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update

Plan would bar deductions for captive, backdated covers

WASHINGTON—The Senate Finance Committee is considering writing new tax legislation that would bar corporate tax deductions for premiums paid to captive insurance companies and for the purchase of backdated liability insurance.

These restrictions are part of a proposal before the committee to change tax law governing insurance to raise revenues. The proposal includes a

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Victories for self-insurers

Judge says federal law should determine coverages written by risk retention groups

By JERRY GEISEL

WILMINGTON, Del.—State regulators are losing their battle to severely restrict the exposures that can be covered by product liability risk retention groups.

A federal court in Wilmington, Del., has struck down as "untenable" Delaware Insurance Commissioner David Elliott's position that state—not federal—law determines the definition of product liability that applies to the groups.

In a case involving the right of the 11,000-member Home Owners Warranty Corp. to operate a Delaware-based risk retention group, known as HOW Insurance Co., U.S. District Judge Walter Stapleton said the federal definition of product liability, as contained in the 1981 Risk Retention Act, is the only guide to the exposures the groups can cover.

"If this were not so, a state could prevent the formation of a risk retention group that met the relevant federal criteria," Judge Stapleton wrote. "This would thwart the intent of Congress."

Meanwhile, in Washington, the Senate unanimously approved—despite opposition from the National Assn. of Insurance Commissioners—an amendment, S. 1046, to the Risk Retention Act.

That amendment, introduced by Sen. Robert Kasten, R-Wis., and now pending in the House Energy and Commerce Committee, reaffirms that the broad definition of product liability contained in the 1981 law shall be the sole basis for determining the scope of coverage provided by the groups.

Graphic: Jim Bakasetas

Both the Delaware court decision and the Senate vote are victories for insurance buyers that have fought state regulators' actions to restrict the groups formed under the Risk Retention Act.

The Delaware court ruling "confirms and reinforces HOW's position that it is the federal law that controls questions of insurance regarding an organization's qualification as a risk retention group," HOW said.

The Risk Retention Act allows businesses to band together to form captive insurance companies—or risk retention groups—to self-insure their product liability exposures with minimal interference from state regulators.

The act, passed to give employers another alternative to fund their product liability exposures, permits companies that receive a charter from Bermuda, the Cayman Islands or any state to operate as risk retention groups in all states if they meet the capitalization requirements of at least one state.

As risk retention groups, these companies do not have to be licensed in every state or use a fronting insurer to avoid run-ins with state regulators.

But almost ever since the Risk Retention Act was passed, state regulators have been fighting those who

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Court upholds deductions for workers comp reserves

By DOUGLAS McLEOD

SAN FRANCISCO—Employers self-funding workers compensation risks in nine Western states can take tax deductions for reserves to pay uncontested workers compensation claims, according to the 9th U.S. Circuit Court of Appeals.

The three-judge federal appeals court in San Francisco earlier this month affirmed a lower-court ruling last year that Kaiser Steel Corp. is entitled to a tax deduction covering reserves for uncontested workers comp claims for the year 1964, which was at issue in the case.

Under the decision, Kaiser would also be entitled to $15 million in deductions taken in years after 1964.

The appeals court said that although Kaiser's reserves—established in 1964—were not always accurate in each case, they were accurate in the aggregate, entitling Kaiser to use the accrual method of accounting in determining its taxable income.

Although lawyers involved in the case expect the Internal Revenue Service to request a review of the decision by the Supreme Court, the Oct. 7 appeals court ruling strengthens the hand of self-insurers that want to deduct workers compensation loss reserves from their incomes.

The states in the 9th Circuit affected by the ruling are Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington, plus Guam.

In California alone, 1,400 employers self-fund their workers compensation risks.

Many self-insurers that aren't already taking the deduction have been waiting for the appellate decision, and some say that they will now consider deducting reserves on the strength of Kaiser's victory.

Other self-insurers that have taken the deduction all along express relief that the decision has gone their way, observing that it further supports their own claims to the deduction.

Still other companies that are not self-insurers may decide to take the self-funding route in light of the newly confirmed tax advantages, lawyers involved in the case say.

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Insurers to pay most of Love Canal settlement

By LEN STRAZEWSKI

NIAGARA FALLS, N.Y.—Occidental Petroleum Corp. is on the verge of settling more than $10 billion in personal injury claims over the pollution of the Love Canal area for only about $25 million.

Of that amount, about $20 million will be covered by insurance.

The agreement in principle, announced early last week by Occidental Chairman and Chief Executive Officer Armand Hammer, covers 1,345 of the 1,431 lawsuits pending against Occidental and various public entitities in and near Niagara Falls.

The suits were filed in 1978 after 237 families were forced to abandon their homes in the Love Canal area when state environmental officials detected cancer-causing chemicals leaching into the soil and the basements of homes.

The homeowners charged that Hooker Chemical & Plastics Corp., which was acquired by Occidental in 1968 and has since been renamed Occidental Chemical Corp., dumped the chemicals in a landfill from 1947 to 1952.

The proposed settlement, Mr. Hammer said in a prepared statement, called for Occidental itself to pay out between $5 million and $6 million, "being substantially the cost of self-insurance."

Insurance schedules filed in court when Occidental sued its insurers in a coverage dispute over Love Canal claims do not specify deductibles or self-insured retentions (*BI*, Jan. 21, 1980).

Neither Mr. Hammer nor Occidental's attorneys, however, would disclose the total value of the settlement, but a source close to the litigation confirmed that Occidental's primary and low-layer excess insurers would contribute about $20 million to the settlement fund.

Hardest hit among the insurers, sources said, is Hartford Accident & Indemnity Insurance Co., a Hartford Insurance Group unit and Occidental's primary liability insurer from before 1942 through 1973.

Hartford, which underwrote a peak of $10 million in comprehensive general liability coverage, will contribute "more than Occidental itself," about $7 million to $10 milllion, a source close to the negotiations said.

Approximately 14 other insurers from among Occidental's more than 40 liability underwriters from 1967 to 1979 will also contribute to the settlement fund, according to insurers and sources close to the negotiations. They include:

- Continental Insurance Co., which underwrote $100,000 in primary liability coverage from 1973 to 1976.
- Unigard Mutual Insurance Co., International Surplus Lines Insurance Co. and Lloyd's of London underwriters in combination with other British insurers, which underwrote $4 million of coverage in excess of $1 million from 1973 to 1976.

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Plan would restrict deductions

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new definition of insurance that would exclude captive and backdated liability insurance by defining insurance as the spreading and shifting of an "*insurance* risk."

While a committee discussion paper doesn't clearly define an "insurance risk," the paper says captive and retroactive arrangements would not be treated as insurance. And, since backdated and captive coverages no longer would be considered insurance, companies could not take tax deductions for premiums under these arrangements.

The committee also is considering a proposal that would require property/casualty insurers to discount loss reserves to their present value for federal income taxes, except reserves to pay for claims with a short tail, like automobile and homeowners claims. The initial discount rate would be approximately 5%, according to a committee paper.

Currently, insurers can reserve the full amount of a claim they expect to pay anytime in the future and are entitled to a full tax deduction when they establish the reserve.

Insurers say policyholders might have to pay more for coverage if they are forced to discount their reserves.

Washington attorneys stress that the committee proposals represent the views of a few staff members and not the senators. They say the proposals need much more refinement before the committee seriously considers them.

Prudential-Bache theft insured

NEW YORK—Prudential-Bache Securities Inc. says it is insured under an employee theft policy for an estimated $15 million illegally diverted from the dividend department of its New York office.

A spokesman for Prudential-Bache, a subsidiary of Prudential Insurance Co. of America, says Aetna Life & Casualty Co. is the lead underwriter on the policy. He said the policy limits are sufficient to cover the full amount of the loss if the money is not recovered, but would give no further details of the coverage.

John Efler, 38, a 10-year Prudential-Bache employee who worked as a section manager in the dividend department, has been charged with stealing more than $5 million by depositing phony dividend checks in the bank accounts of companies that had no financial dealings with the firm. The money was later withdrawn by three other men who also have been arrested. None of the money has been recovered yet.

The Prudential-Bache spokesman says that as much as $10 million more may have been stolen, going as far back as November 1981.

Mr. Efler and the three other men have pleaded not guilty to the charges against them.

Republic unions propose ESOP

MINNEAPOLIS—Unions representing Republic Airlines workers may ask the company to create a new Employee Stock Ownership Plan, through which employees could possibly buy a 25% interest in the company.

Union officials emphasized that the ESOP would not be an attempt to take over the company, but added Republic should give something to employees in exchange for a 15% wage cut the workers recently accepted.

Officials of Republic's six unions, meeting in Las Vegas last week, agreed to propose the ESOP plan to their master executive councils when they meet on Nov. 3. Republic, which has about 13,300 unionized workers, would have to agree to the plan.

A spokesman for Republic said that no formal proposal had been received by the company as of late last week. But he said that such a proposal would be evidence of the employees' faith in the company's future. The company has offered payroll-deduction stock purchase plans to employees in the past, he said, noting that about 8,300 out of the company's 14,500 employees are shareholders, owning 15% of the company's outstanding stock.

Hospital faces $25 million award

BROOKLYN, N.Y.—Maimonides Medical Center, a Brooklyn acute-care hospital, is facing a $25 million jury award in connection with the July 1980 death of a woman awaiting treatment in the hospital emergency room.

"We don't know if that will be the final award," said a hospital spokeswoman. An appeal is being considered, she said.

Administrators at the facility would not release details of its insurance program, though the spokeswoman said Maimonides had medical malpractice insurance.

A Brooklyn Supreme Court jury on Oct. 4 awarded Anthony Corda $8 million for pain and suffering, $17 million for wrongful death and $8,000 for funeral expenses, stemming from the death of his wife, Theresa. The jury found the medical center guilty of malpractice and the wrongful death of Mrs. Corda.

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Rath receives more time to repay debt to PBGC

By JERRY GEISEL

WASHINGTON—Rath Packing Co. is getting more time to repay its debt to the Pension Benefit Guaranty Corp.

Under an agreement reached last week, Rath will be allowed to repay on a fixed monthly schedule the $1.7 million, plus 12% interest, that the packing company was to have paid the PBGC by Sept. 15.

Rath made its first installment payment of $87,473.06 Oct. 7. It must make another payment of about $71,000 later this month and continue making monthly payments of $71,000 through February.

Beginning Feb. 15 and continuing through August, Rath must make monthly payments of about $110,000. Finally, on Sept. 15, 1984, Rath will make a $580,000 payment to the PBGC, the last installment on the $1.7 million debt incurred when the company terminated three pension plans last year (*BI*, Oct. 11, 1982).

But, while the agreement gives Rath more time to repay the $1.7 million, it also extends the period during which the Waterloo, Iowa, meatpacker must share its profits, if any, with the PBGC.

The original October 1982 agreement between Rath and the PBGC required Rath to give a portion of any profits between 1985 and 1994 to the PBGC. The latest agreement gives the PBGC the right to a share of Rath's profits through 1997.

Last week's agreement comes three months after Rath told the PBGC that it needed more time to pay its debts to the agency because of financial problems. In the six-month period ended April 2, Rath lost $6.6 million, compared with a loss of $3.5 million during the corresponding period of 1982 (*BI*, Aug. 8).

Rath's problems with the PBGC date back to October 1982 when the federal agency agreed to take over three underfunded pension plans with 6,300 participants that Rath said it wanted to terminate because it could no longer afford them.

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Comp rate cut meets criticism in Michigan

By CAROL CAIN

LANSING, Mich.—Employers and workers compensation insurers alike are protesting the state insurance commissioner's decision to slash the rates charged by the State Accident Fund.

Eight insurers have filed suit in Livingston County Circuit Court seeking to bar the rate decrease, which Insurance Commissioner Nancy A. Baerwaldt estimates could be as high as 17%.

They say that they cannot match the state fund's decreased rates, especially since Michigan work comp rates have been reduced by about 30% in the past two years.

The insurers also have requested an administrative hearing with Ms. Baerwaldt to discuss the proposed rate cut.

Employers, oddly enough, also oppose a decrease in state fund rates, expressing fear that Ms. Baerwaldt's order could hinder competition under Michigan's new open rating law and eventually pave the way for a monopolistic state fund.

However, Ms. Baerwaldt does not see her decision to order the fund to slash its rates by Jan. 1 as anticompetitive. "We will use the Accident Fund as a competitive tool," she says.

Ms. Baerwaldt ordered the rate decrease because of the fund's $115 million surplus, which compares

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To preserve old, the new often must be altered

By STACY SHAPIRO

YORK, England—Sometimes the old and the new just don't mix.

The remains of a 1,000-year-old Viking village, which will be exhibited to the public in York next year, cannot be equipped with a sprinkler system, since the water from the sprinkler heads would dissolve the ancient wood in no time.

But that doesn't mean that the York Archaeological Trust, the group that has invested 2.6 million pounds ($3.9 million) to preserve the Viking remains, is letting its investment go unprotected.

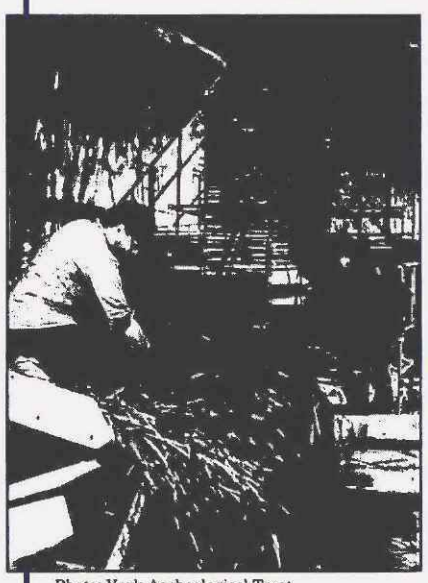

Photo: York Archaelogical Trust

The thatch on the roofs was thinned to make it safer.

"So, instead (of a sprinkler system), we have put in a smoke extract system," says Anthony Gayner, project director of the New Jorvik Viking Centre.

The extraction system is connected to the air conditioning unit in the exhibit building and can remove smoke from the area at the rate of 7.5 cubic meters per second.

The system is designed to help save any exhibit visitors from smoke inhalation, while the York City Fire Department would be called to put out the fire.

The system, built by the Yorkshire Fire Research Centre, has been approved by the York City Fire Department as a substitute for sprinklers.

Preventing smoke and fires at the Viking exhibit is just one of the loss-prevention problems faced by the York Archaeological Trust as its tries to preserve the past in this historic British city.

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Attorney says Raymark headed toward bankruptcy

By STEPHEN TARNOFF

CHICAGO—Another asbestos defendant may file for reorganization if it does not obtain interim funding from its insurers to help pay asbestos claims, one of its attorneys says.

Raymark Corp. attorney Frank Heap told Cook County Circuit Court Judge James C. Murray that the company could not continue for long to pay defense and compensation costs in asbestos cases without reimbursement from its insurers.

Raymark is currently paying $4.5 million a quarter for such costs and could follow in the paths of other asbestos defendants that have filed for bankruptcy if it must continue to do so, said Mr. Heap of the Chicago firm of Bell Boyd & Lloyd.

"Our client is not going to be here long enough to go on" if there are long delays without interim funding, Mr. Heap said. "This company's financial condition is perilous."

However, a spokesman for Raymark said last week that Raymark has "no plans at this point to file" for reorganization. "We have no present intention to file for bankruptcy," the spokesman said.

Three other asbestos defendants—Manville Corp., UNR Industries Inc. and Amatex Corp.—have filed for

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errors & omissions

• CIBA-Geigy Corp. in Ardsley, N.Y., negotiated benefit cost-sharing with some of its unions, but not from a concessionary point of view as reported Oct. 10. "We are not asking our people for cuts and freezes," said Robert D. Urbont, labor relations manager. "We are asking for benefits cost-sharing to take some of the pressure off the company, but we are increasing wages. Cost-sharing is not a concession."

Banks' insurance activity inevitable: Panel

By DOUGLAS McLEOD

WHITE SULPHUR SPRINGS, W.Va.—Banks' entry into the insurance business is not a question of when, but how, a panel of experts suggests.

Will banks act as underwriters, or merely as agents and brokers? Will they offer a broad range of insurance products, or will they specialize? Will they form their own insurance units, or will they acquire an insurance subsidiary?

The answer is probably all of the above, a panel told an audience at the 1983 conference of the National Assn. of Casualty & Surety Executives and the National Assn. of Casualty & Surety Agents.

"You are going to see a little bit of everything," said Joseph Spanholz, senior vp with New York's Chemical Bank.

Mr. Spanholz said that since banks, by lending money, are already in the risk-taking business, they might gravitate naturally toward underwriting insurance rather than simply distributing it.

He added, though, that the whole issue of banks jumping into the insurance marketplace is "not as hot a topic as some people might think.

"At the present time, we have no plans to enter the insurance business," Mr. Spanholz said, "though we did make the ritual pilgrimage out to South Dakota," where a recently passed law allows state-chartered banks to engage in "all facets" of the insurance business (*BI*, Sept. 12).

Only "a handful of banks" are interested in insurance underwriting, agreed William W. Wyman, senior vp and director of financial services industry practice for Booz-Allen & Hamilton Inc. in New York.

Mr. Wyman added, though, that as banks' profit margins are squeezed, they may well decide to sell the products of others, including insurance companies, to improve their bottom lines.

Richard J. Rice, a senior vp with broker Johnson & Higgins, wondered aloud why banks would want to get involved in the property/casualty business at all, given the current state of the commercial insurance market.

"You're looking to get into a savagely competitive business as if you were lining up at an Oklahoma land rush waiting for a cannon to go off," he observed.

Mr. Spanholz replied that bank entry into insurance is "irrelevant" for just that reason: Because the market is already so competitive, the presence of a few more competitors won't hurt insurers much more than

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Executives see no rate relief

WHITE SULPHUR SPRINGS, W.Va.—Insurance industry executives gloomily predict that competition will probably continue in the property/casualty insurance marketplace.

At their yearly meeting at The Greenbrier, a resort hotel in White Sulphur Springs, the executives discussed the bleak prognosies.

Some of the executives, members of the National Assn. of Casualty & Surety Executives and the National Assn. of Casualty & Surety Agents, admitted, though, that some signs of firming prices can be seen.

But widespread firming in the near future probably won't come without instability in reinsurance markets or a few catastrophic property losses, they noted.

"It's really not getting any better; it's just getting more competitive. We don't see any improvement," said DeRoy C. Thomas, chairman and chief executive officer of Hartford Insurance Group and the newly re-elected president of NACSE.

"Commercial lines are the leaders in the deterioration," he added.

Industrywide combined ratios for general liability lines rose from 116% in 1981 to 129% in 1982, and are likely to inch up to about 130%

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Photo: Roe DiBong

One of Ms. Merzroth's employees created a substitute to attend staff meetings.

It's not where but how you do job

By MARGARET LeROUX

NEW YORK—When she set the date to renew a $2.5 million group health insurance plan for Salomon Brothers in New York, Jane P. Metzroth had no idea she'd be negotiating from a hospital bed instead of at a conference table.

The insurer representatives that exchanged ideas on premiums and retrospective rating for major medical and surgical coverage with Ms. Metzroth, Salomon Brothers' vp and director of human resources, never did know.

That's because the resourceful human resources director figured out—quite creatively—how to keep up a full load of work while she was confined to bed because of complications of her pregnancy.

One of her assistants at the securities firm set up the policy renewal meeting as a conference telephone call, informing the insurance company representatives that her boss was in Florida at a convention.

"I had all my calculations done ahead of time," Ms. Metzroth said. "I knew what we wanted and instead of putting it all off until after the baby arrived, I decided to go ahead and get it over with.

"I don't think the results would have been any different had I done the negotiating in person," she said. Salomon Brothers actually "came out ahead" on the advance premium paid on the retrospectively rated policy, she adds.

Ms. Metzroth declined to name the insurer that writes Salomon Brothers' group health plan. "I don't want them to think I wasn't taking the negotiations seriously," she said.

"But, in terms of our bargaining position, I didn't want to reveal my life history to explain why I was in bed."

Although Ms. Metzroth was in bed in her home in New York, the insurers,

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Asbestos suits name Denver firm by mistake

By STEPHEN TARNOFF

DENVER—Rockwool Industries Inc. has never manufactured, used or distributed asbestos, but asbestos litigation is costing it several hundred thousand dollars.

Whether it's a case of mistaken identity or merely guilt by association, the Denver-based mineral wool insulation manufacturer has been named in several hundred lawsuits brought by asbestos victims.

Virtually all of the lawsuits have been dismissed, but it has been an expensive proposition for the company both in time and money.

"These things aren't cheap," says the company's attorney, Craig D. Joyce of the Denver firm of Roath & Brega. "It's kind of an expensive nuisance."

> 'They take a shotgun approach. I suspect they look up insulation manufacturers and name them all. It's guilt by association,' Mr. Joyce says.

"No plaintiff has ever recovered and no claim has ever been paid," he adds. "But when you're sued, you have to respond."

Joseph Kurtiss, secretary of the Susquehanna Corp., Rockwool's parent corporation, estimates these suits cost the company about $1,000 each. It is estimated about 500 suits have been filed altogether, bringing total costs to several hundred thousand dollars.

Home Indemnity Co. in Manchester, N.H., is defending the cases, but Mr. Kurtiss points out there is a deductible on each claim, and the numerous claims could hurt Rockwool 's loss experience, triggering higher premiums later.

The lawsuits are also very time-consuming, Mr. Kurtiss said. The time he spends addressing the claims is time taken away from other Rockwool business matters, and Rockwool's outside counsels are also involved.

Furthermore, Mr. Joyce points out, asbestos victims lose when companies are wrongfully named in suits. The time the plaintiffs' lawyers spend chasing Rockwool takes away from the time they should be using to pursue the real asbestos manufacturers, he says.

Both Mr. Kurtiss and Mr. Joyce believe Rockwool is being named as an asbestos defendant because plaintiffs' attorneys choose defendants from a list of insulation companies, often without checking out exactly what the company manufacturers.

"They take a shotgun approach," Mr. Joyce says, noting the plantiffs' attorneys name anyone they think might have manufactured or distributed asbestos.

"I suspect they look up insulation manufacturers and name them all. It's guilt by association."

In addition, there are other insulation manufacturers with names similar to Rockwool. For example, there is a Rock Wool Manufacturing Co. Inc. in Alabama that is a bona fide asbestos defendant.

The first case naming Rockwool was filed about three or four years ago, and the lawsuits are still coming in. The lastest arrived within the last two months, Mr. Kurtiss said. Four have been filed in the last six months, adds Mr. Joyce.

When Rockwool is notified of a suit, it sends out a letter and an affidavit signed by a vp for manufacturing stating that Rockwool has never been involved with asbsetos and explaining what rock wool is.

A copy of the complaint is also sent to the company's insurer.

The affidavit notes that Rockwool maufactures a single product—mineral wool insulation, which is a thermal insulation material intended for use in residential housing construction.

Rock wool is a byproduct of steel and copper slag that is transformed into fibers of mineral or rock wool.

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Federalize asbestos compensation: Attorney

By CAROL CAIN

ATLANTA—A federal compensation program for workers with asbestos injuries is the only way to curb escalating litigation and rising costs.

That's the belief of the attorney who helped draft a federal asbestos compensation bill, but he stood alone on a panel of five that tried to answer the question: Will occupational disease compensation be federalized?

The panel was sponsored by the National Council of Self-Insurers on the opening day of the annual convention of the International Assn. of Industrial Accident Boards & Commissions last month in Atlanta.

The others on the panel believe that the states, which are working on solutions to the multilateral problem, should continue to be the arena for workers compensation.

However, Michael Goldberg, chief counsel for the House Labor Standards subcommittee who worked on the asbestos bill introduced by Rep. George Miller, R-Calif., disagreed.

The workers compensation system has been in the "hold box" for about a decade, waiting for a fix-up remedy, but Rep. Miller's pending bill, H.R. 3175, would move it to the "out box," he said.

Rep. Miller's bill would establish a single administrative mechanism under the Labor Department for delivering benefits and create a special task force within the department to expedite processing of asbestos claims (*BI*, May 30).

Statistics underscore that workers compensation, especially in the relatively new area of occupational disease, is not working—for the injured worker, the employer or the insurer, Mr. Goldberg said.

Instead of seeking compensation only through the work comp system, many workers exposed to asbestos are filing lawsuits against asbestos manufacturers, users and distributors. Currently about 25,000 lawsuits are pending nationwide.

"As we see it, a lot of people are sick, in need of compensation," said Mr. Goldberg. "The workers compensation system is responding inadequately to these workers.

"The unanticipated reliance on the tort system has proven itself to be destructive, slow, inadequate to the victim, but costly to the defendent and disruptive for business. And, there will be a lot of asbestos cases—workers comp liability cases against the employer and third-party tort liability cases against the manufacturer," he said.

The options to deal with "the world as it is today," Mr. Goldberg said, include:

- Do nothing.
- Fix the state work comp laws.
- Fix the product liability law.
- Draw a new social compact that tries to construct a new workers compensation system that deals with the world as it is today.

The final option is the thrust of Rep.

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Illinois Legislature to review vetoed comp bills

By CAROL CAIN

SPRINGFIELD, Ill.—A bill that expands the Illinois Industrial Commission by one member but also increases its workload is expected to make it through this month's veto session of the state Legislature.

The measure, which also raises interest rates applied to awards in appealed work comp cases and increases the statute of limitation on asbestos injury claims, has been criticized by employers and also, though more quietly, by the commissioners.

In its veto session that begins Oct. 18, the Legislature acts on bills that the governor has vetoed or amended and either accepts the changes, tries to override the veto or lets the bill die.

A key provision in S.B. 1070 increases to six the number of industrial commissioners, forming two three-member panels to hear disputed work comp cases.

Currently, cases are heard before three of five commissioners, although all five may vote. A decision must be approved by three of the five members unless the parties waive that requirement. In those instances, only a simple majority of those hearing the case is needed.

Proponents of the bill say the extra member will lighten the workload by spreading it over two panels, but opponents are afraid that the panels will reach different decisions on similar cases.

"You run the risk of each panel deciding a point of law differently. . .that can only be settled by the Supreme Court," said Chicago attorney Thomas D. Nyhan, executive secretary of the Illinois Self-Insurers Assn.

Another provision of the bill would send disputes over a worker's eligibility for work comp benefits to a commissioner for a hearing, rather than to an arbitrator, as is the practice now.

If the commissioner decides the injury is compensable, the case then would go to an arbitrator and follow regular procedure, said Tim Bramlet, director of industrial relations for the Illinois Manufacturers' Assn.

The provision also puts a 30-day deadline on the commission to hear the dispute. There is no deadline now and some disputes take upwards of 60 days to be heard.

Opponents say switching this responsibility to the commissioners from the arbitrators will slow down the handling of work comp cases.

"The problem with that is that you have 24 arbitrators hearing those things now and they want to switch it to six commissioners," Mr. Nyhan said.

"They would be spending three to four days a week to hear these eligibility cases," Mr. Bramlet said.

With an estimated 300-to-400-case backlog, commissioners are not eager to take on additional work, but they have remained relatively silent on the issue. They testified when the bill was taking form, but have not publicly criticized the final version.

The commissioners are appointed by the governor and some of them believe they represent the administration and, therefore, should not be overly vocal.

S.B. 1070 is to take effect July 1, 1984. In his amendatory veto of the bill Sept. 26, Gov. James Thompson let the expedited hearing provision for eligibility stand, but only for a six-month period. According to the veto, on or after Jan. 1, 1985, the commission must vote on whether to keep the procedure.

"We're very much concerned about the bill, even as amended. We believe the expedited hearing will not work and it will just clog up the commission more," said Leonard Day, manager of labor relations for the Illinois Chamber of Commerce.

Mr. Day also believes that this procedure could hamper the effectiveness of a recent change in Illinois law that requires commissioners to write out their reasons for reaching their decisions. When commissioners are hearing disputes over eligibility instead of an arbitrator, they will not be required to write out their decisions as they do otherwise, he said.

"And uniformity in the commission is essential," he added.

Another provision of S.B. 1070 sets the interest rate earned on benefits delayed by an employee or employer appeal at 1% above the prime interest rate. Currently, awards earn 6% interest while a case is under appeal.

The provision was included to discourage insurers from delaying payment, but it also will discourage employers with legitimate complaints from appealing, Mr. Bramlet said.

Employers wanted to see the interest rate tied to a more realistic figure, like the interest earned on Treasury Bills, rather than 1% above the prime rate.

S.B. 1070 also increases the statute of limitation for asbestos injury claims to 25 years after exposure. Currently, these claims must be filed within three years.

When S.B. 1070 was originally introduced by Sen. George Sangmeister, D-Mokena, it contained only the asbestos-injury statute of limitation provision. The other provisions on the number of commissioners, eligibility cases and interest rates were added after other bills on those topics died or failed in the spring session. Sen. Sangmeister is expected during the veto session to introduce a motion to concur with the veto amendments to the bill.

The governor also issued an amendatory veto for H.B. 186, introduced by Rep. E.J. "Zeke" Giorgi, D-Rockford. Though the amendment primarily is on minor technical points, the language of the bill became garbled in the final draft and legislative aides discovered that some of the original provisions of the bill were inadvertently left out.

The bill called for the establishment of two separate guaranty funds for employers that self-insure their workers compensation loss. One fund was for individual self-insurers and the other for group self-insurers.

Initially, the bill only covered individual self-insurers, said Ron Nelson, an attorney for the Illinois Self-Insurers Assn. A separate bill setting up a fund for groups died because of a parlimentary procedure, he said, so it was agreed to tack those provisions onto H.B. 186.

The final copy of the bill, however, left out some of the language for individual self-insurers and now in some parts doesn't make any sense, a legislative aide said.

