after it announced a $582 million aftertax charge in connection with the Hartford reserve strengthening (*BI*, Oct. 5).

"...JUST CLOSE YOUR EYES, OPEN WIDE, AND SWALLOW!"

In addition, very few property/casualty insurers will report good earnings for 1992, thanks to hurricanes Andrew and Iniki and the unprecedented amount of hail claims insurers will pay this year. Red ink will be everywhere—what's a little more?

But the real reason insurers should admit their reserve errors is that it is simply the honest thing to do. Underreserving will make shareholders happy in the short term but very angry in the long term when the piper is finally paid. And, underreserving does not give current and potential policyholders a true picture of an insurer's financial well-being.

ITT's announcement took courage. We hope other insurers can show they have the courage to do the right thing, too.

Letters

Greenberg's call for price hikes is not heroic

To the editor: I was amazed by your "Leaders in Short Supply" editorial (*BI*, Sept. 28) in which you declare Jeffrey Greenberg of American International Group Inc. courageous for the memo he wrote calling for price increases on the very day that Hurricane Andrew struck Florida.

You conclude this because you say, "Commerical rates must rise: American International Group knows that; other insurance executives do, too, and so do most risk managers."

Really?

May I call your attention to the article, "Soft Property/Casualty Market Expected to Endure Storm," on page 1 of the Aug. 31 issue of *BI*? Among the passages from that article:

- ". . .It seems that the bottom line for this industry is not hurting that badly," says Gloria Vogel of Lehman Brothers.
- "The industry is in a position to absorb these losses and I don't think they will be enough to produce any change in rating," said Michael A. Lewis of Dean Witter Reynolds.
- A sustained hardening of the market would require economic changes more fundamental than a string of catastrophe losses, said Barbara Stewart of Stewart Economics, who added that commercial insurers remain overcapitalized.

The fact is that the commercial insurers' profit for 1992 translated into a return of 15.9% on surplus or, if workers compensation insurance is excluded, a return of 21.7%! And the first half of 1992 was even better for insurers. This is logical because the recession is a boon to commercial insurers: Less shopping means fewer slips and falls, fewer commercial miles per truck, etc. Lower risk, higher profits!

Not only that, policyholder surplus rose to $158.7 billion at year-end 1991 from $138.5 billion at year-end 1990, a rise of $20.2 billion or 14.6%. According to *Business Insurance* (you should really read it), insurers' first-half surplus grew by 11.2% over the year-earlier figure from the major insurers.

The AIG memo was plainly and simply an attempt to unnecessarily raise prices. This 1980s sort of greed has become unseemly in the 1990s. Your anointing of Mr. Greenberg as a hero is worse than wrong; it heightens consumers' fear that the industry is really hyping an outrageous price hike and is willing to stoop even to the extent of duping you or enlisting you.

J. Robert Hunter
President
National Insurance
Consumer Organization
Alexandria, Va.

RIMS responsible for NAIC reclassification

To the editor: The Risk & Insurance Management Society Inc. has frankly "shot itself in the foot." In our haste to pursue and endorse federal insurance solvency regulation and in light of our efforts on behalf of member companies' captives, our status has been changed by the National Assn. of Insurance Commissioners from a consumer group to that of an industry group (*BI*, Oct. 5; Sept. 28).

Did we change our image, or was it perceived that we changed our image and our goals from a consumer group to an industry group? Actually, we have created a dichotomy. We are both a consumer group and an industry group. Faced with a selection and decision, the NAIC reclassified us. RIMS created the situation that required the NAIC to make the decision.

I think RIMS should spend more positive time mending fences with the NAIC instead of criticizing a decision that falls within NAIC prerogatives.

John R. Rath
President
Wisconsin Chapter
RIMS
Milwaukee

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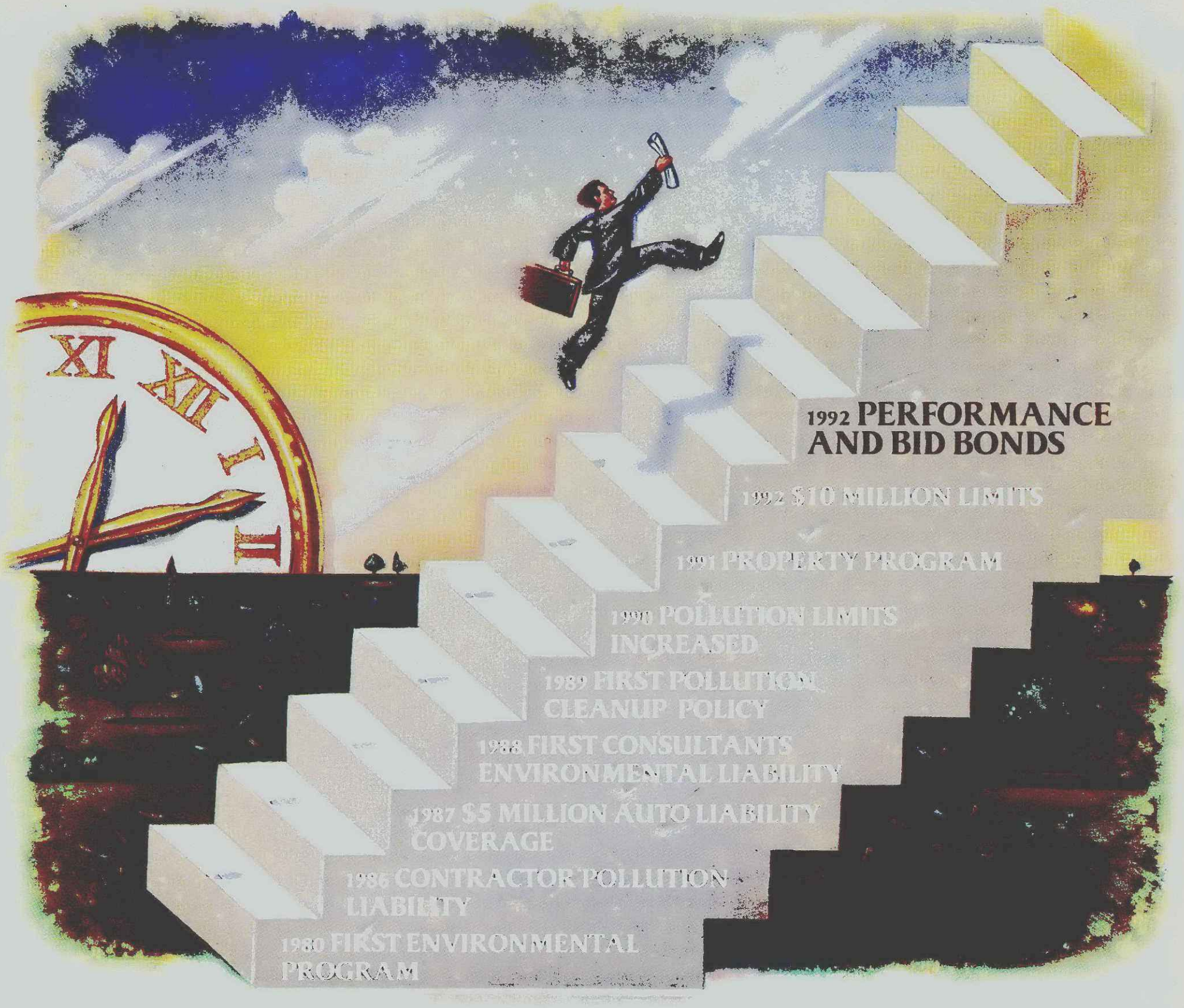

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... Employee Benefits Communication Awards ...

Newsletter increases perceived value of benefits

By EILEEN P. GUNN

ROWAYTON, Conn.—Even though enrollment in its flexible benefits program was 100%, Duracell International Inc. wanted to "market" the plan to increase its perceived value to employees.

.... BENEFITS NEWSLETTER ....

This was one objective behind a benefits newsletter, "Duracell and You," the company began sending to employees' homes in the fall of 1990.

The company also wanted the newsletter to help employees plan their 1991 options within the flexible benefits plan, which had been newly adopted that year.

To do all this, Duracell and consultant Hewitt Associates in Rowayton, Conn., needed a way to catch and hold the attention of a diverse employee population.

"We're working with an audience that includes scientists, employees at manufacturing facilities, a sales force and corporate employees," explained Meg Glendon, a training manager at Duracell who was manager of employee benefits services when the newsletter was produced. "We had to ask ourselves, 'How can we inform the most people in an effective way?' "

The newsletters worked so well that Duracell used them again to announce changes to its flex plan in 1992. Four mailings went out to the company's 4,000 employees in September and October to prepare them for upcoming meetings and to introduce to them a new computer enrollment process.

The Duracell newsletters also caught the attention of judges, who awarded it Best of Show in the benefits newsletter category of *Business Insurance*'s 1992 Employee Benefits Communication Awards.

The four-page newsletter, which cost $67,000 for four issues, featured blocks of text set against and around graphics in soft shades of blue, purple and pink.

"We consciously used high production values and graphics to create something that was more inviting than straight-running text," said Kelley Haslun of Hewitt.

Each 1992 issue had a separate purpose. The first reviewed the flex plan that had been introduced the year before, and summarized additions and changes in the 1992 plan. Two issues focused on specific aspects of the program like flexible spending accounts or health care coverage options. The fourth issue reviewed "Duracell Direct," a computer program that would allow employees to model different benefit combinations.

"(The newsletter) is intended to give employees a preview of the benefit plan so they will have an idea of what will happen and what will be talked about at employee meetings," Ms. Glendon said.

Many employees said the preview helped them get more out of the meetings, she said. "They could pay attention to details rather than worrying about what's new, what's next," she explained.

Employee meetings also ran smoother and training sessions were more effective because employees prepared questions in advance, Ms. Glendon said.

Duracell had the same challenge as other companies developing flex plans: to make sure employees understand what is being offered, how the plan works and how to best take advantage of it.

For instance, employees had to be made aware that flexible spending account options would reduce their taxable income. And, they had to be told that money left in the account at year-end would be forfeited.

A newsletter is a "quick and painless" way to make sure employees' families know of benefit plan changes, explained Ms. Glendon. "It encourages people to take the time to reference the employee booklet where there is more detail because they know what they're looking for."

The letters were mailed to employees' homes to "underscore their importance," but also because they were "a vehicle to share with the family. . .and to keep as a reference," said Ms. Glendon.

Partly due to employee requests, "Duracell and You" was used for 1993 enrollment and will be used for 1994, as well. "A pattern is evolving where people like the newsletter as a means of communication," she said.

Ms. Glendon and Ms. Haslun agreed that while the block text format is effective and should remain the same, a different look each year keeps readers interested.

"The visuals are evolving," said Ms. Haslun. "We try to change the graphic design to keep it fresh and interesting." ■

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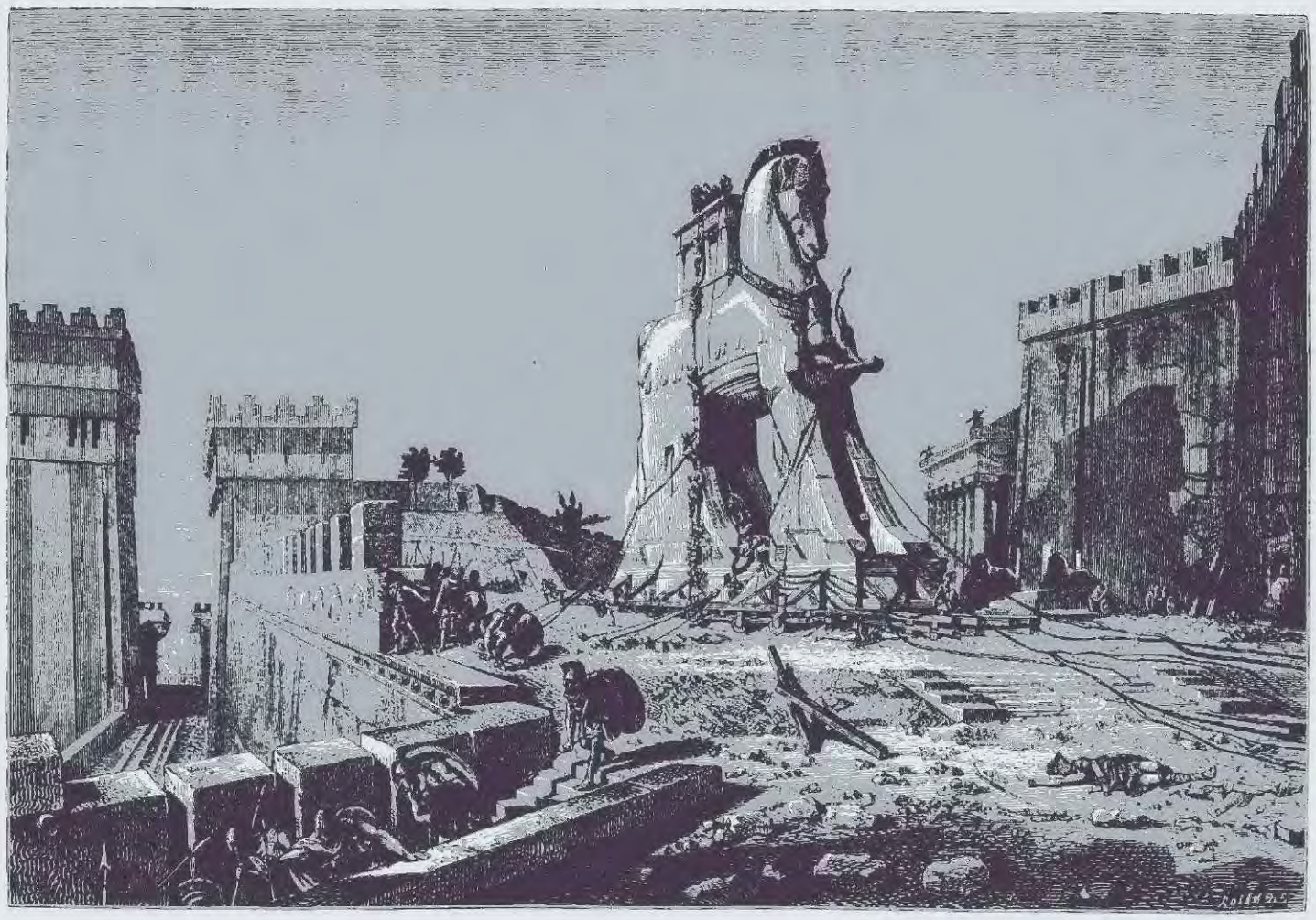

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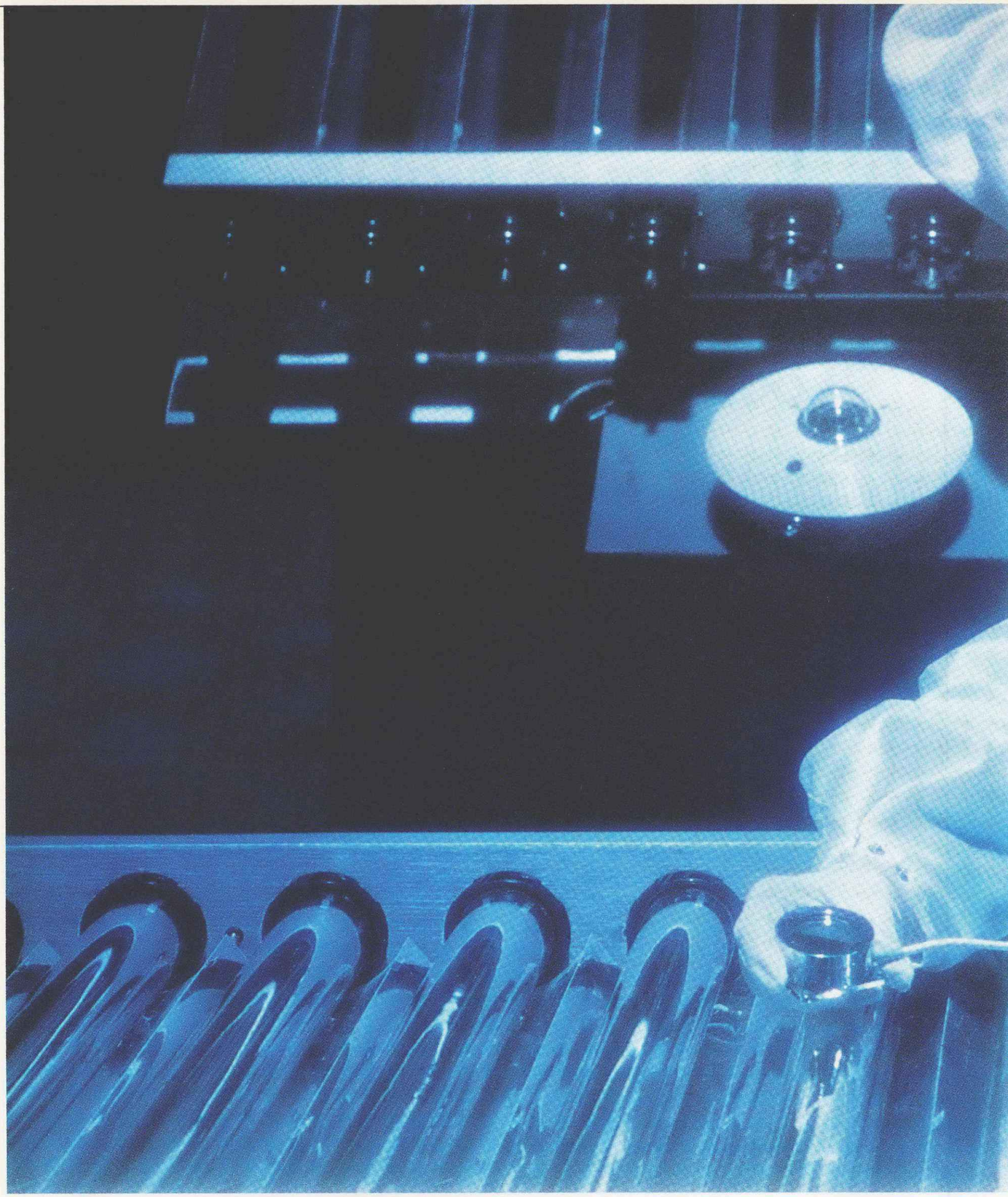

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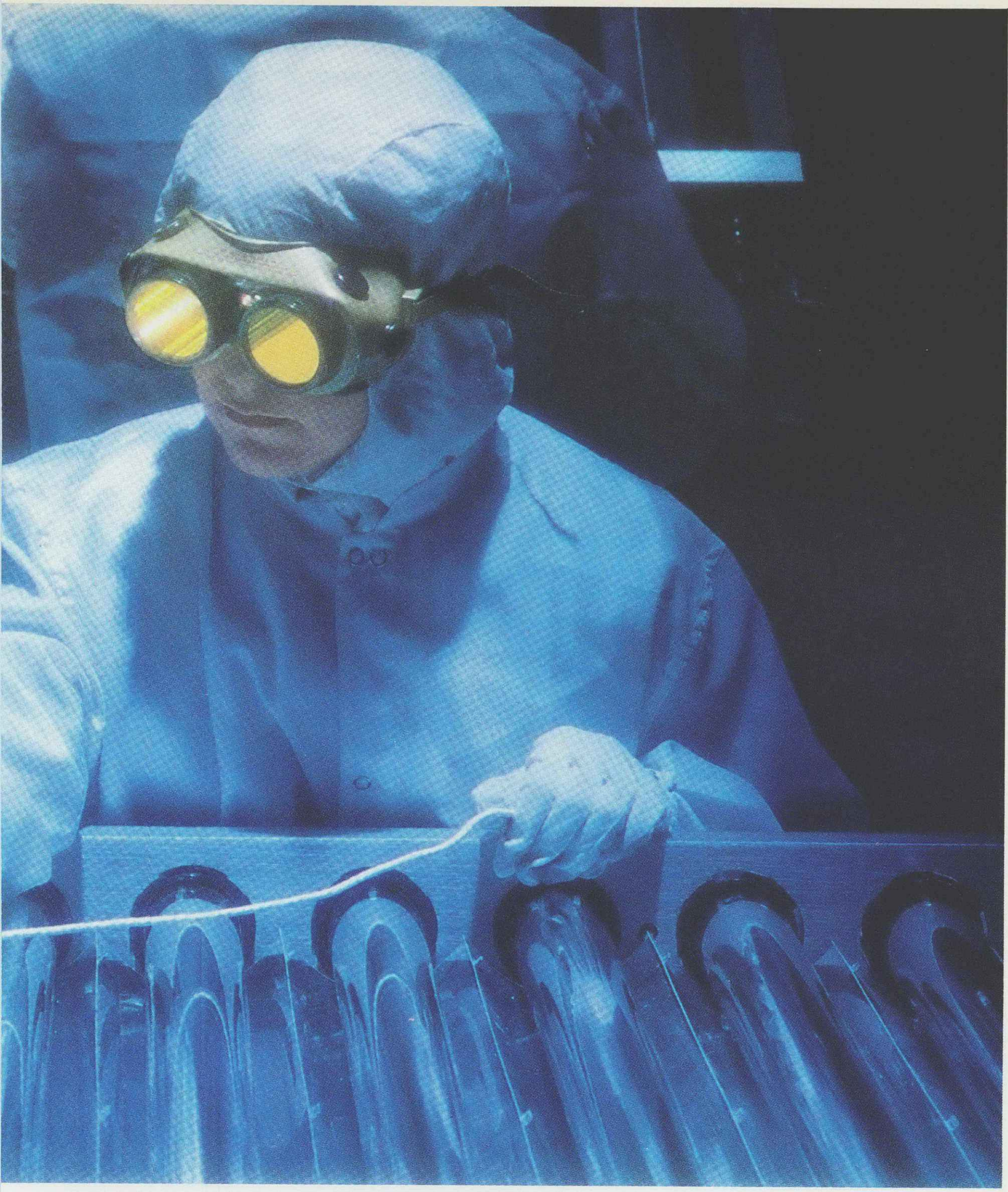

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... Employee Benefits Communication Awards ...

Newsletter makes enlightened consumers

PITTSBURGH—Duquesne Light Co. wanted to turn its employees into well-informed health care consumers, but knew the employees had no time to wade through long tracts.

So the utility, aided by Hewitt Associates, devised a quarterly newsletter full of concise information blocks and bold graphics to "capture employees' interest for a short time, but get the message across," said Ruth Reed, director of benefits.

Rather than inundate employees with information, Duquesne set out to "communicate a statement that would stay with them," Ms. Reed said.

The newsletter also stayed with the judges, who gave the newsletter an Award of Excellence in the newsletter category of the 1992 *Business Insurance* Employee Benefits Communication Awards.

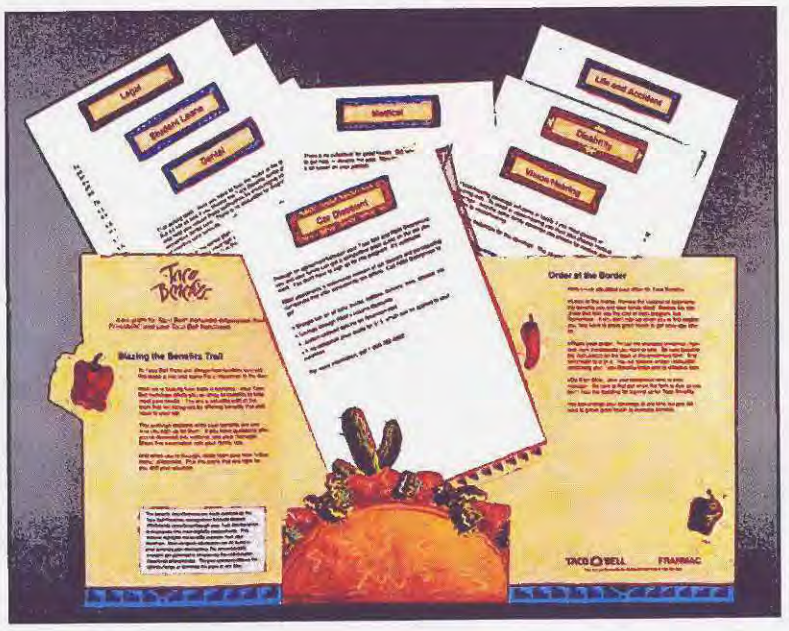
Supplementing the quarterly newsletter are editions that recap important aspects of its benefit package and emphasize upcoming changes before employees enroll for the following year.

At a total cost of $243,000 last year, the newsletter reaches 4,300 employees and retirees.

With the newsletter, employees are "more aware of what their benefits are," said Ms. Reed, "and more aware of the whole health care issue."

For example, she noted that employees are looking into generic drugs for the first time and are scrutinizing bills more carefully.

—By Eileen P. Gunn



Enrollment kit gives employees the whole enchilada

By MICHAEL SCHACHNER

PURCHASE, N.Y.—When PepsiCo Inc. last year developed a new multi-option benefit program that Taco Bell franchises could customize for their employees, it wanted a communications package as zesty as its menu.