Rep. Giorgi said he will attempt to have the bill restored in the veto session since all parties had agreed to it initially. ■

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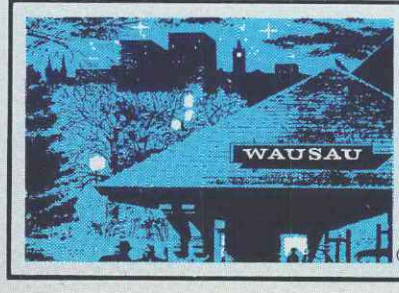

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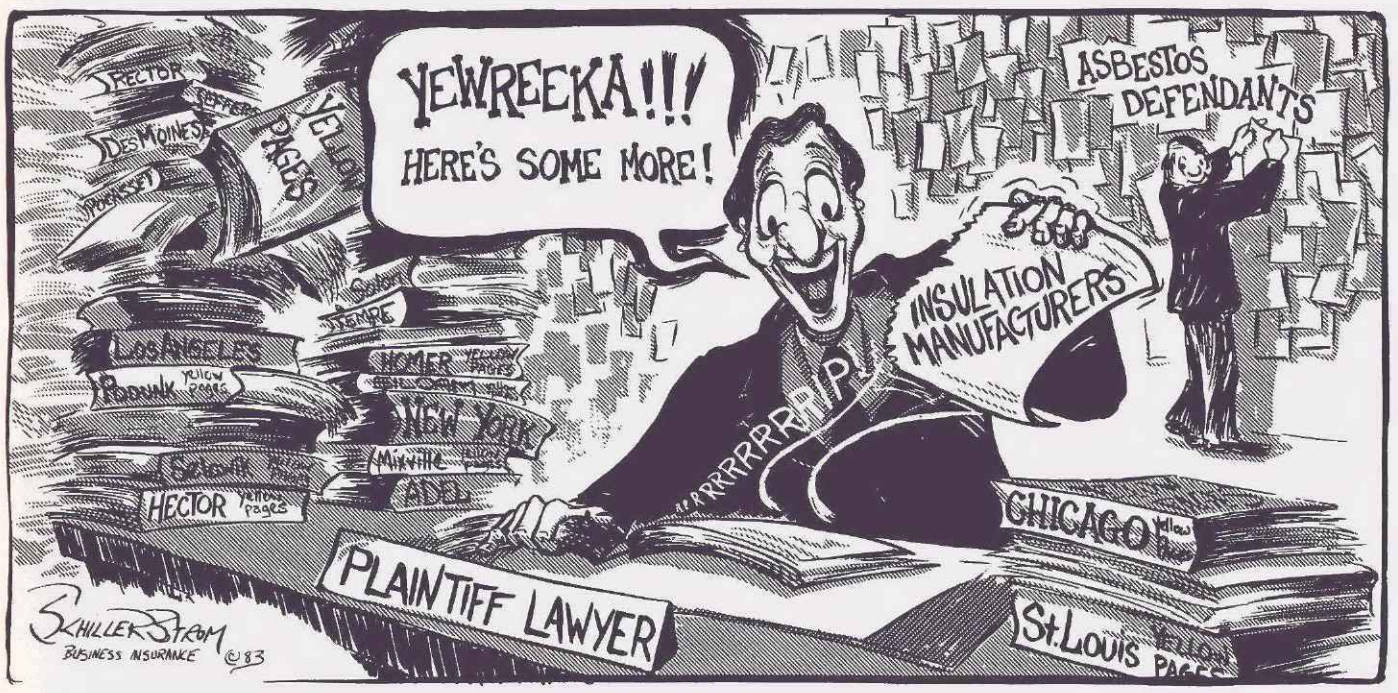

The expense of innocence

BEING INNOCENT should not cost several hundred thousand dollars.

But that is exactly what it is costing Rockwool Industries Inc. because it has been wrongly named in hundreds of asbestos lawsuits. The company does not and never has manufactured, used or distributed asbestos or asbestos products, but plaintiffs' attorneys apparently don't know that or haven't taken the time to learn it.

Rockwool officials believe part of the problem is that another firm that is an asbestos manufacturer has a name very similar to Rockwool's—a classic case of mistaken identity.

But another part of the problem, according to Rockwool officials, is that plaintiffs' attorneys in their zeal to get the largest awards for their clients name anyone and everyone they *think* may have been associated with asbestos.

Apparently, the plaintiffs' attorneys choose their defendants from a master list of insulation manufacturers without checking any further into the specifics of a particular company's manufacturing process. In Rockwool's case, it uses a steel and copper byproduct—not asbestos—to produce an insulation material used mainly in residential housing construction.

We have some sympathy for the plaintiffs' attorneys who honestly confuses two firms with very similar names. As editors and reporters, we have experienced similar problems in reporting the news. What we do to avoid naming the wrong company in a story is double-check our facts. It's surprisingly easy to do if you make a habit of it.

What we can't understand, though, is how an attorney could name a company in a lawsuit without first confirming that it has anything to do with the complaint at hand.

We understand that it is often necessary to rely on other people's research when preparing complaints and that there is probably a master list of asbestos companies prepared by someone somewhere that names Rockwool as a logical defendant.

But, Rockwool has been wrongly named 500 times! After the first 50 or 100 times, you'd think some plaintiffs' attorney would have noticed the error and somehow the word could have been spread before Rockwool was socked with another 400 lawsuits.

It's incredible that a company has to spend a half-million dollars to correct someone else's carelessness.

But, mistakes do happen. And when they do, the person who erred usually pays the price for the mistakes. That is what we would like to see happen in Rockwool's case and other similar cases.

When a company is mistakenly named in a lawsuit, the attorney who made the mistake should pay for the company's cost to correct the error. When the attorney realizes the error and asks the court to drop a certain defendant from a suit, the judge should oblige and also order the attorney to pay the innocent defendant's costs. Or if the attorney refuses to request the dismissal and the innocent defendant must make a court appearance to get off the hook, then the attorney should pick up these additional costs, too.

After all, being innocent should not cost a cent, let alone several hundred thousand dollars.

Turning adversity into creativity

WE LIKE Jane Metzroth's commitment and creativity.

When complications developed in her pregnancy, Ms. Metzroth—vp and director of human resources for Salomon Brothers—figured out a way to complete negotiations on the securities firm's group health insurance coverage without making her personal problems part of the talks.

As the story on page 3 explains, she negotiated the coverage renewal from a hospital bed in her home but kept the extraordinary circumstances a secret from the insurer so as not to compromise her company's position in any way.

We compliment her for a job well done.

And we also compliment Salomon Brothers for the flexibility it showed in dealing with this employee who presented it with a unique problem.

A key employee was telling the securities brokerage she would be confined to bed for a couple months before her child was born and then would need time off after the birth, and Salomon agreed to work with Ms. Metzroth to make it possible for her to continue to work from home until she could return to her job full-time.

If you have not faced this situation yet in your benefits or risk management department, it is very likely you will. More and more women that started their careers five or 10 years ago are taking time out now to start their families.

Be forewarned: It is hard to anticipate the employee's needs. Anything could happen during the pregnancy or childbirth to change the employee's plans.

But if this person is a valued employee, you should try to be as creative as Ms. Metzroth and Salomon Brothers in finding a solution that will work for your company, your risk management or benefits department and your employee.

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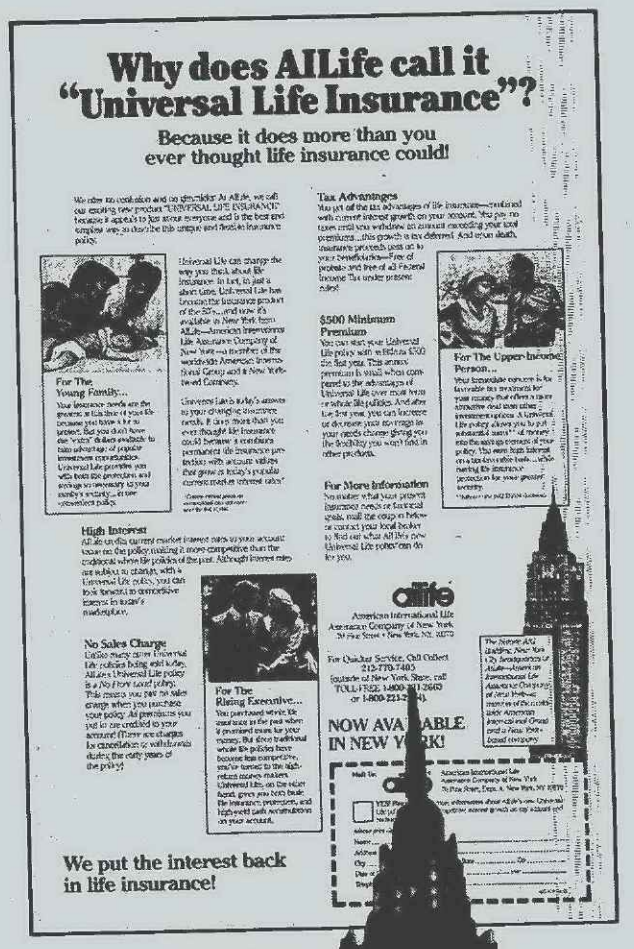

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Benefits communication conference

CHICAGO—It's not too late to sign up for *Business Insurance's* annual conference, "The Dollars & Sense of Communicating Employee Benefits."

The conference, to be held Nov. 1-2 in Chicago, will focus on how to persuade employees to use their benefits wisely through a variety of communications media.

A highlight of the conference will be the presentation of awards in *BI's* 11th annual Employee Benefits Communications competition, which honors companies that implement innovative and successful employee benefits communications programs.

Early registration at the conference site, The Knickerbocker Hotel, will be from 6 p.m. to 7 p.m. Monday, Oct. 31. Registration will resume at 8:15 a.m. Nov. 1, and the conference officially opens at 9.

The cost of the conference is $495, with a 10% discount for additional participants from the same company. The fee includes all sessions, educational materials, a workbook, breakfast, coffee breaks and two lunches. It also includes a cocktail reception and the awards dinner for the Employee Benefits Communications competition.

Special discount airfares are available through Travel Headquarters Ltd. in Chicago at 800-621-1676; in Illinois, call 312-641-3088.

To register for the conference or to obtain additional information, contact the *Business Insurance* Communication Services Department, 220 E. 42nd St., New York, N.Y. 10017; or call Ann Vazquez at 212-210-0137 or Beth Levine at 212-210-0229.

Travelers will pay in dioxin case

By STEVE TARAVELLA

ST. LOUIS—Travelers Insurance Co. of Hartford, Conn., is among the insurers that will pay out more than $2.5 million in the first substantial settlement reached in litigation over the toxic substance dioxin.

Independent Petrochemical Corp., a unit of The Charter Co., will pay four victims of dioxin exposure a total of $2.68 million, according to the settlement.

Independent is fully insured for the settlement, says Thomas J. Terbrueggen, Charter's risk manager. He says the company's primary liability layer, underwritten by Travelers, is not substantial enough to cover the settlement and that at least two of "a number of excess carriers" will be tapped.

However, he would not reveal the names of the excess insurers or the policy limits. The deductible, he says, will be determined only when it has been decided what policy year will apply to the case.

Travelers refused comment on the settlement and would neither confirm nor deny any liability.

The settlement, finalized Sept. 27, represents only compensatory damages, notes plaintiffs' attorney Jerome J. Schlichter of the firm of Carr, Korein, Kunin, Schlichter & Brennan in East St. Louis, Ill. As part of the settlement, punitive damages were dismissed.

Independent is the St. Louis-based chemical distributor that was hired by Northeastern Pharmaceutical & Chemical Co. in the early 1970s to dispose of dioxin, an unwanted byproduct of an industrial cleaner NEPACCO manufactured.

The suits allege that Independent then hired Russell M. Bliss, a Missouri waste-oil hauler, who mixed the highly toxic chemical with waste oil and sprayed it at two Missouri horse stables in 1971 to control dust.

NEPACCO, the manufacturer of the dioxin, was not the primary defendant in the case, explains Independent's attorney F. William McCalpin, because it is no longer an operating company.

Under the terms of the settlement, Andrea and Lori Piatt of Wright City, Mo., now 18 and 23 respectively, will receive $1 million each. In addition, Patricia Drinkard of New Bloomfield, Mo., will receive $600,000 and her husband, Paul Drinkard, will receive $80,000.

The four plaintiffs had originally asked for a total of $3 million in compensatory damages and $10 million in punitive damages.

The plaintiffs all had regular contact with the stables that were sprayed with the dioxin mixture and claim to have suffered serious and recurring health problems.

As children at the time of the spraying, the Piatt sisters played and rode horses at Shenandoah Stables, near Moscow Mills, Mo., of which their mother was part owner. Mr. and Mrs. Drinkard managed Timberline Stables, near New Bloomfield.

These cases differ from other dioxin suits because of the high level of dioxin involved.

The dioxin measured 33,000 parts per billion, Mr. Schlichter explains, or about 110 times greater than the amount found in Times Beach, Mo., where exposure to dioxin became so hazardous that the federal government purchased all private property.

Because of such a high dioxin content at the stables, plaintiffs began to suffer noticeable effects from their exposure to the chemical "within a matter of days," Mr. Schlichter says.

Since that time, the Piatt sisters have complained of joint pains, fatigue, recurrent headaches and nosebleeds, as well as nervous and emotional problems. One suffers from a kidney infection and the other has developed lumps on her breasts.

Ms. Drinkard has suffered from progressive, crippling arthritis since Timberline was sprayed and has become a near-invalid. Her husband, who also suffers from arthritis, sued for loss of his wife's companionship.

"All these people were very physically active people and were around horses a lot," says Mr. Schlichter. "None of them do any of that any more."

Exposure to dioxin is believed to seriously affect the major body functions as well as the muscular and skeletal structure and the reproductive, immunity and urinary systems.

Dioxin is 150,000 times more toxic than cyanide, Mr. Schlichter notes.

Independent may sue NEPACCO and Mr. Bliss, co-defendants in the case, to recover part of the award, says Patrick J. Phillips, an attorney with Evans & Dixon who also represents Independent. He says the company will have decided on any further legal action within 30 to 60 days.

This case will be rescheduled for trial after Jan. 1, Mr. Phillips says, to resolve cross-claims that were pending between the co-defendants at the time of settlement. "All three co-defendants had cross-claims against one another," he says.

About 600 other dioxin lawsuits are pending nationwide, mostly concentrated in Missouri and Illinois. ■

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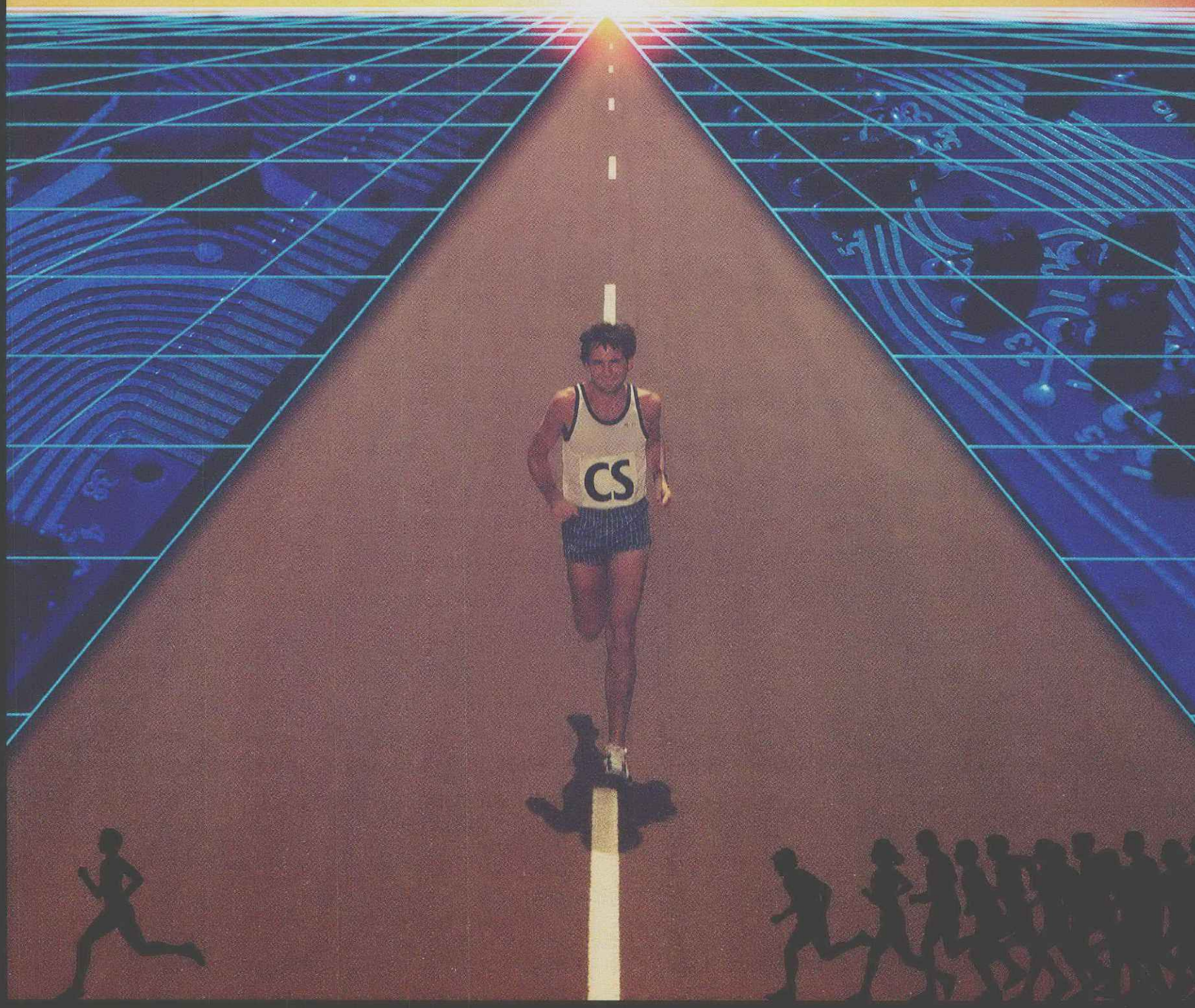

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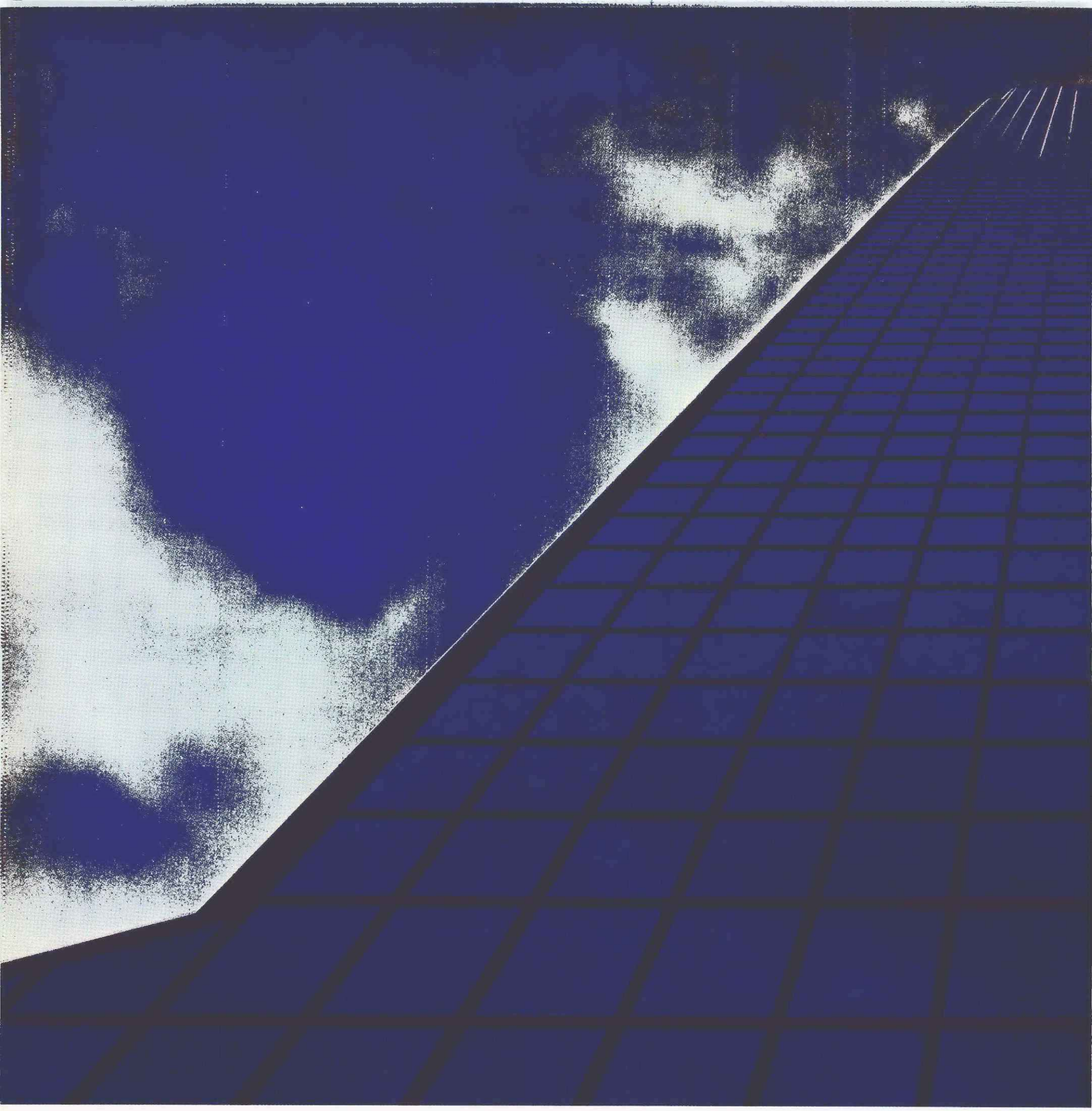

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Insurers, banks could form alliances

Continued from page 3

they're being hurt right now. Rather than starting their own insurance operations from scratch, banks are more likely to form "strategic alliances" with insurance companies, said Robert M. Raziano, a partner with the accounting firm of Coopers & Lybrand. Insurers would thus improve their distribution systems while banks would gain an additional source of profit, he said.

Joseph E. Luecke, chairman and chief executive officer of Chicago-based Kemper Group, agreed that mergers and joint ventures between banks and insurers are probably in the cards.

"We're in for a period of fairly rapid change for a long period of time," he observed.

Mr. Spanholz offered that Chemical Bank had already been approached by insurance companies about forming such alliances. "It's not a one-way street," he said.

As sectors of the financial services industry converge, companies will have five options, according to Mr. Wyman of Booz-Allen. These include:

- Operating nationally and offering a broad line of financial services.
- Specializing in a particular product.
- Specializing in a particular market segment.
- Operating as a "low-cost producer," offering a basic, mass-marketed product at minimal cost.
- Ceasing to exist as an independent company by being absorbed into another conglomerate.

Mr. Wyman noted that he doesn't expect a proliferation of financial services "super companies," and Mr. Spanholz agreed. Even Chemical Bank's $2 billion in assets is small compared with the $7 billion held by American Express Co., and American Express still is not large enough to squeeze out smaller competitors, he suggested.

"No one has the concentration of assets to do everything," he explained.

While Mr. Spanholz and Mr. Wyman said that deregulation of financial services will eventually produce a competitive market that will work to consumers' advantage, Mr. Rice said he favors a proposal in Congress to place a moratorium on further expansion of bank powers.

"A lot of people could be hurt unless a level playing field is established before banks go into these areas," he said.

One of insurers' big worries about competition from banks is that the banks will use their leverage as lenders to coerce sales of the banks' insurance products.

Not to fear such "tie-in" sales would "assume an inefficient marketplace" and would be unrealistic, Mr. Spanholz conceded.

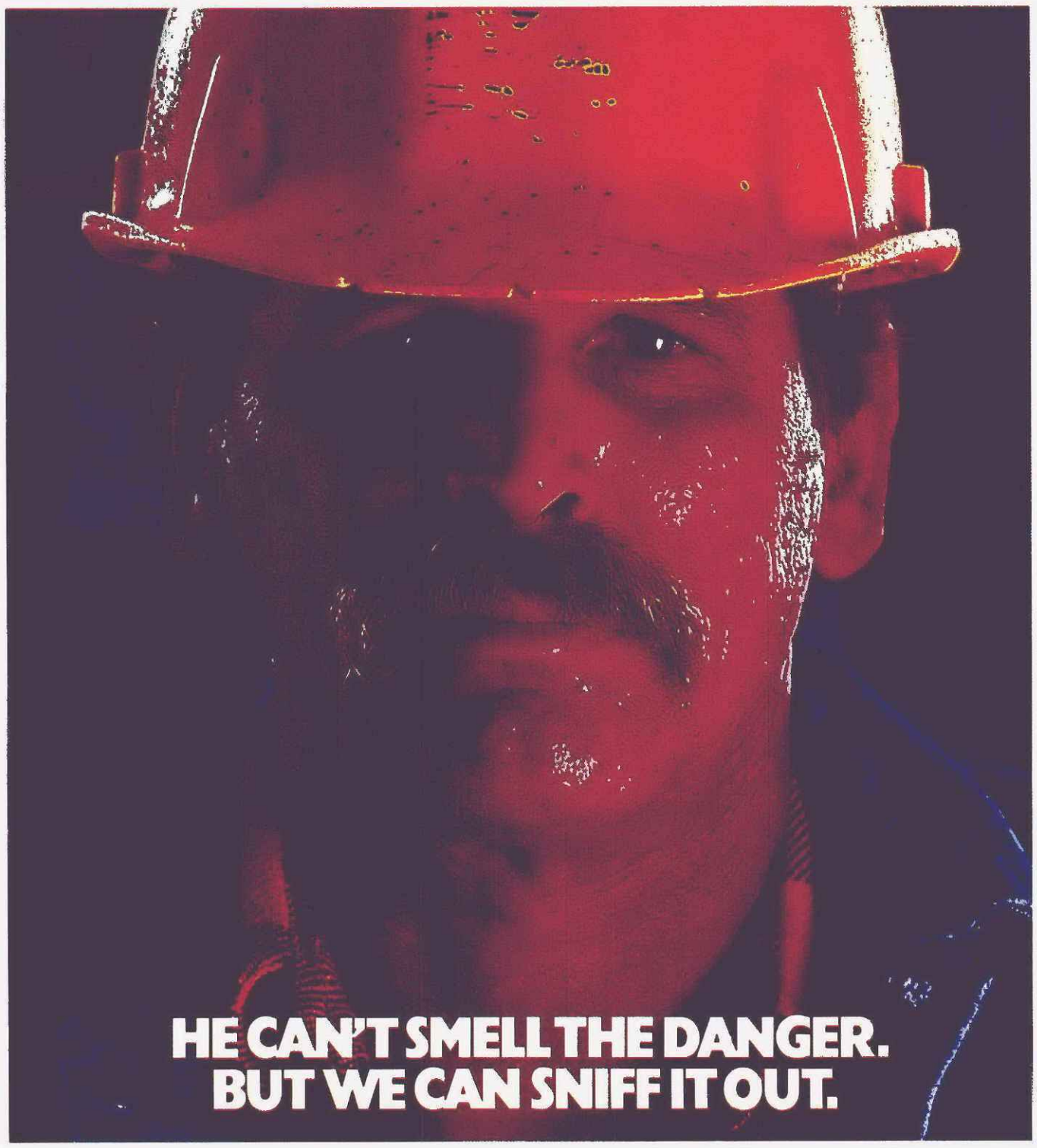
But the greatest danger of tie-in sales would be in small and medium-sized cities in the smaller states, Mr. Raziano said.

A recent study showed that in the most densely populated states, the handful of top banks command only a 15% share of the total market for bank services, while in the smaller states, the top banks control an average 50% of the market, he said.

In the largest metropolitan areas, the largest banks hold the same 50% of the market, while in smaller cities, the top banks may control as much an 80% share, he said. The concentration of assets in these latter banks may create the biggest danger of tie-in sales, he noted.

However, Mr. Wyman replied that concentrating on the possibility of tie-in sales ignores the increased consumer sophistication that has been sparked by inflation, high interest rates and the offering of innovative new financial services products.

With consumers unbundling their financial services, the "opportunity for tie-in sales is limited" unless a serious credit shortage occurs to narrow consumer choice, he said. ■



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Deregulation to challenge underwriters

WHITE SULPHUR SPRINGS, W.Va.—If insurers are going to survive financial services deregulation, they'll have to start thinking more about their consumers and less about regulators, one deregulation expert says.

As the insurance, banking and securities industries are freed from the safe haven of federal oversight, they will have to change ingrained habits of thought, shifting their attention to what is best for the buyer and, therefore, most profitable for them.

The expert, Richard J. Ferris, claims to know a thing or two about coping in a deregulated arena: He is chairman, president and chief executive officer of UAL Inc., the parent company of United Airlines.

Although United had supported airline deregulation, it had trouble handling the problems that arose when deregulation arrived during the Carter administration, Mr. Ferris told the 1983 conference of the National Assn. of Casualty & Surety Executives and the National Assn. of Casualty & Surety Agents.

"We thought we were prepared for a free market," he said. "We were, but not enough."

In its fight to stay profitable in the ferocious competition that has marked the deregulated airlines industry, United has learned some lessons that might be of use to insurers that may soon be facing similar pressures, Mr. Ferris said.

For one thing, insurers will have to unload the decades of "mental baggage" accumulated in a tightly regulated environment. This baggage consists mainly of outmoded ideas of what can and can't be offered in the way of products and services, he explained.

"Regulated thinking seeks to limit competition. But market thinking seeks product superiority and cost efficiency to rebuff competition," he said.

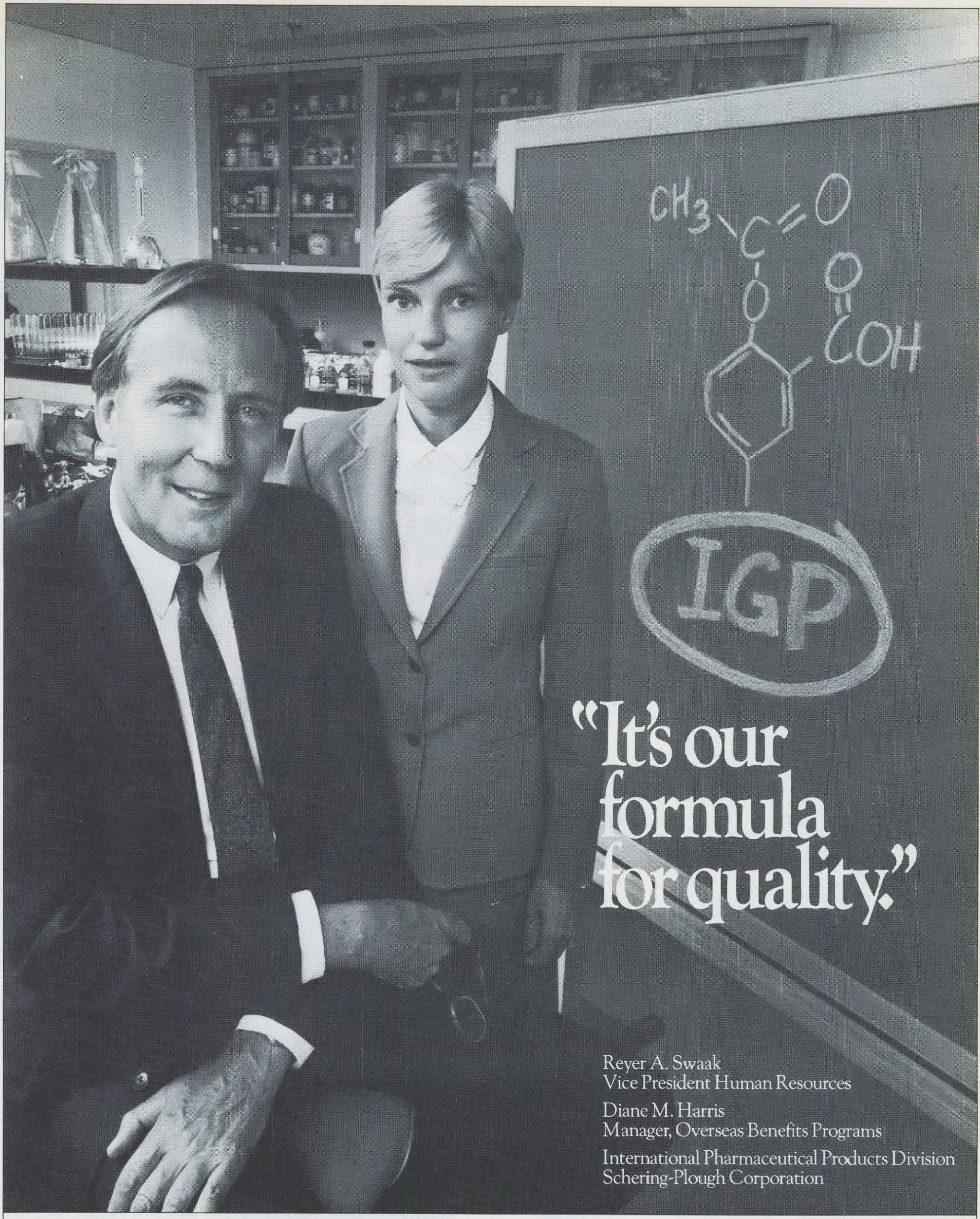
Insurance companies also will have to make each product or service support itself with its own profits, he added.

Rate regulation in the airline industry allowed "cross-subsidization" of some airline services: The profit from regulated areas was used to support less-profitable ones, he explained. Without the kind of price stability that regulation brings, each product and service has to justify its existence with profitability.

"Regulated thinking permits cross-subsidization. Market thinking dictates that (companies) must be cost-conscious," he said.

Maintaining products and ser-

Continued on page 14



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Insurers see steady rates during 1984

Continued from page 3
this year, he said. The average combined ratio on commercial auto climbed from 112% in 1981 to 119% last year, and will likely top 120% this year, he added. For all commercial lines, the average combined ratio will probably top 115%, Mr. Thomas said.

The situation is made worse by the fact that capacity is still plentiful, he suggested.

"Entry into the business is easy. All you need is a little money and a fountain pen."

The possibility that banks may be among those entering the business as financial services are deregulated could make for more insurer woes (see story, page 3).

"The dangers of financial instability vs. the advantages of competition are unsettling," he said.

Still, a few harbingers of tighter underwriting are on the horizon, Mr. Thomas noted. Some insurers are making "spotty" corrections in lines that have been especially unprofitable, he said. Further rate increases may also come with the shrinkage of investment income (excluding capital gains), and as suspicions grow about the quality of reinsurers' loss reserves, he added.

The cycle could be turning, but "perhaps too slowly to suit many of us," he concluded.

Jack Moseley, chairman and chief executive officer of United States Fidelity & Guaranty Co., agreed that competitive rating practices will remain the rule for the near future.

"I don't think we'll see harder prices anytime soon," he said.

He expressed less hope than Mr. Thomas, though, of an orderly end to the current rate wars. What will it take to turn the underwriting cycle?

"A major insolvency would be a nice thing," Mr. Moseley replied.

Barring that, he said, a few "major catastrophes" might also turn things around, though they would have to pack more of a wallop than Hurricane Alicia, which produced an estimated $675.5 million in insured losses when it hit the Gulf Coast in August.

Mr. Moseley also worried, though, that such shocks might bring too much of a good thing. If underwriters raised rates too much in the wake of a catastrophe or a catastrophic reinsurer failure, policyholders might opt for self-insurance, as they did in the hard market of the mid-1970s.

"We've seen enough bad news and red ink" without that, he said.

Whichever way the underwriters go, at least one major broker is prepared for the worst.

Edwin Knetzger, president of New York-based Johnson & Higgins, said that J&H is operating on the assumption that rates will remain competitive. Since J&H derives a large part of its income from commissions, continued low rates mean a continued struggle for new business to make up declining revenues, and continued belt-tightening.

While none of this news seems likely to bring joy to the hearts of insurers or brokers, they still could enjoy themselves. Confining the bad news to regular meetings each morning, insurance executives were free in the afternoons and evenings to compete more profitably with one another on the golf courses, the tennis courts and the dance floor.

In golf, at least, low numbers are a good thing. ■

Insurers told to prepare for deregulation

Continued from page 12
vices will be made all the more difficult by heightened competition. Although many property/casualty insurers may think they've reached a zenith of free-market competition, Mr. Ferris told them they haven't seen anything yet.

"If you think it's intensive now, just wait," he warned.

Because change is likely to be quick in a deregulated financial services industry, Mr. Ferris recommended that insurers decide now what their long-range goals are and how those goals will be met.

"If you don't know where you're going, the last thing you want is to get there in a hurry," he said.

United formed an issue management committee to establish long-range company policy, Mr. Ferris said. But even then, he added, the airline had to cope with the unexpected complications of rising oil prices, the air traffic controllers' strike, the national recession and extended price wars.

Insurers, likely to sympathize with the victims of price wars, were cautioned to expect the unexpected.

Mr. Ferris' other recommendations for coping with the financial strains of deregulation included:

- Breaking revenues and expenses down by product line or by geographical area to determine where the money is being made and where expenses can be reduced.
- Reducing expenses by automating wherever possible, by scaling back office and other facilities and by reducing staff. United has reduced its workforce by 13,000 employees since deregulation, and has enjoyed a 22% improvement in employee productivity, Mr. Ferris said.

He likened a company's unnecessary expenses to an onion whose layers can be peeled away one at a time. "The onion is bigger than we thought, and we're going to be peeling it for some time."

- Paying more attention to the needs of insurance buyers, since insurers will stay in business only by supplying what the market demands.

Another speaker at the meeting, Sen. Jake Garn, R-Utah, suggested that he would like to see financial services integration addressed in legislation soon.

Sen. Garn, chairman of the Senate Banking, Housing and Urban Affairs Committee, said he plans to combine about 15 bank deregulation proposals now pending in Congress into one package bill. He added that he hopes Congress will act on the package in 1984.

Sen. Garn also said that he's against a proposal in Congress that would place a moratorium on further bank deregulation. He said financial institutions should be able to offer whatever services they like as long as there is not a public policy reason for prohibiting them.

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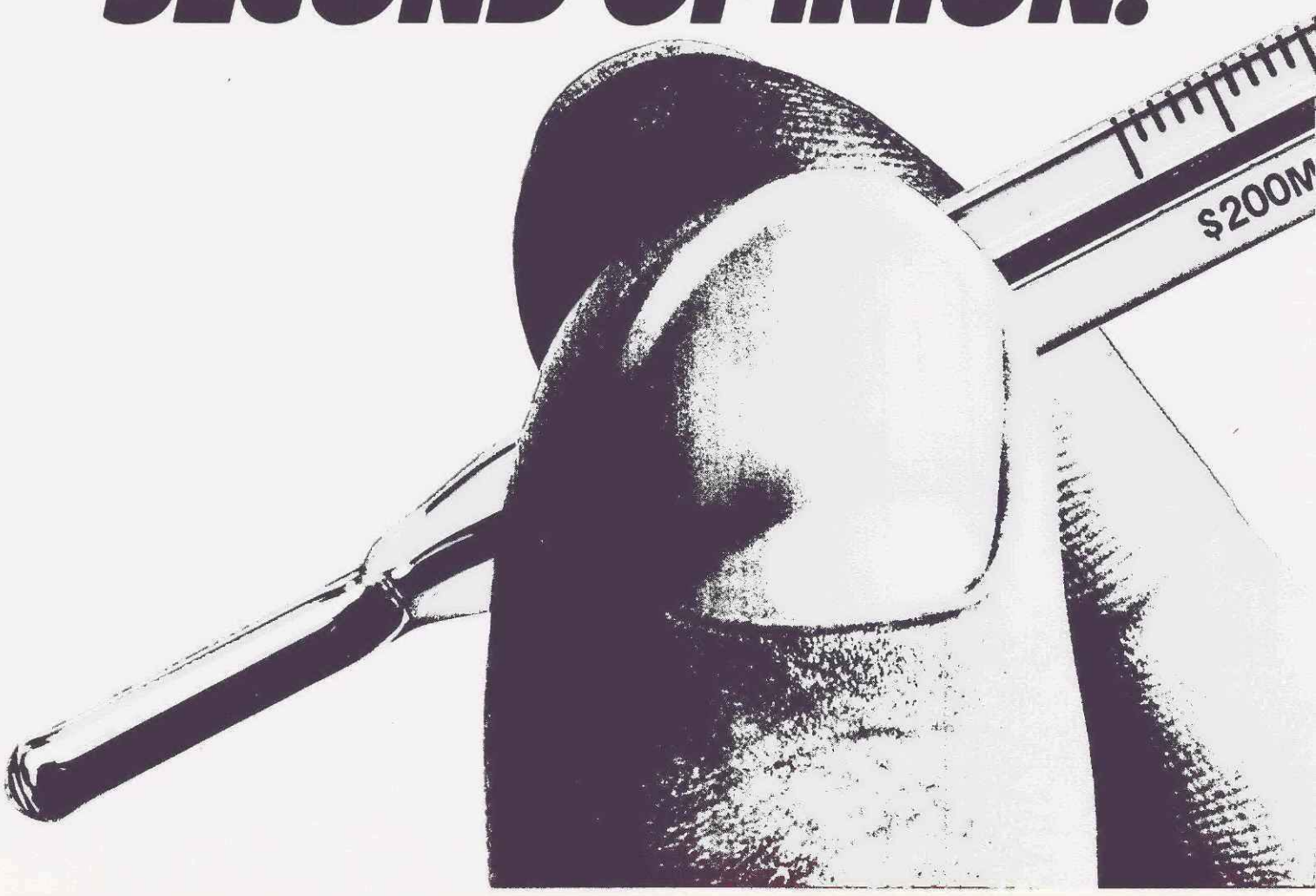


Reinsurer criticized for slow payments

By STACY SHAPIRO

london line

LONDON—The British and Argentines again are squaring off, but this time the conflict is over reinsurance payments, not the Falkland Islands.

The dispute centers on a letter sent by Lloyd's of London insurance brokers C.E. Heath & Co. (Insurance Broking) Ltd. to 300 insurer groups concerning the slow payment of claims by Rasareafianzadora y Reaseguaradora de America (RASA), a reinsurer incorporated in Panama but headquartered in Buenos Aires.

Ramon Pooley, the Heath joint deputy chairman who wrote the letter, says that RASA owes Heath clients millions of dollars in claims and is not paying quickly enough. In the letter, he asks ceding companies to band together and to demand prompt payment.

"We are concerned at the recent failure of RASA to settle accounts and have been conducting extensive negotiations with them for payment," Mr. Pooley explained.

"As a consequence, funds have been forthcoming, but in view of the large balances due and unsettled, we consider it desirable that all our principals should be fully informed of the situation and become more closely involved in negotiations for the continued handling of this account."

Colin Terry, the manager of RASA's London office, takes exception to the letter.

Although Mr. Terry agrees that RASA owes a large, unspecified sum to Heath's clients and admits that claims payments have been slow, "I do not think the letter was constructive and it was an unclever thing to do," he said, adding that RASA has paid $2.4 million in the past year.

Mr. Terry had several specific complaints about Heath's action, including:

- The letter was sent to all Heath clients that reinsure with RASA, not just to those that are owed money.
- RASA is still owed premium payments from some of the companies that say they haven't had claims paid.
- It asserts that RASA's slow claims payments result from animosity between Britain and Argentina.

"We are a Panamanian company with Argentine owners, so (the animosity) does not affect us," he said.

Mr. Terry says payments are slow in part because RASA's retrocessionaires are not paying claims to RASA.

"It is the same everywhere in the worldwide reinsurance market; money moves like glue," he commented.

Mr. Terry says the bulk of the unpaid claims were incurred during RASA's expansion into the worldwide reinsurance market in 1979-1980. At that time, RASA's premium volume grew to between $20 million and $25 million annually.

Now, the company has decided to stick to what it believes will be profitable, mainly writing surety bonds for Latin American risks. Accordingly, RASA's premium volume has been reduced to $8 million, he said.

Safety hazards

British companies probably will spend about 25 million pounds (about $37.8 million) to comply with the British Health and Safety Commission's expected regulations on major workplace hazards.

Last month, the commission published its draft regulations to control major industrial accidents. The rules are designed to follow a similar European Economic Community directive.

"The purpose of the proposed regulations is to reduce the likelihood and potential severity of major industrial accidents, whose costs must be enormous," the commission said.

The commission mentions that chemical explosions in Britain and Italy have cost companies between 44 million pounds ($66.4 million) and 50 million pounds ($75.5 million) to clean up, adding that preventive measures will cost far less.

Next year, manufacturers of certain dangerous explosives and flammable or toxic substances will have to file a report with the commission identifying their hazards, according to the proposals. Companies also will have to report the measures that have beeen taken to prevent accidents and the emergency plans that will be followed if accidents do occur.

Aviation losses

Commercial aircraft losses in 1983 are climbing ever higher.

During the month of September, three large commercial airliners were lost with hull claims totaling about $25 million, sources in the London aviation insurance market estimate.

On Sept. 14, a Chinese Trident passenger airliner collided with a jetfighter on the runway at the airport in Guilin, China, killing 11 passengers and crew and injuring 20.

On Sept. 23, a Gulf Air Boeing 737 jetliner crashed in the desert on its way to Abu Dhabi, killing all 105 passengers and six crewmembers aboard.

And on Sept. 25, R&N Cargo Services, a Nigerian cargo company, lost a Boeing 707 jetliner when it caugh on fire, although no one was killed in the accident.

Although they estimate hull losses at $25 million, the aviation insurers have not yet determined the liability costs from any of the accidents.

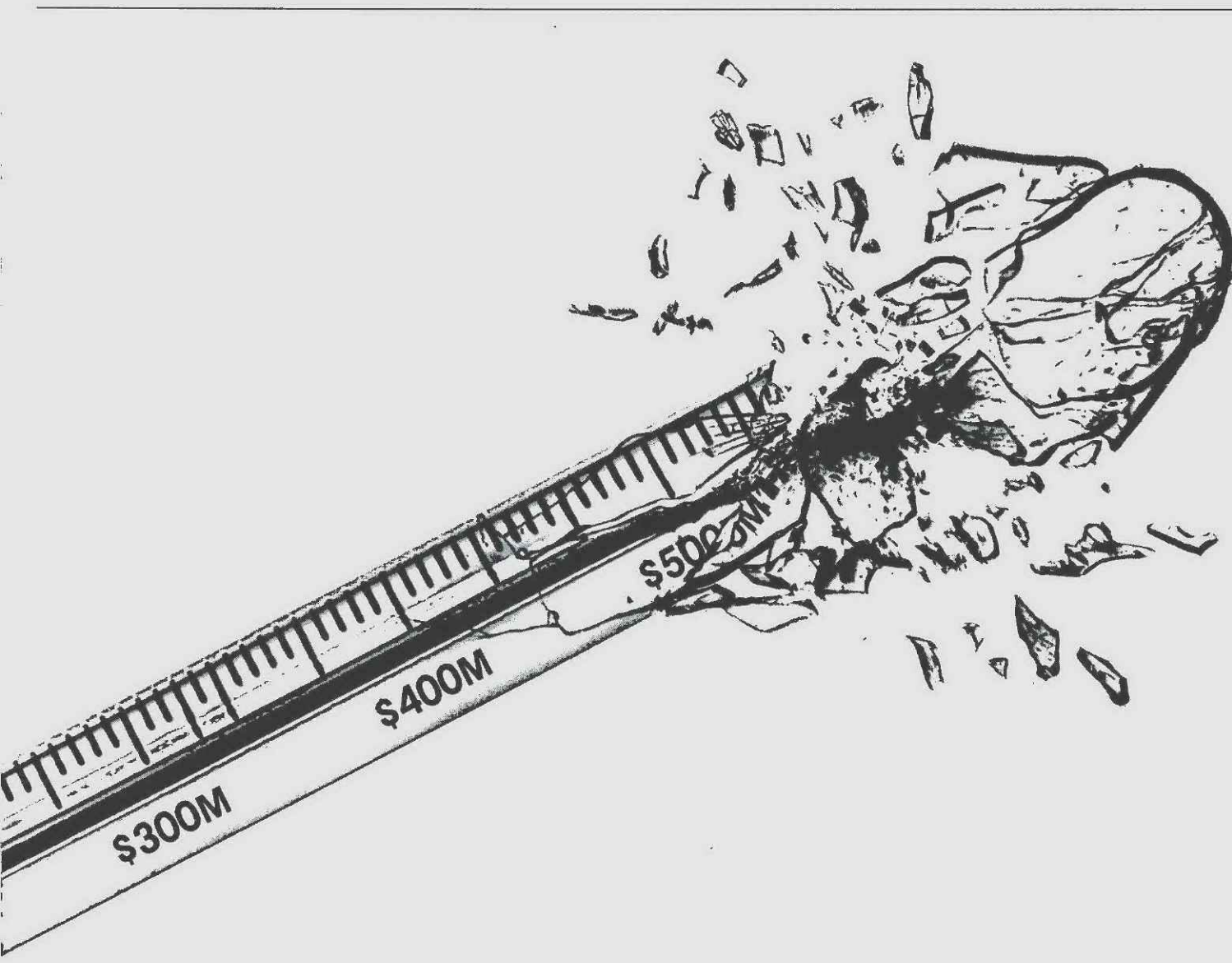
Lloyd's suspension

The Council of Lloyd's has suspended underwriters Raymond Brooks and Terrence Dooley for six months.

Earlier in the year, the Lloyd's Council decided not to impose a suspension on the two Lloyd's underwriters while a special committee looked into the underwriters' relationships with one of their syndicates, reinsurers Fidentia Marine Insurance Co. in Bermuda (*BI*, April 4).

"But the inspectors' report has brought further material information, which has changed the Council's view," said Lloyd's Chief Executive Ian Hay Davison, though he would not reveal what the information was.

Neither Mr. Brooks nor Mr. Dooley would comment on the suspension. ■



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SIIA conference

New self-insurance rules not far away: Woodyard

By STEVE TARAVELLA

SAN DIEGO—Self-insurers have been too successful at attracting business from the traditional insurance market to remain unregulated for very long, a former insurance regulator says.

Self-insurers, including employers and third-party administrators, should accept the fact that regulation is not far away and begin to lobby regulators and legislators for regulations that will be sound and fair, says William H.L. Woodyard III, a former Arkansas insurance commissioner.

Mr. Woodyard, who now practices corporate and insurance-related law with the firm of Mitchell, Williams, Selig, Jackson & Tucker in Little Rock, Ark., offered his advice at the third annual educational conference of the Self-Insurance Institute of America.

"The forces that are going to try to impose additional regulations, regardless of the motivations, are in motion. They are unstoppable," said Mr. Woodyard, who also is a past president of the National Assn. of Insurance Commissioners.

"The only question that you (face) is, Are you going to sit back and observe these changes, or are you going to be a participant in structuring a rational regulatory plan?

"Government abhors a vacuum," he said. "(The self-insurance community) is a regulatory vacuum, and some government agency somewhere is going to move in and fill it. It's in your best interest to help educate the people who'll be making those decisions, and help mold the regulatory framework."

Educating regulators about self-insurance practices, he stressed, is key to sound legislation. "If people don't understand something, they tend to move in more heavy-handedly than they would if they understood it to begin with.

"One of the common failings of the traditional insurance industry is that the industry talks to itself and not to others; you don't want to fall into that trap. You have to make your case known and explain (to regulators) the legitimate self-insurance interests," he advised.

Self-insurers should target their efforts at the state level, Mr. Woodyard said. "The (U.S.) Department of Labor does not want to regulate this stuff."

But if the states do not address the issues properly, "You will see efforts in Congress to assume a more vital role in this, for the very simple reason that there's too much money in this. A cursory review of some of the activities going on in the states will certainly support the premise that those are the people to watch," he said.

Mr. Woodyard noted that the NAIC is currently considering a controversial model bill that would regulate workers compensation self-insurance pools. "That report genuinely calls for increased scrutiny of self-insurance in the workers compensation market," he noted.

The model bill, which has been criticized by self-insurers for allegedly favoring insurance companies (*BI*, Sept. 5, Oct. 10), is expected to be put to a vote at the NAIC's December meeting.

Mr. Woodyard encouraged self-insurers not to wait until the NAIC model legislation or another bill is pending in state legislatures before they start their lobbying activities.

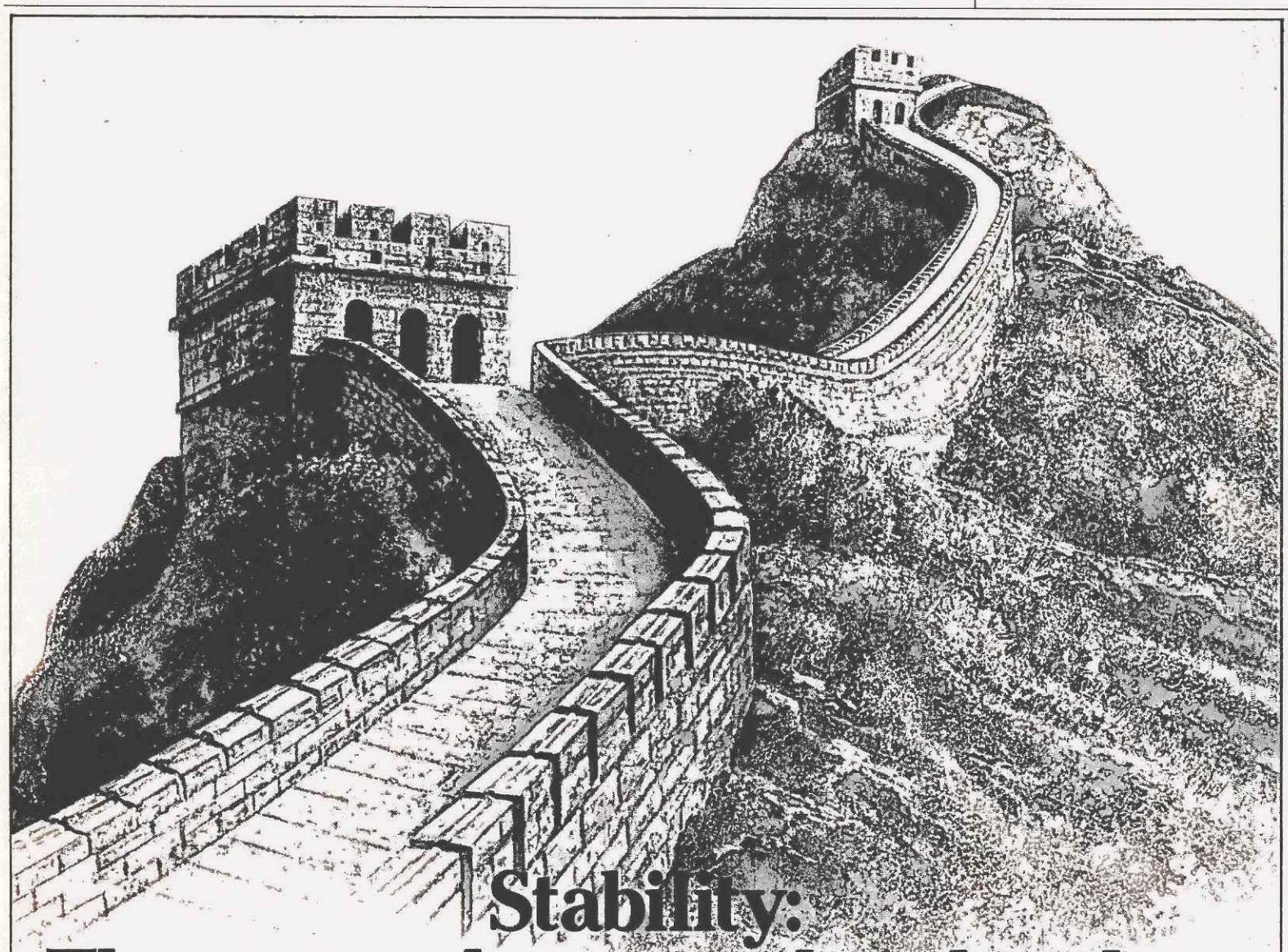
"That's a little bit late to start educating people," he said. "You need to be involved at the very beginning, from both an educational and a political point of view."

Mr. Woodyard said he expects legislation proposed both by the NAIC and the individual states to clearly define the roles and activities of all parties involved in self-insurance, including employers and administrators.

"Defining whether (a risk) is insured or self-insured may not be all that important to those of us in the private sector. We all understand that it's just a method of distributing dollars (and using) combinations of administrators, reinsurers and stop-loss coverages.

"But in the regulatory world, it's critically important. Labels are ex-

Continued on page 18



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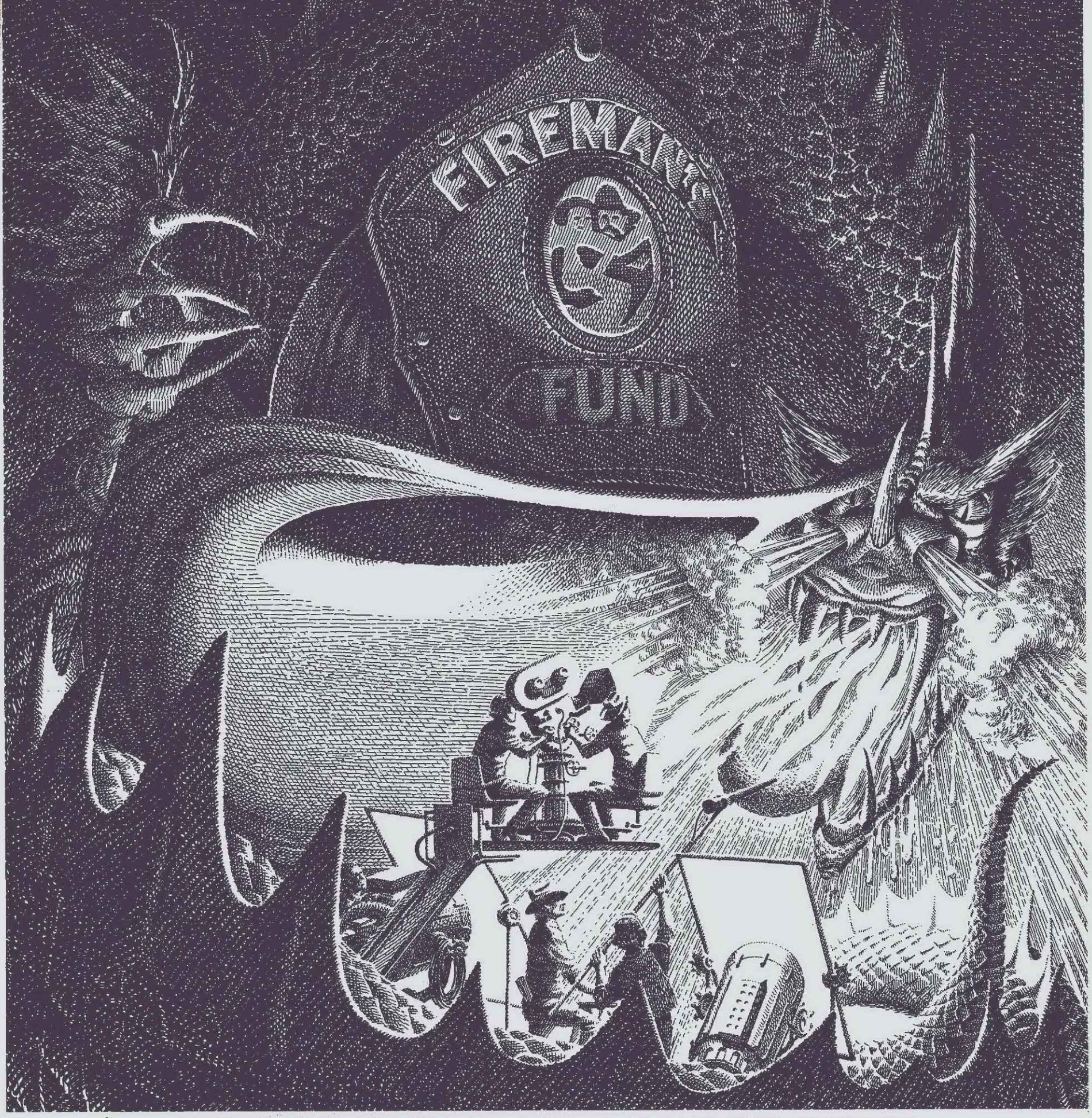

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Self-insurers told to work with regulators, legislators

Continued from page 16

tremely important in deciding who's going to be regulated. It's the nature of legislation and regulation to want to define and pigeonhole everybody," he said.