To persuade franchisees to offer the new benefits program and to encourage employee en-

MULTI-
... SUBJECT BOOKLET ...

rollment, PepsiCo's benefits communication staff decided that an information folder packed with lively copy, brilliant colors and Southwestern images would grab the intended audience's attention.

And, it appears to be working. Communication of the "Taco Benefits" program, which gave franchise owners the opportunity to provide employees with a set of four core benefits as well as any of four auxiliary benefits they wish to include, has been a great success.

Under the multi-option benefit plan, which is similar to a flexible benefits program, the franchise selects which options will be made available to its employees.

For 1992, 90% of the company's franchise owners are offering the new program to employees and more than 60% of eligible employees have enrolled.

The enrollment package, which was mailed to approximately 300 Taco Bell franchise owners last October and was also hand delivered to more than 3,000 eligible employees during plan enrollment meetings, is a bright, bouncy explanation of the company's new benefit plan.

Much of the package's wording is based on Taco Bell's marketing vocabulary and images of old Mexico and the Southwest. Throughout the package, readers regularly come across references to "blazing trails," "crossing the border," "the whole enchilada" and "healthy menus."

It's also designed to be as pleasing to the eye as a freshly prepared taco or burrito.

Bold colors and illustrations of cacti and chili peppers jazz up the materials.

It was this combination of phrases and images—as well as the package's design, which allows franchises to customize the package to explain only those benefits they offer—that garnered the "Taco Benefits" communication effort the Best of Show award in the multi-subject booklet category of *BI*'s Employee Benefits Communication Awards.

"To communicate our new

Continued on page 16

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Whole enchilada

Continued from page 14

program, we looked for something attractive and in the desert motif," said Lorna Mackey, manager-benefits communication with Purchase, N.Y.-based PepsiCo, the parent company of Taco Bell.

"Our audience is mostly younger people with only a high school education or maybe a year or two of college. So we wanted something with broad appeal that was colorful and would hold someone's interest," she said.

The packet was put together by Dungan Communications Resources of Chevy Chase, Md.

Vicki Dungan, the company's president, has completed several other communications projects for PepsiCo. She said the Taco Bell project was a challenge because it had to be both exciting and adaptable to allow individual franchise owners to include only the information about benefits they wanted to offer.

"We had to put something in place that would both sell owners on the value of buying into the program and would also convey to employees the value of the benefits and their value to the company," said Ms. Dungan.

The cover picture of the three-paneled enrollment package features an over-stuffed taco floating above a cactus plant and Southwestern designs.

On the inside of the cover is a general explanation of the new trails Taco Bell and PepsiCo blazed by offering employees the choice of signing up for certain benefits.

The cover inside also explains that the benefits are actually being provided by FRANMAC, the Taco Bell Franchise Management Advisory Council, which is composed of franchisees. PepsiCo helped FRANMAC design the program and directed communication of the benefits.

In the center of the foldout, a taco-shaped pocket holds individual cards that explain only the benefits a franchise has chosen to offer its employees.

All packets come with an explanation card of the plan's four core benefits: insured medical benefits through Aetna Life & Casualty Co.; vision and hearing benefits; life and accident coverage; and legal benefits through Hyatt Legal Plans Inc.

Franchise owners wishing to offer employees additional benefits can insert cards on four options: dental coverage; disability insurance; a guaranteed student loan program; and a program that provides employees with discounts on automobile purchases.

On the inside of the back panel is a reminder to employees to "Order at the Border." It tells the reader to look carefully at all inserts, to place their order and to do it on time.

"This is probably the biggest hit of my career," said Ms. Mackey. "Nothing we have done before has captured this much attention. The employees like it and the franchise owners love it. We're very pleased with the results. It was a first-class effort by all involved."

Ms. Mackey said the enrollment package project, which targeted franchise owners, their managers, assistant managers and other full-time workers, was produced in conjunction with a rap music video and slide presentation (see story, page 23).

The cost of the project, including consulting fees, production and distribution costs, was about $60,000. ■

... Employee Benefits Communication Awards ...

Company finds smaller benefit book easier to swallow

SALT LAKE CITY—Employees at Intermountain Health Care are finding it much easier to obtain benefits information now that a 240-page explanation of their benefits has been replaced by a packet of smaller specialized booklets.

Last fall, the Salt Lake City-based non-profit health care system, which has 17,800 employees in Utah, Idaho and Wyoming, refocused its existing benefits communications book into nine individual booklets, none of which is more than 71 pages.

Now employees who want information on their group medical benefits, for example, can turn to a specific booklet rather than paging through the old book in search of the subject, explained Andrea Davis, Intermountain's human resource specialist in charge of communications.

The new nine-volume communications packet, which fits into an accompanying box, contains booklets on: general information; a summary of benefits; the company's flexible benefits plan; medical benefits; dental benefits; reimbursement accounts; life insurance; long-term disability; and the company's retirement program.

"After conducting a survey last year, we realized that our people simply weren't reading the old book. It was just too big," said Ms. Davis, who coordinated the in-house project.

'We realized that our people simply weren't reading the old book. It was just too big,' says Ms. Davis.

The new, multi-colored packet earned Intermountain an Award of Excellence in the multi-subject booklet category of the 1992 *Business Insurance* Employee Benefits Communication Awards competition.

Not only is the new packet of benefits materials easier to understand, it is also easier for the company to revise.

"Now when we make benefits revisions, which happens almost every year, we don't have to revise an entire 240-page book and redistribute it," Ms. Davis said.

The entire project cost about $6.60 per packet of nine booklets based on a run of 20,000 packets.

According to Ms. Davis, the communication project will pay for itself within three years.

"We were spending about $3 per employee each year to revise the old book. We should be able to recoup our costs in two to three years," she said.

The new booklets were printed by Jackson Printing Co. of Salt Lake City.

—By Michael Schachner

... Employee Benefits Communication Awards ...

Employees star in 401(k) communication

By SARA J. HARTY

ST. LOUIS—Big changes in Ralston Purina Co.'s 401(k) plan called for a big communications push.

Eight of every 10 eligible employees participate in the retirement savings plan. So when Ralston Purina decided to change record keepers and add new investment options, it wanted to assure employees that their savings would not be adversely affected, said Carl Londe, manager of employee benefit planning and communication.

The video and an accompanying informational packet for employees earned the St. Louis-based company a Best of Show award in the multi-media program category of the 1992 *Business Insurance* Employee Benefits Communication Awards competition.

Vanguard Group, the mutual fund company that Ralston chose as its new record keeper, helped produce the materials.

.... MULTI-MEDIA PROGRAM ....

"We really let Ralston identify what their objective was," said Chip Weldon, manager of institutional communication services at Vanguard, which is based in Wayne, Pa.

Ralston Purina decided to limit the role that the video would play. Rather than using it to explain all the details of the 401(k) plan, Mr. Weldon said the company used the video to convey a simple message: "It's to the employees' advantage to participate in the plan, there are eight investment selections and there is an 800 number there to support employees with questions."

The accompanying information packet contained more in-depth plan information.

Ralston Purina employees who participated in the filming of the video received "absolutely zero scripting," Mr. Weldon said. "We took pains in preventing them from knowing what was about to happen. We wanted genuine reaction."

The spontaneity shows. Early in the video, a group of employees are given a choice between watching one of several popular movies and watching Ralston Purina's video—"Saving for Your Retirement." One man explains, at considerable length, that he chose "Batman" over "Saving for Your Retirement" chiefly because he knew Kim Basinger starred in "Batman" and he doubted the actress had a role in the company video.

"You can't write lines like those," said Ralston's Mr. Londe.

The video amounts to 11 minutes of humorous education. Employees watch as nearly half a million dollars is dumped out of bank bags onto the table in front of them. They are each asked to guess the amount of money on the table, and then to guess how much they could accumulate if they began to contribute 6% of their income to the 401(k) savings plan—an amount that Ralston matches dollar for dollar—and kept doing so for 35 years.

No one, of course, guesses that given a certain income level they could save roughly the amount of money on the table.

Later in the video, other employees play a game of miniature golf that demonstrates how a wise investor makes a variety of investments, some risky, some relatively safe.

The number of golf balls that each employee received was proportionate to the years left to retirement. An employee in her 20s received five balls, while another in his 50s received only two balls.

There were three different holes on the course. One, representing a low-risk 401(k) investment—funneled the ball to the hole; another involved a more or less straight shot—medium risk; a third required the golfer to get past a windmill barrier—high risk.

Sinking a high-risk shot earned the golfer 10 times the investment; a medium-risk shot was worth five times the investment; and a low-risk shot two times the investment.

The video also reminded employees that they had already received a packet of detailed information on the plan.

"(The packet) is an important piece of the overall program," said Caroline Churchill, director of communication services at Vanguard and a member of the team that put the printed materials together. "It's what stays in people's hands as something they can use as a reference tool in the months ahead."

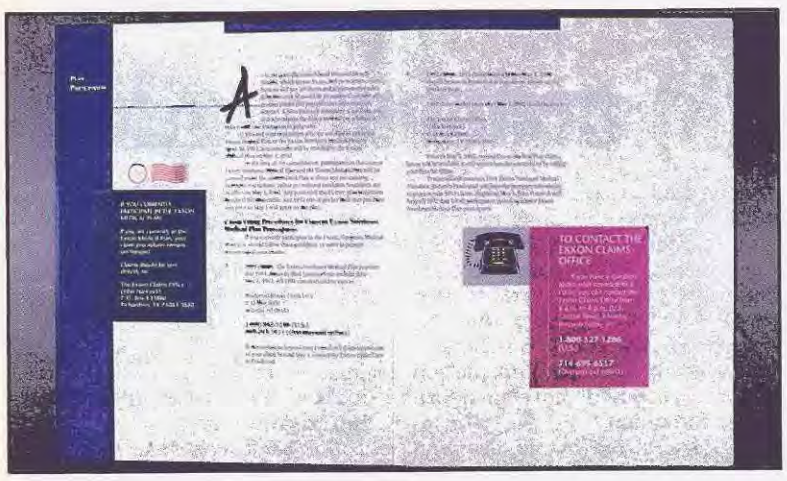
Designed to guide employees through the new 401(k) investment options and other plan changes, the packet goes into far more detail than the video. New investment options are compared to old ones, and employees are told how to use the toll-free number to check balances or change investments.

Also included in the book are an investment guide and details on the available investment funds.

Neither Vanguard nor Ralston-Purina would break out the costs of the communications program.

That cost was included in the one-time fee that Vanguard charges for trustee, record keeping and communication services, Mr. Londe said. "That one fee is certainly less than what we paid before just for record keeping services."

Employee response has been "very positive," Mr. Londe said, though it's too early to know whether the program will achieve one of its secondary goals: increasing employee participation in the already popular plan. Employees "have always indicated that the Savings Investment Plan is one of the most appreciated benefits." ■



... Employee Benefits Communication Awards ...

Exxon turns to sizzling colors in health plan booklet design

By MEG FLETCHER

IRVING, Texas—Exxon Corp. wanted its new medical plan booklet to do more than explain several major plan changes.

Exxon wanted to establish a new look with the booklet that could also be used to enliven communications about other em-

.... SINGLE SUBJECT BOOKLET ....

ployee benefits in addition to educating employees about the nation's health care crisis.

The oil giant wasted little time. On the front cover of its medical plan booklet is a brightly colored graphic—a wheel of comet-like tails in seven different colors swirling around a gray center—intended to illustrate the company's seven benefit programs.

Vivid colors pervade the 20-page book. Deep blue bars run vertically along the outer edge of each left-facing page and horizontally across the center of all pages. Contrasting boxes of fuchsia, teal and gray scattered throughout the booklet contain bits of information. Example: 46% of all employees covered by U.S. employer-sponsored plans were enrolled in managed care plans.

Graphic icons like telephones and a calendar page are used to catch the reader's eye.

In addition to setting a communication style, a more immediate goal of the booklet was to introduce a new mental health preferred provider organization and to let employees know that it was consolidating two different medical plans into one new plan for most coverages as of May 1.

The colorful and comprehensive approach helped Exxon win the Best of Show award in the single subject booklets category of *Business Insurance*'s 1992 Employee Benefits Communication Awards competition.

Oil companies generally have been slower than companies in other industries to use bold colors and graphic icons to present benefits material, said Mike Paolucci, an account manager at Hewitt Associates, who consulted on the booklet.

Most of Exxon's materials had previously been done in black and white. "It was difficult to distinguish one plan from another," Mr. Paolucci said.

Exxon did not use colors just to grab attention. The color wheel was designed to have long-lasting importance across the range of its seven different benefit programs.

The wheel was conceived with seven colors—blue, red, yellow, fuchsia, teal, purple and orange—because planners thought that specialists for each of the seven different types of company benefits may want to use color consistently in their materials.

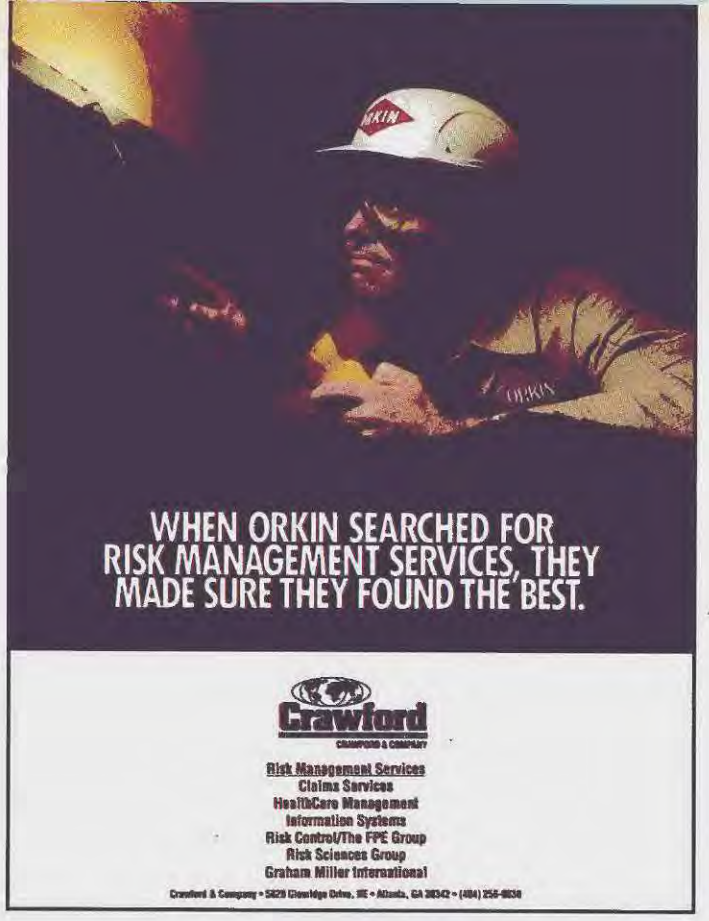
"It serves as a stepping off point for benefit communicators," said Paula Mendenhall, Exxon's benefits specialist. Since the medical plan booklet was published, an Exxon thrift plan booklet adopted teal as its primary color while red was used to convey some Medicare supplementary insurance information.

"It helps each plan to have an identity, but still be part of a family of benefit programs," said Rhonda Newman, Hewitt's production manager on the project.

The materials were designed to be appropriate for a range of employees—from oil refinery technicians with high school diplomas to senior managers with graduate degrees.

The company "wanted to give them the facts without coming across too 'salesy' or with too

Continued on page 20



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Exxon booklet

Continued from page 18

much fluff," Mr. Paolucci said.

A chart was used to clearly describe coverage under the old plans vs. the new plans, which frequently adopted the most comprehensive coverage option offered by the two previous plans. The chart also outlined advantages of the plan consolidation.

A challenge in writing the booklet was that only about half the people were familiar with PPOs, Ms. Mendenhall said.

Again, charts were used. Two colorful flow charts emphasize the differences in operation of an optional preferred provider organizations for medical care and a new, mandatory PPO for all mental health care. The flow charts emphasized that while the medical PPO required pre-certification for only inpatient treatment, the mental health PPO required it for both inpatient and outpatient care.

Though restrictions in mental health coverage affected comparatively few employees, "it is a sensitive issue for those affected," according to Ms. Mendenhall. ■

. . . Employee Benefits Communication Awards . . .

Using a single guide simplifies flex plan communication

NEW YORK—The Equitable Life Assurance Society of the United States has adopted a more streamlined approach to communicating changes in its flexible benefits program.

The new format for its "Choice" flex plan enrollment guide is a combined booklet/folder that describes the plan changes and contains pockets to hold inserts on specific flex plan options. The new booklet replaces several laminated books that separately described individual plan options, said Eileen Maraldo, director of welfare benefit plans for the New York-based insurer.

The Choice guide describes dental, medical, vision and disability income coverage and contains an insert for certain employees eligible for a spending account for unreimbursed medical expenses. The guide also includes an enrollment form.

The Choice guide adopted a new color scheme of taupe, beige and indigo blue. A graphic icon of an accent mark in gold enlivens the cover and is repeated throughout the material in different colors.

"We were not looking for a flashy look but a more understated, clean-lined, simple look in keeping with our management's conservative outlook," Ms. Maraldo said.

The enrollment guide, developed with assistance from Buck Consultants Inc. in Secaucus, N.J., received an Award of Excellence in the single-subject booklet category of *Business Insurance*'s 1992 Employee Benefits Communication Awards competition.

Equitable's aim in adopting the new communication approach was to inform approximately 15,000 employees at about 100 locations that the company was introducing CIGNA Corp.'s managed care network for both medical and dental benefits. Health maintenance organization options were being eliminated, except in locations where a CIGNA network provider was not available.

In addition, employees had the option of choosing the Equitable Health Plan for group medical care, which offered the same benefits as the CIGNA plans but required different contributions, deductibles and out-of-pocket amounts.

"Equitable wanted participants to make the best informed choice for themselves," Ms. Maraldo said. "By and large, it was a fairly smooth transition," despite Equitable canceling 30 of 40 HMOs, she added.

—By Meg Fletcher

Booklet explains investment hows, whys

OAKLAND, Calif.—Kaiser Permanente Medical Care Program wants its employees to know that the company will help them build a retirement "nest egg," but they will have to individually decide just how to invest it.

Last November, the Oakland, Calif.-based health care firm launched a communications campaign to inform 88,000 nonphysician employees nationwide that it was adding three new investment options to its tax-deferred retirement plans.

While their only option had been guaranteed investment contracts, employees can now choose from GICs, a money market fund, a stock-and-bond fund and a stock-only fund.

The time was right because GICs worth $65 million were expiring—though trouble-free—and company officials hoped employees would consider some of the new options, said Ellen Canter, the director of retirement plans administration.

In "a very different approach," the company moderated its "knee-jerk" reaction against describing the advantages of stocks, which are more volatile than other, lower-risk investments.

The company emphasized that conservative investments could be risky too, if they did not provide a retiree with enough income, Ms. Canter explained.

Four of the company's 12 regional employee benefit managers and a consultant from William M. Mercer Inc. in San Francisco helped develop the materials.

The program, called "Teaming Up For the Future," resulted in employees transferring $28 million of the $65 million in expiring GICs to more aggressive funds, like the stock fund, Ms. Canter said.

Even though stocks have not fared well this year, few if any employees have blamed the company, she said.

One advantage to offering more investment options is that by doing so companies can transfer investment risk to employees.

Communication materials for the program netted Kaiser Permanente an Award of Excellence in the single subject booklet category of the 1992 *Business Insurance* Employee Benefits Communications Awards competition.

All employees received a brochure announcing the new investment choices. A few days later, they received a detailed brochure and a personalized letter with individual account balances.

—By Meg Fletcher

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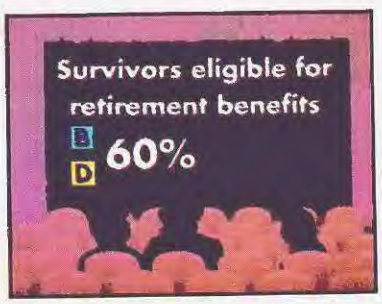
... Employee Benefits Communication Awards ...

Cracking the case of the confusing retirement plan

By DEBORAH SHALOWITZ



PASADENA, Calif.—The detective's phone rings. Big Ray needs help. He has to choose a retirement plan. Fast.

"I thought to myself, 'How hard can it be to pick a retirement plan?' Eeny, meeny, miney, moe," says Big Ray's detective friend.

The audio continues: "But Ray said it wasn't that easy. There were lots of facts and figures to know about. And, if that wasn't bad enough, it was all explained in some strange gibberish. Words like non-contributory and defined benefits. Defined? Undefined? It sounded like English, but what did it mean?"

.... AUDIO-VISUAL PRESENTATION ....

Dressed in a trench coat, hat cocked over one bushy eyebrow, the 1940s-style detective ponders these and other mysteries in a video on retirement options produced by the Los Angeles County Employees Retirement Assn.

"Investigating Your Retirement Plan," a 15½-minute video that parodies the Philip Marlowe/Sam Spade-type detective stories, captured a Best of Show award for audio-video in the *Business Insurance* 1992 Employee Benefits Communication Awards competition.

The detective, who moves through scenery using simple animation, discovers that safety personnel, such as police, firefighters and lifeguards, are eligible for only one retirement plan, which is contributory. Other county employees, such as judges, administrators and clerks, can choose between two retirement plans—one contributory and one non-contributory.

With approximately 500 new hires per month throughout Los Angeles County, LACERA personnel found they could not personally explain the retirement plans to each employee, said Sylvia Miller, LACERA section manager for disability retirement.

"If we can't be there, let's give them second best—and that would be a video," she said.

So, copies of the video were sent to 50 LACERA offices throughout the county, Ms. Miller said. All new hires watch the video, as can other employees by request.

The still-figure format was chosen primarily for financial reasons, said Rebecca Ayers, vp in charge of video production for Sheppard Associates, the Glendale, Calif.-based communications and consulting firm that worked with LACERA on the project.

"We knew that they didn't have the money for full-blown animation," Ms. Ayers noted.

Instead, the detective was drawn by an artist on paper and then scanned into a computer, she explained. Then the figure is manipulated through the computer. For example, while his square chin doesn't quiver, the detective's blue eyes shift from side to side at times and turn into twirling black stars when he is overwhelmed.

"It's a lot faster and cheaper than drawing it on the computer itself," Ms. Ayers explained.

Background scenes are single frames of real scenes shot by a video camera, Ms. Ayers said. The scenes were touched up by the computer to serve the storyline.

The video is chock-full of details—it covers plan contributions, cost-of-living adjustments, dental and vision benefits, eligibility for post-retirement medical, long-term disability benefits, maximum retirement payments, retirement payment eligibility, survivor benefits and vesting periods.

However, the storyline and tongue-in-cheek approach keep the viewer's interest throughout the lengthy presentation.

For example, at one point the detective is in his car and sees a car with the license plate "FMFDORP." That stands for "Follow Me for Differences of Retirement Plans," he explains.

The "FMFDORP-mobile" leads the detective to a theatre, with a lighted marquis reading "FACTS. . .Boring, but Necessary!"

"I give a lot of credit to the people that head up" LACERA, Ms. Ayers said. "There are not very many people that will take a risk with something as important as their retirement plans."

Inside the theatre, the "show" is a series of explanations about the retirement plans.

Ms. Ayers declined to give the cost of producing the video. However, she said that typically, this type of program costs between $3,000 and $4,000 per finished minute. ■

... Employee Benefits Communication Awards ...

Taco Bell rap video appeals to audience

PURCHASE, N.Y.—"We got something new for all of you at the border/It's not on the menu, but it's something you can order," sings a young rapper in a black and yellow Taco Bell uniform with Southwestern images flashing behind him.

"It's a summary of the programs to choose/Taco Bell pays for some so you really can't lose," continues the video, designed to explain the fast food franchise's new benefits plan.

The "Taco Benefits" video won Taco Bell's parent, PepsiCo Inc. of Purchase, N.Y., an Award of Excellence in the audio-visual presentation category of the 1992 *Business Insurance* Employee Benefits Communication Awards competition.

The video, which also features several female backup dancers, was produced last year by PepsiCo to help inform franchise owners of the new benefits plan for full-time employees and to encourage employee enrollment.

The announce-with-a-bounce seems to have worked: for the 1992 plan year, 90% of Taco Bell franchise owners are offering the new multiple-option benefit program and more than 60% of employees have enrolled.

The approximately four-minute video covers the core benefits available under the plan to Taco Bell's young, mostly high school-educated employees: "There's insurance for your health, for your life and your sight/We've got coverage for your hearing and a legal plan that's right."

"In the fast food industry, they're used to quick things," said Lorna Mackey, manager of benefits communication with PepsiCo. "That's why we wanted to give them something quick and snappy."