He also pointed out that the once-clear distinction is blurring between commercial insurers, which are significantly regulated, and self-insurers.

"If you look at it from that perspective, it's in your best interest to help the people that will be making these decisions. . .to really understand the marketplace," he said.

Self-insurance is only now being noticed by state regulators because of the success self-insurers have enjoyed, he said.

"You've been too successful," he told the self-insurers and third-party administrators. "You've done a good job, and in doing a good job, you have taken dollars away from the traditional, regulated insurance market. Therefore, you are no longer invisible.

"A business which has attracted millions of dollars from a previously somewhat-sedentary, heavily regulated industry is certainly going to attract the attention of the regulators," he explained.

The commercial insurance market is now greatly concerned about inequities in the regulation and tax treatment of self-insurers, he noted, which also is increasing the pressure on insurance departments to increase regulation.

Commercial insurers, he said, currently believe that self-insurers have a competitive edge because of the lack of regulation. "Rightly or wrongly, I think that's true. The self-insurance arena now has a competitive advantage, and one of the reasons it has that advantage is because it's relatively unregulated," he observed.

"The competitors in the traditional insurance market are concerned about collapses in self-insurance that will reflect on the entire risk-sharing community. They're also concerned about your getting their business, so you're going to see an increased attempt to level that playing field."

But the insurance departments and state legislatures now considering regulation have not been pressured only by the competition-conscious insurers. Many regulators are studying new self-insurance rules out of a sincere, legitimate concern for the public interest, Mr. Woodyard noted.

He said that problems encountered by regulated insurers, like the insurance subsidiaries of Baldwin-United Corp., are increasing regulators' concerns about self-insurers.

Also, he said, regulators have noted that several self-funded multiple employer trusts have gone broke, leaving employees without health insurance coverage.

Florida, for example, recently passed a statute that prohibits the existence of any multiple employer trust not formed by employers who have any relationship other than that provided by the formation of the MET.

Mr. Woodyard said that many not well-acquainted with self-insurance believe "that it's simply a matter of time before there's a very major financial crisis in self-insurance, whether it be a very sophisticated corporation or a group," Mr. Woodyard said.

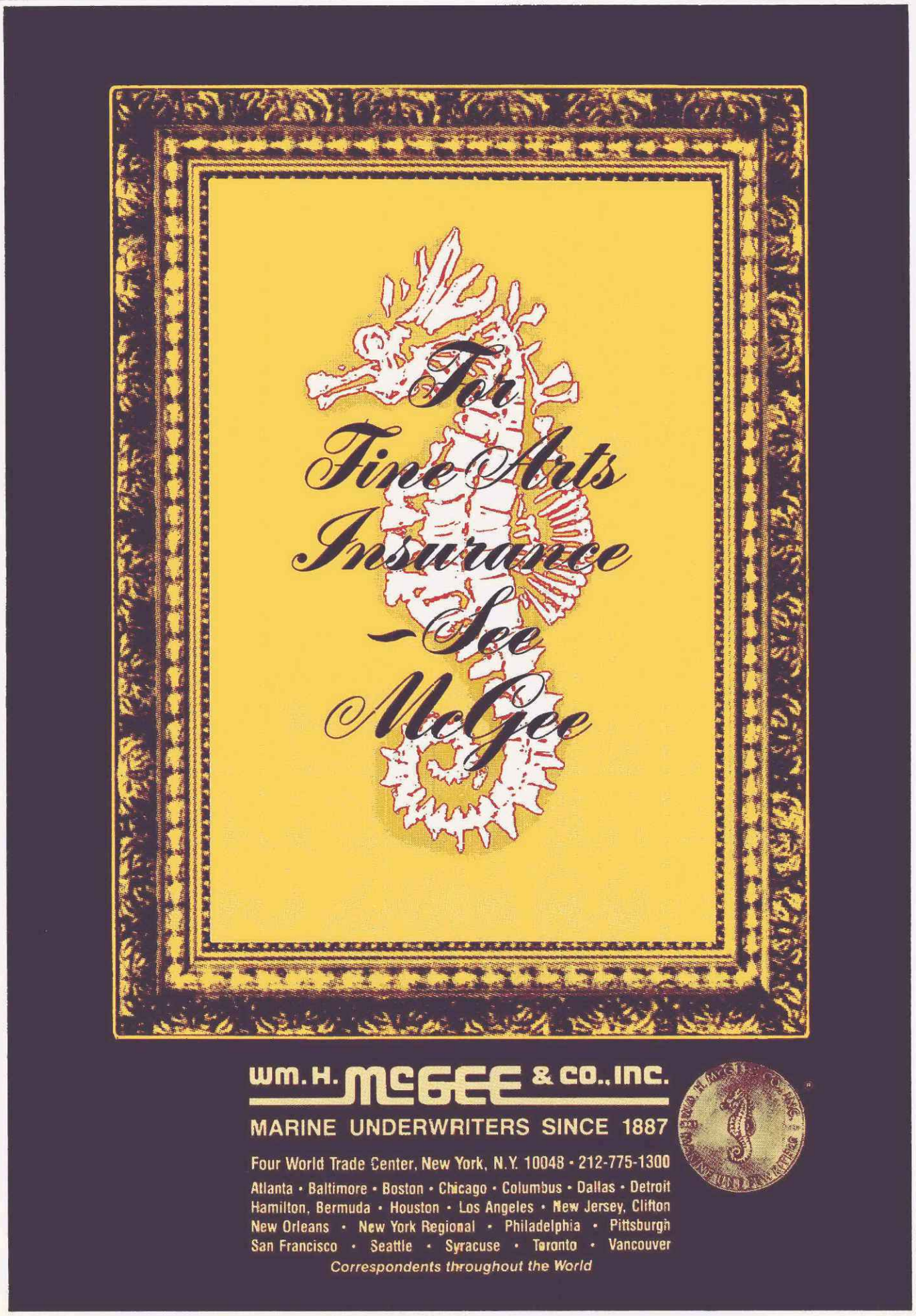
"Everybody is sitting back, waiting for a crisis, and then will come the overreaction. Most of the bad laws in the regulatory arena are drafted and fostered as an overreaction to the crisis because they weren't prepared in advance," he noted.

Contacting regulators now can help avoid any rash legislation that may arise from a financial disaster in self-insurance in the future, he explained.

Mr. Woodyard offered encouragement to self-insurers and TPAs that are hesitant to work with regulators.

"It's not uncommon for a group of self-insurers, just as the mass-marketers did several years ago, to want to remain invisible," he reassured them. "No one wants to raise their hand and say, 'Here I am. Come look at me and see if you want to regulate me.'

"Trying to understand what is going on in the marketplace is not the same as trying to curtail the activities. It's very important for the decision makers to understand the business of self-insurance." ■



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Hidden costs add to comp expense: Consultant

By STEVE TARAVELLA

SAN DIEGO—Indirect and hidden expenses often add 5% to 10% to the cost of workers compensation claims, a loss-control expert says.

Companies that want to reduce their overall work comp costs must take note of these ancillary costs, says Tom E. Prendeville, president of TEP & Associates, a loss-control consulting firm in Arcadia, Calif.

Lost production is probably the largest hidden expense accompanying workers compensation claims, Mr. Prendeville told the Self-Insurance Institute of America's third annual educational conference.

An employee who is injured and off the job is not contributing to the company's production, Mr. Prendeville noted.

Productivity is also lost when employees stop working after an accident to assist their injured coworker, express sympathy or simply to gawk.

Often, an employer won't even know how much lost production hurt the company. The cost of lost production time "doesn't show up anywhere on a book or ledger."

Besides the lost production time, the employer frequently must pay to train someone to fill the shoes of the recuperating employee, he added. In addition, there's the cost of the paperwork needed to arrange for a substitute, plus any other expenses the company incurs when it hires a new employee.

Sometimes, Mr. Prendeville says, an employee who returns to work is not able resume former responsibilities fully and must be put in a limited work program. However, the worker is still paid full salary, even though not accomplishing the same amount of work as before the injury.

Investigating the cause of the accident is also costly and time-consuming, Mr. Prendeville says, as is attending lengthy workers compensation board hearings.

The best solution to avoid unnecessary expenses related to employee injuries is to "know what to do when it happens," he advises.

For instance, having an investigative procedure worked out in advance can cut down on paperwork, claims reporting and legal services costs, he says.

The original workplace injury also can lead to other work comp claims, Mr. Prendeville noted. Additional injuries may occur in a wave of excitement or emotion following the original accident since employees in an excited or frenzied state are more likely to be careless in their job performance.

"You can appreciate that if it happened once, it's going to happen again—and probably in threes," Mr. Prendeville warns.

The experience of a Pennsylvania hardware manufacturer illustrates the possibility of subsequent accidents. "I went six months without an accident, then I had three within one week," said Frank J. Coppola, director of personnel at Saegertown Manufacturing Corp. in Saegertown, Pa.

Employers can control the frequency and severity of on-the-job accidents only to the degree that they understand their causes, Mr. Prendeville explained.

About 15% of all work-related accidents are caused by unsafe conditions, while about 85% are caused by the unsafe actions of an employee, Mr. Prendeville estimated.

Both situations can be controlled, he noted.

Supervisors faced with unsafe work conditions have three basic choices to reduce the chance of an employee injury, he said:

- Repair the situation.
- Report the situation to a higher authority to have it repaired.
- Make employees aware of the unsafe condition. For instance, a recently mopped hallway should be noted with a "wet floor" sign.

Employees' unsafe acts are generally caused by a lack of knowledge or skill, a personal fault or an improper attitude, he said.

Training is the best way to prevent injuries due to lack of an employee's knowledge or skill. For example, it's cost-effective to instruct employees on proper lifting techniques to avoid costly back injuries, he said.

Controlling accidents caused by an employee's poor attitude is a bit trickier, he admits, but can be done. Discipline is necessary for attitude adjustment, he noted but it is more effective if delivered in a positive form, such as mixing it with a compliment, than to threaten penalties.

Personal faults that can lead to accidents range from those faults that are easily detectible, like obesity or poor eyesight, to those that are often hidden, like alcoholism.

These hidden problems also include mental and emotional problems, which can be either temporary or permanent, he explained.

Employees with a temporary emotional problem—such as someone adjusting to a recent divorce or to a death in the family—threaten the safety of the work environment because they cannot concentrate on working carefully, Mr. Prendeville says.

He suggests that employees with a temporary emotional problem be temporarily removed from potentially hazardous working situations.

"The cost of sending someone home for a few days is going to be a lot cheaper than an accident," he said. "But for some reason, I have more problems with supervisors over this than with anything else."

If the nature of the job prohibits letting an employee go home for a few days, he recommends shifting the worker to less hazardous duties. "Have the guy hold the ladder instead of climbing it." ■

Self-insurers discuss wide array of topics

SAN DIEGO—They came from as far as Toronto and Miami, Spokane, Wash., and the Bahamas.

They included employers, third-party administrators, attorneys, bankers, underwriting managers and excess insurers.

And, they all journeyed to San Diego for the third annual educational conference of the Self-Insurance Institute of America, Sept. 28-Oct. 1.

The SIIA, a non-profit, educational organization serving the self-insurance community, has an international membership of 250 companies and growing.

The greatest concern discussed by the 275 registrants—in conference sessions during the day and over dinner and cocktails at night—was how to control soaring health care costs.

"If you can only spend $1 on health care, spend 99 cents of it on diagnosis and one cent on treatment, because if you have the wrong diagnosis, you're in trouble," suggested William E. Hembree, director of the Health Research Institute in Walnut Creek, Calif., during a session on health care costs.

Promoting good health among employees, such as encouraging them to quit smoking or otherwise improve their lifestyle, is one "ingredient that will bring health care costs under control," he told the self-insurers.

But health care cost control, a perennial subject, wasn't the only topic discussed by any means. Others included the role of preferred provider organizations, regulation of the self-insurance community, the specific and educational needs of self-insurers and the importance of clear communications of benefits to employees.

And the computer software industry also took center stage, as both employers and TPAs examined the latest automated equipment for self-funded claims handling.

During a conference session on effective benefits communication, employers were told that simple words, short sentences and clear graphics in benefit plan booklets will help employees realize "that their benefits are really worth something."

Richard Coffin, a vp with consultant Towers, Perrin, Forster & Crosby in San Francisco, told self-funded employers that clear communication is "absolutely essential" to the success of any benefit plan. He suggested that benefit managers devise a strong graphic to serve as a trademark for the plan that employees will immediately identify with benefits.

And, he advised, "Be even-handed—tell them the bad as well as the good."

In another session, employers learned more about the good and the bad of a recent benefits innovation: the preferred provider organization.

PPOs are here to stay, but probably not in their current form, explained Rick Tirell, president of Admar Corp., a third-party administrator in Santa Ana, Calif. He explained that health maintenance organizations gave rise to PPOs, and that PPOs will eventually pave the way for yet another, more sophisticated, health care system, though he could not predict what that newest innovation will be.

"It's a movement thing," he explained. "I sincerely believe PPOs are not as effective this year as they will be next year."

Others expressed concern about legislation and regulation of self-insurers (see story, page 16). As one third-party administrator from Texas put it, "That's life and death to us now."

For instance, one hot topic of conversation was a recently passed Florida statute that requires the bonding and licensing of TPAs that service self-insurance groups.

The administrators must furnish the state Insurance Department with information about their operations, including financial statements, and must post either a bond or a securities deposit, ranging from $50,000 to $500,000, depending on the amount of funds the administrator handles each year.

The statute was designed to protect claimants in case an administrator declares insolvency, an attorney for the Insurance Department recently explained.

"I have no major problem with the statute as written, but the question at this point is how it will be administered," said Lynn H. Jennings, president of Self-Funding Administrators Inc. in Maitland, Fla., and the SIIA's vp of membership services.

Some of those at the conference said regulation could be welcome.

"The right kind of regulation can really be good for the insurance industry. It could get rid of those people handling claims who really don't know what they're doing," said Hugh Ryan, vp of the Michigan Beer & Wine Wholesalers Assn., a non-profit trade association headquartered in Lansing.

Another issue that drew attention at the convention was a move to discourage use of the term "reinsurer" when referring to layers of coverage above a self-funded retention. Some suggest that it should be replaced with the more appropriate term "excess loss carrier" or "direct excess insurance carrier."

Real reinsurance, they point out, can only come into play on layers behind a primary layer of insurance, which theoretically does not exist in self-funded programs. Referring to excess insurers as reinsurers, they say, only causes confusion.

Participants also discussed the danger of employers referring to third-party administrators of bene-

Continued on page 22

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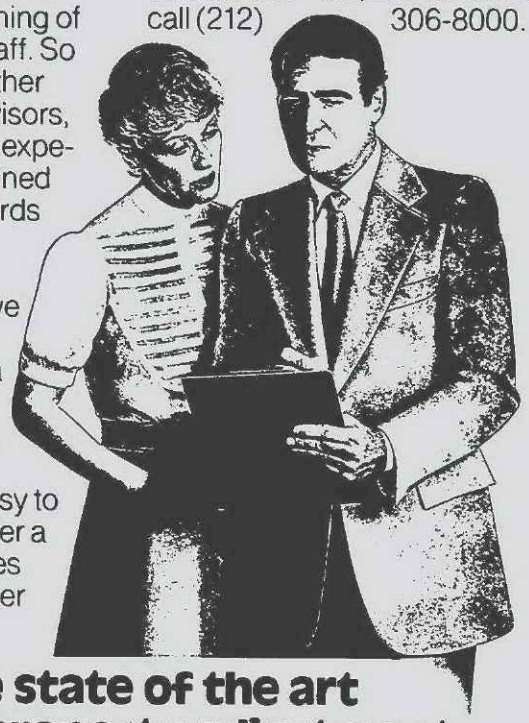

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Self-insurers, administrators air differences at conference

Continued from page 21
fit plans as insurers. Employees must understand that a TPA provides neither health coverage nor any of the company's benefits, administrators point out.

TPAs and self-insured companies also tried to clear the air about problems each has experienced with the other, and discussed ways to improve their business relationships.

One Virginia employer with about 500 employees, who did not want to be identified, said he abandoned use of his TPA about seven years ago "because the TPA didn't really look at claims like we would. It always seemed to take the side of the employee—just paid it without looking at the ramifications."

The company, which pays about $160,000 a year in health care claims, has saved about $25,000 by processing claims itself, he estimates.

"But we never would have left if we had a good TPA. The (SIIA) meeting opened our eyes to the efficiencies of a good TPA."

Conversely, one third-party administrator told employers attending one conference session that, "The more information you give us, the better (our services) are going to be."

The administrator explained that, for various unnecessary reasons, employers sometimes do not give certain files or claims information to their TPAs, which can slow claims handling and leave room for claims handling errors like duplicate payments.

The SIIA conference also provided one of those rare occasions in which employers received free counsel from attorneys.

Employers were advised to take the time to closely examine excess insurance contracts before signing them and to use contracts which specify the time within which the excess insurer must reimburse the employer.

"The best way to protect yourself, whether you're a TPA or an employer, is to put everything in writing," advised David S. Dunkle, an attorney with the Birmingham, Ala., firm of North, Haskell, Slaughter, Young & Lewis.

"By reducing all of these matters to writing on a consistent basis, I think we'll reduce the chances of misunderstanding," he told the self-insurers.

"A good history of communication between the TPA and the employer really sets the stage for (resolving) problems which occur in the future.

"And, the TPA should demonstrate to the employer that he is interested in (providing) tailor-made service," he added.

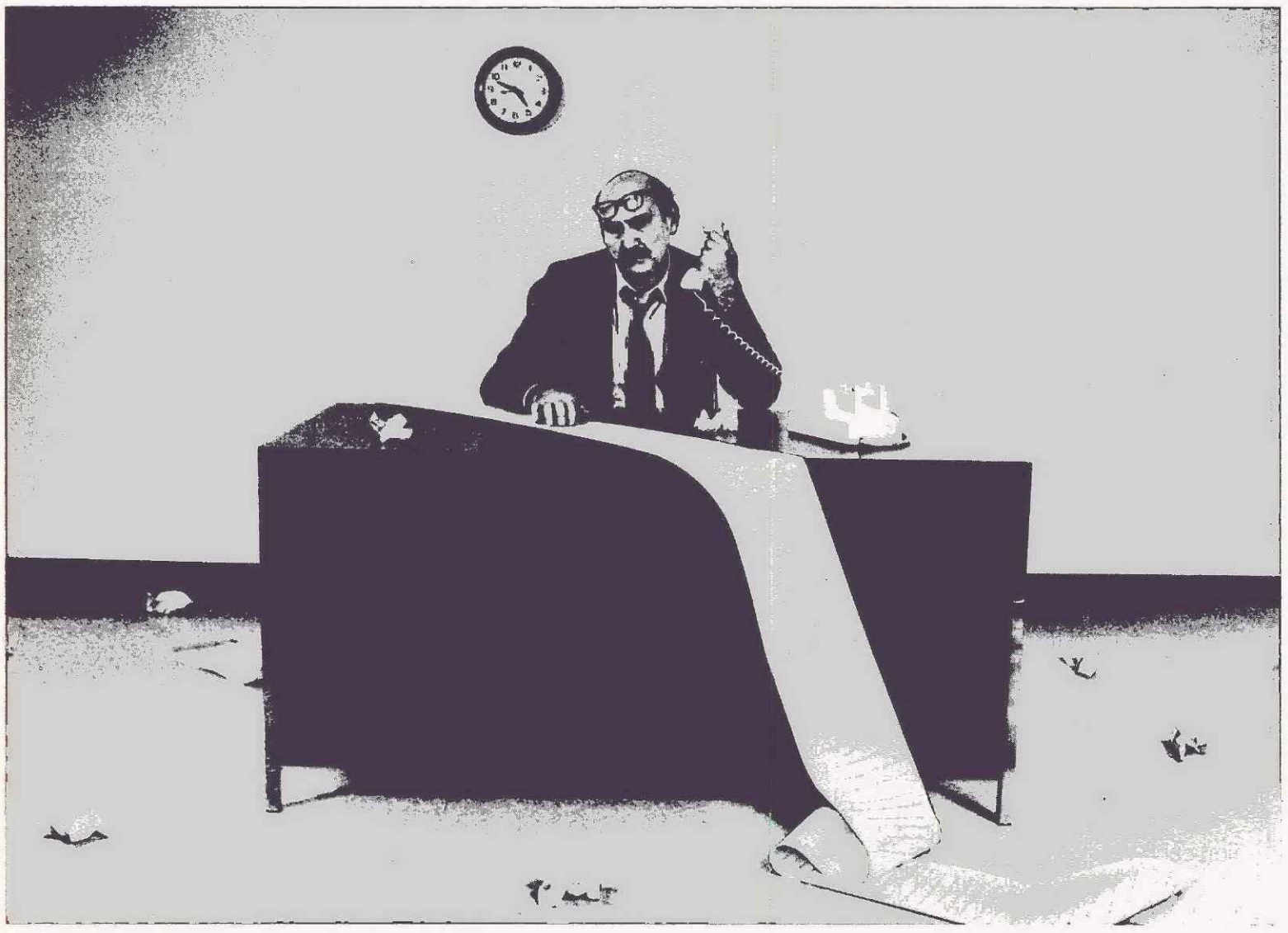
The service agreement between the TPA and the employer should spell out clearly details of the business relationship, he said, including:

- Who selects the excess insurer.
- Who chooses what members of the employee's family that are eligible for coverage in a self-insured health benefit program.
- When and how the service agreement may be terminated.
- What the consequences of termination would be.
- How long records should be kept.

Tax attorney Harvey A. Goldstein, with the Los Angeles firm of Singer, Leuak, Greenbaum & Goldstein, advised self-funded employers to keep abreast of any laws that may affect the taxation of flexible benefit plans.

Before, after and in between sessions, the self-insurers and TPAs attending the conference studied new hardware and software for health claims processing. In fact, all but two of the 13 companies exhibiting their wares at the conference were manufacturers of some type of automated claims-handling equipment.

"There is a very rapid movement toward automation in the TPA marketplace. Two years from now, a claims administrator that isn't automated will be out of the business," suggests John L. Krakauer, president of Benetics Corp., a Mountain View, Calif.,-based computer firm whose participation in the conference marked the debut of its claims-handling system, called Charlie. ■



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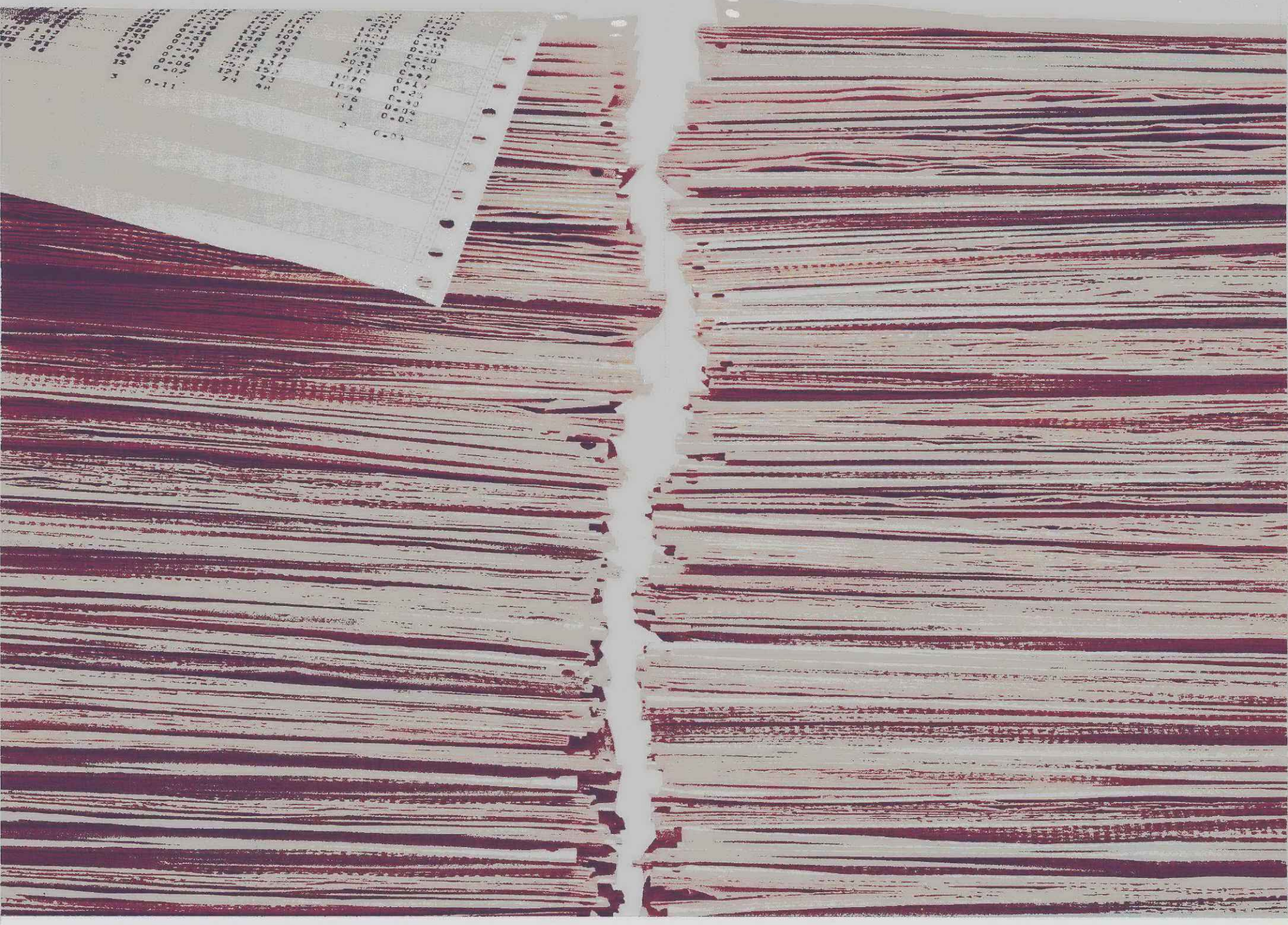

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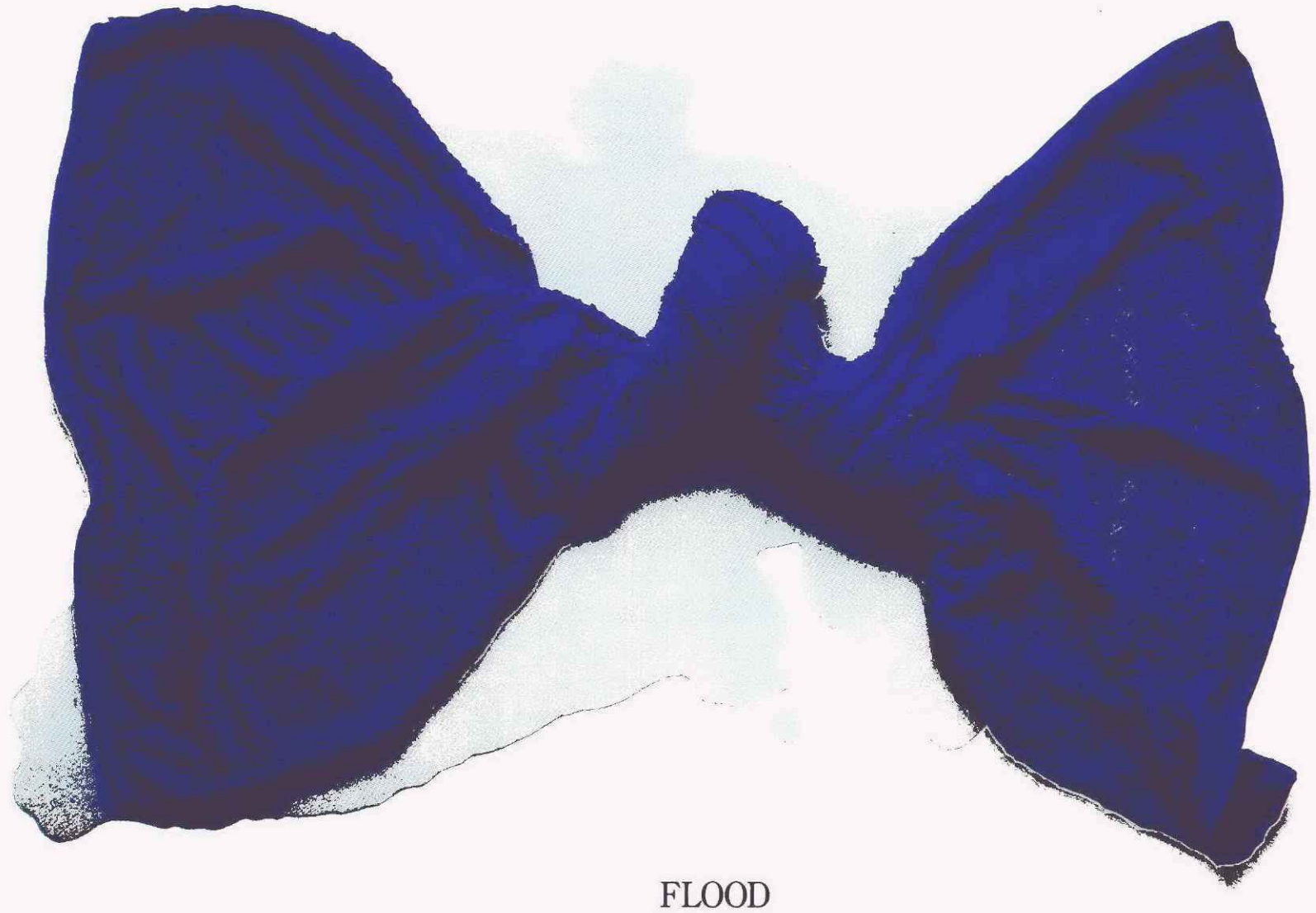

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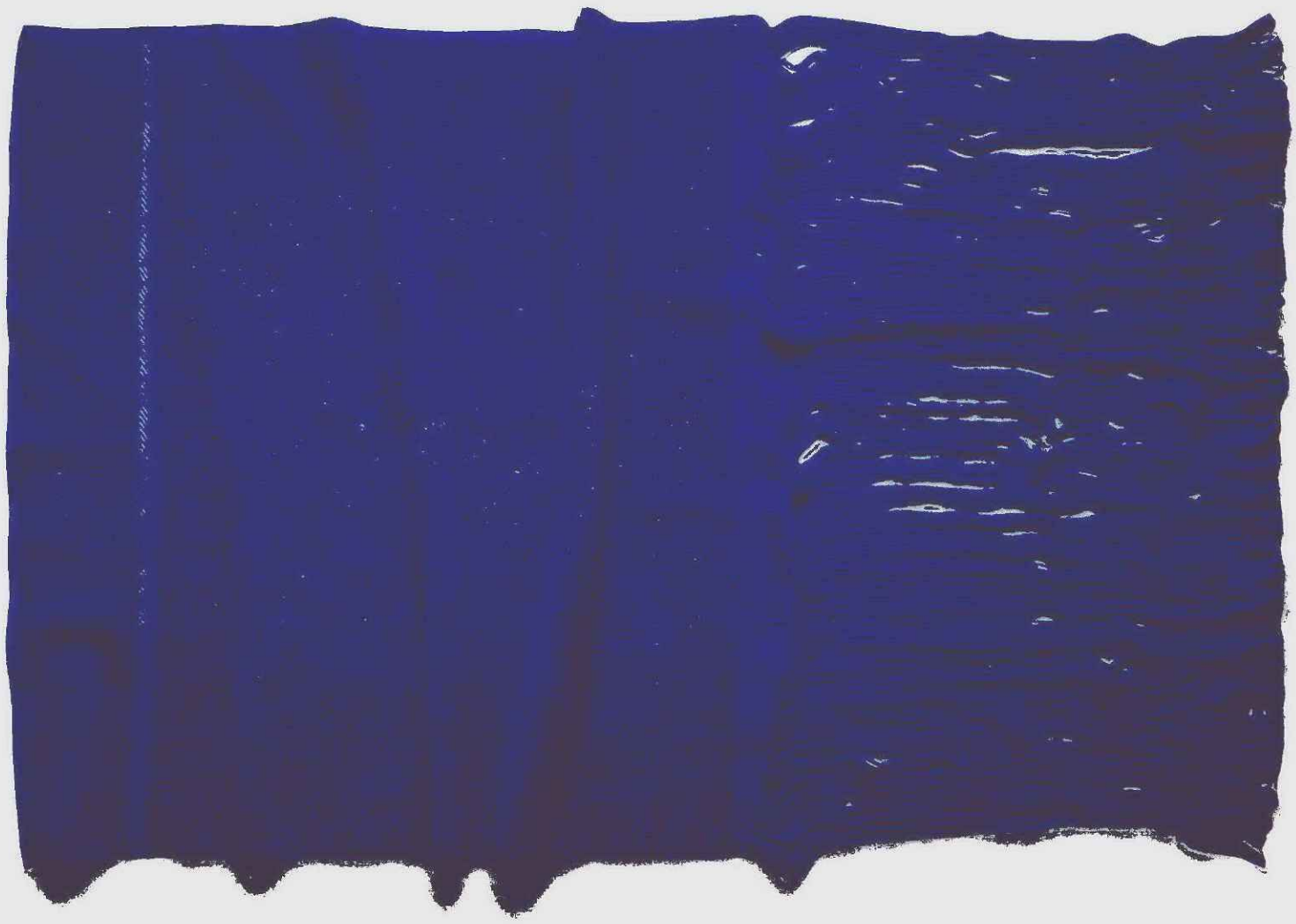

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Technical advances, cost shifting fuel higher costs

THE INFLATING FACTORS IN HEALTH CARE

By D. Kete Cockrell, M.D.

WEARING two professional hats, one for private practice and one for insurance underwriting/claims consultant, I am in frequent contact with hospital administrators, patients, physicians, underwriters, agents and brokers.

Invariably, when the subject of health care insurance is broached with these individuals, premium, benefit and liability costs surface as the main topic. These experiences support the following conclusion held by many economists and insurance analysts: America's most serious health problem is the unrestrained and uncontrolled cost of providing health care.

The magnitude and scope of this problem is emphasized by a review of recent economic statistics. Total health care costs in the United States reached $287 billion in 1981, representing 9.8% of the gross national product. By contrast, in 1971, health care costs represented approximately 4% of the GNP.

It is projected that health care costs will reach $500 billion in 1987, a 75% increase over 1981 costs, and $1 trillion in 1997, a 350% increase over 1981 costs. It is difficult for many people to understand these numbers; however, when claims inevitably increase because of these costs, forcing insurance companies to raise premiums by 35% to 60%, they become painfully clear to employers, policyholders, brokers and agents alike.

Half of the economic problem with health care costs is represented by magnitude and scope. The other half is spiraling, uncontrolled inflation.

For the last 20 years inflation in medical care costs has been disproportionately high when compared with the overall Consumer Price Index. For the 12-month period ending Oct. 31, 1982, medical costs rose 11.1%, or more than twice the 5.1% rise in the overall CPI for the same period.

Economists project this trend at least through the year 2000. The following statistics are consistent with this projection: The average hospital room charge in 1981 was $344 and the average hospital stay charge was $4,000; by 1999 the average room charge will be $2,600 and the average hospital stay charge will be $30,000.

Many in the health care professions have epitomized the health care costs crisis by hypothesizing that marketplace forces have the potential to push costs beyond the economic level that we, as a society, can afford. And, with insurers caught in the middle, trying to make a small profit, it is conceivable in the future that they will be forced to price themselves out of business.

Identification of the major factors sustaining and increasing health care costs is the first step in understanding the overall economic problem.

An increased percentage of the population over age 65, medical technological advances and cost shifting account for more than 95% of the inflation in claims and health costs. These three factors are self-perpetuating, self-sustaining and self-regulating. Their potential inflationary effects are unlimited. Finally, due to their complicated qualities and potential economic effects, we must subject each factor to a thorough individual appraisal.

Now people age 65 and over represent 11% of our total population; yet their health care requirements account for one-third of the total annual national health care bill. Within 25 years this segment will be 50% of our population.

Simply stated, the average person in the United States is living better and longer, but, not living better longer. This is a medical and statistical truism.

It isn't difficult to explain this dichotomy in vital statistics if one understands modern medical practices. In the evolution of medical science our ability to diagnose and treat diseases, and thereby prolong life, has dramatically surpassed our capability to cure diseases and control the aging process.

As a result of this "evolutionary scientific imbalance" in medicine, we can prevent premature death and catastrophic illness due to disease, but we can do little to alter the natural course and subsequent complications innate to all disease.

The effect of this medical theorem on patients and their health care costs can be exemplified by considering the disease diabetes. We can treat some diabetics with insulin and diet and prevent acidosis, coma and eventual death.

Modern therapeutic methods have made it possible for diabetics to undergo surgical procedures and survive critical illnesses. Regrettably, in these same patients, it is impossible to prevent diabetic retinal degeneration frequently resulting in blindness; arterial degeneration leading to heart attacks and other problems. This is true because we don't know the cause of diabetes; therefore, we can only treat and control the manifestations of the disease, not cure it.

Diabetes represents the diagnostic, therapeutic and complication norm in medicine today—not the exception. The example clearly illustrates that medicine is succeeding in helping diseased patients live healthier, fuller and longer lives.

At the same time it is increasing the probability they will live long enough to suffer unavoidable complications from their disease. Also, as the incidence, number and frequency of age-related diseases is increased, the quality of medical care afforded elderly people will constantly increase and enable them to live even longer.

These health care costs and claims will mushroom as the number of elderly increases and new methods for health maintenance and treatment are developed. Present and future federal spending reductions in Medicare reimbursements will compound the financial burden to be absorbed by private health insurers and individuals. Barring unprecedented, miraculous discoveries in medicine, the "evolutionary imbalance" primarily responsible for this dilemma will be present for many generations.

Medical technological advances have the potential to exert an infinite inflationary effect on health care costs and claims. Research and development have been and always will be at the forefront of medical science. Supported by a multitude of federally funded grants through the National Institute of Health and, secondarily, by hundreds of private corporations and foundations throughout the world, an army of researchers, statisticians and technicians are at work daily responding to the demands of a diseased world population and man's desire to answer those health mysteries.

This army is restrained neither by time nor money. It is directed only by the path dictated through the postulated and actual facts encompassed by a given research problem. The creativity and knowledge of the researcher, the restrictions of research equipment available, plus existing scientific data are the sole parameters inhibiting this insuppressible force. And, each of these inhibiting parameters has an uninhibited, self-contained and inexhaustable power to expand.

Even though technology has inflationary potential, obviously, it does not exert its maximum potential constantly. If it did, we would have an incalculable and unpredictable inflation rate in health care costs and claims.

To illustrate, technology's influence on health costs and claims in relation to time can be represented by a line that slopes upward, punctuated by a few peaks and valleys. The sloping line signals ever-increasing health care costs and the valleys and peaks seldom, if ever, cancel out each other.

In most industries, applied technology causes improved efficiency and quality with predictable, economical consequences. Conversely, technological advances in the health care, without exception, always propel costs upward, frequently at a highly improbable rate. Occasionally, the initial technological impact is economical, but the net effect is always inflationary.

Therefore, it is accurate to deduce that the current and historic functional relationship between medical technology and its inflationary effect on costs and claims over time is primarily two phase.

One phase is evident in the continuous, smooth upward slope bringing attention to the constant cost-provoking characteristics of medical technology. The other phase is expressed by the peaks and valleys denoting the erratic behavior.

Radiation therapy is an example of phase one.

X-rays were discovered in 1887 and first used in treating cancer in 1889. It is the oldest and most thoroughly investigated form of cancer treatment.

Today, in combination and/or alone, X-ray is the most versatile and cancercidal agent available. Since 1889, physicians and physicists have struggled to perfect a radiation machine capable of delivering an amount of radiation necessary to kill cancer without damaging normal tissue. In spite of slow, steady progress, such a machine has yet to be developed.

Deep therapy, betatron and linear accelerator are the three major machines utilized in the United States since 1950, each evolving closer and closer to the "ideal" machine.

Cost variables associated with the purchase, installation and operation of these machines represent past, present and, in all probability, future inflators of health care costs.

Some of the variables that caused that inflation are:

- More sophisticated X-ray therapeutic machines were developed in the 1950s, 1960s and 1970s.
- The degree of sophistication of each successive machine.
- Inflationary costs outnumbered economizing costs by 3-to-1.
- Each new machine cures more people, enabling more people to live longer than did its predecessor. Therefore, the total number of people receiving treatments is greater and the people treated survive longer and require more follow-up visits. Often, many people live long enough to be treated two or three times by such machines.

These inflationary considerations more than offset the apparent economizing trends implied by reduction in total number of treatments and frequency of follow-up visits.

Oddly enough, diagnostic radiology offers prime evidence of the peaks-and-valleys trend associated with medical technology.

Nearly three years ago, computerized axial tomography, or CAT scans, were mass-produced and marketed. CAT scanners represented one of—if not the greatest—diagnostic discoveries of the 20th century, maybe in medical history.

Painlessly and without the use of barium, dyes or other potentially hazardous substances, the CAT scanner produces virtually flawless pictures of every organ, muscle, bone and cavity of the body. In so doing it supplies the physician with enough information to diagnose approximately 50% of the lesions and deformities known to afflict humans.

Within a year of its introduction, this discovery was considered essential to medicine. Any physician not utilizing one when available is left wide-open for malpractice allegations.

The total number of CAT scanners marketed today is unknown. Safely, it could be stated that any full-service hospital with more than 300 beds has a scanner. In one Midwestern metropolitan area there are at least 10 scanners, or one per 100,000 population, representing a capital investment of $12.50 per person in that area.

CAT scanners have reduced the number of exploratory surgeries, minimized necessary diagnostic tests and economized therapy through early diagnosis. The question is: Have these economizing health care accomplishments been neutralized by inflationary counterparts?

A conventional diagnostic X-ray machine costs approximately $250,000 compared to $1.25 million for a CAT scanner, an inflation factor of 500% in

Continued on next page

Many factors inflate health costs

Continued from previous page
capital investment. Routine diagnostic X-ray procedures range from $25 to $125 opposed to CAT scan procedures that range from $275 to $700, which represents 700% inflation.

CAT scan procedures accounted for one-third the total number of inpatient and outpatient procedures done in the radiology department of one 350-bed metropolitan hospital, according to 1982 year-end reports. Considering these numbers, it is empirically illogical to expect anything but vast acceleration in health care costs accountable immediately to the development, implementation and utilization of CAT scanners.

As revolutionary as the CAT scanner is, it has two major deficiencies: utilization of X-rays and imperfect (not inadequate) image reproduction.

The nuclear magnetic resonance scanner, NMR, does everything the CAT scanner does without radiation exposure. NMRs produce images so detailed the human eye cannot interpret them. Consequently, with every NMR, one computer produces the images and another computer, complete with laser analyzer, interprets the images.

Marketed in 1982, the NMR is increasing in popularity at a slightly slower rate than the CAT scanner. Supersophisticated imagery delineation notwithstanding, operating without radiation exposure is expected to improve NMR scanner demand. The purchase price of one NMR is approximately $2 million with a cost range of $500 to $1,000 per diagnostic test.

In 1980, technology was singularly responsible for a 700% spurt in the cost of some radiological diagnostic services. And there is a very real probability of another 100% flurry for the same services in 1983. Between 1980-83 technology potentially inflated some health costs by 1,400%.

Once this fact is realized, the analogy needs no further illumination. Suffice it to say, CAT and NMR scanners are perfect examples of the peaks-and-valleys characteristic of medical technology.

Hospitals, extended care facilities and other providers incur operating expenses not directly related to patient care. Services rendered to private patients are inflated proportionately to offset these expenses. Since most private patients are covered by health insurers, this practice escalates health care costs and claims.

Last year, cost shifting accounted for 20% of the annual inflation rate in health care costs. This figure could easily reach 50% by 1985-86. Bad debts, indigent patient care, capital-needs funds and cost of services provided for Medicare/Medicaid patients not covered by reimbursement from Medicare/Medicaid are the primary expenses responsible for cost shifting.

Bad debts, indigent patient costs and capital funds are financial millstones borne by all hospitals in the United States. Eighty-five percent of U.S. hospitals are so-called non-profit organizations. In the late 1960s, the Internal Revenue Service adopted the following rule: "Non-profit hospitals cannot refuse admission or treatment to any patient, regardless of their ability to pay, if the hospital is to maintain its non-profit status."

In effect, this ruling shifted a large share of charity patients' costs from city and county hospitals to private non-profit hospitals, and through cost shifting, to private patients and their insurers.

About 30% to 35% of U.S. hospital beds are occupied by Medicare patients, producing 40% to 45% of hospital receipts. Hospital charges submitted to Medicare are reduced a certain percentage before any calculations for allowable costs are conducted, because Medicare never has and does not now allocate any funds for bad debts or charity cases.

Private patients with private health insurance occupy 65% to 75% of U.S. hospital beds; nevertheless, they pay 100% of U.S. hospitals' bad debts, charity and capital needs expenses.

Funding for capital needs represents a small portion of dollars generated by cost shifting. It is the only cost-shifting expense not controlled by federal legislation and bureaucratic guidelines. Accordingly, understanding the current trend in cost shifting requires a working knowledge of current federal health care legislation.

Last year, in the worst recession in 40 years, Congress was faced with a moderate financial crisis, sharply declining federal revenues and blossoming federal deficits.

Two economic alternatives were evident: reduce federal spending or raise federal taxes. In the politicial arena, politicians were face-to-face with a financially distressed public frequently preoccupied with concern over mortgage payments and utility and grocery bills. A national poll was not necessary for legislators to realize that it was not the time to introduce or support "tax hike" legislation. In this economic and political climate, the Tax Equity and Fiscal Responsibility Act of 1982 was born.

TEFRA is the most comprehensive and exacting piece of health care legislation from Washington since the inception of Medicare. Its intent and purpose is to lower Medicare reimbursement benefits. Modifications through 27 bills contained in this act will save Medicare $2.7 billion in fiscal 1983, $4 billion in fiscal 1984 and $5.3 billion in 1985, presenting the insurance industry with $12 billion additional cost-shifting dollars over the next three years.

The sweeping scope and benefit-cutting structure of TEFRA is precedent-setting, breaking the legislative ice for passage of other benefit-slashing acts in the future. TEFRA may represent the beginning of the end for Medicare as we know it. Through it, Congress is signaling a clear message: The federal government cannot afford and the taxpayer is unwilling to pay the taxes to guarantee the liability risk comprised in Medicare.

Americans will remember the financial hardship of the last three years for at least a decade. These memories will make them resist any legislation fostering federal spending and receptive to any legislation moderating federal spending.

A complete review of all bills contained in TEFRA is beyond the reach of this article. Highlights of a few of the bills will pinpoint and estimate impending claims for the insurance industry:

- TEFRA Section 116: "Medicare payments secondary for older workers covered under group health plans." In this section, the Medicare program is made secondary to employment—based health insurance plans for workers and their spouses age 65 to 69. It requires all employers to offer their employees age 65 to 69 the same private health insurance at the same cost offered to younger workers.

The private health coverage would then become the primary coverage and Medicare would become secondary. This applies to all employers with 20 or more full-time employees.

Group premiums will have to be renegotiated due to this measure, and claims will jump due to greater liability represented by the older group. Projected savings to Medicare from this measure are $1 billion over the next three years.

- TEFRA Section 108: "Payment for physician services furnished in institutional providers of services." The purpose of this section is to improve the distinction between physicians' services to patients and their services to providers. This principle is quite important to the hospital and to Medicare because that portion of a hospital-based physician's salary allocated to patient care is reimbursed on a reasonable charge basis, while that portion allocated to provider services—quality control, teaching, etc.—is reimbursed on a reasonable cost basis.

A new method for calculating allowable reimbursement for hospital-based physician's charges is established. Computations are based on the average 1979 salary for these physicians and results in determining a reasonable compensation equivalent, RCE. The RCE is consistently 25% to 30% lower than average and customary charges.

Anesthesiologists frequently supervise the administration of five or six anesthetic procedures simultaneously. This section establishes guidelines disqualifying an anesthesiologist for payment by Medicare if he or she supervises more than two procedures simultaneously.

In the past a unit payment factor was allowed for each 15 minutes of anesthetic administration, but now this bill redefines the unit payment factor and extends the time to 30 minutes. The amount reimbursed for each unit payment factor remains the same.

The amount Medicare will pay for any radiological procedure done in a hospital-based radiology unit is reduced to 40% of the reasonable charge for the same procedure done in a non-hospital-based radiology unit.

This also applies to inpatient and outpatient procedures.

Medicare reimbursement for pathology services are reduced by 35% to 40% by disqualifying them for reimbursement under reasonable charge consideration and requalifying them under reasonable cost reimbursement. Again, this will apply to inpatient and outpatient services.

Projected savings to Medicare program just from the reduction in benefits to anesthesiologists, radiologists and pathologists is $50 million in fiscal 1983.

- TEFRA Section 103: "Elimination of inpatient routine salary cost differential." Since 1979 Medicare has reimbursed hospitals approximately 5% more than the total routine nursing care costs on the assumption Medicare patients generally require more nursing care than non-Medicare patients. This section abolishes this allowance.

Projected savings to Medicare from this section is $93 million in fiscal 1983.

- TEFRA Section 101: "Payment for inpatient hospital services." This is a new method for determining the amount Medicare will reimburse hospitals for inpatient care on a reasonable cost basis. The reasonable costs were based on actual costs incurred while the patient was hospitalized. These costs included room charges, medications, laboratory tests, etc., and were determined from each patient's itemized bill. Under this method Medicare pays about 80% of the charges.

The new calculations are based on average hospitalization charges per diagnosis; those average charges are based on diagnoses discharged between Jan. 1 and Dec. 31, 1982. It is estimated that Medicare will pay about 65% of the charges under this method.

Looking at these specific TEFRA sections, it is evident that:

- Radiologists, pathologists and anesthesiologists will raise fees for services rendered on all inpatients and outpatients to compensate for lost Medicare funds.
- Hospitals will be forced to restructure their entire billing procedure. They must recompense a 15% loss in inpatient care costs, a 5% loss in nursing care costs, and an undetermined percentage lost due to alterations in compensation for hospital-based physicians. Daily room rates will probably bear the brunt of cost shifting by hospitals for these charges.
- Coinsurers, stop-loss and primary insurers will feel a definite negative impact in claims from the massive health care cost shifting caused by TEFRA.

In spite of the above bills and hundreds more like them documented in the Federal Register, politicians and bureaucrats still publicly maintain that they "don't tell hospital administrators how to run hospitals, and don't tell doctors how to practice medicine." Superficially, their statement is true. They only say, "If doctors practice medicine and administrators run hospitals the way Uncle Sam dictates, use Uncle Sam's bookkeeping method, and wait until Uncle Sam pays them, then the government will pay doctors and hospitals what Uncle Sam decides their services are worth."

"Clinging to the purse strings" of billions of health care dollars and legally mandating methods for disbursement, the federal government directly or indirectly influences and controls every facet of medical practice and hospital operation.

In the same vein, politicians and bureaucrats proudly proclaim, "We didn't pass any tax hike legislation in 1982." This statement is true. Yet, through legislation they initiated a chain of economic events, beginning with the reduction of Medicare benefits, that led to gross cost-shifting practices by hospitals and resulted in sharp increases in charges for private patients. These increases were directly reflected in devastating claims to insurers and ultimately culminated in premium increases to policyholders.

This chain of events has prompted some insurance industry spokesmen to refer to cost shifting as "the hidden tax." Factually, that is exactly what it is and, in all probability, exactly what the legislators on Capitol Hill intended it to be.

Yet, this isn't to say nothing can be done by the insurance industry. On the contrary, much can and should be done to ensure marketable benefits and adequate profits. That will be touched on in a future article. ■

Dr. D. Kete Cockrell is a family practitioner in Indianapolis and medical director of Brougher Agency Inc. in Greenwood, Ind. This is the first in a series of three articles by Dr. Cockrell.

National Safety Council book provides a good start to a safety reference library

By Merle Barnes

books & ideas

"Accident Prevention"
National Safety Council
Customer Service Department
444 N. Michigan Ave.,
Chicago, Ill. 60611
392 pages, $45.75; NSC members, $36.50

"ACCIDENT PREVENTION" is a collection of selected readings from the 1974 edition of "Accident Prevention Manual for Industrial Operations." The selected materials are specific and concise, with information beneficial to every individual involved in preventing accidents.

Each reading provides the novice with information necessary to start a safety program.

The expert is provided with directions to specific American National Standards Institute guidelines and National Safety Council publications for detailed information. While the Occupational Safety and Health Administration is not cited specifically, all the safety suggestions and recommendations made do meet its standards.

There is little direct continuity between the readings, since this book is an anthology. The only relationship that exists is that all readings are on different aspects of safety and safety procedures.

The editors have gleaned from the "Accident Prevention Manual for Industrial Operations" subjects that address the safety problems common to a wide range of industries and those problems most frequently encountered by safety professionals.

Realizing the limited number of readings, several topics have not been covered. These topics include powered industrial trucks, welding, industrial hygiene and noise and hearing conservation. The inclusion of these would have made "Accident Prevention" more contemporary and relevant to current issues.

The book is divided into four general sections. The first consists of three readings dealing with the development of a physical plant and its inspections. Information is provided on construction, lighting, walkways and electrical systems. This section concludes with checklists and facility inspection guidelines to assure that the initial safe physical setup is maintained.

The second section is a group of five readings on developing and monitoring of a safety program. These readings on system safety, critical incidents and accident investigation and analysis should be required reading for every safety professional or anyone with safety responsibilities. While only 20 pages long, it stresses the interrelationships among people, tools and environment.

From a practitioner's point of view, I wish more emphasis had been placed on the relationships between minor incidents and severe accidents.

This section also covers techniques on computing accident rates, developing and monitoring accident records and estimating costs. The one drawback of this section is the use of 1 million man-hours as opposed to the currently accepted 200,000 man-hours in determining incident rates. This probably is the result of using the original 1974 "Accident Prevention" edition without updating the calculating information.

The bulk of the book deals with developing safe procedures in a wide range of areas. Material handling and storage, portable power tools, woodworking machinery and foundry health hazards are a few examples. The reader should be selective in this section because not all readings will relate to any one industry.

The section on point-of-operation guarding, for example, provides a basic introduction to OSHA regulations, an excellent comparison of the types of point-of-operation guards that can be used and a comparison of types of guarding materials.

Every practitioner involved in equipping machinery with guards would find this reading useful since it provides a wide range of opinions. As in all readings in this section, information is presented on hazards, methods of reducing hazards and inspection procedures.

The final section deals with the human element in accident prevention, starting with the safety program organization and safety training through human factors engineering and non-employee accident prevention.

Most safety professionals agree that the elimination of physical hazards will reduce only about 20% of the injuries. Getting people to avoid unsafe acts is 80% of your safety program. The National Safety Council has always pushed for eliminating unsafe acts as the primary means of reducing injuries. This point is brought home in the fourth and final section.

"Accident Prevention" is not designed to replace the "Accident Prevention Manual for Industrial Operations." Rather, it is a companion book to be used as reference for specific information relating to the safety area being researched.

Additionally, it is not designed to be read cover-to-cover. The book is most beneficial when used in researching specific information on a selected topics.

Whether by design or oversight, the book is not indexed. This requires the reader to cover an entire section to obtain necessary information.

This can be beneficial, since it will provide a broader range of information on solving safety problems instead of a narrow view provided by simply looking through the index and selecting a single topic.

This volume provides a place to start in developing your accident prevention program and further directions for finding additional safety materials for an in-depth study.

As with all selected books, I do wish more emphasis had been placed on some areas, such as accident investigation and critical analysis, with less emphasis on reducing unsafe conditions. Other readers, naturally, may disagree and wish their specific areas of interest had been covered more thoroughly.

Overall, "Accident Prevention" will not become the sole source for any safety program, but will be a beneficial addition to any safety library. ■

Merle Barnes is safety and training manager at Hon Industries Inc. in Muscatine, Iowa.

Cure 'pre-termination' blues with career counseling

By Kenneth P. Shapiro

management

MY FRIEND, Joe, a middle manager at a large Eastern chemical company, was starting to worry. Something wasn't right. During 14 years with the company, he had moved up regularly, landing a good position in 1980 managing a 30-person physical testing laboratory.

But 18 months ago—after a series of acquisitions, readjustments and consolidations—he was starting to feel left out.

His laboratory, which had been joined with another in the company, was supervised by someone else, although he kept his title. Meetings that he previously attended went on without him. Fewer memos on policy matters stopped at his desk, while fewer of his own policy memos received serious attention.

Joe's dilemma was something that I call a pre-termination condition. When an executive, for whatever reason, no longer fits into a corporation's scheme of thinking, there is usually a period where he or she is given subtle—or sometimes not so subtle—clues that time may be running out.

According to Clifford Benfield, president of Hay Career Consultants, companies "often let managers hang in a corporate limbo for as long as two years." Of course, says Mr. Benfield, "in the tougher economy that we've had lately, the ax does fall sooner."

The unfortunate part about this problem is that many times the fallen-from-grace manager can salvage his or her career within the company, if only given the chance. That is why progressive companies are using the services of career counselors who can help an employee while he or she is still employed.

This process—known variously as early intervention, third-party intervention or career-crisis counseling—is both a time- and money-saver.

In the best case, the counseling will correct the problem and allow the manager to continue to contribute to the corporation.

In other instances, the process will help upper management discover another, more appropriate, slot for the manager within the company. It won't be a "make-work" situation, but one where that person can use the skills that at one time made him or her a valued employee.

Failing that, the career counselor can help the manager find suitable employment outside the corporation.

By getting help early, management avoids the "dangling" period like the one that Joe faced. Departments and units are not disrupted. Co-workers do not have to work around "deadwood." The counterproductive effects of the corporate rumor mill are defused.

So what happened to Joe?