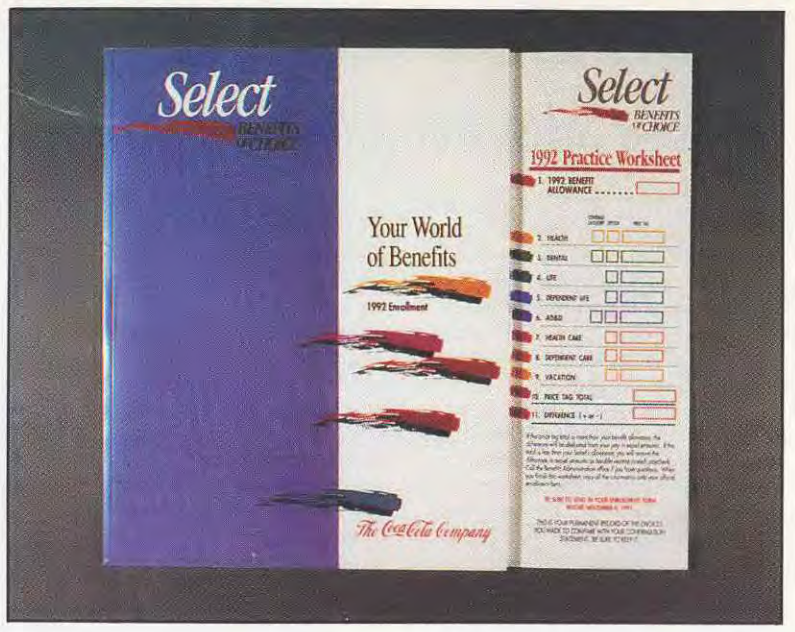
The video was produced by Dungan Communications Resources of Chevy Chase, Md.

At least one copy of the video was sent last fall to each of the approximately 330 Taco Bell franchise owners. Extra copies were distributed as needed.

Ms. Mackey said the video cost about $53,000, including production and consulting costs.

—By Deborah Shalowitz

. . . Employee Benefits Communication Awards . . .



Coca-Cola pops for booklet to explain benefits

By EILEEN P. GUNN

ATLANTA—Taking a tip from a past advertising slogan that told consumers to "catch the wave" by drinking Coke, The Coca-Cola Co. is using a booklet to encourage employees to "catch the wave" of increased benefit options.

"Select," a benefits enrollment booklet, is distributed to 8,000 employees annually and is the Atlanta-based company's largest benefits communication.

Coca-Cola used the Select booklet for the first time during enrollment for 1991. While the 1991 booklet described information on flexible benefits options, the 1992 version added information about total retirement income and other non-flexible benefits.

PERSONALIZED . . . CORRESPONDENCE . . .

"This way employees have one source of reference for all benefits," explained Jeanne Donovan, a communications consultant at The Wyatt Co. in Washington, which assisted Coca-Cola in producing the 35-page booklet.

The Select booklet, which won a Best of Show award in the personalized correspondence category of *Business Insurance*'s 1992 Employee Benefits Communication Awards, explains what is provided by each category of benefits and also provides personalized data on each employee's options and entitlements.

The Select logo is a red splash similar to the red Coca-Cola wave, and each benefit category is represented by a different colored splash: orange for health, blue for life insurance and red for dependent care. The colored logos also mark the corresponding line on the enrollment application.

Continued on page 31

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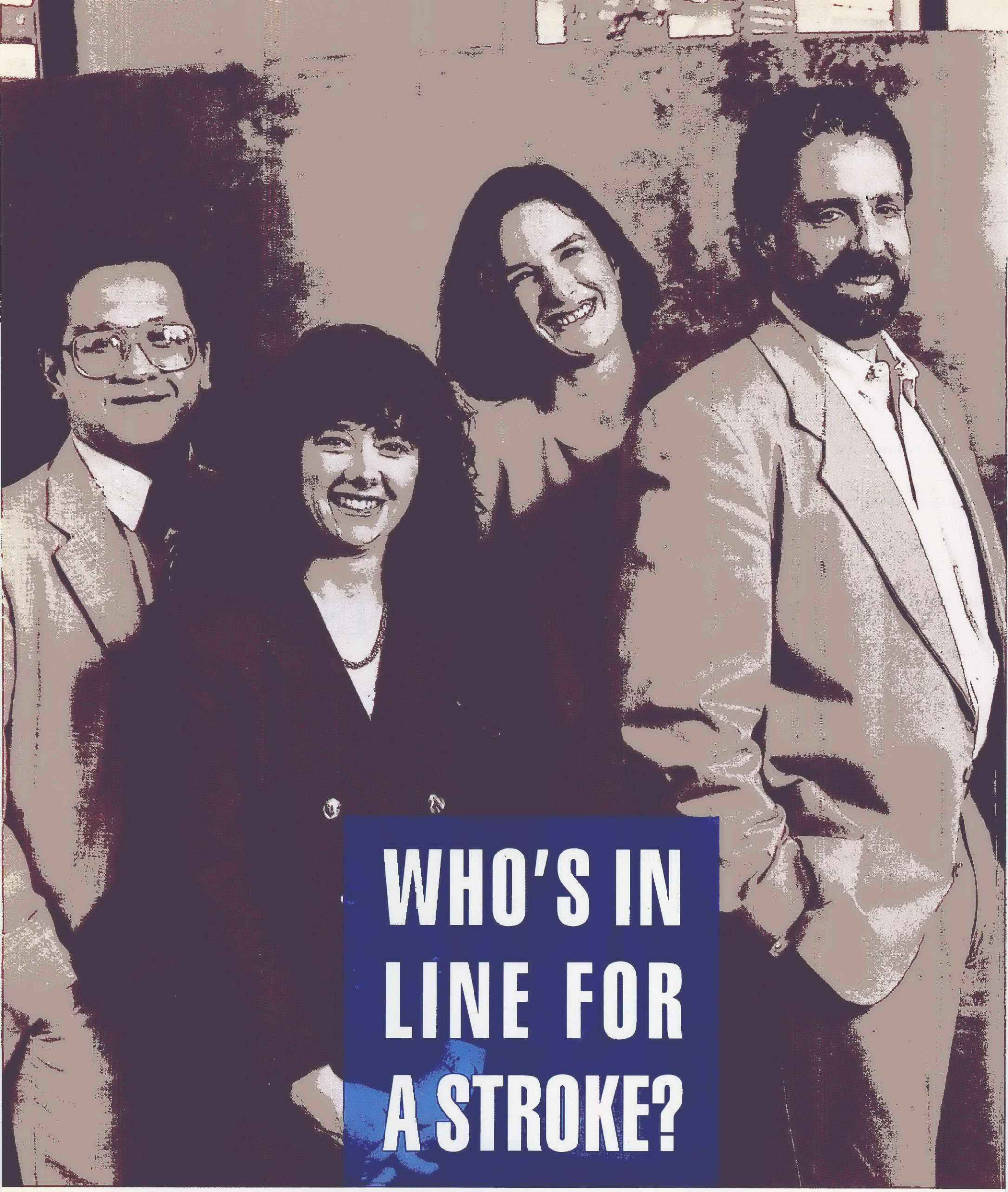

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Managed mental health care

By Susan R. Prest
and Dr. James Richard Prest

'At-risk' contracts offer savings but beware of risks

THE BENEFITS OF "AT-RISK" contracting for the management of mental health and substance abuse treatment have been well articulated in recent articles. These include a potentially substantial reduction in costs, combined with the advantage of a prepaid plan that allows purchasers to know their costs in advance. But there are also hidden risks in purchasing an "at-risk" product for the management of mental health and substance abuse treatment.

Some purchasers have been lulled with marketing promises only to find that when implementing such a plan the hidden dangers become painfully apparent.

As this new product gathers interest and speed across the industry, we hope to assist potential purchasers in making more informed consumer decisions.

At-risk contracting for mental health and substance abuse services is the natural outgrowth of attempts to control these costs through utilization review, health maintenance organizations and point-of-service plans. At-risk contracting is a hybrid of staff model HMOs and point-of-service products with utilization review oversight. Typically, point-of-service products offer employees an in-network benefit with the option of going out-of-network at a reduced benefit. This gives the patient the choice they felt they did not have with the staff model HMO.

At-risk contracting is a prepaid system in which the vendor is usually paid on a per capita basis to provide and manage the care. The option of going out-of-network is eliminated by requiring participants to obtain care from an exclusive provider organization developed and managed by the vendor. A gatekeeper is often used to provide the initial assessment prior to entry into the network.

Under at-risk contracting, the risk that costs will exceed the prepaid amount is assumed by the vendor. The profit made by the vendor is the difference between the capitation rate and the actual cost of services.

You may recognize the old HMO incentive to minimize treatment. The customer profits by contracting in advance for reduced costs and by knowing what those costs will actually be.

At first this type of program sounds like the answer to controlling soaring mental health care costs. But there are many hidden dangers in at-risk contracting that purchasers may not recognize until the program is in place. We will look at a few of these areas:

✔ **Selecting a vendor.** Potential purchasers often accept proposals directly or through a consultant from several vendors. Although there is often little variation in the product description, there can be a wide variation in the fee or pricing. Often the contract is awarded to one of the lowest bidders. In this increasingly competitive area, vendors are slashing their prices to secure contracts. Some of these prices could not reasonably provide for a program of management and adequate care for the treatment needs of the employee population. Some managed care vendors have refused to lower their rates to a level that might compromise care, only to lose the contract to a vendor willing to compromise care to secure the contract.

✔ **How the plan works.** While there are variations in general with implementing an at-risk managed care program, employees and their dependents wishing to access their mental health or substance abuse benefit must first go to the gatekeeper designated by the managed care vendor. This is often an employee assistance program. The gatekeeper evaluates the need for the treatment and refers the patient into the network if necessary. Benefits are not paid for treatment delivered without the gatekeeper's referral or delivered by an out-of-network facility or provider. Utilization review and/or case managers oversee the treatment in the network.

✔ **Benefit levels may change.** Many vendors explain that the benefits in the new program will actually be enhanced by increasing the number of inpatient days or outpatient visits and by increasing the lifetime or yearly maximums payable. What isn't stated is that often specific diagnostic categories included in the previous benefit plan are eliminated.

For example, the previous plan may have covered treatment for attention deficit hyperactive disorder (ADHD) or other chronic disorders. The new plan may increase levels for what is covered but eliminate coverage of certain costly diagnostic categories. Purchasers should clearly understand any variation in the covered benefits. Changes are found in the small print of the contract and may not become apparent until the care is denied as "not a covered benefit."

Some purchasers of at-risk contracts have been lulled with marketing promises only to find that when implementing such a plan the hidden dangers become painfully apparent.

✔ **Restrictions on care.** Many employee populations view these new plans as a reduction or restriction in their benefits and have the internal political clout to make life very uncomfortable for the benefit manager or decision makers. Union, government and school employees are examples of highly sensitive groups. When care is denied, very angry employees can apply a great deal of pressure through unions or through government oversight bodies.

For example, shortly after the implementation of one of these programs for a city, an employee followed instructions by requesting from the gatekeeper continued care for her son who had been in treatment for ADHD. The gatekeeper denied further care because ADHD had been eliminated as a covered benefit. After exhausting internal appeals procedures, the irate mother complained to the city council. The benefits manager who had been the chief decision maker had not been advised of the change by the managed care vendor. In fact, when she had presented the new program to the city council for approval, the manager had stated there would be no reduction in benefits, only enhancements. After only two months in the at-risk program, the city canceled the contract.

✔ **Definition of necessary care.** The professional disciplines in the areas of mental health and substance abuse have not internally come to an agreement on the definition of necessary care. A wide variation in this definition is in practice. Most often the definition is dependent upon the setting. For example, those who are responsible for direct inpatient care in hospital settings often define necessary care far more liberally than utilization review firms. An inherent economic pressure colors the definition. Those executives managing at-risk products stand to lose their profit with a loose definition and may go beyond restrictive definitions to dangerous (for the patient) definitions.

✔ **Pressure on review physicians to deny care.** Psychiatrists or other physicians are most often required to approve denied care. Vendors believe that this reduces their liability. These physicians are asked to offer their medical opinions about the necessity of the care or the level of care. However, if the reviewing physician determines too often that care is necessary, he or she may be replaced by a tighter reviewer. Some physicians have reported offers of stock options, bonuses or other incentives for increasing their denial rates.

✔ **At-risk contracts are insurance products.** Many purchasers and even managed care vendors do not realize that at-risk contracting is an insurance product and therefore subject to regulation by state insurance laws. The product has spread so quickly that this is poorly understood by both purchasers and vendors. Today some vendors that are not licensed to deliver an insured product offer the at-risk products.

✔ **The provider network.** Provider networks span from those closely formed and scrutinized to those loosely formed and unscrutinized. The primary qualification of many vendors for acceptance of a provider into a network is a willingness to accept a discount on their fees, return a form, and indicate a desire to be included. The vendor is then included on the list of providers.

In the rush of competitive bidding, there have been instances when vendors have submitted provider lists with proposals that include providers not under contract. This misrepresentation results in frustration and confusion to purchasers, employees and uncontracted providers. Provider networks should be investigated closely for qualifying requirements, quality assurance and past performance.

✔ **Employee and provider communication.** When implementing an at-risk plan, it is important to explain the new program in detail to employees and to the network providers. These programs are difficult for employees and providers to understand. But communications procedures for this product are not well developed by many vendors. These plans require special communications procedures that go well beyond the traditional written notification.

The vendor should assist with detailed explanations of the new plan at employee meetings. It is recommended that communication begin six months in advance of the new program. Telephone answer lines and focus groups are helpful to employees. Poor communication results in confusion and complaints from both employees and providers. Clear, open, honest and early communication is needed.

✔ **Problems for participants.** There can be problems for all those involved in at-risk plans. Here are a few.

- Gatekeeper: Pressure not to refer patients into the network to access treatment; inadequate education and information about the program.
- Employees: Lack of education about the plan; needed care may be denied for economic reasons; loss of freedom of choice of a provider.
- Vendors: Legal consequences of the rigid denial of care; monetary loss by under-bidding to secure a contract; loss of a contract for non-performance.
- Purchaser: Disturbed employer/employee relationships; joint liability with the vendor for adverse consequences of rigidly denied care.

In addition, relationships between the vendor, purchaser, employee, provider and gatekeeper can be adversarial at many different levels and points of interaction.

Case example: In one patient's case, an at-risk program resulted in insensitive and questionable management. A managed care vendor received a call from an out-of-network and out-of-area psychiatric

Continued on next page

'At-risk' contracting

Continued from previous page
hospital. The hospital reported that a woman, whose mental health benefit was subject to management through the vendor's at-risk program, had been brought to the emergency room by a friend. They reported that the woman was suicidal and acutely psychotic. After a long history of spousal abuse further complicated by her psychosis, the woman had fled to her friend's home in another state to avoid further abuse by her alcoholic husband.

The benefit made an allowance for emergency care out of the area. Two days were authorized by the vendor's utilization review nurse before the next review. At that time the utilization review nurse was advised that the attending physician was attempting to adjust medications to control symptoms, but the patient remained suicidal and acutely psychotic. The patient was under 24-hour observation.

At the end of seven days, the patient was still acutely psychotic and suicidal having been non-responsive to medications. The managed care vendor became concerned about the cost of this case. It had no contract with this hospital nor did it have on-site personnel, both important cost containment mechanisms. The managed care vendor insisted that the woman be transported by air ambulance to the city of her residence to an in-network facility. The attending physician explained that the woman was still suicidal and periodically in restraints.

At this time, the vendor denied further payment for care in this hospital and would only approve continuing payment in an in-network hospital. The attending physician resisted these instructions, the patient was retained and the hospital accepted responsibility for her care without expectable reimbursement rather than participate in this questionable plan. This is one example of the problems created when a vendor secures a contract with an unrealistically low bid.

At-risk contracting is one of the most recent answers to controlling the costs of mental health and substance abuse care. Carefully run programs can be an excellent cost containment tool when implemented and managed properly. Health care cost trends can drop substantially and employees are willing to trade off certain benefits for others if they fully understand the newer programs. But a thorough evaluation and a very careful decision must be made before entering into such a contract.

Factors such as employee expectations, potential reduction in benefits, motivation of the vendor to cut costs (particularly low-end bidders), quality of the provider network and past performances must be scrutinized.

It is important that a purchaser fully understand the implications of this type of managed care product before the hidden dangers make themselves only too apparent. ■

Dr. James Richard Prest is chairman/medical director and Susan R. Prest is president/chief executive officer of Prest & Associates Inc., a Las Vegas-based psychiatric physician review firm that is a consultant to managed health care firms.

ASK A RISK MANAGER

It's become a buzzword, but ergonomics can be a valuable safety tool

Q **Ergonomics appears to be the current buzzword in our industry. Have you been involved in any ergonomic studies and, if so, how have you adapted the findings into your risk management program?**

A You are correct in stating that ergonomics is becoming a familiar term in the risk management vocabulary. And, yes, in recent years I have used ergonomic studies as part of my risk assessment and risk control activities. Not surprising, perhaps, our ergonomic studies have centered on controlling the repetitive motion type injury exposure.

I understand repetitive motion incidents, like carpal tunnel syndrome, are normally described as occupational disease cases.

However, I refer to them as occupational injuries since that appears to be the most applicable description of the phenomena.

My initial experience with ergonomics evolved from a risk assessment program initiated at one of our food-processing facilities. A few employees in the boning department complained of aching wrists, and we suddenly learned the serious impact carpal tunnel syndrome has on employees and the production environment.

I was using an outside risk control service at the time and requested their assistance in performing a thorough task analysis of the boning and packaging departments.

We also hired occupational rehabilitation specialists to assist in the evaluation and to review the basic job descriptions. I was delighted to learn that the recommendations in the ergonomic study did not require us to spend large sums to modify the physical work environment.

Surprisingly, the adjustments we made appeared simple. We began a formal knife-sharpening program to make certain our employees exerted a minimum of effort in slicing or carving product. Individual work stations were adjusted to conform to the employees' physical size. Picture a line of employees, all of varying heights, standing shoulder to shoulder on a production line. To make the repetitive motion process easier, we adjusted the workstation heights for each person and reduced the stress on wrists, arms and shoulders.

Another beneficial outcome of the ergonomic study was the introduction of an exercise program. Now, I'll be the first to admit that the exercise idea caused more than a few raised eyebrows, at least at first.

But, with proper coaching by management, we succeeded in having employees warm up and stretch prior to each shift and after the lunch break. In fact, the results of the ergonomics study were so encouraging, we hired an ergonomics engineer to continue these activities at our other production facilities. As I mentioned, most of the enhancements just made good sense and did not cost a lot of money.

One reason for the current interest in ergonomics is the acute awareness of carpal tunnel syndrome exposure in the office.

I was delighted to learn that the recommendations in the ergonomic study did not require us to spend large sums to modify the physical work environment.

Indeed, we are in the computer age, and all of the "banging away" on keyboards has finally taken its toll. Imagine my chagrin when, after years of working to control carpal tunnel syndrome in our production facilities, one of my staff members developed this malady from inputting workers compensation claims data into a computer day after day!

I now have been working with our facilities director on an ergonomic evaluation of certain job functions in our corporate headquarters.

As was the case in our production plants, our primary focus has been on task analysis and workstation modifications.

Often a simple adjustment is in order, such as raising or lowering a keyboard, supplying a more suitable chair and requiring employees to take regular breaks.

Exercise programs are appropriate in the office environment since it is relatively easy for employees to do routine flexibility exercises without leaving their workstations.

We have also benefited by asking employees how they could perform their functions more easily. Ergonomics in the office requires a personalized approach since what works best for one individual may not have the same positive effect on another.

Educating employees, especially management, of the impact of carpal tunnel syndrome is an important facet of any ergonomics program. Staff "downsizings" in recent years have required us to do more with less. Although headcounts have diminished, the workload certainly has not. It becomes apparent that when management is sensitized to the physical and emotional stresses of today's business environment, ergonomics plays a supporting role in keeping employees happy and healthy.

I an sure you are familiar with the Americans with Disabilities Act and hope you discover opportunities for expanding the use of ergonomics that have resulted from complying with the disabilities law.

Under the ADA, employers must make reasonable accommodations to allow disabled people to enter the workforce. Such accommodations may have an expanded benefit by making the workplace safer for all employees.

Without question, ergonomics will play a greater role in future years. The popularity of health management and medical cost containment programs in the casualty insurance arena give additional credibility to the ergonomic process.

I for one have become a believer and encourage my risk management colleagues to explore the opportunities ergonomics offers us. ■

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefits Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., answers actuarial questions in the casualty field.

Ms. Werner

Ms. Werner's and Mr. Nirtaut's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in December.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Coca-Cola booklet

Continued from page 24

"The idea was to carry out the Coke wave that you are familiar with, and then create bright colors to go with it," said Ms. Donovan.

Enrollment in the company's benefits program was 100% before Select was designed and put into use, but the personalized booklet and enrollment process highlighted for the first time the choices employees have in benefits, according to Ron Cheeley, director of employee benefits at Coca-Cola.

"As the employee picks and chooses each year, you immediately increase his understanding and appreciation (of the benefits program)," said Mr. Cheeley.

By stressing to employees that the point of a flexible benefits plan is to provide them with options, Coca-Cola aims to "empower employees to understand and use their benefits," he continued.

Wyatt's Ms. Donovan believes the booklet is an important resource guide as well as a promotional device.

"You have to arm your employees with information to enable them to make these decisions so they can be wise consumers," Ms. Donovan explained.

"Any benefit communication has to provide information about the choices out there and how consumers can best make use of them."

Surveys and focus groups have indicated that the new Select booklet is the most popular information source Coca-Cola has provided thus far about employee benefits. Previous Select booklets only explained flex plan options.

Much of the positive feedback from the focus groups revolves around the dependent care spending account and an option to sell vacation days and add the money to their benefits allowance, which the booklet explains in detail.

'Employees have one source of reference for all benefits,' Ms. Donovan says of Coca-Cola's booklet.

"People like being able to free up money within the program for dependent care," said Mr. Cheeley.

Employees also like the message in the booklet that they are responsible for deciding how to use their benefits to the best advantage, which the personalized communication allows them to do, he said.

A task force that works on the booklet is composed of benefit specialists from Coca-Cola and Wyatt. The group aims to improve on Select's contents from year to year.

The 1992 edition, for example, included a graph showing total retirement income as a percentage of preretirement income for a broad range of pay levels, and the 1993 book will personalize that graph according to each employee's current income.

"Coke is always looking at how employees can get more out of their benefits, and at how we can make Select a more powerful communication tool," said Ms. Donovan.

Coca-Cola said the cost of producing the booklet is proprietary information. ■

QSP raises awareness of the value of benefits

RIDGEFIELD, Conn.—QSP Inc. wants its employees to know how good they have it.

To make sure its 400 workers understood their 1991 benefit options, QSP—a Reader's Digest unit that coordinates fund-raising for non-profits—and consultant Towers Perrin produced a compact, eye-catching personalized benefit statement.

"We wanted to get across what the company was providing," said Valerie A. Clifford, benefits administrator. "And we wanted to communicate to employees in language they would understand without being condescending."

Using pie charts and graphs to clarify financial points, the 17-page pamphlet summarized health care, disability, retirement, life insurance and employee stock purchasing. Producing the booklet cost $32,000.

It won high praise from employees and from the judges, who gave it an Award of Excellence in the personalized correspondence category of *Business Insurance's* Employee Benefits Communication Awards.

Most QSP employees are salespeople. To be sure they and their families knew what their benefit options were, the company mailed the booklets to their homes.

"We aimed to let the employees know we care about them, and that we want them to understand their benefits," said Ms. Clifford. She added that letters from employees indicate they "feel more comfortable about understanding their benefits" than they used to.

—By Eileen P. Gunn

. . . Employee Benefits Communication Awards . . .

Comedy skits enliven promotional broadcast for new flex program

By SARA MARLEY

NEW YORK—The offbeat comedy duo Penn & Teller, a faux soap opera couple, video-game-playing yuppies and cartoon characters joined forces to introduce New York Life Insurance Co.'s new flexible benefits program.

A two-hour "telemeeting" that reached 1,000 employees in almost 30 locations via the company's satellite network also featured benefit experts explaining the new flex program and answering questions that employees called in live.

The innovative "Directions" show, which was reinforced with colorful, graphic newsletters, posters and an enrollment kit, won New York Life Insurance Co. a Best of Show award in the total benefits program category of *Business Insurance's* 1992 Employee Benefits Communication Awards.

A videotape of the program was used in meetings with the company's remaining 7,200 employees.

Skits served as "commercials" for specific features of the flexible benefits plan, breaking up the talk-show format of a host with guests talking about benefits and a live studio audience.

"It's a terrifically effective means to communicate," said Christina M. Huff, corporate vp of public relations. "Our goal was to make employees realize that it was the first time they had any say in their benefits."

New York Life produced the program, with input from Hewitt Associates.

. . . . TOTAL BENEFITS PROGRAM . . . .

"We brainstormed skits to make it less dry," Ms. Huff said. "We knew we had to make it entertaining with variety in order to make it endurable."