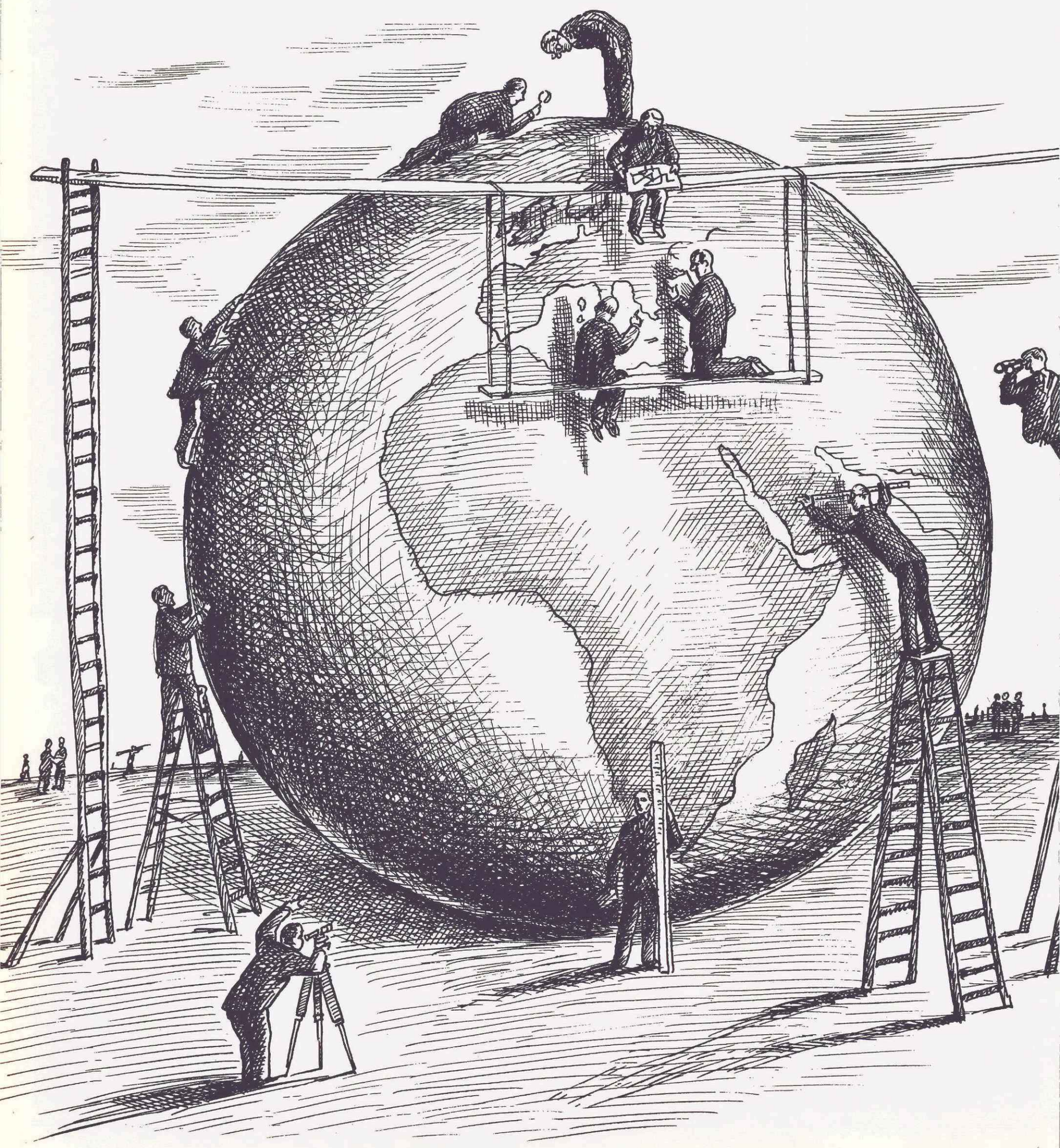
Unfortunately, not much. He still is working, though with little gusto. He had made some limited efforts to search for a new position. But without some help, this kind of search is hard, especially for someone who has not been in the job market for 15 years.

Joe has hesitated to ask directly about his status, for fear of forcing the issue. So he dangles, slowly losing his self-esteem, hardly contributing to his company and wasting any potential that he has to be productive. ■

Kenneth P. Shapiro is president of Hay Huggins Co. Inc. in Philadelphia. His column on management appears regularly in Business Insurance.

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Assistant Copy Editor Claudette Dampier. She can be reached at 312-649-5282.

The smaller the world gets, the bigger



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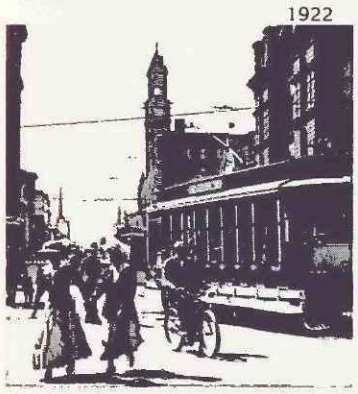

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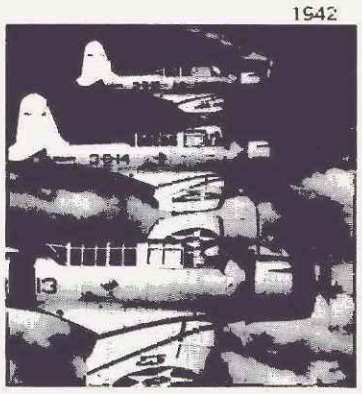

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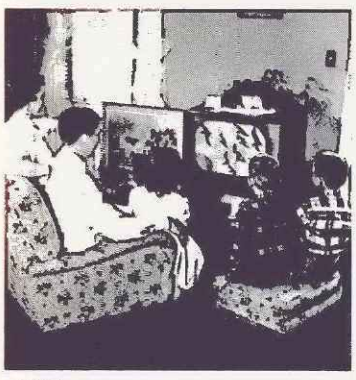

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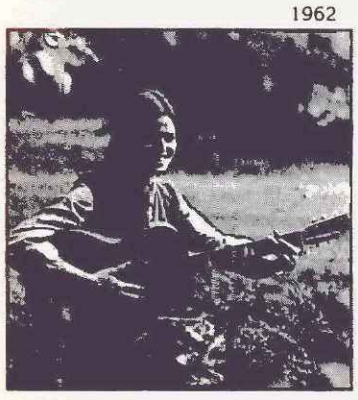

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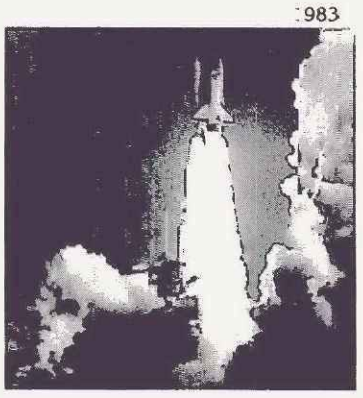

Administration pension bill would especially aid women

washington

By JERRY GEISEL

WASHINGTON—The Employee Retirement Income Security Act should be overhauled to give women more pension rights, the Reagan administration says.

The Pension Equity Act of 1983, introduced in the House this month on behalf of the administration, would make several changes to ERISA to increase pension rights of women workers, the administration says.

Some of these changes include:

- Lowering the minimum age when a company must allow its employees to participate in its pension plan to 21 from 25. Currently, about 40% of pension plans exclude workers from participation if they are under 25, the administration estimates.

"This change is especially important for young working women, whose labor force participation is highest—over 70%—between the ages of 20 and 24," said Daniel Benjamin, the Labor Department's acting assistant secretary for policy.

- Lowering the minimum age for vesting under ERISA from 22 to 21.
- Guaranteeing that individuals on maternity or paternity leave would not incur a one-year break in service for participation and vesting.
- Requiring a spouse's written permission when a plan participant decides not to provide a survivor's benefit.

"Such a provision will provide both members of a couple with the opportunity to participate in the critical decisions regarding their retirement income," Mr. Benjamin said.

- Allowing a spouse, through a court order, to directly attach a part of the ex-spouse's pension benefit.

The Pension Equity Act of 1983, H.R. 4032, was introduced on behalf of the Administration by Rep. John Erlenborn, R-Ill.

IRA contributions

Employees could contribute more money to Individual Retirement Accounts under legislation passed by the House Ways and Means Committee.

In approving H.R. 4065, which also affects the taxation of life insurance companies, the Ways and Means Committee added a provision expanding the IRA concept.

Currently, under the Economic Recovery Tax Act of 1981, an employee may contribute up to $2,000 a year into an IRA and receive a full tax deduction for the contribution.

But under the bill approved by the tax-writing panel, an employee could contribute another $1,750 in income that already had been taxed. The earnings on the additional contribution would be shielded from taxes, though, until the employee withdraws funds from the IRA, which usually occurs upon retirement.

OSHA advisory panel

The Occupational Safety and Health Administration has reappointed four members and named two new members to two-year terms on the National Advisory Committee on Occupational Safety and Health (NACOSH).

Public representative Joyce Hearn, a South Carolina legislator from Columbia, will continue to serve as chairwoman of the 12-member committee, which advises the secretaries of the Departments of Health and Human Services and Labor on the administration of the 1970 Occupational Safety and Health Act.

Also reappointed were management representative Dr. Bruce Karrh of E.I du Pont de Nemours & Co. Inc. in Wilmington, Del.; safety representative B. Gawain Bonner of Tenneco Inc. in Houston; and health representative Dr. Marcus M. Key of the University of Texas School of Public Health in Houston.

The new two-year appointees are labor representative R.V. Durham of the International Brotherhood of Teamsters in Washington and health representative William E. McCormick, formerly with the American Industrial Hygiene Assn. in Akron, Ohio. ■

Retiree wins pension credit for duty with National Guard

HARTFORD, Conn.—A Teamsters pension fund must give a former Connecticut National Guard member pension credit for time spent on extended active duty due to a military-related injury, a federal court says.

The decision, handed down by a U.S. District Court, involved a suit filed by Martin J. Reilly Jr. against the New England Teamsters & Trucking Industry Pension Fund.

Mr. Reilly had been denied pension credits by the Teamsters plan for certain military service when he retired from his job at First National Stores in East Hartford, Conn. Except for intermittent active duty in the Connecticut National Guard, Mr. Reilly had been a warehouse worker and truck driver with First National Stores from 1946 to 1977.

Mr. Reilly first left the company in 1950 when he was recalled to active duty during the Korean War. He was released from active duty in 1952 and was rehired by First National Stores.

To fulfill his annual National Guard duties, Mr. Reilly again left his job for a National Guard camp on June 20, 1958. He was scheduled to return to work after July 15, 1958.

However, because he was injured during a camp training drill, his active duty status was extended through Aug. 20, 1959. He then remained on active duty from Aug. 21 through Sept. 4, 1959, to meet his annual National Guard obligation.

Immediately after that, he returned to work at First National Stores.

When Mr. Reilly retired in 1977, he learned that his Korean War service had been counted toward his pension benefit, but his absence from June 1958 to September 1959 had been treated as a non-work-related illness for which no pension credit was given.

But U.S. District Judge Jose Cabranes ordered the plan to give Mr. Reilly pension credit for his extended military duty while he was injured.

Citing a 1977 Supreme Court decision in Alabama Power Co. vs. Davis, Judge Cabranes noted that pension benefits are prerequisites of seniority protected by the re-employment rights law.

The ruling "affirms the obligation of a private pension fund to credit a veteran's military service toward payment of retirement credits," said William C. Plowden Jr., assistant U.S. secretary of labor for veterans' employment and training.

The decision lends "valuable support to our efforts to end discrimination against veterans in all aspects of their civilian employment," Mr. Plowden added. ■

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Should workers comp be federalized?

Continued from page 3

Miller's bill, Mr. Goldberg said.

"It merges the workers comp remedies and tort remedies into a single no-fault compensation system that provides an integrated funding mechanism through which the parties that are currently bearing that responsibility—the manufacturers and the employers—may fund those benefits in a more efficient, rational and more business-like fashion," he said.

But, "federalization and occupational disease are not necessarily compatible," said Robin Obetz, executive secretary to the Ohio Self-Insurers Assn.

"You're trying to plug in new medical problems in old areas," he said.

The National Assn. of Insurance Commissioners and the IAIABC oppose federalization of workers compensation and point to three current federal programs that are costing much more than originally anticipated: the Longshoremen's and Harbor Workers' Compensation Act, the Black Lung program and the Federal Employees' Compensation Act.

"Every workers compensation program that the federal government has touched has rapidly become a high-cost, poorly administered disaster," said Daniel Minnick, an attorney with Jones & Laughlin Steel Corp. in Pittsburgh and president of the NCSI.

Mr. Goldberg

"From the viewpoint of most employers, the only good federal program in the workers compensation area is one that never sees the light of day in a legislative committee," Mr. Minnick said.

"I want to make it clear that self-insurers are not opposed to employees receiving occupational disease benefits if they are legitimately disabled from occupational diseases. But we think these benefits should be provided under state occuptional disease laws," he said.

The IAIABC generally opposes any legislation that would tend to federalize the system or split off any part of a state system and put it into a federal system, said Robin Waller, a commissioner on the Connecticut Workers' Compensation Commission.

He said commissioners are aware that there is a problem in the area of compensation for occupational disease, but he added that the commissioners disagree with the preamble of Rep. Miller's bill that says state work comp systems are not and cannot handle the claims.

"To the contrary, our position is that local compensation systems can handle the problem. . .that's why we're drafting a model bill."

That model bill is in the infant stage, but should be ready sometime next year, Mr. Waller estimates. The insurance industry also is looking at a state-by-state solution to deal with occupational disease claims.

The fifth member of the panel, Leslie Cheek, vp-federal affairs at Crum & Forster in Washington capsulized the findings of a report by his company and released this summer (*BI*, Aug. 1).

"Our position reminds me somewhat of a series of Fram automotive filter television commercials several years ago. The ads featured a hard-bitten auto mechanic whose view of the timing of the work he did on his customers' cars was invariably summed up with the phrase, 'You can pay me now, or. . .you can pay me later.'

"To apply the mechanic's philosophy to the occupational disease problem, it seems to us that we have a clear choice between paying for a tuneup, an oil change and new air and oil filters on the state workers compensation engine now, or paying for a costly new federally designed engine when the old one freezes up," Mr. Cheek said.

He also labeled the three federal work comp programs as "expensive, cumbersome and inefficient."

The Crum & Forster report contains a dozen broad recommendations for state action. One on the funding of benefits is being further developed by the American Insurance Assn., the NAIC and the IAIABC, with staff assistance from the National Council on Compensation Insurance, Mr. Cheek said.

Since the Crum & Forster report was released, it has been praised for its elaborate efforts and for publically noting that the system is broken, and criticized for not going far enough.

"I believe many of the recommendations (in the report) will lead to substantially increased occupational disease insurance premiums for many employers and increased costs for the self-insured employers," Mr. Minnick said.

One of those recommendations suggests that the last employer that exposed a worker to a harmful substance or condition in the workplace pay full benefits to the worker or his or her dependents.

"Occupational disease is usually created from numerous causes or from exposure in the workplace from several different employers. It is not fair for the last emploer to pay the entire bill," Mr. Minnick said. "By asking the last person to pay this bill, it will discourage people from hiring the handicapped." ■

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Canadian elected to IAIABC presidency

ATLANTA—Lincoln M. Alexander, chairman of the Ontario Workers' Compensation Board, is the new president of the International Assn. of Industrial Accident Boards & Commissions.

Mr. Alexander was elected at the 69th annual convention of the IAIABC last month in Atlanta. The IAIABC is an organization of state and provincial workers compensation comissioners.

This year's meeting attracted 550 commissioners and staffers, insurers, attorneys and employers, some from as far away as Australia and South Africa.

Mr. Alexander takes over the IAIABC presidency from James C. Pullin, secretary-treasurer of the Board of Workers' Compensation in Georgia.

Mr. Alexander

Will S. Defenbach, chairman of the Idaho Industrial Commission, is president-elect. Glenn L. Schilling, of the Kentucky Division of Workmen's Compensation was elected vp, and John Arcudi, chairman of the Connecticut Workers' Compensation Commission, was elected secretary.

Phillip T. Bork of the Washington Board of Industrial Insurance Appeals, and Hugh Russell, deputy administrator of the Wisconsin Workers Compensation Division, were re-elected to the group's executive committee.

Newly elected to the executive committee were Charles Krysiak, chairman of the Maryland Workers' Compensation Commission; Ervin Vahration, a deputy on the Michigan Bureau of Workers Compensation; and John N. Shanks, chairman of the Indiana Industrial Board.

Attending the IAIABC convention was, in some ways, like going back to school.

All participants learned a lesson in chemistry during a discussion about occupational diseases that would have to be dealt with in the 1980s. Slides showing the chemical properties of certain chemicals found in the workplace like dioxin, pentachlorophenol (PCP) and polychlorinated biphenyl (PCB) were shown along with explanations of their health side effects.

As recently as 1981, some 2 million separate chemicals had been identified, and at least 200,000 of them were harmful to humans, said Dr. Tom Howell of the Howell Industrial Clinic in Atlanta.

"And the industrial environment is more dangerous than the community one, because it is entirely man-made," said James L. Burson, an industrial hygienist and division chief of the Georgia Institute of Technology in Atlanta.

About 100,000 new chemicals are developed each year and many of them are being used by industry, bringing potentially new health hazards with them.

Reinsurance also was discussed at the convention. John Pelot, senior vp of Employers Reinsurance Corp. in Overland Park, Kan., discussed some of the policy forms used, while John T. Grush, vp of General Reinsurance Corp. in Greenwich, Conn., talked about the state of the reinsurance industry and its future.

"And I would include self-insurers as participants in my definition of the insurance industry," Mr. Grush said.

When self-insurers look for an excess workers compensation insurer, Mr. Grush said that in addition to price, the following points should be considered:

- Financial strength. The insurer should have staying power that will assure that it will be there to pay when claims payments exceed the self-insured retention, two, five or even 15 years after accidents occur.
- Expertise and experience in writing workers compensation insurance.

The lessons of what it takes for an organization to successfully operate in the excess insurance business are learned only over time, Mr. Grush said.

"Look at your insurer's track record. It may give clues as to its future," he added.

- Flexibility and innovation.

"The insurance business is clearly in a time of major change. The increased sophistication of the commercial insurance buyer, usually the risk manager, is one of the prime causes of this change.

"Insurers and reinsurers who have both the resources and the willingness to work with the buyer to meet his specific risk transfer and financial needs have the best chance of offering the most attractive product. They probably also have the best chance of surviving and prospering in this era of great change," he said.

During a a panel discussion on job placement for injured workers, Gary Billiard, president of Injury Management & Rehabilitation Corp. in Rosemead, Calif., told the commissioners they should encourage injured workers to return to work and encourage their attorneys to support their return.

"In many jurisdictions, there is a financial disincentive for the insurance claimant to return to work. This is one of the major obstacles in the employment process," he said.

One incentive "might be to give the claimant double compensation to return to work rather than to tie wage loss into an award that is forthcoming," he said.

"There is little doubt that the process of rehabilitation within the present compensation system still requires further study and considerable refinement," he said.

But "job placement is a specialty coming into its own," he noted.

When commissioners and their staffs were not attending sessions, they were making plans for next year's convention, to be held in Ontario; April's all-state meeting; and the annual IAIABC Workers' Compensation College, which will be April 1-6 in Phoenix, Ariz.

The group also is considering a tour of Europe to study workers compensation systems in England, Sweden, Denmark and Finland.

Information about the association is available from Executive Director J.T. Noblin, P.O. Box 79109, Jackson, Miss. 39236. ■

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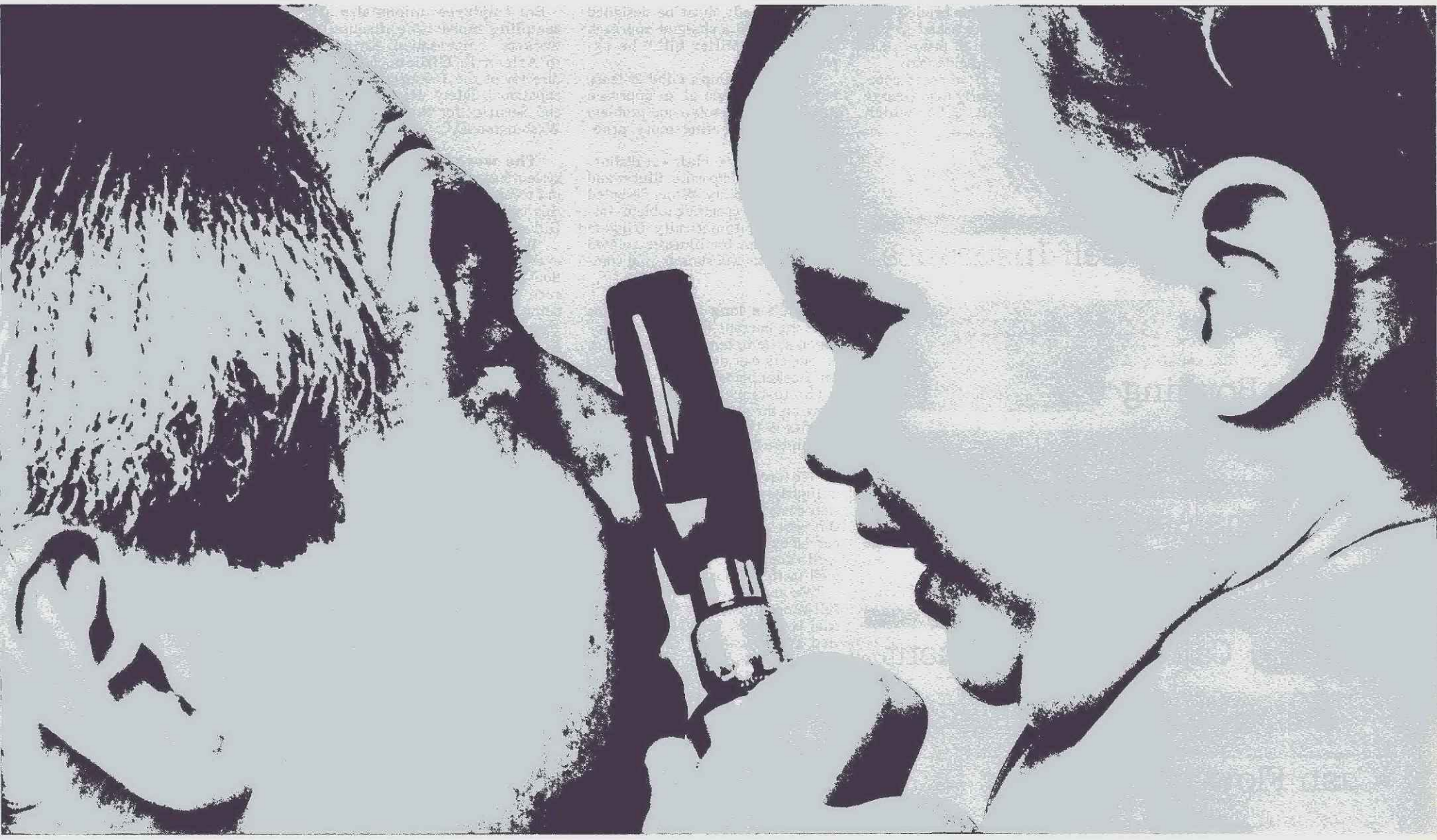

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Comp system asked to do too much: Employer

By CAROL CAIN

ATLANTA—The nation's workers compensation system is in trouble because it is being overextended, one employer says.

"For more than 70 years we had a system that worked well; it had the confidence of employers, unions and employees," says Russell W. Boekenheide, vp at Union Camp Corp. in Wayne, N.J., a forest products company with almost 100 sites worldwide.

"Now it's starting to have its troubles. Why? Basically, it seems to me, we want workers compensation to do more than was originally intended."

Mr. Boekenheide was part of a panel that discussed "Workers Compensation in the '80s" during the annual convention of the International Assn. of Industrial Accident Boards & Commissions in Atlanta last month.

Historically, workers compensation was designed to protect workers from medical expenses and to replace wages, Mr. Boekenheide said.

"It was not a system of awarding damages. . .it is no-fault. . .and it was a system designed and administered by the states, with the view that they could best understand needs and their economic climate," he said.

But the system has eroded and employers are being asked to pay the bill—$22 billion to insure risks in 1982, Mr. Boekenheide said.

Federalization of workers compensation, particularly Rep. George Miller's bill, H.R. 3175, which would create a federal compensation program for workers suffering from asbestos-related diseases, is not the answer, Mr. Boekenheide said.

> 'For more than 70 years we had a system that worked well; it had the confidence of employers, unions and employees. Now it's starting to have its troubles. Why?' asks Russell W. Boekenheide of Union Camp Corp. in Wayne, N.J.

"The remedy must be designed with care, not a shotgun approach such as the Miller bill," he explained.

"In Union Camp's mind at least, here's an example of an approach that in trying to solve one problem succeeds in creating more problems.

"It provides no clear-cut distinctions between exposure, illness and resulting disability. While designed to deal with a specific problem—asbestos—it automatically triggers compensation for illnesses related to other toxic substances," he commented.

There's a long list of problems with the current workers compensation system, but there are things employers can do to resolve them, Mr. Boekenheide said.

For instance, "We need to do more on the positive side to prevent injuries in the first place. We need to do more to promote wellness," he said.

"We have had a dramatic decline in injuries and resultant compensation costs in Union Camp during the past five years. It hasn't occurred by chance; it resulted from a well-thought-out program that is well-staffed and managed.

"We employ corporatewide four full-time physicians, three industrial hygienists, plus a fully qualified safety manager at all major mills.

"We conduct in-depth safety and health audits at every location in the company at least once every three years. We maintain a physical fitness center at our corporate headquarters.

"But most importantly, loss prevention is a No. 1 priority now for all our managers since it is the top priority with our senior executives. Division managers must report on their safety records in person at monthly management meetings, just as they report on profits," he said.

Workers compensation programs also are being given more attention in board rooms because of spiraling costs, Mr. Boekenheide said.

But employee unions also are spending more time discussing workers compensation, according to Arleen F. Gilliam, assistant director of the Department of Occupational Safety, Health and Social Security for the AFL-CIO in Washington, D.C.

"The workers compensation system has failed to adapt to changing technology and lags far behind this country's development," Ms. Gilliam said.

"Workers are more at risk than ever before of developing occupational diseases as the result of exposure to harmful substances and being injured as the result of dangerous machinery and hazardous industrial processes."

The AFL-CIO has long been convinced that the most effective way of assuring an adequate and equitable workers compensation system is through federalization, Ms. Gilliam said.

"Until this is accomplished, we urge the enactment of federal legislation to establish minimum federal standards for this system. Such action is not imminent, so at the very least, state legislatures should be incorporating these standards into workers compensation statutes," she said.

According to Ms. Gilliam, these standards should include:

- Compulsory coverage of all wage and salary workers, without numerical, occupational or industrial exemptions.
- Coverage for agricultural workers that equals the benefits provided workers in other occupations.
- Weekly benefits of not less than two-thirds of the worker's average weekly wage.
- Full statutory coverage of all occupational diseases.
- Allowing workers to file claims for benefits resulting from occupational diseases at least one year after they realize the nature of their disability and its relation to the job.
- Full medical benefits for job-incurred personal injuries and occupational diseases.
- Free choice of qualified physician.
- The workers compensation agency must include a rehabilitation division that should promote full utilization and development of rehabilitation facilities for the benefit of injured workers.
- Benefits for the totally disabled should cover the full period of disability.
- In case of a worker's death, benefits should be paid to the surviving spouse until death or remarriage, to children at least during their minority and to other dependents during the period of their inability to support themselves.
- Prohibition of lump-sum settlements and compromising rights to full medical care unless the workers compensation agency approves such a settlement with input from the rehabilitation unit.

Rep. Miller's bill, from the perspective of the AFL-CIO, represents a positive step in achieving the goal of a rational and comprehensive system for compensation of workers who suffer the effect of exposure to hazardous substances, Ms. Gilliam said.

"A comprehensive federal program is urgently needed to compensate workers and their families for disability or death which results form occupational disease.

"Such a program should include generous time limits for filing claims that take account of long-latency periods for occupational diseases and eligibility requirements that give workers a fair opportunity to prove that their disabling disease is caused by exposure to a toxic substance.

"It should cover known occupational health hazards and provide for coverage through administrative action of additional hazards as they become known," Ms. Gilliam commented.

Legislation should also be developed to authorize medical research to isolate occupational diseases and to assist populations at risk, Ms. Gilliam added.