A Penn and Teller fan on staff landed the duo for their cameo introducing the plan's long-term disability options.

"We had to tone it down some. It was (originally) a little more bizarre," Ms. Huff admits. As is, the introduction included a knife through the hand, dripping fake blood.

"New York Life is pretty conservative. We were pushing it as it was," she said.

Since the Sept. 27, 1991, broadcast, the company has again presented benefits infor-

Continued on next page

Advertiser Index

Issue of October 12

Business Insurance

... Employee Benefits Communication Awards ...

Continued from previous page
mation over the satellite network, which now reaches 200 sites.

Previews came in flyers and newsletters that reached employees through internal mail, and with their paychecks.

The written materials, produced by Hewitt, had to "entice employees to read them," Ms. Huff said. "Traditionally our benefit communications had been Xeroxes nobody ever read."

Previously, the insurer "had not invested a great deal in looking at its benefit communications and strategy," agreed Jane G. Lindenburg, communications consultant with Hewitt in Rowayton, Conn.

Hewitt conducted focus groups at four locations with 100 employees in total. They found that employees wanted more—and more detailed—information about the company's flexible benefits plan. Many wanted it on software, which led to the development of an interactive diskette to model the impact of various flex plan decisions, Ms. Lindenburg said.

The insurer also decided to continue offering its current dental plan, rather than introduce a more expensive one that included orthodontic work, in response to feedback from the focus groups.

The enrollment book itself features profiles of fictitious New York Life employees to show

how people with and without dependents might make benefits decisions.

Homey photographs of everyday objects—golf tees, recipes, notes, magnets and crayons—bring the characters to life and focus on their lives away from work.

Information is grouped into easily digested pieces, allowing employees to get as much or as little information as they prefer, Ms. Lindenburg said.

The campaign was treated as a full-scale promotional effort, beginning with a huge banner in the company's headquarters.

"We wanted to get employees' attention with the new program in the first year out," Ms. Huff said. "In the re-enrollment phase, the communications are much lower key."

In keeping with a changing corporate philosophy, New York Life wanted its benefits communications to be "just as attention-getting and promotional" as its outside advertising, Ms. Lindenburg said. ■

AT&T campaign eases pain of introducing copayments

BASKING RIDGE, N.J.—Employee contributions for dependents' health care and flexible benefits were big changes at American Telephone & Telegraph Co.

And long-time employees, who have already weathered a disruptive breakup, do not welcome big changes.

"It was the first time we asked employees to pay for part of the cost of their dependents," said Jack Hynes, director of health and insurance benefits. "It was a culture change."

While AT&T still provides first-dollar coverage for employees, under a flexible benefits plan they are required to contribute $10 per month for a spouse's health care and $20 for family coverage. Employees who opt for lower levels of care receive cash back.

"We wanted to communicate the rising cost of health care and how AT&T is responding," as well as contain costs, said Lee Saviola, district manager-health care administration.

The campaign, developed in conjunction with The Wyatt Co. in Washington, spelled out the contributions and the reason: Self-insured AT&T receives $1 billion in health care claims annually, 60% from dependents.

The company mailed introductory information to employees' homes, established a hotline and sent employees reminders and "flex facts" through electronic mail as well as internal newsletters.

"No matter where an employee went for information, (they received) the same message," Ms. Saviola said.

The campaign earned AT&T an Award of Excellence in the total benefits program category of the *Business Insurance* Employee Benefits Communication Awards competition.

Flex benefits were introduced for AT&T's 110,000 full-time management employees in the United States and some overseas locations. A managed care program is being introduced for its remaining 125,000 employees in about 30 cities.

—By Sara Marley

... Employee Benefits Communication Awards ...

Flex campaign reaches all employees

MAUMEE, Ohio—When St. Luke's Hospital introduced a flexible benefits plan, benefit managers had to design a single program that could communicate the plan to 600 employees ranging from janitors to upper-level management.

"The primary aim was to educate employees, to get them ready to make choices, rather than focusing on the options themselves," said Stanton Hire, vp-human resources.

The Maumee, Ohio, hospital's communication effort won an Award of Excellence in the total benefits program category of the *Business Insurance* Employee Benefits Communication Awards.

Employees could opt to maintain their existing level of benefits under the new flex plan, but more than 10% changed their health care plan and 25% changed life and disability benefits, both exceeding projections, Mr. Hire said.

He anticipates that employees' use of pretax spending accounts will rise dramatically when the new plan year begins in January.

A series of posters and newsletters written on a sixth- to eighth-grade reading level introduced "FlexCare: The Benefit Plan You Design." Photos of a jointed wooden doll illustrated the flex care concept and provided continuity throughout the campaign.

A detailed enrollment packet arrived a month after the first newsletter. It included a user's guide, enrollment instructions and forms, and spending account worksheets.

A highlight brochure in the enrollment packet reiterated the basic information contained in the newsletters.

The newsletters and enrollment packages were distributed to employees by department heads.

A final poster reminded employees that the enrollment deadline was approaching.

Consultant Findley, Davies & Co. of Toledo, Ohio, assisted with the communications project.

—By Sara Marley

Family images highlight flex video

TULSA, Okla.—Dan Quayle, take note: Family values are alive and well at MAPCO Inc.

Just view the videotape introducing the energy-related products and services company's flexible benefits plan.

It opens with a montage of family photos, then cuts to Chairman and CEO James E. Barnes, casually clad and in his back yard with his granddaughter on his knee, explaining his vision for the company. Sepia-toned footage of MAPCO workers drives the point home.

"We took the time and effort to communicate to employees the philosophical side of why we are making benefit changes," said Michael Willmering, general manager-employee benefits.

The flex plan communication is part of an ongoing "total pay" program to convey the value of benefits to employees, he added.

The video and accompanying newsletters and enrollment booklet earned MAPCO an Award of Excellence in the total benefits program category of *Business Insurance*'s Employee Benefits Communication Awards.

William M. Mercer Inc. assisted MAPCO with the project.

Senior management was initially opposed to the flex plan, fearing employees would perceive it as a cut in benefits or contrary to the company's philosophy. So the benefit managers' campaign began in the boardroom, convincing leaders of the advantages of flexible benefits.

Next, a survey showed that employees favored choice in benefits, but worried about making complex enrollment decisions quickly. They also wanted to know what senior management thought of the flex plan.

Newsletters were mailed first class to employees' homes every month, beginning four months before enrollment.

The PersonalChoice enrollment booklet and form were also mailed to employees. At the same time, meetings were held with screenings of the 35-minute tape. Employees were encouraged to borrow a copy to watch at home.

—By Sara Marley

Employees encouraged to take more active role

By EILEEN P. GUNN

NEW YORK—Companies honored in the 20th annual *Business Insurance* Employee Benefits Communication Awards devoted much of their communication efforts to encourage employees to take a more active role in managing their health care and other benefits.

Companies also tried to educate employees about health care issues and to improve their understanding of old benefits or, in several instances, a brand new program.

"Our goal is the empowerment of employees to understand and use their benefits program," said Ron Cheeley, director-employee benefits at The Coca-Cola Co. in Atlanta.

At Public Service Electric & Gas Co., promoting individual responsibility has consistently been the aim of benefits communications in recent years, said Richard Quinn, benefits planning manager for the Newark, N.J., utility.

These goals were evident through most of the entries, said Judy Nelson, one of the 19 judges in this year's competition.

Companies consistently sent the message, "it's in your hands," said Ms. Nelson, manager of marketing support services at GAB Business Services Inc. in Parsippany, N.J.

Though the number of entries decreased—to 177 submitted by 139 companies, down from 227 entries by 176 companies in 1991—the number of judges increased to 19 from 11, and competition was stiff.

Nineteen prizes were awarded to

Continued on next page

. . . Employee Benefits Communication Awards . . .

Continued from previous page
18 companies. Of those, 17 worked with one of 10 consulting firms in developing their communication strategy.

"This was the toughest panel of judges we've ever had, and there was very little discrepancy within the panel" over which communications were the most effective, said Ronnie Drachman, director of communications for *BI* in New York.

"The winners are unanimously the most effective programs submitted," Ms. Drachman added.

"This year's entrants stated their objectives more clearly than ever before, but they also established more realistic objectives to achieve their communication goals," added Barbara Dalton, special projects coordinator for *BI* in New York.

The winning entries had one strong common characteristic: They were "objective driven," agreed another judge.

"Today's employers need to forget subtlety and focus on being succinct and concise communicators," said Sam Waltz, communications manager at E.I. du Pont de Nemours & Co. in Wilmington, Del. "The ones that were successful took that approach.

Several employers introduced flexible benefits programs in 1992, which require more involvement on the employee's part than previous plans had, and several were introducing or increasing copayments.

In light of these changes, they took advantage of the benefits communications to nurture the employee-company relationship, according to GAB's Ms. Nelson.

"Management today is astute enough to realize the most important variable cost they have is people," explained Mr. Waltz.

One challenge all entrants faced was delivering complicated facts and background in a way that engaged employees and did not take a lot of their time.

"People don't like to sit and read," said Ms. Nelson.

Interactive computer programs, videos and newsletters with high-quality graphics and text are one way to retain employees' interest and increase their comprehension.

"People who use something interactive will better communicate their benefits, but it is expensive," observed Mr. Waltz.

Ms. Nelson agrees that communications need to take more advantage of information age technology, but believes video is the best way to do it.

"A well-planned, carefully-written narrative will get everything in there, so there isn't any question unanswered when the viewer is done watching," she said.

Because some of the videos were intended for home viewing, they were effective in dealing with "the reality of the work-family unit of the '90s," Mr. Waltz added. "One of the challenges industry will have to face when developing communications is looking at the employee as part of a family unit that consumes the benefit."

Companies submitted entries in seven categories in addition to audio-visual presentations. The other categories were: single-subject booklet, multi-subject booklet, newsletter, personalized correspondence, multi-media program, special project and total benefits program.

The judges—who are experts in benefits, corporate communications, design, production and marketing—scored the entries on a scale of 0 to 20 on how well entries fulfilled five basic criteria: the program's objectives, strategy, content, presentation and effectiveness.

"It's important to emphasize that the judges are not evaluating the benefits per se, but how well the company communicates to its employees about the program," Ms. Dalton said.

In addition to Ms. Nelson and Mr. Waltz, the judges for the 1992 EBC competition were:

- Carol Anton, benefits communication manager for Minnesota Mining & Manufacturing Corp. in St. Paul, Minn.
- Dean Stoltz, development leader in employee benefits for the Aluminum Co. of America in Pittsburgh.
- Joan Passerino, manager of retirement programs at Gannett Co. Inc. in Arlington, Va.
- Charles Salter, director of employee benefits at GenCorp Inc. of Akron, Ohio.
- Lacy Spears, vp of human resources at Halliburton Energy Services Group in Houston.
- Kaye Reznick, corporate benefits specialist at Houston Lighting & Power Co. in Houston.
- Julie Ann Maggio, vp of IBF Conferences in Uniondale, N.Y.
- Kevin O'Neal, account executive at Lowe & Partners in New York.
- Jeffrey Turner, director of employee benefits at Merck & Co. Inc. in Rahway, N.J.
- Deborah Thomas, senior benefits representative at the Mississippi Power Co. in Gulfport, Miss.
- John Mongelli, president of Mongelli Associates in New York.
- Dawn Putaturo, benefits administrator at the Newmont Gold Co. in Denver.
- Jim Robinson, vp of human resources at Overlake Hospital Medical Center in Bellevue, Wash.
- Catherine Monahan, vp of research and development at SCOR Reinsurance Co. in New York.
- Jacqueline Belknap, corporate co-chair for employee contributions at Southern California Edison in Rosemead, Calif.
- Carlos Alcala and Steve Goldthwaite, designers at Temel Inc. in Boonton, N.J.

The EBC winners will be honored at an Oct. 13 luncheon at the Sheraton New York. ■

Where candidates stand on industry issues

Business Insurance this week spotlights the major candidates running for the U.S. Senate in Alaska, Idaho, North Dakota, Oregon, South Dakota and Washington.

The candidates were asked for their views on these pressing issues for risk and employee benefits managers and the insurance industry: health care coverage reform, tort reform, insurer antitrust reform and the potential role of the federal government in insurance regulation.

Alaska

Republican incumbent **Frank Murkowski** co-authored a GOP health care reform plan, added as an amendment to the Senate tax bill, that is designed to provide health care to the 37 million uninsured Americans. He opposes "play-or-pay" plans and Canadian-style national health insurance.

The GOP plan would provide tax credits for individuals, families and the self-employed who buy private coverage. For the working poor, it would help states set up health care programs.

For the unemployed, it would expand community health centers.

The plan focuses on preventive care and managed care to cut costs. Reforming the medical liability laws could cut administrative overhead $15 billion, Sen. Murkowski said.

Tort reform is vital to eliminate frivolous medical malpractice lawsuits and control rising medical costs, he argues.

Sen. Murkowski, 59, supported the uniform federal product liability bill that died recently in the Senate (*BI*, Sept. 14).

The senator opposes reforming the McCarran-Ferguson Act, which grants insurers limited antitrust immunity.

He also opposes a federal role in insurance regulation, because the states have proven adept in most cases, he said. "If it isn't broke, don't fix it."

Democratic challenger **Tony Smith,** 50, is a columnist for the Anchorage Times newspaper. He was a member of the U.S. Olympic International Relations Committee, vice chairman of the Anchorage Chamber of Commerce and a board member of the U.S. House-Senate Democratic Council.


Mr. Smith

Mr. Smith also chaired Alaska's Bodily Injury Reparations Committee, created by the governor to develop tort law reforms.

Mr. Smith favors a universal health care system that guarantees all citizens a basic level of care and emphasizes prevention, early detection and cost containment. He would preserve what works now—quality care and choice of provider.

Health care should be financed by sharing costs among everyone covered, he said. He also calls for reducing the estimated $176 billion that is spent annually on health care administration.

On tort reform, he favors alternative dispute resolution techniques.

Mr. Smith said he does not oppose a federal role in insurer solvency regulation and would like to study closer the federal insurer solvency regulation bill, H.R. 4900, that Rep. John D. Dingell has introduced (*BI*, April 20; April 13).

Idaho

Boise Mayor **Dirk Kempthorne** is vying for the seat being vacated by his fellow Republican, Sen. Steve Symms, who is retiring.


Mr. Kempthorne

Mr. Kempthorne, 40, says he "absolutely rejects socialized medicine and the mandatory federal play-or-pay program."

Instead, "we need to reignite the consumer's role in health care and provide incentives to private sector health and insurance providers."

To do this he proposes:

- Making health care costs 100% tax deductible for the self-employed.
- Tax credits for individuals who purchase private insurance and pay their own health care costs.
- Incentives for new physicians to accept Medicare patients.
- Tort reform for "more rational medical liability."

Mr. Kempthorne supports a uniform federal product liability law.

He opposes insurer antitrust reform and says states should continue to monitor insurance solvency and regulation.

Democratic challenger **Richard H. Stallings**, 51, a four-term U.S. House member, says "health care financing" should be reformed, though he does not specify how, and health services in rural areas should be improved.

He favors tort reform "if it strikes a genuine balance between the rights of citizens or corporations to be compensated. . .and the need for citizens and businesses to be freed from abusive suits."

Rep. Stallings also opposes reforming or repealing McCarran-Ferguson and supports state regulation of insurance.

North Dakota

Democrat **Byron Dorgan** is seeking the U.S. Senate seat formerly held by Democrat Kent Conrad.

Rep. Dorgan, 50, is serving his sixth term as North Dakota's only congressman.

"The U.S. health care system is in trouble," he says in an issues booklet.

He recommends a universal health care system and supports price controls and cost-containment programs. The resulting savings should be used to pay for expanded coverage for the needy, including those covered by Medicaid.

Rep. Dorgan also supports tort reform measures "to reduce the number of lawsuits and the amount of defensive medicine that is now

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Rep. Dorgan


Mr. Sydness

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practiced because of the threat of lawsuits."

He also favors: price controls on certain prescription drugs, if "price gouging is occurring"; more research on serious diseases; and strengthening rural hospitals.

In addition, Rep. Dorgan said he is "fighting to change the law so self-employed persons, including farmers, can deduct 100% of their health care costs on their income tax forms, rather than merely 25%."

Republican challenger **Steve Sydness**, 37, works in market development and strategic planning for Great Plains Software Inc. He is on the President's Council on Rural America and has worked as an associate with Henry Kissinger's consulting firm, which provides political and economic advice.

Mr. Sydness said that "nationalized health care or health insurance is not the answer" to the nation's health care problems. But, he added, the government has a responsibility to improve the system.

He also would control health care costs by reforming medical malpractice laws to limit non-economic damages, joint and several liability and contingency fees to lawyers.

Standardized forms and procedures for processing health insurance claims, payments and billings would help lower administrative costs, he said.

He also favors changing antitrust laws to encourage health care facilities to work together to provide effective—but not duplicative—services.

Mr. Sydness also recommends requiring insurers to cut premiums for employers that set up employee assistance programs.

To prevent "job lock"—workers afraid to switch jobs for fear they will lose health insurance—Mr. Sydness would bar insurers from denying coverage based on a pre-existing condition.

He also recommends establishing individual medical accounts, which would allow a person to set aside pretax dollars to pay for medical expenses.

On insurance regulation, Mr. Sydness favors state rather than federal regulation.

The other U.S. Senate seat from North Dakota became vacant last month with the death of Democrat Quentin Burdick, 84. A special election to fill that seat is scheduled for Dec. 4.

Candidates for that seat were nominated Oct. 4 at special party conventions.

The Democratic candidate, **Kent Conrad,** 44, is completing his first term as a U.S. senator. He did not seek re-election to his own seat because of a campaign promise that he would leave the Senate if the nation's budget deficit was not reduced. But, he accepted a unanimous Democratic party draft.

The Republican candidate, **Jack Dalrymple**, a 44-year-old farmer, is a representative in the North Dakota Legislature.

Oregon

Four-term Republican incumbent **Bob Packwood,** 60, believes that "reform of the existing employer-based health care system is the most reasonable and efficient approach" to health care reform.

Sen. Packwood, who first introduced his Comprehensive Health Insurance Plan in 1974, claims it is compatible with the Oregon Health Plan (*BI*, Aug. 10). He has been trying to persuade the administration to grant the Medicaid waiver needed for Oregon to implement its health plan.

CHIP would require all employers to offer basic health insurance to full-time employees and many part-time employees and their dependents. It would limit employee contributions to the cost of the coverage.

Small businesses and low-income working families would receive tax credits to help pay for coverage.

A state-administered program would offer the same basic benefits to the unemployed and some part-time employees.

The bill also calls for administrative simplifications, like uniform

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Candidates' views

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health insurance claim forms, to help cut costs.

Democratic challenger **Les AuCoin,** 50, a nine-term U.S. House member, advocates a single-payer national health program administered by an independent federal agency. The program also would cover preventive care, home care and nursing home stays as well as prescription drugs.

Rep. AuCoin

The federal agency would set budgets to control costs.

Though Rep. AuCoin has worked to gain federal approval of the Oregon Health Plan, he believes it is no substitute for comprehensive national health insurance.

South Dakota

Republican challenger **Charlene Haar,** 51, says a national health care program would be "irresponsible and ineffective. Health care choices should remain in the hands of the people, not government bureaucrats."

Ms. Haar supports a comprehensive health care plan like the plan President Bush unveiled earlier this year (*BI*, Feb. 10). The plan would, among other things:

- Create new tax credits and deductions in the form of vouchers to working low- and middle-income Americans.
- Require insurers to cover preexisting conditions.
- Make health insurance premiums fully deductible for self-employed workers.

On tort reform, Ms. Haar would limit punitive damages: "I seek to restore fairness and predictability to punitive damages by placing appropriate limits on them, dividing trials into two phases to determine liability separately from damages, and requiring clear proof of wrongdoing."

Ms. Haar

Ms. Haar opposes federal involvement in insurance regulation.

"Solvency enforcement and standards should be left to state governments," she said. "If these were transferred to federal responsibilities, it would be only a matter of time until the program would be run by Washington bureaucrats and could end up like the S&L mess."

Tougher federal laws on white-collar crime would reduce the number of insolvencies, added Ms. Haar, a teacher at Madison High School in Madison, S.D.

Democratic incumbent Sen. **Thomas Daschle,** 44, did not respond to requests for his views.

Washington

Vying for the seat of retiring Democratic Sen. Brock Adams is five-term U.S. Rep. **Rod Chandler,** a Republican.

Rep. Chandler, 50, has introduced three bills—H.R. 1565, H.R. 2453 and H.R. 1004—that would make basic, low-cost health insurance available to all citizens.

Under the legislation, insurers would be required to make a core benefits package available to employers. Small businesses would be encouraged to band together to form health insurance purchasing groups.

Rep. Chandler's legislation also would clamp down on health care costs by limiting the amount of money attorneys can receive in medical malpractice cases. His plan encourages alternative means of resolving medical malpractice claims.

Rep. Chandler

He also would control health care costs by promoting health plans that feature managed care, including preferred provider organizations.

The proposals aim to reduce administrative costs by streamlining the insurance billing system.

Patty Murray, 42, a Democrat and one-term state senator, has backed family leave legislation in the state legislature. She says she favors "a national health care system where decisions about our health care are made by individuals and their health care providers, not by the insurance companies (and) where health care is accessible to everyone."

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Los Angeles Bureau Chief Joanne Wojcik, Associate Editors Louise Kertesz in Los Angeles and Meg Fletcher and Laura Mazzuca in Chicago and Staff Reporter Sara Marley in Chicago contributed to this report.

RJR Nabisco plan

Continued from page 1

Cost was not a factor in adopting the new plan, which will cost roughly as much as the plans it is replacing, said Gerald Angowitz, vp-employee benefits with RJR Nabisco in New York.

RJR Nabisco benefit executives say the new plan is the best approach to meeting the benefit needs of an increasingly diverse workforce.

"This provides fairer, more equitable benefits to a more diverse workforce. It is fair to all employee groups—short service, fast trackers, mid-career hires and long-service employees," said Mr. Angowitz.

"This is the first plan to treat all employees in a fair and equitable manner," concurred Eric Lofgren, a consultant in the New York office of The Wyatt Co., which helped design the plan. Wyatt calls it a pension equity plan, or PEP.

"This has a great potential to be a very popular plan. It has virtually all the advantages of both traditional defined benefit and cash balance plans and virtually none of the disadvantages," Mr. Lofgren added.

Other consultants have promoted similar concepts, though no other company has adopted the design. But the move by RJR Nabisco may spur interest elsewhere. "With a major company adopting this design, that in itself will develop a tremendous amount of interest," said Vince Tobin, a group executive and consulting actuary at Buck Consultants Inc. in Secaucus, N.J.

"Frankly, I like it. It is easy to understand and to communicate. It may be a lot more appealing than a traditional plan," said Dale Allen, a principal with William M. Mercer Inc. in Stamford, Conn.

The PEP plan marks the second major departure from the traditional final average pay formula used by defined benefit plans.

The first was cash balance pension plans, which were considered revolutionary when Kwasha Lipton designed one for BankAmerica Corp. in the mid-1980s.

In cash balance plans, which

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have since been adopted by about 200 employers, an account balance is established for an employee. The account balance grows as the employer provides benefit credits equal to a fixed percentage of salary. And companies guarantee that account balances will increase at a certain rate, like the interest rate on one year-Treasury bills. A vested employee is entitled to the balance when leaving the company, regardless of age.

Behind the drive for new pension plan designs lies employer frustration that employees have little or no understanding of their plans. Yet after health care, pensions are a company's most expensive benefit.

"Pension plans have been a black box that the average participant cannot understand," said Wyatt's Mr. Lofgren.

Cash balance plans reduce that problem. At a single glance, an employee knows the value of his or her account—expressed in dollars, rather than some obscure formula.

And cash balance plans have appealed to shorter-service workers. Because benefit accruals tend to be "front-loaded" when the account is established, shorter-service employees receive much higher benefits than they would receive from a traditional final average pay plan. In a traditional plan, benefit accruals typically are "back-loaded," meaning that benefits are skewed to an employee's final years of service.

On the other hand, mid-career hires or fast-track employees whose earnings swell in a short period of time don't fare as well in a cash balance plan compared to a traditional final average pay plan.

One reason is that a major portion of the benefit in a cash balance plan is derived from the compounding of interest earned on the account balance. An employee hired at mid-career simply may not be there long enough for interest to compound significantly.

At the same time, a fast-track employee won't fare as well under a cash balance plan because benefits are based on career earnings and a credited interest rate rather than the employee's highest salary.

RJR Nabisco began to consider a new plan design about 12 to 15 months ago that would combine the best features of other types of pension plans.

"We asked what plan design makes the most sense for the workforce of the future," said Mr. Angowitz.

That workforce is rapidly growing more diverse, with a mixture of mobile short-service workers, mid-career hires, and long-service employees.

"You have a portion of the workforce that is young and mobile. And there is a portion of the workforce—the aging baby boomers—that is settling in. You need a plan that meets the needs and is fair to both groups," Mr. Lofgren said.

"The reality is you don't have a workforce that is overwhelmingly composed of workers who stay 35 years," agreed Larry Sher, a partner at Kwasha Lipton in Fort Lee, N.J.

With a relatively steady accrual of benefits, a PEP program like RJR Nabisco's is fairest to all employees, Mr. Lofgren said.

At the same time, a PEP design may actually be easier to understand than a cash balance plan, in which changing interest rates will affect calculations of the account balance, he said.

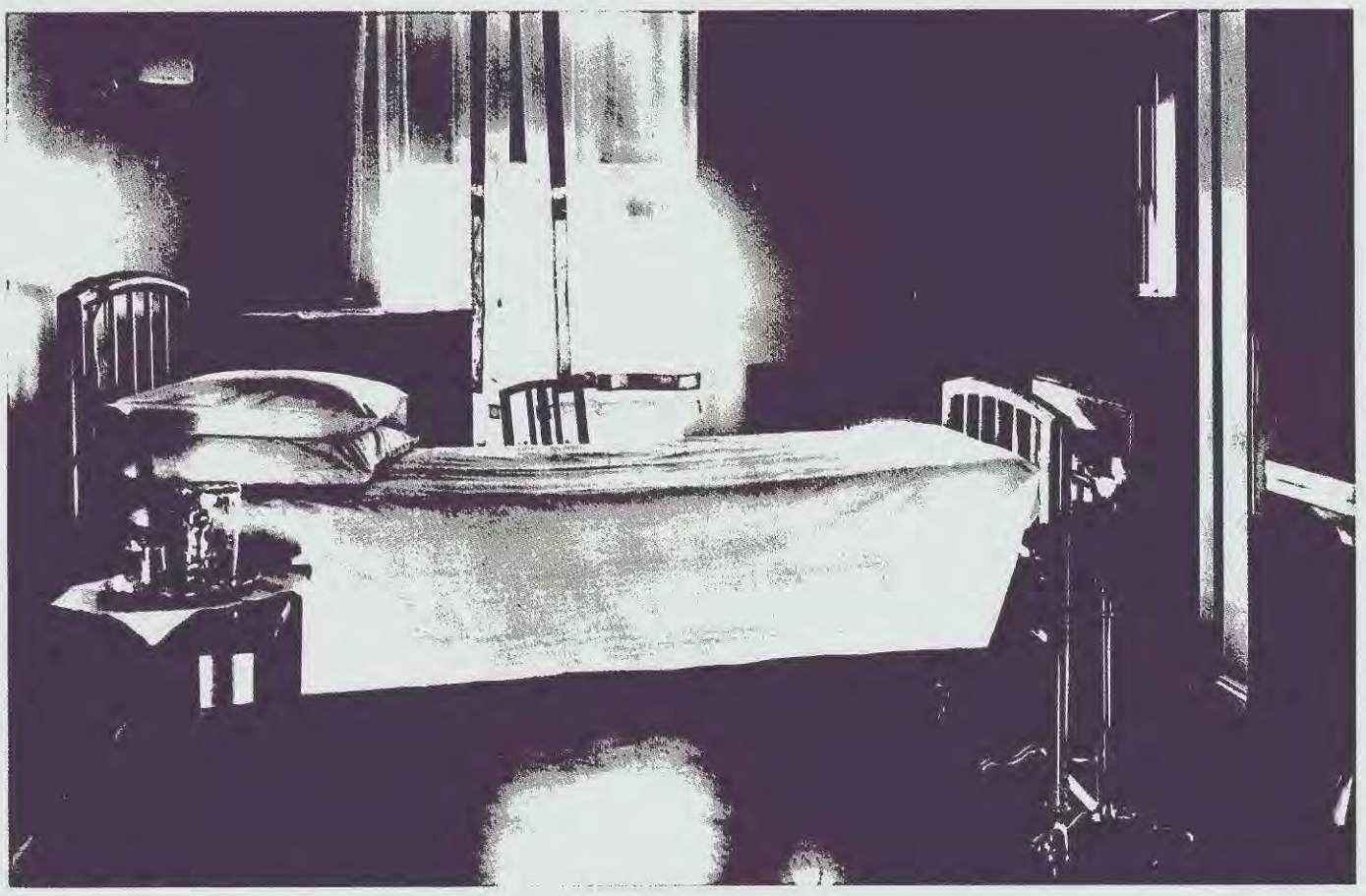
By contrast, PEP plan benefits are based on "knowable" elements —employee's final average pay and age-related credits, Mr. Lofgren added.

Not every company, of course, will want a PEP plan. Some, for example, may not want a plan that is partly based on final average pay, said Kwasha Lipton's Mr. Sher.

The cost of final average pay plans can be very unpredictable during periods of high inflation and big salary increases, he noted.

Mr. Sher says, though, that PEP should not be viewed as a rival of cash balance plans, adding that the plans have more similarities than differences.

Indeed, some benefit experts view PEP as in the middle of the pension spectrum with cash balance plans at one end geared more to shorter-service employees and traditional plans at the other end geared toward long-service employees. ■



Age-related credits key to Nabisco pension plan

NEW YORK—RJR Nabisco Inc.'s new pension equity plan is based on age-related credits and final average salary.

Workers earn the credits, expressed as percentages, for each year that they work at Nabisco. The percentages increase according to the age-bracket in which a worker falls. Each age bracket generally covers a five-year period.

Under the new plan, which was designed in conjunction with The Wyatt Co., credits range from 4% for each year worked under age 30 to as high as 13% for each year starting at age 60.

These percentages are added up and multiplied by final average pay. Final pay is the average of the highest three years of earnings over a worker's last five years on the job.

In addition, smaller age-based percentages are provided for final average earnings that exceed "covered compensation." Covered compensation is the average of the Social Security taxable wage base measured over a 35-year period. These averages are published in tables compiled by the Internal Revenue Service.

The sum of these smaller age-based percentages would then be multiplied by final average earnings above the covered compensation threshold.

The lump-sum benefit to which a worker is entitled would be the sum of the calculation involving all pay and the calculation on earnings exceeding covered compensation.

Wyatt offers an example of how a PEP can be designed and how benefits could be calculated. This example assumes that an employee is retiring at age 65 with 20 years of service and a final average salary of $50,000.

In the example, the percentage credit applied to all pay begins at 9% for each year of service at age 45 and increases by one percentage point in succeeding five-year age brackets until age 60, when the credit reaches 12% and remains at that level.

For pay exceeding covered compensation, the credits are: 0% under age 34, 1% for ages 35 through 44; 2% for ages 45 through 54; and 3% for age 55 and up.

Covered compensation for this employee is $20,000.

For all earnings, the employee earned 45% for service between age 45 and 49, 50% for work between 50 and 54, 55% for service between 55 and 59 and 60% for work between 60 and 64.

The sum of these percentages is 210%. The final average earnings of $50,000 multiplied by 210% is $105,000.

The same steps would be applied for age-based credits for pay above covered compensation. Those credits total 50%. Final average earnings above covered compensation—in this case, $30,000—would be multiplied by 50%. The result is $15,000.

The two sums—$105,000 for all earnings and $15,000 for earnings above covered compensation—would be added producing a lump sum benefit of $120,000.

The retiree could take the $120,000 as a lump sum or convert it into an annuity.

—By Jerry Geisel

For the Record

CNA Insurance names Engel new president

CHICAGO—Philip L. Engel has been named president of the CNA Insurance Cos., succeeding Dennis H. Chookaszian who held the position since 1990.

Mr. Chookaszian was recently named chairman and chief executive officer of CNA Insurance Cos. He succeeds Edward J. Noha, who is now chairman of parent CNA Financial Corp.

Mr. Engel had been executive vp of CNA since 1990. Before that, he was vp of systems and services, following 11 years as vp of marketing. Mr. Engel is also a director of CNA Financial Corp.

Equitable declares first stock dividend

NEW YORK—Equitable Cos. Inc. recently declared its first quarterly stock dividend.

The cash dividend of 5 cents a share on its common stock will be paid Oct. 16 to shareholders of record Sept. 28. Equitable says regular quarterly dividends are expected to begin in November.

Several months ago, the insurer completed its conversion to a stock company from a mutual insurer.

Managed care cuts workers comp rates

JEFFERSON CITY, Mo.—Missouri employers soon will receive a discount on their workers comp premiums if they use a managed care program to hold down workers comp medical costs.

State regulations that take effect Nov. 1 will provide discounts to employers that contract with a state-certified preferred provider organization or any managed care program under contract with the employer's insurer. Those discounts will be at least 5% total over three years.

"The regulations allow employers to exert control over their workers compensation costs and reduce the impact of increasing premiums," said Lewis E. Melahn, Insurance Department director.

Certification requirements for other managed care programs, like health maintenance organizations, are to be developed in the future.

New policy covers loans on polluted land

NEW YORK—A new policy for lenders will cover at least $10 million in loans that go into default on polluted property.

"It covers a bank's principal and interest when they can't foreclose on real estate because it is polluted," explained Tom Vietor, a Johnson & Higgins senior vp and manager of the broker's New York financial group.

The policy, though, "does not cover third-party liability," he said.

American International Surplus Lines Insurance Co., an American International Group Inc. unit, underwrites the coverage. Limits of $10 million are available, and a lender can seek an additional $10 million from the insurer.

Deductibles range from $500,000 to $1 million. Coinsurance requirements range from 10% to 25% after the deductible.

The policy, unveiled by J&H, applies to all loans on a lender's books at the time it purchases the coverage. ■

INTERNATIONAL

Troubles mount in Scandinavian market

By MARIA KIELMAS

STOCKHOLM, Sweden—Troubles continue to mount for Swedish insurers after Skandia Holding A.B. canceled the initial public offering for its U.S. reinsurance unit and Trygg Hansa SPP Holding A.B. posted disastrous interim results.

Both insurers also face increasing hostility from Swedish banks, which are angry that the two insurers refuse to bail out bankrupt credit insurers Svenska Kreditforsakring and International Credit, in which the insurers had significant shareholdings (*BI*, Sept. 14).

The banks contend that the refusal represents an arbitrary about-face from the insurers' policy of supporting the credit insurers earlier this year. And the Swedish government has let it be known that it will not intervene in the dispute between the banks and insurers.

Insurance analysts are not optimistic about the Swedish market's prospects, in light of recent events.

On Sept. 30, Skandia canceled plans to sell a majority of its U.S. subsidiary, Skandia America Corp. (*BI*, Oct. 5).

The final filing price was $18 to $20 per share, down from an original target of $25, said Skandia Secretary, Johan Bergenstjerna. The Skandia offer of 9 million shares was subscribed two times over at $18 per share.

"Since the price on the final filing was exactly the minimum, we decided we could not justify the deal to our shareholders," he said.

The primary factor in this decision was the poor prospects in the U.S. reinsurance market. Projections of hardening rates in the wake of hurricanes Andrew and Iniki had caused a stock rally, but Skandia was not optimistic the market would turn.

"Maybe the rates will rise short-term," said Mr. Bergenstjerna, "but there is still overcapacity."

The gloom in Scandinavia deepened on Oct. 2 when Trygg Hansa posted disastrous January-to-August results. Interim profits, which last year had been 1.09 billion krona ($197

Continued next page

Colombia may bar K&R

Pending legislation would outlaw payment of ransoms

By MARIA KIELMAS

LONDON—Anti-kidnap legislation currently being considered by the Colombian Congress is sending shivers throughout the oil industry there and could prevent some kidnap and ransom underwriters from issuing coverage in the country.

The proposal being considered by the Colombian Senate mainly would:

- Define kidnapping as a major crime and deny its perpetrators any right of pardon, amnesty or parole.
- Create a special section in the attorney general's office to deal with kidnapping.
- Freeze the assets of kidnap victims' families so that ransoms could not be paid.

In addition, an oil or mining company found to have paid a ransom would have its contract with the government terminated.

The threat of terminating contracts if it could be proved a company paid a ransom has come as a shock to the oil industry in Colombia.

National and foreign companies in Colombia generally provide kidnap and ransom coverage for their executives. One Bogota executive said that if this coverage were not provided, no foreigners would live in the country. About 30 foreign oil companies, mostly North American and European but also some Australian, have operations in the country.

The oil industry in Colombia is lobbying fiercely against the anti-kidnap legislation. Industry officials think such a law will be unenforceable and counterproductive, and make oil industry executives even more of a kidnapping target than they are already.

No oil executive has been kidnapped in Bogota for seven years, although kidnapping is frequent at out-of-town oil field sites, a Bogota oil executive said.

The anti-kidnap bill "is a pretty draconian measure, and it will make a profound difference to the way the industry is run in this country. There is no room for maneuver. But maybe we could get someone to pay the ransom through a third party, and the state would have to prove it," the oil executive said.

In his opinion, an equivalent law in Italy has made little difference to the kidnapping risk.

However, Fundacion Pais Libre, a voluntary organization dedicated to combating kidnapping incidents and which initiated the anti-kidnap bill, says the Italian law, which also includes a prohibition on the buying and selling of kidnap and ransom insurance, has decreased the number of kidnap incidents annually to seven from more than 70.

The group collected 1 million signatures from Colombians supporting the legislation, including 56 senators and 74 members of the Chamber of Deputies.

Pais Libre says the traditional U.S. process of coping with a kidnapping, whereby the authorities try to bring the kidnappers to justice after saving the victim, is counterproductive in Colombia, because the public has little confidence in the security services.

In Colombia, negotiations are geared toward saving the victims' life and avoiding legal action against the perpetrators.

Opponents of the legislation say the Colombian authorities would have a jurisdictional problem implementing the law.

Proving that a ransom had been paid by a company would be near impossible, says Andrew Askham, kidnap and ransom specialist at Investment Insurance International, a division of London brokers Hogg Robinson Group P.L.C. K&R policies for executives in Colombia are issued in the United Kingdom or other countries outside Colombia, paid for in U.S. dollars and paid by the insurer and the policyholder's company from the head offices in Europe or North America as part of some global insurance coverage.

An anti-kidnap law in Colombia, he says, would simply drive the payment of ransoms into the hands of third parties in offshore havens.

Mr. Askham says an average company pays $40,000 to $60,000 for $1 million worth of K&R coverage. This coverage can include up to 10 individuals and

Continued on page 43

EIL rate approval sought

German insurers emphasize rates are just a model

By CAROLYN ALDRED and DON LEWIS KIRK

BONN, Germany—The Assn. of Liability & Casualty Insurers in Germany, HUK-Verband, has applied to the German Cartel Office for approval of rates for its new environmental impairment liability policy.

HUK-Verband's "tariff book" lists nine industrial risk categories and determines the premium companies in each category are likely to pay for EIL coverage.

The EIL coverage will be provided by a new pollution insurance policy the association drafted late last year in response to Germany's tougher environmental liability law (*BI*, Oct. 7, 1991).

The law, which took effect Jan. 1, 1991, imposes strict liability for wrongful death, personal injury or property damage caused by air, soil or water pollution, as well as liability for environmental damage caused by "normal operations."

The law also mandates that certain industrial companies purchase EIL insurance or provide financial guarantees that they can meet their new, broader liabilities.

Insurers initially balked at insuring the new liabilities, particularly pollution damage caused by normal operations.

"Insurance costs to companies will depend upon the category into which they fall," says a HUK spokesman in Bonn.

For example, he said, "The model recommends a paper factory have a risk factor of 2.2, which means it requires an insured sum of 2 million deutsche marks ($1.5 million at the current exchange rate) and a net insurance premium of 381 deutsche marks ($285.82) for small factories, 511 deutsche marks ($383.35) for middle-sized and 640 deutsche marks ($480.13) for large facilities."

The model gives facilities like coal liquidation plants a risk factor of 7.0, which means the company requires a policy limit of 2 million deutsche marks and insurance premiums ranging from 3,380 to 7,087 deutsche marks ($2,535 to $5,315), depending upon the size of the facilities.

Insurers have voiced reservation about the HUK rates and emphasize they serve only as a model for insurers to follow.

At least three industrial insurers —Gerling Konzern Versicherungs-Beteiligungs A.G., Haftpflichtverband der Deutschen Industrie VVaG and Mannheimer Versicherung A.G. —say they have worked out their own rating system.

HDI's EIL underwriting expert, Tilmann Hess, said, "Our rates are similar to HUK's model, but it's necessary to set rates according to a client's needs and the demands of

Continued on page 43

Claims payments resumed by MMI

By GAVIN SOUTER

LONDON—Municipal Mutual Insurance Ltd. has resumed paying claims one week after it announced a payment moratorium because a rescue plan to save the troubled insurer had collapsed.

And MMI is confident that it can find other British insurers to take on many of its existing policyholders, said Chief Executive Brian Wright. "It is now clear that a number of parties are interested in purchasing various parts of the group."

Some personal lines business has been transferred to General Accident Fire & Life Assurance P.L.C. and Norwich Union Fire Insurance Society. Talks are continuing with other insurers about taking over the rest of the MMI business, two-third of which is commercial lines.

Meanwhile, local authorities that constitute about 85% of MMI's commercial risks are discussing setting up another mutual or captive insurer to carry their risks, said Martin Pilgrim, finance director of the Assn. of Metropolitan Authorities.

MMI decided to resume claims payments having taken "stock of the situation," Mr. Wright said.

The company puts its total assets at 1.4 billion pounds ($2.37 billion at current exchange rates), but would not disclose its total outstanding liabilities.

In 1991, the insurer lost 238.6 million pounds ($446.2 million at the year-end 1991 exchange rate) on net premiums of 784.9 million pounds ($1.47 billion).

Several local authorities were recently left without coverage as their MMI policies approached an Oct. 1 renewal date (*BI*, Oct. 5).

Most found coverage with other insurers, said Mr. Pilgrim, although at higher premiums and retentions.

Action group to sue

The Rose Thomson Young Syndicate 255 Names Action Group plans in November to serve writs alleging negligence against the Lloyd's members agents who represented them, said Sir David Berriman, the group's chairman.

"Once the writ is issued, we will sit down with RTY's errors and omissions underwriters and try to settle without going to court," Sir David said.

The E&O underwriters had previously indicated that they could not negotiate until formal legal proceedings had been started, he said.

The 600-member group decided Oct. 5 at its annual general meeting to proceed with the writ.

Several days earlier, a Lloyd's loss review committee blamed the losses largely on errors in underwriting

LONDON

judgment (*BI*, Sept. 28). Ineffective management control by the syndicate's managing agents, Rose Thomson Young (Underwriting) Ltd., also contributed to the huge losses, the committee said in a report.

The writs will be followed by a statement of claim.

Syndicate 255, which had 966 members in 1988, has lost 63.3 million pounds ($114.6 million at applicable exchange rates) to date on its still-open account. Each member of the group will be asked to contribute 150 pounds ($256) toward legal costs, Sir David said.

Pension theft policy

The Maxwell pension fund scandal has prompted a Lloyd's of London syndicate to offer pension fund theft insurance.

The policy could offer cover up to 50 million pounds ($85.6 million at current exchange rate) against theft by anyone who has control of or access to a pension fund.

The coverage is led by syndicate 1007 managed by Spreckley Villers Hunt & Co. Syndicate 1007 will offer the first 10 million pounds ($17.1 million) in coverage and a further 40 million pounds ($68.5 million) of capacity is available in the London market, said Simon Haggis, assistant underwriter on the syndicate.

The policy pays out as soon as a theft has been established, regardless of whether there is a criminal conviction of the thief, Mr. Haggis said. There is no need to prove that the thief obtained an improper financial gain for himself, he said.

Meanwhile, a fourth person has been arrested in relation to the saga surrounding the Maxwell media empire.

Robert Bunn, a former finance director within the Maxwell Group, was arrested and charged with conspiracy to defraud a syndicate of banks that had invested in the company.

The scandal erupted after Mr. Maxwell died last year when it was alleged that he stole 426 million pounds ($729.3 million at current exchange rates) from Maxwell-company pension funds to prop up his ailing media empire (*BI*, Dec. 16, 1991).

In June, Kevin and Ian Maxwell, two sons of the late publisher Robert Maxwell, and Larry Trachtenberg, a director of various Maxwell companies, were charged with various criminal allegations surrounding the Maxwell media empire and its pension funds (*BI*, June 22). ■

Swedish insurers

Continued from previous page

million at year-end 1991 rates), disappeared, replaced by losses of 5.57 billion krona ($1.03 billion at current exchange rate).

Most of the loss was attributed to 6.01 billion krona ($1.11 billion) lost through its holdings in:

- Bank holding company Gota A.B., which accounted for 5.51 billion krona ($1.02 billion) in losses for Trygg Hansa.
- Credit insurers Svenska Kredit and International Credit Holding A.B., which produced losses of 500 million krona ($92.5 million).

Trygg Hansa also has a further reinsurance commitment to Svenska Kredit of 100 million krona ($18.5 million).

Insurer analysts also see an attempt by Trygg Hansa to isolate its operating companies from holding company losses as an ominous sign of more losses to come.

Analysts have dubbed the move "the Hafnia model," a pointed allusion to troubled Hafnia Holdings A/S, which put its foreign operating subsidiaries on the block (*BI*, Sept. 21).

Bjorn Sprangare, chairman of Trygg Hansa SPP Holding, went to great lengths to try to quell uneasiness among policyholders. "Pensions are not at risk," he said, and policyholders are only affected "extremely marginally" by the holding company losses.

He was responding in part to a Swedish newspaper report urging Trygg Hansa policyholders to switch insurers.

Analysts note that Trygg Hansa SPP Holding canceled a planned 3 billion krona ($554.1 million) capital increase as the losses from Gota A.B. and Svenska Kredit began to materialize.

Looking for bigger markets for its life and pension business, Trygg Hansa SPP last year initially acquired a 43.5% stake in Gota A.B. The bank's chairman at the time was Mr. Sprangare.

Then in April, when Scandinavian banks were in the process of collapsing under the weight of bad loans and real estate losses, Trygg Hansa boosted its stake in Gota A.B. to 98% to demonstrate its confidence in the bank.

Gota A.B. is now in liquidation and a receiver has been appointed.

At midyear, Trygg Hansa SPP Holding together with Skandia also underwrote a capital increase for Svenska Kredit, whose subsequent failure increased the two companies' joint holding in the credit insurer to 70% from 30%.

But then Trygg Hansa refused to further bail out the troubled company, as it had tried to do with Gota.

The Swedish banks are claiming that Trygg Hansa and the credit insurer's co-owner, Skandia Holding A.B., have more than a moral responsibility in assuming some of Svenska Kredit's liabilities, since Svenska Kredit was a de facto subsidiary of both companies.

Both insurers have written down their investments in the two credit insurers to zero and accounted for the losses in 1992.

But that does not end the matter, because the liabilities of the credit insurer are considerably greater than stated and could be a "black hole," according to an official at a major Swedish bank.

Insurance analysts say that they are beginning to look at a worst case scenario.

Mr. Sprangare's surprisingly strong insistence that pensions and life policies were not in danger was a "sign of desperation," said Jonathan Lawlor of Kleinwort Benson Securities in London.

There is considerable nervousness in the market because of ongoing financial difficulties of Hafnia are still fresh.

Before Hafnia's fall after its abortive attempt to acquire Skandia, the management's first move was to isolate the operating companies from the holding companies. Trygg Hansa's Mr. Sprangare seems to be going in this direction, commented Mr. Lawlor.

Mr. Lawlor believes that Trygg Hansa SPP and Skandia will back each other all the way in their confrontation with the banks over Svenska Kredit, and the banks will fight all the way, too.

"I wouldn't be overly optimistic about their reaching a satisfactory solution," he said. ■

INTERNATIONAL

German EIL policy

Continued from page 41
the market."

Mannheimer Versicherung presented a new EIL policy late last month, which does not use the HUK model as a basis of its rates. Instead, it also evaluates cases individually.

While insurers voice reservations about strict adherence to the rates it has filed, HUK says the model represents general agreement among German insurers about the insurance costs companies are expected to incur for pollution risks.

The HUK model sets the maximum policy limit far lower than than the government requirements as a signal to the government that its requirements are unreasonably high, a spokesman said.

Government officials have set the required minimum amount of insurance coverage at 160 million deutsche marks ($120 million) per facility. However, HUK has set maximum limit at 10 million deutsche marks ($7.1 million).

The German Cartel Office is expected to finish its assessment of HUK rates in November. But the draft policy has sparked dissension between insurers and reinsurers (*BI*, Aug. 17).

The policy has been criticized by reinsurers, who claim it may be too broad to reinsure.

However, Wilhelm Zeller, member of the board of executive directors of Cologne Reinsurance Co., argues that the insurance and reinsurance industry must work together to help the venture succeed. He also urges non-German reinsurers to offer support, citing Germany's excellent past record writing EIL coverage.

According to Mr. Zeller, reinsurers are unhappy about several aspects of the policy.