Also on the panel were attorney Williston C. White from the Atlanta law firm of Smith, Cohen, Ringel, Kohler and Martin; and attorney Don L. Hartman, from the Rossville, Ga., law firm of Harriss, Hartman, Aaron & Townley. ■

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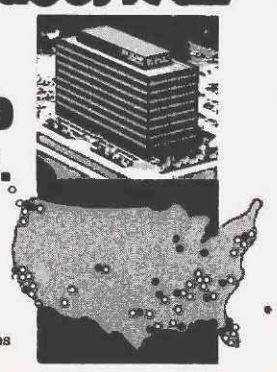

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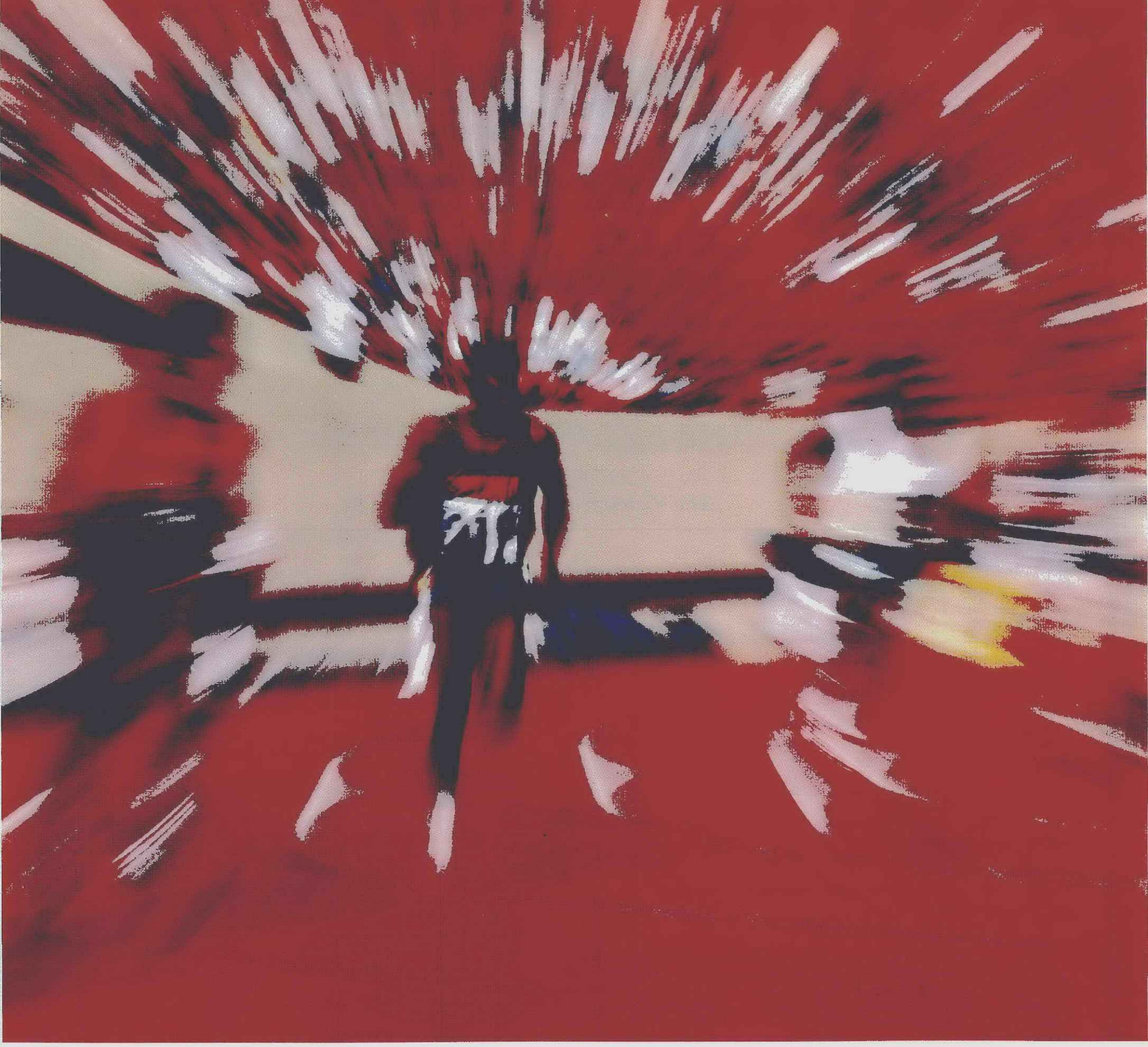

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AGENDA

Monday, October 31 **5:30-7:00 p.m.**
Early registration and cocktail reception. Browse the EBC Gallery and the Literature Gallery.

Tuesday, November 1

REGISTRATION **8:15 a.m.**
A continental breakfast will be served. The EBC Gallery and Literature Gallery will be open.

GENERAL SESSIONS

Opening Remarks **8:45 a.m.**
Kathryn McIntyre, Editor, Business Insurance.

The Art Of Persuasion
Ronald G. Hoff, Exec. VP & Creative Director, Foote, Cone & Belding
Unique in the field of presentation counseling, Mr. Hoff combines top-level, high-stakes business experience with exceptional presentation skills. This expert offers insight into the presentation skills needed to perusade any audience ... the techniques are the same, whether addressing your management or employees about benefits programs, or pitching a big account or proposing a campaign.
"The real measure of any presentation," Mr. Hoff says, "is whether the audience learned anything they can use that very day. It's nice if they're amused. But time is precious, and my main function is to help the audience be more productive, more persuasive, more profitable -- to their companies, to themselves."
This session, "A Presentation on Presentations," will motivate and inspire you.

Regulation & Legal Requirements
Jon Grogan, Partner in the Chicago based-law firm, Mayer, Brown & Platt
On September 2, 1974, the Emloyee Retirement Income Security Act (ERISA) was signed into law. With the enactment of ERISA came a legislatively ordered array of reporting and disclosure requirements intended to assure that private sector employee benefit plans would be operated and managed in the best interest of plan participants and their beneficiaries. This session will highlight the major reporting and disclosure requirements under ERISA and the manner in which the Department of Labor has been recently implementing these requirements through the regulatory process.

Explaining Salary Reduction Plans
Robert C. Penzkover, Director of Employee Benefits, The Quaker Oats Company
The 401 (k) plan has rapidly emerged as a staple product in a modern employee benefit package. Obtaining broad participation to meet discrimination tests depends almost entirely on an effective communication approach. This requires fostering a climate of individual responsibility to manage benefit and compensation planning. In this case, a few relevant numbers are worth a thousand words.

Luncheon

Wellness Programs
William E. Hembree, Director, Health Research Institute;
Denise Maleska, Director of Human Resources, CIBA-GEIGY Corp.;
Dr. Joseph C. King, Director of Employee Health Services, Continental Illinois National Bank & Trust Co. of Chicago
What employers can and are doing to change health habits and lifestyles is the subject of this panel. Concepts and techniques to be covered include cost-benefits, persuasion/motivation, behavior changes, incentives/disincentives, "new age" communications and approaches to employee interface, timeframes, etc.
Nationally recognized professionals will describe wellness programs, what works and what doesn't, an actual case study, accessing resources, and measurement and evaluation of results.

BREAKOUT SESSIONS
Breakout sessions afford you the opportunity to zero in on a specific problem you may be facing. Select the one session that best meets your needs.

Essential Elements/How To Work With Suppliers
J. Frank Swygert, Jr., President, Benefits Media Inc.;
LaRue Foster, Manager, Employee Benefits Communication, Corporate Communications Department, Boise Cascade Corporation
This joint presentation defines the vital components needed to implement an ongoing communications program and takes you through some of the possible pitfalls. Included is an analysis of the various target audiences, goals and necessary ingredients to make benefits communication effective. Case studies will be presented detailing from start to finish the required steps, subject matter, methods, procedures and monitoring of results. Whether you're working in-house or using consultants or production houses, this session provides the nuts and bolts for your decisions and the process of putting together effective communication programs.

Changing Benefits Strategy
Joseph W. Duva, Director, Employee Benefits & Compensation, SCM Corp.;
Dennis B. McKoy, VP and Co-Manager, Actuarial & Consulting Div., Johnson & Higgins
SCM Corporation recently amended their health care program to incorporate major cost containment provisions including increased employee contributions and the introduction of up-front deductibles for hospital charges. In addition, they introduced a 401 (k) feature in their RSIP. The major emphasis of their communication effort was placed on "net-effect" communications and establishing a rationale for the cost containment changes that employees could appreciate.
This session begins with defining the problem and includes developing the solution, setting communication objectives, analyzing the audience, selecting the media, implementing the program and measuring the effectiveness.

Cocktail Reception **6:00 p.m.**
Dinner/EBC Awards Presentation **7:00 p.m.**
Attend a reception and dinner honoring the winners of the 11th annual EBC Competition. One of the winning audio-visual programs will be shown..

Wednesday, November 2

GENERAL SESSIONS

A Look At This Year's Winners **8:45 a.m.**
Herbert Zeltner, Herbert Zeltner Inc., Marketing & Communications Consultant
Mr. Zeltner, invited for a return engagement at the Conference, takes an in-depth look at what makes a winning program. This lively, entertaining, informative session offers a glimpse at what other professionals are doing.

Innovative Ideas
Andrew Corn, Executive Producer, Ad Master;
Polly Carpenter, President, Carpenter Graphic Design, Inc.
This is a chance to pick up tips from two experts who offer innovative ideas for print and audio-visual communication approaches. A look at each medium separately as well as when, where, why, and how the two can successfully work hand-in-hand for your communication needs.

Luncheon
Edward Davey, Executive Director & General Counsel, Association of Private Pension & Welfare Plans
An exciting speaker addresses the question: What can employers do now and in the future to prevent the enactment of unfavorable benefits legislation?

Employee Attitude Surveys
Rhonda Karp, Ed.D., Associate Dean, College of Allied Health Sciences, Thomas Jefferson University;
James B. Weitzul, VP, Consultant, Johnson & Higgins
The theory and reality of using surveys to anticipate, measure, and predict employee attitudes toward benefits will be discussed from both the consultant and client point of view. The session will discuss how surveys invite employees into the overall benefit change process and thereby save the corporation and employees significant amounts of money.

Closing Remarks **The Conference adjourns at 3:30 p.m.**

In today's economic climate, corporations are particularly sensitive to the rising cost of benefits and are concerned about more efficient and effective ways to communicate the value of benefits to employees.

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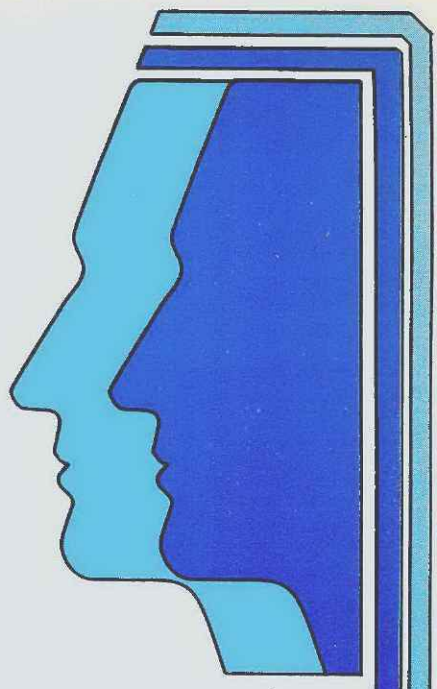

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10/17

Administration hopes to cut federal comp costs

ATLANTA—Federal workers compensation programs are inefficient, but the Department of Labor has a number of proposals that could cut their costs, according to Undersecretary of Labor Ford B. Ford.

"We need legislation at the federal level to correct the problems that have arisen in both the Federal Employees' Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act," Mr. Ford said at the annual convention of the International Assn. of Industrial Accident Boards & Commissions in Atlanta last month.

Both FECA and the Longshore Act are administered by the Labor Department.

FECA covers nearly 3 million federal civilian workers and costs the federal government about $1 billion annually, said Mr. Ford, who just assumed his post two months ago.

"And it is badly in need of reform," he added.

Since the early 1970s when Congress liberalized the program, FECA claims have increased to 193,000 in 1981 from 123,000 in 1974, an increase of about 57%.

During that same period, costs rose to $1 billion from $271 million, Mr. Ford said. "That's an increase of nearly 370%."

The Department of Labor has sent to Congress a draft bill to change FECA to provide greater incentives for injured workers to return to work and disincentives for them to abuse the FECA program, he said.

"For example, we are proposing a waiting period before benefits can be paid, a requirement which almost all state workers comp programs now have," Mr. Ford said.

"We are proposing to give the employer (the federal government) the right to require medical exams by agency-appointed doctors. And, we are asking that employees be paid 80% of their gross salary during the initial 45-day period, rather than 100% as we now do.

"This will eliminate the incidence of employees who have more in their pocket while on disability than they do while they work," Mr. Ford said.

"We are also proposing changes that would eliminate inequities in the system. These changes include setting the compensation rate without regard to family size," he said.

"We are also asking that scheduled awards be equalized so that the same injury does not provide greater payments to higher-ranking government employees," he added.

The administration also supports a bill, S. 38, which would cap benefit increases under the Longshore Act.

The bill, proposed by Sen. Don Nickles, R-Okla., would cap annual benefit increases at 5%. Currently, benefits are increased every October to match the annual increase in the national average weekly wage.

S. 38 was passed by the Senate earlier this year and is pending in the House Education & Labor Committee, where action is expected yet this year.

"We're also asking that work-related injuries covered under state programs no longer be covered by the federal (longshore) program," Mr. Ford said. "We also want to integrate longshore benefits with Social Security retirement benefits.

"As in FECA, our goal is to control runaway program costs and to bring federal programs more closely into alignment with successful state program practices," he said.

The administration is not trying to deprive disabled workers of the support to which they are entitled, but instead is trying to protect those programs that provide the benefits, he said.

Another bill before Congress that would impact the workers compensation system is H.R. 3175, proposed by Rep. George Miller, D-Calif. That bill would create under the Department of Labor a federal workers compensation program for workers who suffer from asbestos-related diseases.

Under the bill, federal compensation would be the sole remedy for these workers, superseding state work comp programs and barring third-party liability suits against asbestos defendants.

The Labor Department has not taken a position on Rep. Miller's bill.

The IAIABC is opposed to any federalization of workers compensation and the erosion of state authority. —*By Carol Cain*

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Quick treatment a must: Medical director

ATLANTA—The key to returning an injured worker to the workplace quickly often lies with the first-line supervisor, a company doctor says.

"We need to emphasize to supervisors not to be overly concerned whether an injury is compensable, but that we want to get it treated," said Dr. Eugene Sims medical director for AT&T Communications in Atlanta.

He cited a case in which an accident at work resulted in a small back problem for the worker.

"The supervisor raked him (the injured worker) over the coals," Dr. Sims said, and what was just a small injury turned into a lasting disability.

Aggravation from a supervisor often aggravates the injury, Dr. Sims noted.

In a similar case, "We began to pay a little attention to the worker and changed supervisors," and the injury did not get out of hand, he said.

Dr. Sims stressed the importance of the communication triangle—doctor, employer and employee—to members of the National Council of Self-Insurers, who were meeting concurrently last month with the International Assn. of Industrial Accident Boards & Commissions.

"There needs to be a good supervisor education program, teaching supervisors how to communicate with a worker after an on-the-job injury," he said.

The issue also was the subject of a presentation by claimant's attorney Don L. Hartman of the Rossville, Ga., law firm of Harriss, Hartman, Aaron & Townley.

He painted pictures of injured workers who aggravated their injuries because they weren't given specific enough information.

For instance, one worker wound up with soggy gauze under a plaster leg cast after taking a bath to relieve the itching. No one apparently told the worker not to get the cast wet, he said.

"The injured worker just isn't talked to by the company physician," Mr. Hartman said.

He also emphasized the importance of communication "and pathos" by employer representatives, like the company doctor, as a method to prevent on-the-job injuries from becoming long-term disabilities. ■

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Insurer ordered to indemnify college for sex-bias lawsuit

ANNAPOLIS, Md.—A CNA Financial Corp. subsidiary will appeal an order by the state Insurance Division that it must provide coverage to a college in a pending sex-discrimination suit.

The order against Continental Casualty Co. stems from a dispute involving a lawsuit filed by a former female professor with the federal Equal Employment Opportunity Commission against Anne Arundel Community College of Arnold, Md., in 1977 (*BI*, Aug. 22)

The suit, which gained class-action status last year, alleges that AACC discriminated against 62 current and former female faculty members in both pay and benefits.

Continental's appeal will be filed with the Baltimore State Circuit Court, according to Stuart P. Ross, an attorney representing Continental Casualty.

The appeal will contend that the insurance division does not have authority to make determinations in disputes over coverage, such as the one involving AACC, he said.

Rather, this question should be decided in court, Mr. Ross said, adding that Continental filed such a suit in mid-summer with the U.S. District Court for the State of Maryland.

Continental contends that AACC's $2 million comprehensive general liability policy does not cover a back-pay settlement with the female employees, because the college was unjustifiably enriched by paying the women lower salaries.

But Assistant Maryland Insurance Commissioner Thomas P. Raimondi, in a mid-September ruling, sided with the college's position that its liability policy does cover a back-pay settlement, which could amount to as much as $500,000.

Continental Casualty also was fined $10,000 for unreasonably delaying payment of the back-pay settlement.

Had Continental provided payment, college officials said, an out-of-court agreement with the teacher could have been reached. ■

Michigan state fund rate cuts opposed

Continued from page 2

with a $15 million surplus in 1977. The fund, originally established to serve the residual market, is the fourth-largest work comp insurer in the state, writing about $21 million in premium last year, while paying $17.7 million in losses.

Michigan ranked seventh in the nation last year with a total of $522 million in written workers comp premium, according to A.M. Best Co. Inc.

Before the open rating law went into effect earlier this year (*BI*, April 4), workers compensation rates in the state were filed by the Workers' Compensation Rating & Inspection Assn. of Michigan. The new law abolished the WCRIAM and Ms. Baerwaldt believes that statute gives her the power to make sure that the Accident Fund is "neither more nor less than self-supporting."

But insurers and self-insurers alike say they do not think the Michigan workers compensation insurance market needs any manipulation by the commissioner to increase competition.

"The companies in our association are at or near the break-even point currently. I can't imagine that they can swallow another 17% cut," said Terry Buckles, president of the Michigan Assn. of Insurance Companies in Lansing.

"There are those of us in business who fear that soon there won't be a reasonable market," added R.A. MacAskie, vp of Corporate Services Inc., a Grand Rapids self-insurance administration firm.

The lower rates in the past two years—partly the result of the open rating law and partly the result of a 20% rate decrease mandated last year by the Legislature—is one of the factors that may have driven 38 self-insurers back to commercial insurance last year and 39 self-insurers this year, a state Labor Department spokesman said.

But self-insurers don't believe the proposed rate reduction will have a great effect on their numbers.

"Self-insurance is down. But a lot of companies want to remain self-insured and will remain that way regardless of rates," Mr. MacAskie said.

Employers groups are worried that interference in the market by Ms. Baerwaldt could hurt, rather than enhance, competition.

"Our concern is that the competitive framework set up by the Legislature has not had the opportunity to function. We're concerned that if there is not competition, we may end up with a monopolistic state fund," said James Barrett, president of the Michigan State Chamber of Commerce in Lansing.

Six states, including neighboring Ohio, currently operate monopolistic state funds and bar workers compensation insurers from writing coverage.

"The long-range implication of these actions is quite disturbing," Mr. Buckles added. Current developments must be viewed as a possible step toward establishment of a monopolistic state fund.

"If state government is allowed to depress rates in the marketplace, regular carriers could be forced to withdraw. Then a state-controlled monopoly could be created to become the only source for workers comp for Michigan employers," he said.

Ms. Baerwaldt, whose term as insurance commissioner is set to expire this month, denies charges that there is a master plan to create a monopolistic state fund.

"The legislators mandated open and competitive rating. Their intent is clearly to have open rating," she said.

Even legislators are worried about the turn of events.

"I think what the governor is attempting to do is create a monopolistic fund, like in Ohio," said House Minority Leader Michael J. Busch, R-Saginaw.

Gov. James Blanchard is taking credit for reducing state fund rates, calling the move one of his plans to get the business climate in Michigan back on its feet.

The state fund controversy isn't the only work comp issue opposed by both employers and insurers. They're also criticizing the recent appointment of Clifford D. Allo as chairman of the 15-member Worker's Compensation Appeal Board, which hears contested work comp cases.

Mr. Allo, a 37-year-old former University of Detroit law professor, served as a counsel-consultant to the United Auto Workers union several years ago while Michigan workers comp laws were being amended.

"He was a UAW hatchet man. He set up roadblocks for workers comp reform, even though he's very intelligent and very nice," said Bernice Clark, the owner of Yummy Land, a Detroit store that sells baked goods, candy and sodas. She also is founder and director of the 6-year-old Board of Michigan Businessmen.

"We don't question the governor about his right to appoint Allo to the board, but we have a concern about his being in the role of chairman," the Chamber's Mr. Barrett said.

"The chairman not only has the role of administrator, but also influences workers compensation policy and proposed changes," he explained.

However, the Michigan Manufacturers Assn., another large employer group, is remaining neutral on the appointment.

"Everyone is prejudging Allo before he ever decides a case," said Richard E. Augenstein, vp of government affairs for the MMA.

Mr. Augenstein also pointed to Mr. Allo's recent announcement that a blind-draw system of assignments will begin at the Appeal Board Nov. 1. The new procedure will "blindly" select the cases the board's five three-member panels will hear.

"On that basis, I have no control over where each file goes," Mr. Allo said.

Mr. Allo agrees with Mr. Augenstein that his critics have prejudged him. "My guess is that people are going to be surprised that I'm a moderate employee rep on the board," he said.

Republican legislators, however, are urging employers to contact the governor and members of the Senate Administration, Rules and Elections Committee to cite their opposition to Mr. Allo's appointment. That committee has scheduled a confirmation hearing on the appointment for Oct. 19.

Meanwhile employers, insurers and workers comp administrators are trying to wrestle with some of the other problems facing the Michigan work comp system.

For instance, the MMA is developing a list of priority items that will be given to legislators for their consideration. Better definitions of disabilities and strengthening and reasserting the exclusive remedy doctrine will be on the list, Mr. Augenstein said.

The governor also has appointed a University of Michigan law professor, Theodore J. St. Antoine, as a special counselor to review the entire state work comp system.

Mr. St. Antoine, who will not be paid for his services, expects to have a report ready sometime next year.

"I will systematically search out both opinion and data from every interested group that I can identify," said Mr. St. Antoine, who will teach workers compensation law at the university next term.

One of the things Mr. St. Antoine is expected to examine is the backlog of cases at the Bureau of Workers' Disability Compensation. As of Aug. 1, 38,000 contested cases were backlogged in the bureau, according to Director Rudy Redmond. So far this year, about 23,000 cases have been heard.

The 29 administrative law judges who currently hear the cases are expected to be supplemented by 12 to 14 more judges next year after a new law goes into effect Jan. 1. That law will require a $100 filing fee by both parties for redemption cases—those cases in which an employer's future liability is ended with a lump-sum settlement.

About 70% of Michigan's contested cases are settled by redemption, Mr. Redmond said, noting there were 18,000 such cases last year.

The $100 filing fee is expected to net at least $3.6 million next year, enough money to hire the additional administrative judges, a systems analyst and clerks, Mr. Redmond said. ■

Panel to study health coverage

SPRINGFIELD, Ill.—Gov. James M. Thompson signed a bill last month that sets up a commission to monitor health insurance and health care costs.

The Commission on Health Assistance Programs will study insurance and assistance programs and will recommend possible changes to both the governor and the state General Assembly.

The commission is composed of the directors of the state Insurance and Public Health departments, eight members of the state Legislature and six members of the public appointed by Gov. Thompson, a Republican.

Virtually every aspect of private and public health care coverage available in Illinois will be studied by the commission, including plans established under the auspices of the federal government.

The Commission on Health Assistance Programs intially was established in 1981 to study catastrophic health insurance. It received no funding in fiscal 1981, but received a $130,000 appropriation in fiscal 1982.

It has been estimated that at least $150,000 will be required to fund the commission during the coming year. ■

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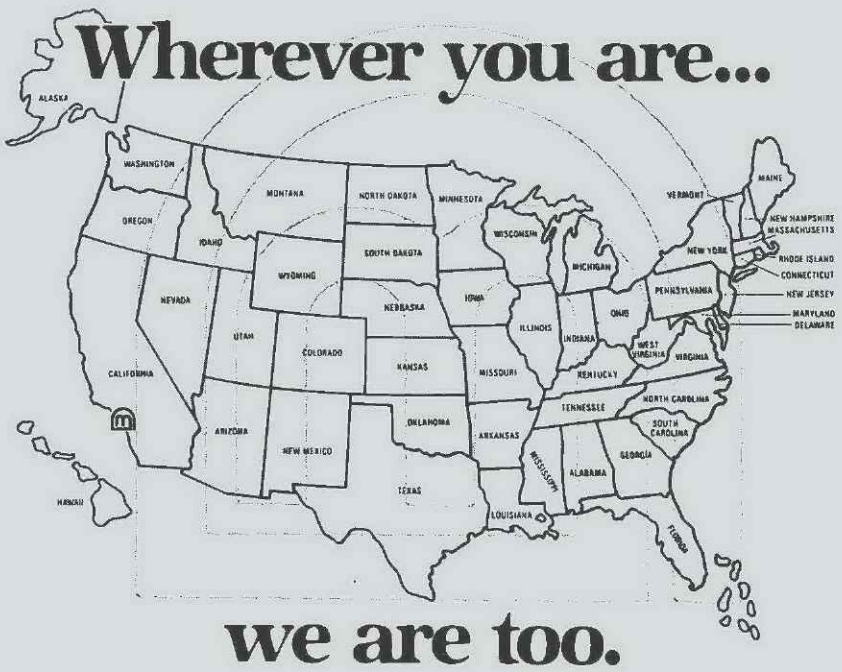

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Raymark could seek reorganization: Attorney

Continued from page 2
reorganization under Chapter 11 of the Federal Bankruptcy Act because of their inability to handle overhelming asbestos litigation.

Raymark currently faces about 14,000 suits involving 17,000 asbestos claimants and has paid out about $19 million in defense and claims costs.

In addition, Zurich Insurance Co., one of Raymark's several primary insurers, has paid more than $33 million on the company's behalf, according to Zurich attorney Peter C. John of the Chicago firm of Phelan, Pope & John.

Other Raymark insurers, including Commercial Union Insurance Co. and Federal Insurance Co., contend they are not liable since the asbestos claims do not fall within their coverage period.

Recently, however, CU and Federal agreed to pay about $1 million to Raymark, with Federal paying $750,000 and CU $250,000, according to Mr. Heap.

Mr. Heap's comments about Raymark's future came at a hearing on the implementation of a coverage decision handed down by Judge Murray in late September that is generally considered favorable to Raymark.

That decision said that coverage is triggered both during the period when a victim inhales asbestos and during the period when the disease is manifested in the victim, often many years later (*BI*, Oct. 10).

How that decision will be implemented, however, is still uncertain. Which insurers will have to defend and indemnify Raymark and how they will go about doing it were left unresolved by the ruling.

Raymark is concerned that consideration of these issues could further delay payments from insurers, which would put the burden of defense back on its own shoulders, Mr. Heap argued.

Both Zurich and Raymark contend that the coverage and defense allocation issues have been partially argued already and can be settled quickly.

"It's my impression that the issues aren't that complex and can be dealt with rapidly," Mr. Heap said. A lengthy delay would require the parties to argue issues already decided, he said, adding that Judge Murray's order was good on its face.

But attorneys representing Commercial Union and other insurers did not agree that Raymark was in serious financial danger or that the court should order interim funding before various motions are considered.

Barry Kroll, representing Commercial Union Insurance Co., said Mr. Heap was "just crying wolf" by contending Raymark was in serious financial trouble.

"I don't think the investment community or Raymark itself feels it is in a bankruptcy situation," Mr. Kroll of the Chicago firm of Jacobs, Williams & Montgomery said last week.

"It is a stong company and can afford to expend these funds."

Whether Raymark can afford to pay is not a reason for the court to avoid dealing with legal issues or to impose obligations on insurers for which they did not contract, he added.

Mr. Kroll said that Commercial Union will file a motion for reconsideration of Judge Murray's order and also one for clarification and amplification on various defense and allocation issues.

One purpose of these motions will be to establish a record so that when the case goes before an appellate court, all issues could be considered.

Besides asking for a quick resolution of the allocation issue, Mr. Heap said Raymark will ask the court to refuse to consider CU's contention that primary insurers are not required to provide a defense if the limits of pre-1966 policies are exhausted.

CU, though, recently obtained a ruling from a Pennsylvania court that said primary insurers *should be required* to provide defense after limits are exhausted. Mr. Heap contends that CU should be "judicially estopped" from arguing the opposite in the Raymark case.

(CU is a successor company to Employers Liability Assurance Corp., which was a primary insurer for Raymark from 1941-1945 and 1947-1950.)

But Mr. Kroll defended CU's contention that Raymark's primary insurers should not be forced to defend after limits are exhausted.

"I don't think you can ever have estoppel on a question of law," he said. "That (Pennsylvania) case doesn't bind us to that position."

He added that the contracts between CU and Raymark are governed by the laws of New Jersey, Connecticut or Massachusetts and that the laws in those states may differ from those in Pennsylvania.

"The reason we're making the motions is not for delay," he added.

Mr. Kroll indicated that interim funding arrangements could be worked out with Raymark, but they should be independent of the legal issues before Judge Murray.

Mr. John, the attorney for Zurich, added that Zurich wants to know what its obligations are, particularly with respect to its duty to defend and how costs will be allocated among insurers.

Zurich ultimately expects to recoup some of the $33 million it has paid to Raymark after the court determines how coverage allocation should take place, said Mr. John.

"Zurich has complied with its obligations all along. It's not in Zurich's interest to stall," he added.

Raymark's primary insurers include Zurich, CU, Federal and Globe Indemnity Co., which insured Raymark as far back as 1941. Northbrook Excess & Surplus Insurance Co, an excess insurer of Raymark since 1976, was also named in Raymark's coverage suit.

The parties have until Oct. 29 to file petitions for reconsideration or clarification and amplification of last month's order. A status hearing is set for Oct. 31.

A briefing schedule on the issues for clarification will be set up, followed by a final opinion by Judge Murray. The parties will then have 30 days to appeal. ■

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PBGC gives Rath more time

Continued from page 2
Rath said it would pay the PBGC about $13 million as well as turn over a share of future profits in exchange for a quick PBGC takeover of the plans and their $38 million in liabilities.

The 1982 agreement called for Rath to pay $1.8 million to the PBGC in 1982, as well as $1.7 million to cover the minimum contributions Rath was supposed to have made to the plans in 1980. The Internal Revenue Service had earlier given Rath permission to temporarily waive the 1980 contributions because of the company's troubles.

Rath paid the $1.8 million to the PBGC last year; last week's agreement gives Rath more time to pay the $1.7 million to the PBGC.