First, while most EIL coverage is provided worldwide on a claims-made basis, the new German policy is based on a new concept of "verifiable first discovery" during the policy period that bodily injury or property damage had occurred.

"There is no apparent flaw in the design of this trigger concept. However, it is a fact that the concept is new and untried," noted Mr. Zeller.

However, he said, "More important is the lack of a sweeping exclusion clause for pre-existing pollution."

The new policy excludes "claims for losses that had already occurred at the commencement of policy."

Thus, Mr. Zeller argues, if claims arise from environmental impairment that had occurred before the policy inception but had not been discovered until the policy was in force, they would be covered.

Another major concern is the EIL policy's coverage for environmental impairment resulting from "normal business operations."

Although it excludes "claims for losses that are caused by environmental impacts that are unavoidable, necessary, or expected, based on the conditions of the operation of the business," an important exception to the exclusion was successfully negotiated by the industrial sector.

This exception, a so-called "savings clause," means the exclusion does not apply if the insured "can prove that he could not have recognized the possibility of a loss of this nature."

For example, he said, chemical plants nationwide could be permitted today to emit a substance currently regarded as harmless. If continuous exposure to minute amounts of the substance are found years later to cause respiratory ailments, insurers and reinsurers would be "confronted with an unlimited accumulation" of insured damages, he said. ■

Colombia

Continued from page 41
their families. Oil companies tend to buy coverage with limits of between $5 million and $10 million. Rates for some high-risk policies are as much as $90,000 per $1 million of limits.

However, Cassidy Davis Underwriting Ltd., a large K&R underwriter and manager of Lloyd's syndicate 582, disagrees with the theory that the law would drive ransom payments to third countries.

Cassidy Davis Director Robert Davis said his company will not violate any law in the country where the policyholder is located. Furthermore, if Cassidy Davis were to pay a ransom in a country where ransom payments are outlawed, the underwriter would be vicariously responsible for the crime under British law, said Mr. Davis.

He said Cassidy Davis would not issue policies through subsidiaries in third countries in order to circumvent anti-kidnap laws.

Mr. Davis added that the outcome of the Colombia anti-kidnap legislation is as yet uncertain. The security authorities may accept as part of the law that a ransom in some cases is unavoidable, he said.

Kidnapping as a lucrative business took off in Colombia in 1985 when a German construction company, Mannesman GmbH, allegedly paid insurgency group Ejercito de Liberacion Nacional $5 million for the release of several engineers working on an oil pipeline. The company has neither confirmed nor denied the payment.

Military sources say the two main insurgency groups, Fuerzas Armadas Revolucionarias Colombianas and ELN, earn $250 million annually from their principal activities of kidnapping, robbery and drug trafficking.

In Colombia, kidnappers have at times demanded ransoms of up to $20 million for oil executives, but negotiators have been able to talk those amounts down to about $1 million. ■

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re:

Petition of Christopher John Hughes, Ian Douglas Barker Bond and Gareth Howard Hughes, as Joint Provisional Liquidators of Walbrook Insurance Company Ltd.,

Debtor in Foreign Proceedings

Case No. 92-B-44623 (PBA)

PRELIMINARY INJUNCTION ORDER

This matter has come before the Court on Petitioners' request for a Preliminary Injunction Order pursuant to Bankruptcy Rule 7065 and Federal Rule of Civil Procedure 65(b). The Court has considered and reviewed the Petition filed in this case, the Affidavit of Ronald DeKoven, one of the attorneys for the Petitioners, duly sworn to on the 16th day of August, 1992, the Declaration of Gabriel Moss, Q.C., duly verified on the 14th day of August, 1992, the Declaration of Ian Douglas Barker Bond, one of the Petitioners herein, duly verified on the 14th day of August, 1992, and the Memorandum of Law in support of the application, and the responses filed thereto, and having held hearings and heard arguments by counsel on August 19, 1992 and September 25, 1992, and based on the foregoing the Court finds and concludes as follows:

1. Petitioners have demonstrated a substantial likelihood of success or have raised serious questions on the merits of the contentions that Walbrook Insurance Company Ltd. ("Walbrook") is subject to foreign proceedings, that Petitioners are the foreign representatives of the debtor, that the commencement or continuation of any judicial, administrative or regulatory action or proceeding against Walbrook, or any of its property in the United States, should be enjoined* pursuant to 11 U.S.C. § 304(b) to permit the expeditious and economical administration of the foreign estate in the pending proceedings brought under foreign law, and that the relief requested will not cause hardships to parties which are not outweighed by the benefits;

2. Unless an injunction is issued, it appears to this Court that one or more parties in interest will relinquish or dispose of property of Walbrook in the United States, or will commence or continue the prosecution of judicial, administrative or regulatory actions against Walbrook and/or seek to retain assets of Walbrook, thereby interfering with, and causing harm to, Petitioners' efforts to administer the Walbrook estate pursuant to the foreign proceedings, and that as a result Petitioners will suffer immediate and irreparable injury for which they will have no adequate remedy at law;

3. Unless the injunction is issued, Petitioners will be unable to acquire sufficient information about pending litigations and U.S. assets of Walbrook to properly protect the interests of Walbrook in the United States, subjecting Walbrook to the risk of default judgments and resulting in the further depletion of Walbrook's limited assets;

4. The interest of the public will be served by restraining the disposition of Walbrook's property and the commencement or continuation of such judicial, administrative or regulatory actions or proceedings; and

5. Venue is proper in this district pursuant to 28 U.S.C. § 1410;

NOW, THEREFORE, IT IT HEREBY ORDERED as follows:

ORDERED, that all persons (except as provided in the New York Superintendent Orders) are hereby enjoined and restrained from:

(1) relinquishing or disposing of any property of Walbrook in the United States, or the proceeds of such property, to third parties;

(2) commencing or continuing any judicial, administrative or regulatory action or proceeding against Walbrook or any of its property in the United States; and

(3) enforcing any judicial, administrative or regulatory judgment, assessment or order and commencing or continuing any act or any judicial, administrative or regulatory proceeding to create, perfect or enforce any lien, set-off or other claim against Walbrook or any of its property in the United States; and it is further

ORDERED, that nothing in this order shall in any respect prevent the continuance or commencement of proceedings against or involving other London Market insurers or any other insurance company defendant; and it is further

ORDERED, that pursuant to Bankruptcy Rule 7065, the security provisions of Fed. R. Civ. P. 65(c) be, and the same hereby are, waived; and it is further

ORDERED, that this Preliminary Injunction Order shall be served (A) by hand delivery, facsimile or United States mail, first class postage prepaid, on or before September 30, 1992 upon the parties in interest appearing in this case and in *In re Petition of Christopher John Hughes and Ian Douglas Barker Bond as Joint Provisional Liquidators of Kingscroft Insurance Company Ltd., et al.,* Case Nos. 92-B-41974 through 92-B-41977 (PBA) (Bankr. S.D.N.Y.), at the time of such service; and (B) by publication of a summary of this Preliminary Injunction Order in *Business Insurance Magazine* on or before October 19th, 1992; and that service pursuant to this paragraph shall be deemed good and sufficient service and adequate notice; and it is further

ORDERED, that the time to answer or move with respect to the Petition is extended *sine die,* but that parties wishing to move for modification of or relief from this Order or otherwise may do so in accordance with the schedule set forth by the Court herein and in any subsequent Scheduling Order entered by the Court in this case;

ORDERED, that this injunction shall remain in effect pending further order of the Court, after a hearing scheduled to be held in Room 617 of the Alexander Hamilton House, One Bowling Green, New York, New York on November 17, 1992 at 2:30 p.m.; and it is further

ORDERED, that all papers submitted for the purpose of controverting the petition or opposing a continuation of the relief provided for in this Preliminary Injunction Order shall be filed with the Court with a copy to the Chambers and delivered personally or by overnight mail or so as to be received by Shearman & Sterling, 599 Lexington Avenue, New York, New York 10022 (attention: Ronald DeKoven), Attorneys for Petitioners, on or before November 6, 1992.

Dated: New York, New York
September 25, 1992
3:10 p.m.

/S/PRUDENCE BEATTY ABRAM

U.S.B.J.

*Petitioners' request for relief, and the terms of this Order, are subject to the provisions of any temporary restraining order or order of conservation to be obtained by the New York Superintendent of Insurance ("New York Superintendent Orders").

U.S. market

Continued from page 2

end of 1993. Others, though, dismiss those predictions, saying they've heard it all before.

While the mood at The Greenbrier was optimistic, most conceded that the meeting was much more "quiet" than in past years. Attendance was down by about 10%, with some companies like Fireman's Fund Insurance Cos. skipping the meeting and others sending smaller delegations.

The conversations among industry executives on the golf courses, at the tennis courts, over dinner and in private meetings were generally low-key.

The news of the day dominated many conversations: the still-rising damage estimates from Hurricane Andrew, including Allstate Insurance Co. raising its claims estimate by nearly $700 million; ITT Hartford Group Inc. taking a $1.15 billion pretax charge to increase reserves (*BI,* Oct. 5); and Continental Corp. putting its reinsurance subsidiary on the block (*BI,* Sept. 28).

Others pointed to recent resignations at major insurers as a reason for the more somber atmosphere at The Greenbrier.

"You work for years to build a relationship and suddenly they're gone," one broker pointed out.

Even though the U.S. Supreme Court agreed to review the antitrust litigation pending against industry defendants (see story, page 1), several executives said that pricing was often not discussed because of antitrust considerations.

While executives did discuss the need for rate hikes and expressed hope that the market would turn quickly, "wait and see" still is the order of the day.

"The market is in limbo—but hopeful," summed up Donald R. Bell, chairman and chief executive officer of Frank B. Hall & Co. Inc. in New York. "Everyone is waiting for others to make the first move. They're trying to hold their breath and still breathe at the same time—that's pretty hard to do."

"All the companies expect rates to change but aren't saying anything concrete," said William Cohen, CEO of Insurance Management Associates Inc., a Wichita, Kan., brokerage.

"I am hearing a lot about a market turn. There's a lot of hope out there," one insurer executive said.

"All things together, the market will change a little—but not like in 1985," said Edward Jobe, chairman and CEO of American Re Corp. in Princeton, N.J., the holding company formed in the leveraged buyout of American Re-Insurance Co. from Aetna Life & Casualty Co.

"In 1985, it was a struggle for your life," Mr. Jobe said. "We're not there yet. Companies have not lost that much money yet."

However, he noted that some portions of the reinsurance market are already firming, like the markets for retrospective coverage and property catastrophe reinsurance. And he said that many ceding companies' reinsurance-buying habits would change: They will buy more coverage in the working layers, where rate hikes and capacity problems are not rampant, to "take the pressure off their catastrophe layers."

"Retentions have been very high," Mr. Jobe observed.

Others took a "show me" stance rather than the "wait and see" approach to a market turn.

"I will know the market has turned when premiums rise and quotes are hard to get. At our firm, we have not seen that yet except in isolated lines," said Alan G. Page, senior vp at Johnson & Higgins in New York, during a roundtable discussion that closed the meeting Wednesday.

"First-half earnings for the industry were good, and combined ratios were below our rule-of-thumb tipping point for the market of 119% to 120%. Simply put, more money has to drain out of underwriters' surplus by way of high combined ratios or declines

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in investable assets," Mr. Page said.

While the losses from Hurricanes Andrew and Iniki will be a drain on insurers' surplus, more companies will follow Hartford's lead and boost reserves to make up for years of underreserving, some executives suggested.

"Some of that has to happen," Mr. Jobe remarked. Some insurers may decide that since 1992 will be a bad year for profits because of catastrophe losses, they "may write off '92 and start fresh in '93" by correcting reserve deficiencies now, he suggested.

Another factor that will reduce surplus is the introduction of risk-based capital standards, which could possibly be applied to property/casualty insurers' 1993 annual statements, some executives said.

Risk-based capital will "restrict the level of capital in the business," noted Robert A. Anker, president and CEO of Lincoln National Corp. in Fort Wayne, Ind., during the roundtable discussion.

"In theory, risk-based capital makes a lot of sense. You should base the capital requirement on exposure to loss," Mr. Jobe said in an interview.

That "sense" will come at a price, though. "The insurers that it will hit the hardest will be the very large companies with a lot of reinsurance to recover and a lot of subsidiaries," he said. "It will whittle away some surplus."

Another factor that will reduce surplus is Financial Accounting Standard 106, which will force companies to reflect their retiree health care liabilities on their financial statements (*BI*, Oct. 5).

"A big piece of capacity will come out of the industry" because of FAS 106, said Mr. Anker. "For some companies, it will be a very big piece."

Despite all these pressures, however, one insurer executive predicts that insurers will have to lower rates, not raise them.

"You have to lower both prices and costs. Our customers will demand it," said William A. Bolinder, president and CEO of Zurich-American Insurance Group in Schaumburg, Ill. Policyholders squeezed by the recession will not stand for rate increases, he noted, adding that rate hikes will only cause more business to flow from the commercial market to risk-financing alternatives.

"Even if competition becomes a bit more sane in certain parts of the marketplace, customers will only pay us what they are paying now, and many will demand to pay less," he explained in an interview.

To reduce rates, insurers will have to increase their effectiveness, Mr. Bolinder said. "Efficiency" is often used to mean cutting back on service, but that is something insurers cannot afford to do. Instead, they "have to cut the cost of doing business," he stressed.

"The transaction between the independent agent, customer and insurance company can be redundant," he said, explaining that error rates in the industry are "obscene."

J&H's Mr. Page noted that the large number of "handoffs"—or transactions in which a document or file is passed from one person to another—needed to place a risk hurts the industry. Just as in football, each handoff creates the risk of the task being "fumbled."

"Insurance organizations with the shortest distribution chain and the fewest handoffs will win in service quality and in retained business," Mr. Page said.

Throughout the meeting, insurers and brokers like Mr. Bolinder and Mr. Page repeatedly said that companies must "re-engineer" their operations. They were borrowing a term Darryl Hartley-Leonard, president of Hyatt Hotels Corp., used during a speech on how Hyatt restructured its operations to better compete in the cutthroat hotel business.

Participants in the roundtable discussion referred to Mr. Hartley's remarks several times as they stressed the importance of providing quality service to policyholders.

A key question facing the insurance industry is "Do we have

Continued on next page

U.S. market

Continued from previous page

the capacity to provide the service that clients need?" Lincoln National's Mr. Anker said.

Many insurers are patting themselves on the back for their work following Hurricane Andrew, noted Mr. Anker. However, "it shouldn't take a catastrophe to get us to get up and wave the flag and say, 'Gee, look how good we are.'

"We need to take the attitude that we should do a good job every day," commented Mr. Anker, who added that the key to success in the insurance industry is the "ability to deal with the needs of our customers every day."

Lincoln National's objective, he said, is to "give customers what they need and want, not what we think they need or want."

Brokers, too, "have to diversify. We have to provide a variety of services to clients beyond traditional property/casualty services," said Harry F. Custis, chairman and CEO of The CIMA Cos. Inc., a brokerage in Alexandria, Va.

Among the services that brokers must especially offer, he said, is loss-control advice. Risk managers will regard loss control programs "as the real way that they can control their costs."

Brokers must "help our clients determine what risks they need to worry about and what they don't need to spend much time on," he said.

Mr. Bolinder, who also participated in the roundtable discussion, agreed.

'It shouldn't take a catastrophe to get us to say, "Gee, look how good we are," ' says Mr. Anker.

"We have to help policyholders manage loss costs." That can consist of helping a company compile data about its exposures, turn it into information that can be analyzed "and then do something with it."

And, the "something" may be help in using an alternative financing mechanism rather than traditional insurance, he said in the interview.

The adoption of total quality management principles is an effective way insurers can reassess their commitment to service, Mr. Bolinder said.

"You have to re-engineer your companies and you have to have a formal process for doing it," he noted, explaining that Zurich-American adopted such a program 2½ years ago.

Lincoln National's Mr. Anker also stressed the need for insurance companies to adopt total quality management.

"All of the things we learned about how to do things are probably wrong," he said.

"Those who choose not to get on the train of total quality management—or whatever you call it —will be left behind."

Mr. Custis pointed out that management's commitment to serving the policyholder is not enough; insurers and brokers must be sure that workers at all levels of the organization put service to the client first and foremost.

However, roundtable moderator J. Bransford Wallace, chairman of the Willis Corroon division of Willis Corroon P.L.C. in Nashville, Tenn., emphasized that any change in an organization must come from the top, not the bottom. ■

Outside factors fuel debate on solvency

By JAMES M. BURCKE

WHITE SULPHUR SPRINGS, W.Va.—The debate over how to regulate insurer solvency has been triggered by a problem of "perception, politics and regulatory weakness," says the outgoing president of an insurer group.

NACSA/NACSE CONFERENCE The Greenbrier

The public perceives a need for stronger insurance solvency regulation because "once 'robbed' by the S&L industry, (the public) does not want another financial industry taking its money," remarked Joseph C. Eanes Jr., whose term as president of the National Assn. of Casualty & Surety Executives ended last week at the group's annual meeting at The Greenbrier.

Through public relations campaigns, insurers can try to alter that perception, but just as important are the measures insurers can take "to tighten the moral fiber of our society," said Mr. Eanes, who also is president and chief operating officer of Fidelity & Deposit Co. of Maryland in Baltimore.

"Ethical behavior should be high on our list, and consistently fair treatment to claimants, insureds, (agency) principals and others is essential. Our deeds will speak far louder than words."

The "political" problem is caused by public servants who "are far too eager to make the solvency question a leading issue," Mr. Eanes explained. "In the aftermath of the S&L crisis, protecting the public against insurer insolvency—whether imagined or real—is a can't-lose political proposition."

However, he insisted that insurers need stronger solvency regulation. "Strengthened solvency regulation is particularly important to the well-managed companies that make up most of our industry. These companies. . .suffer a double penalty when regulation fails to make less reasonable companies accountable for their actions," he said, explaining that well-managed insurers lose business to cut-rate competitors and then "pick up the

Continued on next page

The Professional Marketplace

RATES AND CLOSING TIME:

Rates: *Display classified is $130.00 per column inch, minimum of one inch. Straight classified is $11.50 per line, minimum of 5 lines. Count 34 characters per line (include each space and punctuation as a character). Additional $17.50 charge for all blind box ads. Only those reponses which fit into a business size envelope will be forwarded. Responses are forwarded daily.*

Closing: *Published every Monday. Copy must be in typewritten form by noon Tuesday, 6 days preceding publishing date. No verbal phone copy accepted. Prepayment required for all advertisements. Mail ads to Margaret Hikido, Classified Advertising, 740 N. Rush St. Chicago, IL 60611. For more information call 312-649-5340. FAX 312-649-7799.*

NOTICES

NOTICE

The Illinois Director of Insurance, as Rehabilitator of Millers National Insurance Company, wishes to advise all persons that he has recently learned that policies of commercial automobile and truck insurance, with current effective dates, are being circulated in Millers National Insurance Company's name. Millers National Insurance Company has not issued or renewed any policy of insurance since it was placed into conservation on May 17, 1990, nor has it had the authority to issue or renew any such policy since that date. Accordingly, all persons should be advised to beware of any policies of insurance which purport to be issued by Millers National Insurance Company. These alleged policies do not constitute valid and enforceable liabilities of Millers National Insurance Company. Please contact your insurance agent or broker if you have any questions regarding Millers National Insurance Company.

NOTICE TO CREDITORS

IN THE MATTER OF
THE BERMUDA COMPANIES ACT 1981

IN THE MATTER OF
American Guaranty Insurance Company Ltd.- in voluntary liquidation

NOTICE is hereby given that on September 29, 1992 the Members of the above named Company at a Special General Meeting voted to wind the Company up voluntarily. This decision was confirmed by the Creditors at a Creditors' Meeting held later that day.

NOTICE is hereby given that the Creditors of the above-named Company are required on or before November 16, 1992 to send their names and addresses and the particulars of their debts or claims to the undersigned of Ernst & Young, Reid Hall, 3 Reid Street, P.O. Box HM 463, Hamilton, HM HX, Bermuda, the Liquidator of the said Company, and if so required by Notice in writing from the said Liquidator to come in and prove their said debts or claims at such time and place as shall be specified in such Notice or in default thereof they will be excluded from the benefit of any distribution made before such debts are provided.

Dated this 4th day of October, 1992.

David A. Brown
Liquidator

Continued from previous page
tab" assessed by guaranty funds when those competitors go broke.

Mr. Eanes said the federal solvency regulation bill proposed earlier this year by Rep. John Dingell, D-Mich., "is a step in the right direction" for making "solvency regulation more rational and more effective" (*BI*, April 13). He added, though, that "the bill needs work."

Another area in which insurers must work to achieve effective change is the debate over the McCarran-Ferguson Act.

Noting that negotiations have broken down between the insurance industry and Rep. Jack Brooks, D-Texas, the author of a bill that would eliminate much of insurers' antitrust immunity, Mr. Eanes said failure to reach a compromise "will lead to a bitter fight in the House of Representatives should H.R. 9 reach the floor of the House."

"While we are united as an industry against the Brooks proposal, we should not overlook the opportunity to push for a better solution to this issue. Let's work together toward modifying McCarran in a way that strikes a balance between concerns of critics and essential business interests.

"There are some in the industry who are intent on maintaining the status quo. . .but I believe the industry would be better served by taking the initiative to advance positive solutions."

In his last speech as president of the National Assn. of Casualty & Surety Agents, whose meeting was held last week in conjunction with the NACSE gathering, William P. Wallace underscored the need for insurance agents to become involved in the effort to amend the Superfund law.

Superfund is an issue "that has the potential for far greater damage to our industry than Hurricanes Andrew and Iniki together," said Mr. Wallace, deputy chief executive officer and chief financial officer of Wallace, Welch & Willingham Inc. in St. Petersburg, Fla.

"I believe that it is crucial that agents fully join the battle over the reauthorization of Superfund," he said. "The current system pits us as companies and producers against our policyholders. Producers have an interest in the viability of the companies we represent as well as the continued integrity and financial condition of insureds."

Mr. Wallace pointed out that it will cost from $500 billion to $1 trillion to clean up the sites currently targeted under Superfund, compared with a total U.S. property/casualty industry surplus of about $160 billion.

It "seemed fair" when it was proposed in 1980, but "the legal concepts of retroactivity, strict liability, and joint and several liability were written into the law in a late-night session on Capitol Hill," he said.

"These concepts have turned Superfund implementation into a nightmare" in which one company—and maybe its insurers—can be held liable for 100% of the cleanup costs at a site polluted by many companies, even if its dumping was legal at the time. ■

For Bush, good news (wins poll) and bad (it doesn't count)

NACSA/NACSE CONFERENCE
The Greenbrier

WHITE SULPHUR SPRINGS, W.Va.—President Bush may be lagging far behind Bill Clinton in the national polls, but he's way out front in the view of insurance industry executives.

President Bush received a whopping 73.6% of the vote in a straw poll taken last week at the joint NACSA/NACSE annual meeting. Democratic challenger Bill Clinton garnered 20.9%, while independent Ross Perot trailed badly at 4.9%.

Both agents and insurers voted overwhelmingly for President Bush.

Among the agents, 76.1% voted for the president, 19.6% favored Gov. Clinton and 4.3% cast ballots for Mr. Perot. Among the insurers, 70.2% selected President Bush, 24.6% picked Gov. Clinton and 5.2% voted for Mr. Perot.

One agent said he was surprised that the president did not win by a bigger margin given the "electorate."

"It's because they let the spouses vote," he said, explaining that he thought women were more likely to vote for Gov. Clinton than men because of Gov. Clinton's pro-choice stance.

One amused observer—who did not vote—was former Democratic presidential candidate Paul Tsongas, who addressed the agents and insurers immediately after the vote was announced.

"That was an interesting poll. . .this will be short," he quipped as he began his speech.

Other speakers addressing the meeting included Defense Secretary Dick Cheney, who said the United States must maintain sufficient military force to maintain its world leadership role; former Republican political operative Edward J. Rollins, who discussed his short-lived tenure as director of Ross Perot's presidential campaign; and Darryl Hartley-Leonard, president of Hyatt Hotels Corp., who discussed how to "re-engineer" companies to meet changing market conditions.

—*By James M. Burcke*

Harvard AIDS benefit

Continued from page 2
The benefit will "provide employees with an ability to meet lifetime costs," like mortgages and their medical school loans, as well as "provide financial stability in the future" to their families, he said.

Because full-blown AIDS can take five to 10 years to develop, employees also can save the money to pay future medical costs not covered under their medical plan, he added.

As a well-respected and prestigious institution, Harvard will draw a good deal of attention to the new benefit, but it is not clear that other health care institutions will—or should—follow suit, benefit consultants say.

"I don't know if this will be a trend, but it is clearly an issue whose time has come," said John Bunker of The Wyatt Co. in Washington.

"People will be watching it, but there will be no rush" to follow Harvard in offering the benefit, predicted David Sundwall, vp and medical director at the American Health Care Systems Institute, a Washington-based national health care alliance of hospital systems.

And Lance Tane, a partner at Kwasha Lipton in Fort Lee, N.J., cautioned that Harvard may be "opening up a hornet's nest of issues" for itself.

While the $100,000 may "take the edge off concerns" that medical professionals have about contracting the virus, the benefit may not be enough to compensate them for taking the risk, Mr. Sundwall said.

In addition, this sort of benefit is not needed for the many hospitals with few HIV-infected patients, he said.

And, while health care facilities are concerned about their workers contracting the HIV virus through a work-related incident, like being stuck with a contaminated needle, most have taken precautions against such exposures, said Stephen Brink, a consulting actuary for Milliman & Robertson Inc. in Milwaukee.

Therefore, this may be "more of a gimmick than an actual need," he said.

Offering the benefit may also raise questions of employer liability.

For example, by paying $100,000 to any employee who becomes infected with HIV on the job, is the hospital saying it is responsible? Mr. Tane asked.

He also questioned whether an employee who contracts the disease at work because he did not follow safety procedures—like wearing gloves—should be paid the benefit.

One reason Harvard developed the benefit was because of the reciprocal commitment it feels it has with its health care workers, Mr. McCarthy said.

Because employees are asked to put themselves at risk by treating all patients equally, including those infected with the AIDS virus, the hospital should provide the employees "with some cushion. . .regardless of negligence," he said.

Benefit consultants also raised other questions about the benefit.

For example, how does Harvard compensate health care workers who contract other infections through their work? Mr. Tane asked.

Are health care workers exposed to HIV more often than to other diseases? If not, why should a worker infected with HIV get a benefit that a worker who contracts another disease, like hepatitis, will not receive? he asked.

"It's not appropriate to single this issue out," Mr. Brink agreed. "Hepatitis B is just as severe."

However, a person who contracts Hepatitis B can survive if the disease is diagnosed and treated in its early stages.

Mr. McCarthy pointed out that other diseases, unlike AIDS, are "not guaranteed to be deadly."

Additionally, the other diseases medical professionals can contract through their work "don't carry the same social stigmas" that HIV and AIDS do, said Sue Velleman, managing director for William M. Mercer Inc. in Boston, a consultant that worked on the Harvard project.

Mr. McCarthy also pointed out that while a Harvard health care worker's anxiety about being infected with HIV can be high, the risk of contracting the disease through work is low.

The university estimates that no more than three of its 50,000 hospital employees will contract the AIDS virus through work-related incidents each year.

To claim the $100,000, employees must show they were infected while working, Mr. McCarthy said. They must report any suspected exposure and then obtain a confidential HIV test within five days. Since signs of the HIV virus in the bloodstream take weeks to develop, the initial test must turn out negative, he said.

Six months later, when antibodies can begin to show, the employee must take another test. If those test results show the employee is infected with the virus, he or she will receive the $100,000, Mr. McCarthy said.

An employee who has contracted the virus can continue working and will be offered counseling, he said.

In addition to the benefit and counseling, all employees are provided educational programs and other support services as part of an overall AIDS prevention effort, Mr. McCarthy said. ■

Antitrust action

Continued from page 1

much in error in the 9th Circuit decision," said Mr. Shapiro. "I regard this as a very good omen."

In their lawsuit originally filed in 1988, state attorneys general allege 32 defendants engaged in a boycott to manipulate the U.S. liability insurance market. The defendants include major U.S. insurers and reinsurers, the Insurance Services Office Inc. and the Reinsurance Assn. of America, as well as several London underwriters.

The suit alleges the boycott forced ISO to rewrite its commercial general liability form to exclude coverage for pollution incidents, and to include a retroactive date in the claims-made version of the form.

Insurers' limited antitrust exemption does not extend to boycotts or coercion.

The two McCarran-related issues the Supreme Court has agreed to hear are:

- Whether normally exempt domestic insurers forfeit their exemption under McCarran-Ferguson because they participate with foreign reinsurers in the business of insurance.
- Whether agreements among primary insurers and reinsurers on such matters as standardized advisory insurance policy forms and insurance coverage terms constitute a boycott outside the McCarran exemption.

Two of every three cases the Supreme Court reviews are reversed, says Mr. Shapiro.

The Supreme Court did not agree to review the case on the basis of the state action doctrine. That doctrine provides immunity from antitrust laws if an anticompetitive act reflects a state's policy and if a state supervises the anticompetitive practices.

Observers note the court has recently dealt with that issue in *FTC vs. Ticor Title Insurance Co.*, in which it denied insurers antitrust immunity when states had not "actively supervised" their alleged restraints on trade (*BI*, June 22).

In deciding to take the case, the court was silent on the issue of whether the attorneys general have standing to sue.

Attorneys say it is now unclear when or if that issue will be resolved by the high court next year, though it may decide to discuss it in its opinion on the other issues.

The Supreme Court took the case despite a brief by the solicitor general—which the justices had requested—that had advised against it (*BI*, Aug. 17).

Defendants were naturally pleased that the case will be reviewed, as well as optimistic about their chances of reversing the verdict.

Bartless H. McGuire, an attorney with Davis Polk & Wardell in Washington, which is representing ISO, commented: "They took our petition on the two most important issues and the two broadest issues, and I think that's obviously encouraging."

Meanwhile, the state attorneys general say they are not discouraged.

"What's notable about this is from our point of view we have a lot of chances to win here and we're confident we will," said Richard L. Schwartz, assistant attorney general in New York. "Obviously we're somewhat disappointed, but we're also confident we're going to win on the merits."

"I think we're all excited about the opportunity" to have the case heard, said James R. Lewis, assistant attorney general for Colorado. "We remain pretty confident that our positions will prevail. Beyond that, you can read the tea leaves in all sorts of ways."

Review by the Supreme Court represents danger to the states, but also an "enormous opportunity" to make new law that will affect the whole country, said Thomas Greene, supervising deputy attorney general for California.

Most observers said a possible factor in the Supreme Court's decision to not follow the solicitor general's advice was his comments on the importance of the case, and his reservations on the 9th Circuit's "suggestion" that domestic insurers forfeit their antitrust immunity by acting in concert with foreign reinsurers.

The solicitor general's brief states that "although we are troubled" by this suggestion, "that does not alter the result."

"It's not entirely surprising that the Supreme Court would want to look at the issues when the solicitor general's brief also raised some questions" about the appellate decision, said Robert N. Mitchell of Seyfarth, Shaw, Fairweather & Geraldson in San Francisco, who represents the Reinsurance Assn. of America.

The solicitor general's brief discussed a number of substantive points of law, said California Deputy Attorney General Kathleen E. Foote. "It's certainly possible the court wishes to adopt a number of those points."

But Michael L. Weiner, an attorney for Skadden Arps Slate Meagher & Flom in New York, which represents General Reinsurance Corp., said he does not believe the Supreme Court's failure to follow the solicitor general's advice is necessarily significant.

Statistically, the Supreme Court tends to follow the solicitor general's advice, he said, "although it doesn't always happen that way. I don't read a lot into it." ■

ERISA issues in 3 cases before high court

By MARK A. HOFMANN

WASHINGTON—The Supreme Court may decide three major cases involving the Employee Retirement Income Security Act during the term that began last Monday.

In one case, the court will decide whether ERISA pre-empts a District of Columbia law requiring employers to provide certain benefits to employees eligible for workers compensation.

A second case the court has agreed to hear raises the issue of a pension plan actuary's liability under ERISA when the actuary's faulty work causes benefits to be reduced.

The justices are awaiting a brief from the solicitor general before deciding whether to hear a third ERISA-related case. This case involves a question of whether ERISA protects an employee afflicted with AIDS when a self-insured employer restricts health benefits specifically for the disease.

But the justices refused to interpret liability insurance policy language in three pollution cases and let lower court decisions stand.

The justices on Nov. 3 will hear oral arguments in the first ERISA case—*District of Columbia vs. Greater Washington Board of Trade*.

The case involves a challenge to a 1990 district law that requires employers to extend to employees eligible for workers comp one year of health coverage equivalent to that provided to uninjured employees (*BI*, Nov. 12, 1990).

The business group contended that the law violates ERISA by requiring employers to pay the full cost of health benefits for the employees receiving workers comp. The district characterizes the law as a workers comp—not benefit plan—regulation.

A U.S. District Court found that the law violated ERISA, and the local government then sought Supreme Court review.

"What is at stake here is the breadth and broadness of the ERISA pre-emption," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"The district tried to accomplish indirectly what it couldn't do directly—regulate an employee benefit plan under ERISA," he said. In effect, the district created a "shadow plan" for some workers in an attempt to regulate the real plan, he said.

In reviewing another case, *Mertens vs. Hewitt Associates*, the justices will decide the extent of a consulting firm's liability when benefits are cut due, at least in part, to its faulty calculations.

Hewitt served as pension actuary to Kaiser Steel Corp., which went bankrupt and had its pension plan taken over by the Pension Benefit Guaranty Corp. in the mid-1980s. Beneficiaries, angered that their benefits had been reduced, sued Hewitt, claiming that the consultant had fiduciary responsibility for the plan. The 9th U.S. Circuit Court of Appeals last year found the firm had no such duty.

"The case before the Supreme Court involves a technical issue: whether ERISA permits an action by plan beneficiaries against a nonfiduciary who provides services to the plan. The case arises out of a situation where the plan is insolvent, and the plan sponsor bankrupt," Hewitt said in a statement.

"When as a service provider you're told to provide service 'X,' you're the agent of the fiduciary," not the fiduciary itself, said Kyle Brown, an attorney with The Wyatt Co.'s research and information center in Washington.

"The basic question is where do you draw the line with an adviser becoming a fiduciary under ERISA," said Foster Higgins' Mr. Saveth. "At what point does advice cross over and become control?"

Should the court rule for the pensioners, it could change the status of attorneys and accountants who act as plan advisors, as well as that of consultants, said Mr. Saveth.

The ERISA-related case that the court has not yet decided whether to accept is *Greenberg vs. H&H Music Co.*

This appeal involves a lawsuit initially filed by John McGann—who has since died—against his employer, H&H Music Co. of Houston (*BI*, Aug. 6, 1990).

Mr. McGann was diagnosed with AIDS in late 1987 and informed H&H of the diagnosis. In July 1988, the company altered its health plan, dropping what had been a $1 million lifetime cap on benefits to $5,000 in the case of AIDS. As it cut benefits, the company also switched from an insured to a self-funded plan.

Mr. McGann sued, charging H&H and its parent company with discrimination, which is prohibited by ERISA. A federal trial court dismissed the suit, holding that although ERISA establishes uniform standards on reporting, disclosure and fiduciary responsibility, it does not require employers to provide equitable benefits for workers with AIDS. The 5th U.S. Circuit Court of Appeals concurred.

Mr. McGann's estate appealed the ruling in a case renamed *Greenberg vs. H&H*. The Supreme Court has requested comment from the solicitor general before proceeding with the case.

The case gives the court an opportunity to determine "whether there is anything in ERISA that would preclude an employer from amending a welfare plan," said Foster Higgins' Mr. Saveth.

In another benefits-related case, the justices agreed to review whether the transfer of unencumbered property in lieu of cash to a defined benefit pension plan is permitted by the Internal Revenue Code. The IRS said that such a transaction is prohibited.

But the 5th U.S. Court of Appeals held early this year—in *Keystone Consolidated Industries vs. Commissioner of Internal Revenue*—that Keystone was within its rights to fulfill its pension funding obligations by contributing five truck terminals to a trust for the plans. According to the court, the code only prohibits the transfer of property subject to a lien or mortgage, not all property.

"The financial impact can be pretty obvious. A lot of employers are strapped for cash" and would find it easier to contribute property, said Wyatt's Mr. Brown.

Mr. Saveth said that while the case involved a "hypertechnical dispute," a Supreme Court ruling supporting the practice might encourage some other companies to fund obligations with property.

Meanwhile, the justices decided to stay out of property/casualty insurance coverage litigation by refusing to consider appeals of these three cases involving pollution coverage:

In *Liberty Mutual Insurance vs. Triangle Industries*, the 4th U.S. Circuit Court of Appeals ruled that the pollution exclusion in the comprehensive general liability policy bars coverage unless the discharge is sudden and accidental.

In *Broderick Investment Co. vs. Hartford Accident & Indemnity Co.*, the 10th U.S. Circuit Court of Appeals held that if wastes were deliberately dumped in unlined pits, the pollution exclusion in the CGL applied even if subsequent release of the substances into groundwater was not intentional.

And, in *Citizens Electric Corp. vs. United States Fidelity & Guaranty Co.*, the 8th U.S. Circuit Court of Appeals held that costs of cleaning up a waste site weren't "damages" under Missouri law and therefore weren't covered by insurance. ■

Hurricane Andrew losses

Continued from page 2

weeks have been increasing their original storm-related loss estimates (*BI*, Sept. 28).

Allstate's new loss estimate is a whopping 64.8% greater than its original $1.05 billion estimate. The net aftertax loss for Sears, Roebuck & Co. unit will be approximately $1.15 billion.

Allstate has not altered its initial estimate of 159,000 hurricane-related claims, but the extent of damage is more severe than initially thought, a spokeswoman said.

A.M. Best Co. said Allstate's consolidated A rating is "under review with negative implications" as a result of the revised estimate.

Although Allstate expects its hurricane losses will be largely offset by 1992 statutory earnings and "other positive surplus adjustments," it is "nonetheless anticipated that the group's 1992 year-end surplus will decline from 1991's year-end figure of $5.4 billion," Best said.

That will put "further pressure on the group's leverage, which historically has been high relative to other personal lines insurance companies," Best said.

The new loss estimate should not affect Sears' plan to spin off up to 20% of Allstate stock, an Allstate spokesman said.

Allstate's revised estimate could be the largest-ever loss sustained by a U.S. insurer due to one event, according to the Insurance Information Institute.

Allstate's new estimate exceeds the estimated $1.61 billion in Andrew-related losses reported by State Farm.

State Farm, meanwhile, says it has added $2 billion to its State Farm Fire & Casualty Co. unit to cover losses stemming from Hurricane Andrew and Hurricane Iniki in Hawaii.

State Farm Fire & Casualty estimates its Andrew-related losses at more than $1.6 billion and its Iniki-related property and auto claims at about $194 million.

State Farm Fire & Casualty's surplus as of Aug. 31 was about $3.8 billion.

Other insurers increased their Hurricane Andrew-related loss estimates last week:

- United Services Automobile Assn. estimates its losses will reach $500 million, more than three times its original $150 million estimate.

Reinsurance is expected to cover more than $125 million of the losses, according to USAA.

- Liberty Mutual Insurance Co. increased it estimated gross losses from Hurricane Andrew to $217 million from $195 million.

Liberty Mutual also increased its estimated Hurricane Iniki-related gross loss to $3 million from $2.9 million.

- Allendale Group is estimating losses at $106 million before reinsurance and taxes. That figure has grown from about $90 million a month ago.
- Nationwide Mutual Insurance Co. and affiliates Scottsdale Insurance Co. and Wausau Insurance Co. expect gross losses of around $84 million, up slightly from an earlier $83 million estimate.
- Arkwright Insurance Co. is estimating losses at $36 million after reinsurance and taxes, up from about $30 million a month ago, a spokesman said.

Rating agencies Best, Standard & Poor's Corp. and Moody's Investors Service Inc. expect to downgrade several insurer ratings as new, higher loss estimates continue to roll in.

Late last week, S&P placed the AA claims-paying ability rating of Prudential Reinsurance Co. on CreditWatch with negative implications. S&P said the move is tied to its earlier placement of the AAA rating of parent Prudential Insurance Co. of America on CreditWatch (*BI*, Sept. 28).

Despite the recent revised loss estimates by several insurers, S&P "does not believe at this time that the (industrywide) estimate will be materially changed," said Alan Levin, a senior vp in New York.

But, if revised figures on total insured damages exceed $10 billion, a turn in the market becomes more likely, Mr. Levin said.

"Frankly, every time another announcement is made about this catastrophe, it increases the possibility that insurance company management might change their minds and in fact start demanding adequate rates," he said.

But, "the fact is that even with those increased numbers, the average insurance company is going to find the cost after reinsurance to be about 3% to 3.5% of their surplus," said Gloria Vogel, first vp with Shearson Lehman Brothers Inc. in New York.

Andrew "brings us closer" to a market turn, but it is not enough to turn the market, she said.

The current regulatory climate and the economy are working against a market turn, she added.

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Associate Editors Mark A. Hofmann and Michael Bradford and Staff Reporter Sally Roberts contributed to this report.

Threatened tax bill veto would sink pension reform

WASHINGTON—Pension simplification and relief from new pension distribution withholding rules may have to wait for the next congressional session.

Both the House and Senate last week approved tax legislation, H.R. 11, with a broad array of provisions that would begin to lift some of the rules that have made pension plan administration so complex.

The measure also includes a retroactive extension of the tax-favored status of employer-provided educational assistance benefits through next June 30. The tax-favored status of those benefits expired in June.

But these provisions, welcomed by employers, appear unlikely to become law. President Bush has threatened to veto the tax legislation because of unrelated provisions that would increase taxes. Mr. Bush vowed earlier to never "ever" approve a tax increase.

Congressional leaders say President Bush will stick to his vow.

"It's too bad that legislation that provides a number of provisions that would have been helpful to employers is likely to be vetoed. The measure was a modest but welcome change in direction," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"This is the problem of trying to deal with benefit issues through tax legislation. The fate of benefit provisions hangs on totally unrelated issues," said Frank McArdle, a consultant with Hewitt Associates in Washington.

The legislation's wide array of provisions to simplify administration of pension plans includes:

- Making it easier for employers to run non-discrimination tests on 401(k) plans.

Employers would be able to use the previous year's average deferrals by non-highly compensated employees to determine how much highly compensated employees can defer. Deferrals of the two groups now must be compared on a current-year basis.

- Simplifying the numerous definitions of who is considered a highly compensated employee for non-discrimination testing purposes.
- Allowing certain tax-exempt organizations, like trade associations, to offer 401(k) plans.
- Exempting defined contribution plans from the so-called minimum participation rule. Under current law, both defined benefit and defined contribution plans are not considered qualified unless they cover 50 employees or 40% of employees, whichever is less.
- Requiring the Internal Revenue Service to give employers more advance notice of annual cost-of-living increases in the maximum benefits that can be funded through defined benefit plans and contributions made to defined contribution plans.

Other provisions in the tax bill would exempt pension distributions of less than $500 from a recent federal law that imposes a 20% withholding on distributions that are not directly transferred to an individual retirement account or to a pension plan of a worker's new employer. Handling these small distributions is a nuisance for employers.

The measure also would require the Pension Benefit Guaranty Corp. to give Congress an annual report listing the names of employers sponsoring pension plans with more than $25 million in unfunded liabilities.

The legislation again would allow upper middle-income employees who are covered by pension plans to make tax-deductible contributions to IRAs and would provide limited tax breaks to very small property/casualty insurance companies.

—By Jerry Geisel

El Al crash

Continued from page 1

to John Westcott, chairman of the Lloyd's Aviation Underwriters Assn.

About one-third of the El Al reinsurance cover in London was placed at Lloyd's and the remainder in the London company market. The Ariel syndicate led the coverage at Lloyd's, while British Aviation Insurance Group led the company market.

An El Al spokesman said the airline has "more than enough" insurance to cover any possible claims from the crash, including those from the deaths on the ground. In addition to its liability insurance, El Al is insured against acts of terrorism by Inbal, the Israeli state insurer.

Preliminary investigations suggest the crash was caused by a mechanical or technical failure, not by sabotage or pilot error. Insurers pointed out, however, that El Al would be unlikely to confirm a breach in its security precautions. The airline spends about $40 million annually on security.

The Boeing Co., the manufacturer of the 14-year old aircraft, and engine manufacturer Pratt & Whitney are also potentially vulnerable to liability claims.

Boeing's product liability coverage is led in London by Lloyd's syndicate 955, managed by Dann Kiln & Co. Underwriting Agencies Ltd., confirmed Peter Morris, the syndicate's underwriter.

The policy was renewed in May and has liability limits in excess of $1.3 billion, he said.

Insurance for Pratt & Whitney, a subsidiary of United Technologies Corp., is placed mostly in the U.S. market by Marsh & McLennan Cos. Inc. and led by Associated Aviation Underwriters.

Both Boeing and Pratt & Whitney sent experts to Amsterdam to help Dutch officials and Israeli representatives investigate the crash site.

The crash could represent the biggest third-party liability claims scenario the airline industry has ever faced, said Graham Nichols, chairman of the Aviation Insurance Offices' Assn. in London and director of underwriter Westminster Aviation Group.

"Although underwriters have succeeded in improving their premium base over the past two years, we need to get more premium to cope with a deteriorating casualty situation and pressure from the airlines for ever-higher limits for liability cover," said Mr. Nichols.

Potential liability claims from the El Al crash will be limited by the Dutch courts, which do not allow compensation for bereavement or pain and suffering. However, the Netherlands has not ratified the Rome Convention of 1952, which sets limits on third-party liability claims caused by foreign aircraft.

Underwriters suggested that claims could be limited by the large number illegal immigrants living in the Bijilmermeer estate apartment buildings, saying that the families of these victims are unlikely to bring claims that could draw attention to themselves.

Claims relating to the loss of cargo and the deaths of the three crew and one passenger will be limited by the Warsaw Convention, unless negligence by the airline or the manufacturers can be proved. The aircraft was carrying about 120 tons of textiles, electronic equipment and perfume.

Prior to the El Al and Pakistan Airlines crashes, hull and liability insurance renewals were expected to produce relatively small rate increases and, in some cases, no rate hikes at all (*BI*, Oct. 5). However, about 75% of renewals for major world airlines take place in October, November and December, and some insurers last week said these latest air disasters could affect future rates.

"We need to have rate increases of between 30% and 60% and I think claims from the El Al crash could do it," said Nigel Rogers, managing director of Lloyd's underwriting agency Octavian. "The cost of aviation claims has exceeded premiums for years and this has to stop. But there is still overcapacity in the market worldwide."

"I hope these recent accidents will mean higher rates but I am concerned that they might not. All the other accidents this year have not made a difference in the resolve of some underwriters to take on business that is half priced," says Mr. Westcott of Lloyd's Aviation Underwriters Assn.

"Both losses will be very expensive and people may say that they have finally had enough of low rates," he said. "The market needs some sort of catalyst for higher rates and lower capacity and this may be it."

He added that major airline hull losses have totaled more than $400 million so far this year, excluding the El Al and Pakistan Airlines crashes.

"Losses are running at a rate of almost twice premiums received this year," said Mr. Westcott. "And we have almost three months to go."

However, William Barham, chief executive of Willis Corroon Aerospace, said underwriters may be forced to scale down the amount of aviation business they write before they are able to make substantial rate increases.

"Certainly the El Al incident is putting pressure on the market to increase rates," said Mr. Barham. "But there is so much excess capacity around that the market won't be able to raise rates unless all underwriters agree to do so."

"The El Al crash is going to cost about $200 million, but it doesn't seem enough to drive out the extra capacity in the market," commented Jerry Frick, an aviation broker with M&M in New York.

"The next thing to affect rates will be the Jan. 1 reinsurance renewals and we will have to wait and see what happens then," Mr. Frick said.

Bill Smith, managing director of aviation at broker Leslie & Godwin International Ltd. in London, said the El Al loss may lead to higher excess-of-loss reinsurance rates at year-end renewals.

"It may not have a large effect on direct renewals this year as a lot of comparison goes on in the market and those airlines renewing in November and December will not want any larger increases than those imposed on Oct. 1 renewals. However, excess-of-loss underwriters may take the opportunity to extend the increases they imposed last January," he said.

Some insurers saw their excess-of-loss reinsurance costs double during the last year-end renewals, he noted.

The El Al crash will likely have a bigger impact on reinsurers as the losses will blow through most direct underwriters' retentions, Mr. Smith said, even though many retentions were increased to $50 million or $100 million per crash last year.

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Associate Editor Gavin Souter in London contributed to this report.

Pension investment rules

Continued from page 2

like an equity fund, would have to be diversified and not invested solely in one stock.

Participants would have to be given the opportunity to switch from one fund to another at least quarterly.

Employer stock also could be offered, but only as a fourth alternative and only if it is publicly traded with sufficient frequency and volume to assure liquidity. Participant shareholders also must have voting rights.

According to Labor Department estimates, the final rules affect about 100,000 defined contribution plans—principally 401(k) plans—that give employees the opportunity to direct their contributions.

The final rules, which generally take effect Jan. 1, 1994, make a number of changes from the proposed rules.

A notable change involves employers that offer company stock as an investment option to defined contribution plan participants.

Under the proposed rules, companies would have been required to use an independent fiduciary, like a bank, to handle participants' investments in company stock.

Independent fiduciaries will not usually be required under the final rules. Instead, companies would have to establish procedures to ensure the confidentiality of these investments. A plan fiduciary would have to be designated to ensure that those procedures are adequate.

In addition, the final rules eliminate an earlier requirement that in-house managed funds, like a guaranteed investment contract fund, use an independent fiduciary to qualify as an investment alternative.

Also under the final rules, employers will have to disclose more information to plan participants to qualify for the 404(c) exemption.

For example, immediately after investing in a fund that is subject to the Securities Act of 1933—like a mutual fund—the company must give participants a copy of the fund's most recent prospectus.

Participants must be informed of any designated investment managers and a description of any transaction fees or expenses that are charged to the participant's account.

In addition, participants must receive a description of the investment alternatives available under the plan, including a general description of the investment objectives and the risk and return characteristics of each alternative.

"We believe the rules are a win-win situation for employees and plan participants," said Assistant Secretary of Labor David Ball. ■

Update

New Chicago union contract

CHICAGO—The City of Chicago and a coalition of 36 trade unions reached an agreement late last week that could save the city up to $42 million in health care costs next year.

The wage and benefit agreement, which would run retroactively from Jan. 1, 1992, through June 30, 1995, significantly changes the city's health plans. Of the potential savings, as much as $28 million could result from PPO plan changes, like limiting inpatient mental health and chemical dependency coverage and encouraging the use of generic prescription drugs.

Chicago will save $14 million more by shifting costs to employees, reports William M. Mercer Inc., which helped design the plan.

The 10,000 workers covered by the 3½-year agreement will make the same pretax health plan contributions whether they choose an HMO or the PPO. Those contributions will now be based on salaries.

The city, which spent $200 million on health care last year, projects its health costs will rise only 3.2% in 1992.

With contracts expiring in December, the tentative agreement, which includes wage increases of 3% each year through 1994 and 1.5% in 1995 plus additional life insurance, will soon be presented to individual union members for ratification.

Blues rate hike request upheld

ALBANY, N.Y.—Insurance Superintendent Salvatore Curiale will appeal a state court ruling that he exceeded his authority in rejecting a rate hike sought by Empire Blue Cross & Blue Shield.

A court order requiring the department to approve the rate increase cannot take effect until after appeal.

But Empire claims the decision supports its position that the superintendent is legally bound to approve the rates an insurer needs to restore its reserves to levels required by law. Empire sought a 12.4% rate increase for small-group and individual health policies.

Without that hike, Empire claimed its liabilities would exceed assets by as much as $40 million by year end. Empire also claimed that its reserves are below state requirements (*BI*, Aug. 3).

Mr. Curiale rejected the rate hike based on a new state law that requires commercial insurers to accept all risks and to use community rating, which is expected to help BC/BS plans compete (*BI*, June 15).

Dredging firm sues Chicago

CHICAGO—The company that installed the pilings believed to have caused Chicago's underground flood in April has filed suit against the city for failing to notify the contractor of the underground tunnel system's existence.

The pilings apparently caused the roof of a tunnel running underneath the Chicago River to collapse, flooding basements throughout the city's Loop business district (*BI*, April 20).

Great Lakes Dredge & Dock Co., now owned by investment bank Blackstone Group, filed suit in U.S. District Court last week, claiming it has no liability for the flood or that its liability should be limited. The Oak Brook, Ill.-based dredging company says any of its liability and that of its surety bond writer, Reliance Insurance Co., should not exceed $634,000—the value of the two barges used for the project in August and September 1991, the launch used to bring them to the site and their pending freight. Great Lakes was owned by Itel Corp. when the work was done.

"The city of Chicago failed to maintain the tunnel" and failed to repair it after learning of a breach in the walls, the contractor claims.

Plaintiffs suing Great Lakes and the city in Cook County Circuit Court now must file with the federal court by Nov. 15.

Briefly noted

Attempting to soften the impact of FAS 106, **McDonnell Douglas Corp.** is replacing its company-funded health care plan for non-union retirees with one paid for by the retirees themselves. Funds will be taken from the company's overfunded pension plan. . . .Maine Gov. John R. McKernan Jr. has signed into law a **workers comp reform bill** that places the burden of future residual market deficits on employers, rather than splitting deficits equally between employers and insurers. Employers in the current residual market will become members of one of eight mutual insurers created by the law effective Jan. 1 (*BI*, Sept. 28). . . .The first chairman of the **Lloyd's of London new Regulatory Board** will be Brian Garraway, the current deputy chairman of B.A.T Industries P.L.C. Mr. Garraway will assume the post in January. He will retire from B.A.T at the end of the October. . . .**American International Group Inc.** has been granted a license to operate in the People's Republic of China. . . .A proposal to raise the **federal reinsurance excise tax** to 4% from 1% on coverage bought from companies domiciled in tax havens was dropped from S. 776, an energy bill passed by Congress last week (*BI*, June 29). . . .Another provision tucked into the energy bill would allow surplus assets to be transferred from an overfunded **coal industry pension plan** into a new fund—formed by merging two existing multiemployer funds—to provide health care coverage to retired coal workers. . . .Louisiana liquidators of **Champion Insurance Co.** have recovered $585,382 from a Cayman Islands bank set up by the Eicher family, Champion's former owners, and $400,000 from the sale of the Eichers' house in Baton Rouge. . . .A Massachusetts appeals court last month struck down a statutory $515 appeal fee required of a **workers comp claimant** represented by an attorney, and replaced it with a $1 fee. . . .A tentative agreement between the Pension Benefit Guaranty Corp. and unsecured creditors of **Trans World Airlines Inc.** calls on TWA to issue a note—secured by international routes and a Kansas City maintenance base—and make payments on that note over 15 years to cover a portion of the airline's $1.2 billion in unfunded pension liabilities. TWA, in turn, could terminate its two pension plans.

Perot's health plan

Continued from page 1

creases for federal civil servants.

In "United We Stand," a book he released this year, Mr. Perot calls the current tax treatment of employer-paid health insurance "another subsidy for the rich" and argues that not taxing such benefits supports the rich and encourages excessive health costs.

Instead, Mr. Perot favors treating as taxable income employer health plan contributions that exceed $335 per month for family coverage and $135 per month for individual coverage.

"This is not a radical or revolutionary idea," said Ellen Goldstein, director of communications and health policy of the Assn. of Private Pension & Welfare Plans, a Washington corporate lobbying group.

In 1984, the Reagan administration proposed taxing health insurance contributions but later dropped the idea (*BI*, Feb. 6, 1984). President Bush also included such a proposal in his budget, but it was rejected by Congress. And, the proposal echoes some of the statements made by the Conservative Democratic Forum, a group of conservative House Democrats.

Mr. Perot "is obviously speaking as a businessman because he would not roll back the employer tax deduction for providing health benefits," Ms. Goldstein added.

But few companies favor taxing employees, noted Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York. About three-quarters of the companies Foster Higgins surveyed earlier this year opposed all taxes on employee health benefits. About a fifth favored taxing employees above a certain amount.

Self-insured companies, in particular, would have trouble administering such a tax because they often don't know what their total health care costs are until many months after the year ends. That's because many claims are incurred at the end of a year and are not paid until the next year, consultants explained.

Labor groups also oppose taxes on employer-provided health plans.

"The single most important reason (such taxes) shouldn't go forward is because there is a major gap in the price that individuals or groups of individuals pay for health insurance protection and the value of that protection," said Karen Ignani, director of the department of employee benefits for the AFL-CIO in Washington.

Taxing health benefits would penalize workers in high-risk industries, like mining, and retirees who often are charged higher premiums, Ms. Ignani said.

As an example, she cited manufacturing industry retirees, whose insurance costs may total $5,000 to $6,000 per year. "That doesn't mean they are getting a deluxe health care package. It just means they have to pay proportionately more because they are a higher risk in the market."

Taxing health insurance benefits also would discriminate against employees in areas where health care costs are higher, Ms. Ignani said.

Convincing Congress to eliminate the tax break on employees' health insurance benefits will be a tough sell. "It's a situation where the Chamber of Commerce and the AFL-CIO could go marching down Main Street hand in hand," Mr. Saveth said.

Mr. Perot's book also says a plan to reform the nation's health care system should be "put into effect as quickly as possible." His proposals lack details, but he favors "comprehensive national health care reform based on a public-private partnership" that would:

- Establish a national health board as an independent federal agency to oversee cost containment and comprehensive health care reform efforts.
- Set a national health policy.
- Encourage problem solving by everyone involved, which one consultant described as "more of a prayer than a policy."
- Reach a consensus on a set of principles for reform.
- Determine a basic benefit package for universal coverage and appropriate tax treatment of health benefits.
- Ask states to submit comprehensive health care reform proposals that adhere to agreed-upon principles and meet cost containment targets.
- Change federal rules to allow states the necessary flexibility to conduct pilot health system reform programs.

Changing federal rules "sounds like a challenge to the ERISA pre-emption," Mr. Saveth said. "That would be of great concern to multi-state employers who would then have to comply with different health plan rules in different states."

"Allowing states to create a patchwork quilt of health care laws is both fiscally and socially regressive," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington benefits lobby.

Meanwhile, in his book, Mr. Perot also targets entitlement programs.

Arguing that the programs have "grown out of whack," he suggests removing the $130,000 ceiling on the 1.45% portion of the FICA tax that covers Medicare Part A. "Those who can afford it should pay more to support the program. Better-off Americans stop paying Medicare taxes on income over $130,000 a year. We should lift that cap."

Doing so would increase costs for both employees and employers—both of whom currently pay the 1.45% tax, consultants point out. If the $130,000 cap were lifted, both employees and employers would pay the additional taxes on earnings.

Mr. Saveth questioned whether this would generate much revenue because "the group of individuals that make more than $130,000 per year is relatively small."

Mr. Perot also favors increasing Medicare Part B premiums to 35% of the cost of the supplemental medical insurance program, up from 25%.

Currently, Medicare beneficiaries pay $31.80 per month for Medicare Part B coverage. If Mr. Perot's increase were adopted, those premiums would jump to $44.52 per month.

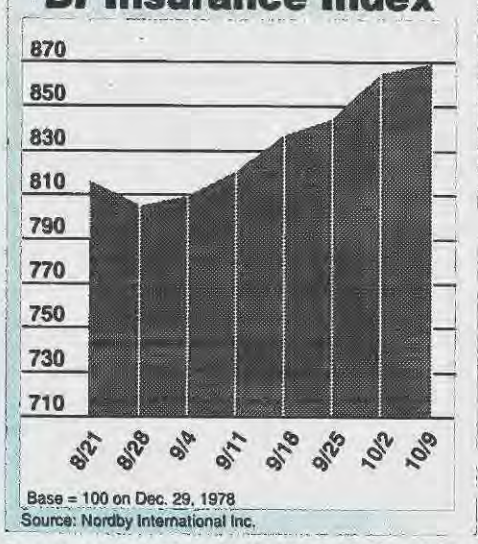
But Congress already plans bigger increases than that. The Omnibus Reconciliation Act of 1990 calls for Medicare Part B premiums to increase sharply to $46.10 per month in 1995, so it's unlikely that Congress would approve Mr. Perot's suggested increase, consultants say.

While this would be a big revenue raiser, the burden would fall exclusively on the elderly, and many think that is the reason Congress would never grant the increase. In fact, neither President Bush nor former President Reagan got very far with this politically hazardous policy (*BI*, Jan. 20).

"Whenever you talk about increasing Medicare Part B premiums, Congress thinks about Medicare Catastrophic and what a disaster that was," Mr. Saveth pointed out.

Perot campaign headquarters in Dallas did not respond to repeated phone calls. ■

BI Insurance Index



Insurance industry stocks inched ahead last week, as the *Business Insurance* Index rose 4.0 points to 868.0 on Oct. 9 from 864.0 on Oct. 2. Advancing issues for the week were led by FHP International, up 15.3%; Re Capital Corp., up 13.0%; and Harleysville Group, up 8.0%. Declining issues for the week followed United Fire & Casualty, down 5.9%; Old Republic International, down 5.5%; and Liberty Corp., down 5.0%. The most active issue for the week was U.S. Healthcare, with 5.0 million shares traded. The *BI* Index was up 0.5%; the NYSE Composite was down 1.6%; the Standard & Poor's 500 was down 1.9%; and the Dow Jones 30 Industrials fell 2.0%.

British Issues

Oct. 8 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	514	N/M	31.5	6.1	514	497
Genl Accident	506	N/M	35.7	7.0	510	485
Gdn Royal Exch	150	N/M	10.0	6.7	150	143
Royal	183	N/M	7.0*	3.8	183	173
Sun Alliance	286	N/M	19.0	6.6	293	273
Brokers						
Bradstock	116	13.0	6.3	5.4	118	116
CE Heath	288	16.8	34.5	12.0	289	288
Hogg Group	122	11.5	10.9	8.9	122	122
JIB Group	136	10.5	10.0	7.3	137	136
Lloyd Thompson	209	16.9	7.5	3.6	209	207
Lowndes Lmbrt	258	10.0	16.8	6.5	258	257
PWS Holdings	54	6.2	5.3	9.8	55	54
Sedgwick Grp	131	10.4	8.0*	6.1	131	126
Steel Brrl Jones	179	8.9	17.7	9.9	179	176
Willis Corroon	206	13.0	17.6	8.5	206	195

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

OCTOBER 5, 1992 THROUGH OCTOBER 9, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	25.25	-3.35	23.17	27.38	18.00	541	1.00	3.96	105	13.10	1.93
Gallagher Arthur J. & Co.	NYS	28.63	2.69	27.93	28.63	19.00	140	0.64	2.24	21	5.88	4.87
Frank B. Hall	NYS	3.00	0.00	-29.41	5.50	2.63	28	0.00	0.00	-3	1.95	1.54
Hilb, Rogal & Hamilton	NYS	14.25	-2.56	7.55	15.63	11.00	117	0.40	2.81	23	3.56	4.00
Marsh & McLennan	NYS	90.00	-0.41	10.60	92.50	70.00	939	2.68	2.98	21	28.00	3.21
Poe & Associates	OTC	13.25	-1.85	10.42	16.00	11.25	26	0.40	3.02	17	2.82	4.70
BROKERS	AVERAGE		-0.9	8.4					2.1	26		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	43.63	-0.57	43.03	45.50	25.00	379	0.36	0.83	15	36.95	1.18
Berkshire Hathaway Inc.	NYS	9305.00	-1.53	2.82	9305.00	254.69	0	0.00	0.00	31	7270.00	1.28
ITT (Hartford Group)	NYS	64.63	-3.54	11.90	70.63	50.00	1193	1.84	2.85	18	112.05	0.58
Sears (Allstate)	NYS	42.00	-2.33	10.89	48.00	32.50	4918	2.00	4.76	11	34.50	1.22
CONGLOMERATES	AVERAGE		-2.0	17.2					2.1	19		
INSURERS/REINSURERS												
AEGON N.V.	NYS	40.50	-2.99	15.71	41.88	28.75	32	2.68	6.62	7	N/A	N/A
Aetna Life & Casualty	NYS	41.63	0.60	-5.40	47.00	33.88	1101	2.76	6.63	14	87.60	0.48
Allied Group Inc.	OTC	28.50	0.44	67.65	29.25	16.25	94	0.64	2.25	8	19.85	1.44
American General	NYS	48.63	-0.77	9.27	50.38	39.00	770	2.08	4.28	11	60.00	0.81
American Heritage Life Ins.	NYS	31.38	-3.46	2.45	32.50	21.94	7	0.84	2.68	16	N/A	N/A
American Indemnity/Fin'l	OTC	5.13	0.00	7.89	9.25	4.50	0	0.08	1.56	8	12.93	0.40
American International	NYS	106.63	0.95	8.39	108.00	80.13	4106	0.56	0.53	14	99.30	1.07
Aon Corp.	NYS	47.88	-2.30	20.82	50.25	35.38	438	1.68	3.51	12	39.70	1.21
Argonaut Group	OTC	28.63	-2.97	20.53	30.25	21.75	18	0.84	2.93	8	20.96	1.37
AVEMCO Corp.	NYS	25.88	0.49	3.50	28.00	21.50	46	0.40	1.55	25	9.55	2.71
Baldwin & Lyons Inc.	OTC	30.75	2.50	19.42	33.00	23.50	10	0.48	1.56	8	24.29	1.27
Chandler Insurance	OTC	4.63	0.00	42.31	7.63	2.25	17	0.00	0.00	42	5.95	0.78
Chubb Corp.	NYS	82.75	-0.90	7.47	87.50	61.38	3030	1.60	1.93	13	42.67	1.94
CIGNA Corp.	NYS	51.75	-0.48	-15.34	61.75	45.50	1068	3.04	5.87	11	117.15	0.44
CNA Financial Corp.	NYS	93.25	0.95	-4.85	104.50	78.50	116	0.00	0.00	10	70.23	1.33
Continental Corp.	NYS	24.63	-1.01	-10.86	34.75	20.00	1440	2.60	10.56	17	40.00	0.62
EXEL Ltd.	NYS	42.75	1.18	14.00	44.50	29.75	1017	0.92	2.15	8	N/A	N/A
Fund American Corp.	NYS	70.25	-0.18	0.54	71.25	62.50	64	0.68	0.97	18	36.11	1.95
Fremont General Corp.	OTC	26.50	0.95	8.72	26.75	17.00	177	1.00	3.77	7	45.55	0.58
Frontier Insurance Group	NYS	33.38	-3.96	23.61	40.50	21.91	36	0.60	1.80	12	26.65	1.25
Gainsco Inc.	ASE	13.25	6.00	41.96	13.75	7.28	224	0.04	0.30	20	3.37	3.93
General RE Corp.	NYS	107.63	1.41	5.64	108.00	77.50	1727	1.80	1.67	15	78.65	1.37
Guaranty National Corp.	NYS	19.50	-1.27	34.48	20.38	12.63	52	0.48	2.46	13	N/A	N/A
Hanover Insurance Co.	OTC	46.00	-0.81	28.67	47.75	28.50	38	0.44	0.96	10	37.44	1.23
Harleysville Group	OTC	27.00	8.00	27.06	27.00	16.75	730	0.64	2.37	11	22.99	1.17
Hartford Steam Boiler	NYS	57.38	-0.86	-0.22	59.25	45.13	67	2.12	3.69	17	35.50	1.62
Kemper Corp.	NYS	23.88	1.06	-37.38	46.13	20.75	561	0.92	3.85	10	50.00	0.48
Lawrence Insurance Group	ASE	8.13	-2.99	-26.97	11.13	7.00	3	0.48	5.91	18	4.71	1.73
Liberty Corp.	NYS	26.13	-5.00	18.08	32.88	20.13	88	0.48	1.84	11	29.35	0.89
Lincoln National	NYS	63.88	-3.04	16.67	67.50	48.00	519	2.92	4.57	11	81.00	0.79
Markel Corp.	OTC	28.75	2.68	30.68	28.75	17.75	24	0.00	0.00	7	15.59	1.84
Mutual Risk Mgmt. Ltd.	NYS	35.25	6.02	0.36	37.75	22.25	58	0.24	0.68	22	-	-
NAC Re Corp.	OTC	34.75	-2.11	10.32	34.75	21.75	1068	0.16	0.46	15	18.90	1.84
National Re Corp.	NYS	27.13	3.33	N/A	27.13	17.00	489	0.12	0.44	14	N/A	N/A
Navigators Group	OTC	33.00	0.76	-19.51	48.25	28.50	44	0.00	0.00	18	13.52	2.44
Nobel Insurance LTD.	OTC	4.50	-2.70	12.50	6.00	3.50	6	0.00	0.00	3	7.76	0.58
NWNL Companies	NYS	37.75	-2.89	21.29	43.75	26.00	107	1.48	3.92	11	62.65	0.60
Ohio Casualty Corp.	OTC	64.00	-1.54	29.29	66.63	44.00	257	2.68	4.19	10	18.00	3.56
Old Republic Int'l	NYS	23.50	-5.53	32.39	25.63	15.56	419	0.40	1.70	9	33.09	0.71
Orion Capital Corp.	NYS	39.75	0.00	25.69	41.00	29.00	31	0.92	2.31	7	43.50	0.91
Phoenix RE Corp.	OTC	12.25	-3.92	16.67	12.88	8.50	136	0.20	1.63	25	13.30	0.92
Provident Life	NYS	25.50	-1.92	9.68	28.00	18.00	89	1.00	3.92	11	39.50	0.65
Re Capital Corp.	ASE	15.25	12.96	6.09	16.38	12.25	24	0.24	1.57	19	16.07	0.95
Reliance Group Holdings	NYS	5.13	0.00	24.24	5.88	3.50	101	0.32	6.24	3	6.40	0.80
RLI Insurance Corp.	NYS	20.63	0.00	25.00	21.38	15.13	28	0.52	2.52	9	14.41	1.43
St. Paul Companies	NYS	73.50	-2.33	0.86	80.75	58.50	1277	2.72	3.70	7	86.60	0.85
SAFECO Corp.	OTC	52.50	-2.10	7.69	55.25	36.13	2457	1.64	3.12	14	51.65	1.02
SCOR U.S. Corp.	NYS	17.25	-0.72	12.20	18.88	13.13	11	0.28	1.62	9	11.19	1.54
Seibels Bruce Group	OTC	2.63	0.00	-52.27	6.75	2.13	111	0.36	13.71	-1	10.60	0.25
Selective Ins. Group	OTC	20.88	7.05	24.63	23.50	15.25	77	1.12	5.37	8	30.75	0.68
Statesman Group Inc.	OTC	7.25	-1.69	26.09	8.13	4.88	171	0.00	0.00	4	2.48	2.92
Tokio Marine & Fire	OTC	45.63	0.83	-11.41	55.25	32.25	4	0.00	0.00	-	70.93	0.64
Torchmark Corp.	NYS	49.50	-2.22	28.29	53.38	33.41	471	1.04	2.10	15	40.95	1.21
Transamerica	NYS	43.25	2.37	8.46	46.75	35.63	650	2.00	4.62	22	55.00	0.79
Transatlantic Holdings	NYS	45.50	-2.15	17.04	46.63	29.38	163	0.24	0.53	14	18.38	2.48
Travelers Corp.	NYS	22.50	0.56	4.05	23.75	17.13	1943	1.60	7.11	9	59.00	0.38
Trenwick Group Inc.	OTC	37.50	2.04	31.58	40.50	23.00	528	0.80	2.13	13	21.71	1.73
United Fire & Casualty	OTC	40.00	-5.88	33.33	42.50	28.84	0	1.00	2.50	8	35.39	1.13
Unitrin	OTC	38.75	5.44	8.39	38.75	31.00	183	1.20	3.10	12	37.23	1.04
UNUM Corp.	NYS	44.50	4.71	9.88	45.00	31.50	467	0.64	1.44	13	37.70	1.18
US Facilities Corp.	OTC	8.75	-4.11	-41.18	19.00	7.00	147	0.00	0.00	7	9.58	0.91
USF&G Corp.	NYS	10.38	-4.60	43.10	15.00	5.63	2200	0.20	1.93	-12	12.30	0.84
USLICO Corp.	NYS	18.75	1.35	1.35	20.38	17.00	14	1.00	5.33	-20	33.15	0.57
USLIFE Corp.	NYS	45.38	-3.97	-5.22	52.50	39.00	133	1.72	3.79	9	84.55	0.54
Washington National	NYS	22.88	0.00	44.09	23.50	14.00	15	1.08	4.72	-57	33.50	0.68
Zenith National Ins.	NYS	16.75	-1.47	-0.74	19.50	13.75	92	1.00	5.97	8	13.14	1.27
INSURERS/REINSURERS	AVERAGE		-0.2	11.5					3.4	11.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	20.75	15.28	45.61	20.75	9.88	2364	0.00	0.00	21	15.50	1.34
Pacificare Health Sys.	OTC	40.00	2.56	1.27	43.50	10.75	156	0.00	0.00	24	28.25	1.42
Safeguard Health Enter.	OTC	7.63	0.00	-18.67	14.75	6.75	16	0.00	0.00	10	3.53	2.16
Sierra Health Services	ASE	32.00	4.92	245.95	32.75	12.38	330	0.00	0.00	16	1.78	17.98
United Healthcare Corp.	NYS	51.38	5.38	-31.04	52.75	26.69	1218	0.01	0.02	36	43.60	1.18
United Medical Corp.	ASE	7.00	-1.75	0.00	8.75	5.88	1	0.20	2.86	39	8.79	0.80
U.S. Healthcare	OTC	47.00	6.21	69.88	47.00	17.16	5030	0.36	0.77	29	20.55	2.29
HMOs	AVERAGE		4.7	44.7					0.5	22		
ALL COMPANIES	AVERAGE		0.4	20.4					2.8	14		

System design: Nordby International Inc.

Each year, in late October, Canadian geese sense the onset of winter and begin their seasonal migration southward. This journey takes some of the geese over 2,000 miles in search of the warm marshes that will sustain them through the winter.

Knowing That Change Is Coming Is One Thing. Doing Something About It Is Another.

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