Last week's agreement does not affect Rath's earlier promise to pay the PBGC $750,000 annually for 13 years beginning in 1985, which comprises the bulk of the $13 million Rath said it would pay.

The original agreement between Rath and the PBGC forestalled what could have been a lengthy legal battle. Under the Employee Retirement Income Security Act, the PBGC has a right to collect 30% of a company's net worth to pay vested pension benefits when an employer terminates an underfunded pension plan.

However, conflicts can occur in this process because the PBGC and the employer may use different formulas to determine net worth.

The 1982 agreement between Rath and the PBGC eliminated a possible conflict over the issue. Rath's lenders had been reluctant to extend working capital to the company until the net worth issue was resolved.

The PBGC also gained from the 1982 agreement. If Rath's financial problems had forced it into bankruptcy, the PBGC might have gotten nothing from Rath except its pension liabilities.

PBGC Executive Director Edwin Jones believes the 1982 agreement "was a responsible thing to do at the time." In addition, Mr. Jones says last week's agreement to give Rath more time to pay some of its debt is an equitable solution to a complex problem.

"Fundamental to the solution was the finding of an arrangement that would reasonably protect PBGC's obligations to plan participants and, at the same time, enable Rath to continue in business on a financial basis considered sound by Rath," Mr. Jones said.

If Rath cannot pay its debt to the PBGC, even under the easier terms, the debt ultimately will fall on other employers.

Under ERISA, employers with defined benefit pension plans must pay an insurance premium to the PBGC to guarantee pension benefits for workers whose companies go broke or, like Rath, terminate insufficiently funded plans.

Rath officials could not be reached to comment on the latest agreement with the PBGC. ■

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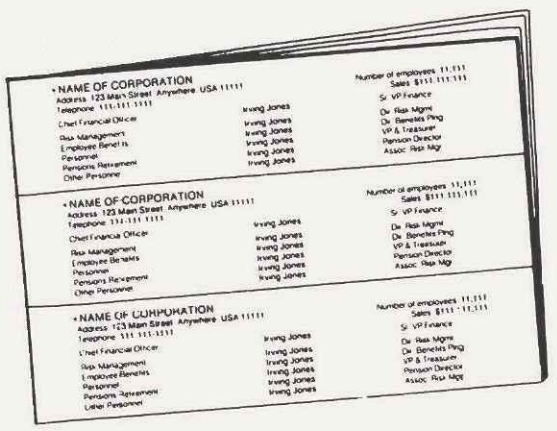

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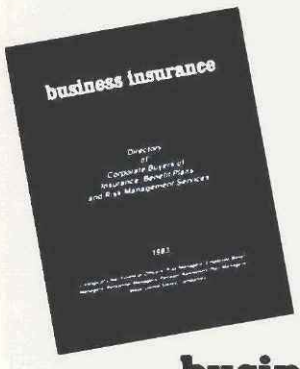

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1,000-year-old Viking village uses modern loss control

Continued from page 2

The trust, a non-profit organization, was established in 1972 to complete "rescue digs" in and around the city.

Underneath almost every section of York are remnants of past civilizations that had conquered England and used York as the capital of their northern territory.

For instance, the Romans occupied the area between 40 B.C. and 400 A.D. In fact, Emperor Constantine was crowned in York in 306. The archaeological trust is currently excavating an insurance company parking lot in search of a Roman building.

Several hundred years after the Romans left, the Vikings conquered Britain and set up a city called Jorvik, now York, which is the subject of the new exhibit.

The York Archaeological Trust attempts to unearth the remnants of the ancient cities underneath York before too much is built on top of them. It now employs about 60 people, including about 25 archaeologists.

"We go in before a great big pile of concrete goes in and crushes anything in the layers of soil below street level," a trust spokeswoman explains.

The trust's biggest task to date has been the restoration of the Viking ruins, which lie underneath a modern shopping center, and their transformation into the Jorvik Viking Center for public display.

Amid the 9 meters of Viking debris the archaeologists discovered are wooden structures, metal objects, leather boots, Viking padlocks and even a sock.

Although locating and unearthing the Viking village was a major task, the trust found that trying to meet the fire regulations for a public attraction was almost as tough. But visitors to the center will find that safety equipment and procedures will not detract from the exhibit.

Visitors will glide through the Viking village in groups of four while riding in electric cars. Since visitors do not leave the automated cars, security and safety officials will know exactly how many visitors are in the building housing the exhibit and exactly where they are in case of an emergency.

On their journey through time, visitors will pass several thatched roof cottages, authentic except for the fact that the thatch is only 5- to 6 inches thick instead of the usual 15 inches to reduce the chance of a fire. The thatch also has been treated with a fire-retardant solution.

And although they will be able to see how Vikings lived 1,000 years ago, the visitors will not be able to see the smoke extraction system or closed-circuit television cameras.

Despite the age of the exhibition, these safety and security features will make the village easy to insure, the trust's Mr. Gayner says. "It's an easier item to insure than a 50-year-old museum."

Mr. Gayner reckons that the entire exhibit will be insured for about $15 million. The trust's insurance broker, Bain Dawes Ltd. in Leeds, England, is now placing the insurance. ■

Wrong firm faces asbestos lawsuits

Continued from page 3

"Rockwool Industries Inc. does not manufacture, fabricate, distribute, supply, sell or in any other way have any connection at all with asbestos or asbestos-related products," the affidavit says.

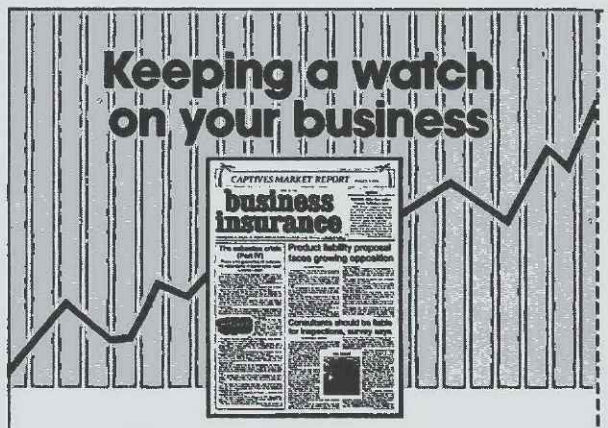
So far plaintiffs' attorneys have been very cooperative about dropping the suits once the true nature of Rockwool's product is explained.

"We've been able to get dismissed from all of them as soon as we explain it to plaintiffs' counsel," Mr. Kurtiss says. "To date we've had good cooperation from plaintiffs' counsel."

Rockwool has not yet had to appear in court to defend against any claims, Mr. Kurtiss says. But still, Rockwool wants to get the record straight before the lawsuits come in.

To do so, the manufacturer recently started a campaign, "an educational program," according to Mr. Kurtiss, to let plaintiffs' attorneys know Rockwool shouldn't be sued.

"All we're trying to say is don't come after us. There's no basis for you doing so." ■



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December 14 & 15, 1983
The Doral Hotel and Country Club
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- Current U.S. tax, legal and regulatory problems facing captive insurers;
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December 13, 1983

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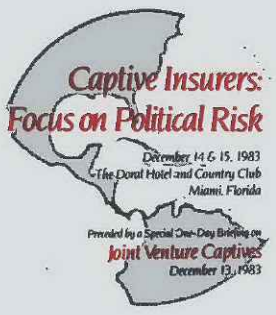

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Insurers to pay most of Love Canal settlement

Continued from page 1

- Highlands Insurance Co., which underwrote two $50,000 primary liability policies from 1976 to 1978.
- Central National Insurance Co., which underwrote two $950,000 in excess of $50,000 policies from 1976 to 1978 and participated in other policies through 1979.
- Insurance Co. of the State of Pennsylvania, Stonewall Insurance Co. and Harbor Insurance Co., which shared with other insurers several excess liability policies for $4 million in excess of $1 million from 1977 through 1979.
- National Union Fire Insurance Co. of Pittsburgh, Pa., and other American International Group Inc. insurers, which provided $1 million in primary liability insurance from 1978 through 1979 and participated in several excess insurance policies for various limits at various times from 1967 through 1979.
- California Union Insurance Co., which shared $4 million excess of $1 million in coverage in 1978 and 1979.

Conspicuous by its absence from the contributors is Argonaut Insurance Co., which underwrote a low-level excess policy for Occidental from 1974 through 1976 and participated in higher excess policies from 1973 through 1976.

Argonaut, which encountered financial difficulties during the 1970s, is still embroiled in litigation relating to many claims from this period and is not being pressed to contribute to the Occidental settlement at this time, a source explained.

The settlement—which includes as co-defendants Occidental subsidiary Occidental Chemical Corp. (formerly Hooker), the city of Niagara Falls, the Niagara Falls School District and Niagara County—"is not an admission of any negligence on the part of the company and should not be viewed or interpreted as such," Occidental's Mr. Hammer said in his prepared statement.

"Recognized medical authorities who have studied Love Canal thoroughly have publicly concluded that there is no established medical link between the landfill and claimed illnesses," he added.

The question of negligence, however, may not be the only unresolved issue in the announced settlement.

Richard Lippes, a Buffalo, N.Y., attorney who is representing the 1,345 plaintiffs involved in the announced settlement, told *BI* that Occidental's public statement was premature and that no final settlement has been agreed upon.

"We have had some significant breakthroughs. That's true," Mr. Lippes said. "But there is a whole range of issues still to be decided, not the least of which is the total dollar value of the settlement and how that money will be apportioned out to the claimants."

Also at issue is a release from damages Occidental is seeking from the plaintiffs.

"We are negotiating on a daily basis and we think that the horizon for completing a settlement is short, perhaps two weeks to a month," Mr. Lippes said. "But the possibility remains that negotiations could collapse and that we will proceed with litigation."

Mr. Lippes could not confirm which insurance companies are contributing to the settlement fund, adding that he "really didn't care where the money came from as long as (his) clients get what they deserve."

However, Mr. Lippes remarked that "Occidental's insurance arrangement is one of the most complex and confusing I have ever seen."

David Floyd, an attorney with the Buffalo law firm of Phillips, Lytle, Hitchcock, Blain & Huber and chairman of Occidental's defense team, confirmed that the settlement is not yet final but said the total value had been agreed to, along with the joint participation of Occidental and its insurers.

Although Mr. Floyd said the agreement in principle did not preclude subrogation or other conflicts among Occidental's insurers, other sources involved in the litigation said that a moratorium on coverage disputes, which was agreed to before the settlment process began, should continue to apply.

In 1978, Occidental sued primary and excess insurers to clarify its liability coverage. Several years ago, though, Occidental and the insurers agreed to a moratorium on the coverage litigation, pending the outcome of settlement negotiations with the plaintiffs.

Sources also noted that while a final agreement may be submitted to a federal judge for approval in as little as two weeks, funding and allocation of the settlement could take as much as one year to complete as individual plaintiffs fight among themselves for portions of the fund or reject the settlement offer altogether.

If all the suits encompassed by the agreement were settled, Occidental would still face approximately 36 personal injury suits, as well as a lawsuit filed by the federal government seeking to make Occidental pay Love Canal cleanup costs. ■

Seminar to focus on financial services

COLUMBIA, S.C.—A joint All-Industry Day seminar and luncheon will be held Nov. 9 in Columbia.

The topic of the seminar, sponsored by the South Carolina Chapter of the Society of Chartered Property & Casualty Underwriters and the Palmetto Chapter of the Risk & Insurance Management Society, is the integration of financial services and its impact on the insurance industry.

The cost of seminar and lunch is $25. For more information or to register for the seminar contact Cathy Breitman, The Seibels Bruce Group Inc., P.O. Box 1, Columbia, S.C.; 803-748-8323. The registration deadline is Nov. 1. ■

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Insurance Management: vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc.	5,865
Government, Associations, Unions, Educational Institutions	1,024
Commercial Consumers Sub-total	**23,176**
Insurance Agents & Brokers	9,639
Insurance Cos.	5,384
Financial Institutions	385
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,779
Others allied to the field	1,020
TOTAL	**42,383**

*Source: Business/Occupational breakdown of qualified circulation, May 2, 1983 issue, as submitted to BPA for June 1983, BPA Publisher's Statement.

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Risk Retention Act

Continued from page 1

want to form new groups under the act.

For example, last year the NAIC passed, over the objections of several business groups, a model bill that would restrict a risk retention group to funding only those product liability risks recognized under the laws of the state in which it is chartered.

Because state product liability laws differ, risk retention groups under the model law would be subject to the conflicting requirements of the various states, making it impossible for them to operate, some experts have predicted (*BI*, Oct. 25, 1982).

So far, Texas is the only state to adopt the NAIC model bill.

Last year, Mr. Elliott, the Delaware insurance commissioner, told the Home Owners Warranty Corp. that HOW Insurance Co. was not a risk retention group.

Other state regulators quickly followed Mr. Elliott's lead.

In Texas, the state government returned a $146,642.63 check that HOW had sent to pay premium taxes on policies it sold to home builders in that state in 1982.

Lyndon Olson Jr., a member of the Texas State Board of Insurance, said it would not accept HOW's premium check until Mr. Elliott certified HOW as a risk retention group (*BI*, May 30).

And in Georgia, Insurance Commissioner Johnnie Caldwell issued a cease-and-desist order to stop HOW from selling insurance in the state.

The department considered HOW an unauthorized insurer because it had not been certified as a risk retention group in Delaware, its home state. HOW later won an injunction in federal court that stays Mr. Caldwell's order.

In May, HOW went to federal court to obtain the ruling that it was indeed a bona fide risk retention group.

In his 22-page opinion, Judge Stapleton dismissed most of Mr. Elliott's reasons why HOW could not be considered a risk retention group.

In the most significant point, Judge Stapleton dismissed Mr. Elliott's contention that state law, and not the broad definition of product liability as contained in the federal Risk Retention Act, determines whether HOW really is writing product liability insurance.

Mr. Elliott said HOW wrote surety and property coverages, based on Delaware law.

But Judge Stapleton said there is only one law that defines the product liability risks a group can offer: the Risk Retention Act.

"This federal definition necessarily pre-empts any state definition," Judge Stapleton wrote.

Mr. Elliot also contended that even if federal law applies, HOW does not sell product liability insurance because the new homes its policyholders build are not products. Under the act, product liability covers damages arising out of the manufacture, design, lease or sale of a product.

But Judge Stapleton noted that courts have recognized that homebuilders that assemble raw materials and components do so in a process comparable to that used by manufacturers of other products.

"There is thus nothing in the nature of the liabilities or the needs of the home-building industry that might have motivated Congress to draw a line that would exclude it from the scope of the RRA. I similarly decline to draw such a line," he said.

Mr. Elliott also objected to HOW because he said the company's insurance program against major structural defects that may occur between three and 10 years after a new house is sold is property coverage, not product liability insurance.

Under the major structural defect policy, HOW promises its policyholders—home builders—that it will repair, replace or pay for damage caused by defects for which the builder is liable.

This coverage, in reality, is property loss coverage to the homeowner, Mr. Elliott argued. Such coverage would be illegal since the Risk Retention Act says a group can only provide coverage to member-owners, not to the general public.

But Judge Stapleton rejected that analysis. The structural defects policy is issued only to a participating builder in return for the payment of premiums based, in part, on that builder's claims experience.

"Homeowners themselves cannot buy HOW's insurance. . . .Accordingly, I conclude that this coverage is not a subterfuge for selling property loss insurance to homeowners," Judge Stapleton said.

However, the judge said a minor portion of the HOW program, in which HOW guarantees builders' warranties during the first two years after a new house is sold, is not product liability insurance because there is no spreading and sharing of risk among member-owners of the group.

Under this part of the program, if a builder defaults on its home warranty, HOW guarantees the warranty. HOW then can recover resulting expenses from the defaulting builder.

"HOW insurance performs a builder's obligation under the warranty if the builder does not and has a right to be paid for doing so. Accordingly, it does not assume and spread any potential liability of the builder," Judge Stapleton said.

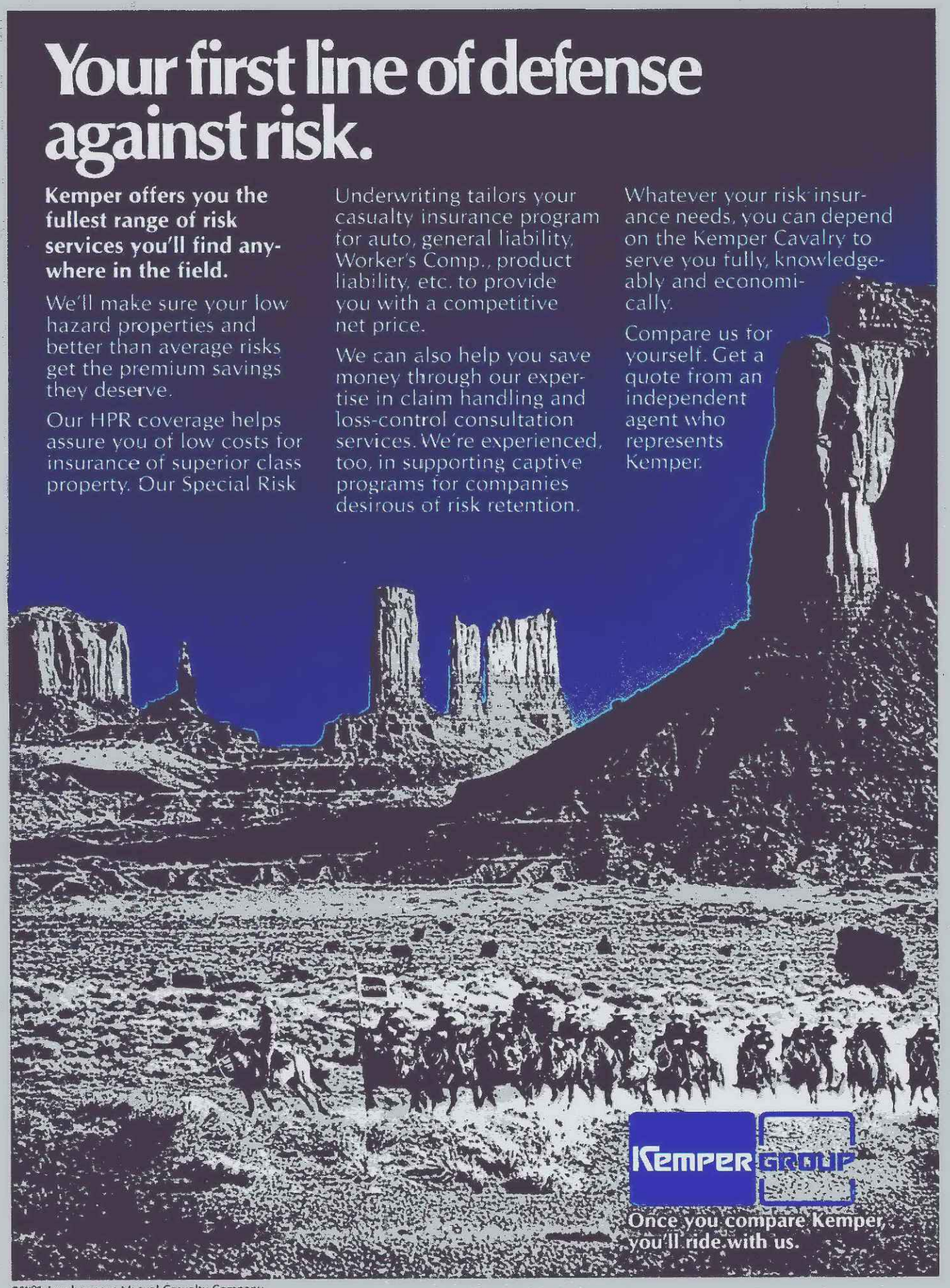
However, even though part of HOW's coverage did not qualify as product liability insurance, that doesn't mean HOW is not a risk retention group.

Judge Stapleton noted that under the act, a group qualifies as a risk retention group if its primary activity consists of assuming and spreading the product liability exposures of its members.

HOW counsel Terence S. Cooke said the "overwhelming majority" of HOW coverage is for major structural defects, which Judge Stapleton ruled is product liability insurance.

HOW will file papers with the court to prove that the structural defect policy is HOW's primary product. It also is possible that HOW might alter its builder's default policy, a source said.

Commissioner Elliott declined to comment on the case because of its "sensitivity and because it is in litigation." ■



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Deductibility of work comp reserves upheld

Continued from page 1

"There's no question that a lot of companies have been watching this case very closely," said Paul H. Dawes, a lawyer with the San Francisco firm of Thelen, Marrin, Johnson & Bridges, which represented Kaiser.

"This case goes as far as it's reasonably possible to go in giving self-insurers the flexibility to claim a deduction," added Marc M. Levey, a former Justice Department attorney who argued the lower-court case for the government, but who now represents self-insurers as a member of the San Francisco firm of Baker & McKenzie.

The appeals court upheld a decision entered in Kaiser's favor last August by Judge William A. Ingram of the U.S. District Court for the Northern District of California (*BI*, Oct. 11, 1982).

The decision applied only to the 1964 tax year, in which Kaiser started self-insuring its workers compensation risks. That year, Kaiser took its normal tax deduction for paid claims, plus a $425,418 deduction for uncontested claims it said would become payable in the future for injuries suffered during 1964.

The IRS disallowed the reserve deduction, and Kaiser paid additional tax under protest while filing its lawsuit against the government.

Judge Ingram granted the company a $146,151 tax refund plus interest and attorneys' fees, which have brought the award to about $475,000, according to Mr. Dawes.

Central to Kaiser's case on both the trial and appellate court levels was whether the company met the so-called "all-events test," a federal rule governing tax deductions.

Under the all-events test, Kaiser had to prove two things:

- That all of the "events" controlling the fact of Kaiser's liability for workers' comp losses had occurred during the tax year.
- That the amount of its liability for the losses could be determined with "reasonable accuracy."

In its now-famous 1975 Crescent Wharf & Warehouse decision, the 9th Circuit ruled that for uncontested workers' comp claims, the injury itself is the only "event" necessary to prove an employer's liability under the all-events test.

The government argued in its appeal of the Kaiser case that the fact of Kaiser's liability wasn't established until the amount of the liability could be accurately calculated.

But U.S. Circuit Judge Charles M. Merrill, writing for the appeals court, rejected this argument, pointing to Crescent Wharf and noting that if it agreed with the government's position, it would be "fusing" the two prongs of the all-events test into one.

The main issue before both the trial and appeals courts was the second prong of the test: whether Kaiser had determined its liability with "reasonable accuracy."

The 9th Circuit's ruling in the Kaiser case is the first time the appeals court has considered this second issue. In Crescent Wharf, the appellate judges remanded the case to the trial court for consideration of how "reasonable accuracy" may be determined, but Crescent Wharf settled before the new trial was heard.

In its appeal in the Kaiser case, the government argued that the amount of Kaiser's liability for workers comp claims should be "fixed, definite and determinable by objective facts" before a deduction could be claimed.

It also contended that the accuracy of reserves must be proved on a case-by-case basis and that accuracy in the aggregate is not sufficient for income tax purposes.

The government said that in several individual cases, Kaiser established reserves for claims that it never paid and that in other cases the reserves were "considerably off the mark."

The fact that the reserves were accurate when taken as a whole doesn't qualify it for a deduction, the government claimed.

Mr. Dawes called the government's method for calculating the accuracy of Kaiser's individual reserves "self-serving and self-generated," indicating that the government distorted the differences between what was reserved for and what was actually paid.

Judge Merrill came down solidly against the government, pointing out first that the law requires only that reserves be estimated with "reasonable accuracy," not that they be "fixed, definite and determinable" amounts.

The appellate court also upheld Judge Ingram's ruling that aggregate accuracy is enough to satisfy the all-events test.

The 9th Circuit's opinion points out that Kaiser reserved $425,418 as of Dec. 31, 1964, and paid out $455,737 in claims from that year between January 1965 and December 1979. That translates to a difference of only 7%, and Kaiser underreserved rather than over-reserved, Judge Merrill noted.

Although there were individual inaccuracies in Kaiser's reserves, they all involved minor injuries and had no effect on the accuracy of the aggregate figure, he added.

The ability to use an aggregate accrual of reserves for tax purposes is one of the crucial elements of the decision, according to Mr. Dawes, who called it a "practical, applicable and scientific" method for meeting the "reasonable accuracy" test required for deductions.

Most companies, faced with having to make accurate reserve estimates for each individual case, would be deterred from even attempting to take a tax deduction, he indicated.

While acknowledging court testimony that Kaiser's reserving practices were better-developed than was typical at the time, Mr. Dawes added that other self-insurers need only follow "textbook, workmanlike" procedures to succeed in their pursuit of a deduction.

"This decision doesn't apply only to the hypersophisticated taxpayer," he explained.

"It certainly makes clear what the District Court was trying to say, in that self-insurers will no longer be subject to the rigors of previous case law in establishing accruals for deductions," Mr. Levey said.

In arguing its case, the government pointed to court rulings from other circuits, along with three cases decided by the U.S. Supreme Court, that it claimed contradicted the 9th Circuit's ruling in Crescent Wharf on the all-events test. These other cases, the government said, showed that the fact of liability isn't established if there are any events that occur after the end of the tax year that relieve the employer of its obligation to pay.

Judge Merrill dealt with each of these cases in his opinion and concluded that there was no contradiction.

Still, the issue of intercircuit conflict could be raised by the government if it seeks a Supreme Court review of the decision, Mr. Levey suggested.

A Justice Department lawyer involved in the case said the government has several options it could pursue, only one of which would be filing a writ of certiorari. He would not comment on which option the government plans to pick.

The government will have to file notice of its intention to file a writ of certiorari by mid-January. Given that hundreds of millions of dollars in tax revenues are at stake, both Mr. Dawes and Mr. Levey think this is likely.

"I would be very surprised if the government didn't seek a writ of certiorari to the Supreme Court," Mr. Levey said. "Get your tickets now."

Some California self-insurers that haven't yet taken reserve deductions may not wait for a Supreme Court decision on the subject, though.

Advanced Micro Devices, a semiconductor manufacturer based in Sunnyvale, hasn't taken a deduction for self-funded workers compensation claim reserves in the four years since it started self-insuring work comp exposures for its 4,500 employees, but it may think about it now, according to its risk manager, Brec Woodbridge.

"I would thing it would be worth looking into," he said.

When AMD started self-insuring, its reserves amounted to only "a drop in the bucket" and didn't merit consideration as a tax deduction, he said. Since then, the reserves have grown to about $500,000.

AMD might take a significant part of that as a reserve deduction, rather than waiting until claims are paid to enjoy the tax benefits, said Cliff Jernigan, the company's general tax counsel.

"Maybe we're talking about a $200,000 (deduction) this year instead of next year. That's beneficial," he said.

Mr. Jernigan added that the company wouldn't necessarily wait for the outcome of a Supreme Court appeal to try to take advantage of the tax break.

But, self-insurers that want to switch to taking a deduction for comp reserves would still have an IRS hurdle to clear, according to James Power, a tax partner with the accounting firm of Deloitte, Haskins & Sells. They would still have to file a form outlining the accounting change and have it approved by the IRS as a "proper method," he said.

Other companies that have already taken the deductions express relief that the practice now has the sanction of the 9th Circuit.

Carter Hawley Hale Stores Inc., a Los Angeles-based retailer with about 54,000 employees, has succeeded in deducting 80% to 90% of its reserves for incurred-but-not-paid losses in the past, though it has recently run into problems with the IRS on the deductions, according to David Sands, manager of risk management and insurance.

"Once we have a precedent for doing something in the IRS game, we're substantially home," he said.

"I would expect it to be less of a problem, though it hasn't been much of a problem (for us) in the past," said the corporate insurance director of a Los Angeles-based drug manufacturer who asked that the company not be named.

The company, which has about 1,100 California employees, has been self-insured for part of its work comp risks since the 1950s, and has always deducted its reserves, which amount to about $150,000 in a typical year, the insurance director said.

Mr. Dawes and Mr. Levey said that they also know of several companies that have not self-insured work comp risks in the past, but now may decide to do so on the strength of the tax advantages clarified in the Kaiser decision.

Neither attorney would name any of the companies. ■

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A. Total No. Copies Printed (Net Press Run)	45,333	47,324
B. Paid Circulation		
1. Sales through Dealers and Carriers, Street Vendors and Counter Sales	0	0
2. Mail Subscriptions	27,874	28,313
C. Total Paid Circulation (sum of 10B1 and 10B2)	27,874	28,313
D. Free Distribution by Mail, Carrier or other means: Samples, complimentary, and other free copies	15,497	15,305
E. Total Distribution (Sum of C and D)	43,371	43,618
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G. Total (Sum of E, F1 and 2—should equal net press run shown in A	45,333	47,324

11. I certify that the statements made by me above are correct and complete.
Gertrude R. Crain
Chairman

It's not where but how you do the job

Continued from page 3

making small talk during the conference call, asked her how the weather was in Florida.

The well-prepared Ms. Metzroth cleared that potential pitfall beautifully.

She had called her mother, who lives in Florida, to check on the weather before the session started and was able to give an accurate response.

"It's nice and warm, 75 degrees, but it looks like we'll be having rain soon," Ms. Metzroth told the insurers.

Salomon Brothers' group health plan for 2,500 employees throughout the United States is described by Ms. Metzroth as "a wraparound to a Blue Cross hospitalization plan."

The policy covers major medical and surgical expenses after a $100 deductible.

The same insurer provides the securities firm's group term life insurance coverage.

Negotiating the group helath insurance policy renewal was but one of the many responsibilities Ms. Metzroth fulfilled from a rented hospital bed in her Park Avenue apartment during the last 70 days of her pregnancy last spring.

Ms. Metzroth had a direct telephone line to her Wall Street office and received materials daily from a courier. She also received a lot of support from her boss and cooperation from the staff of 20 she directs, she says.

For her her staff, there were twice-weekly meetings in front of the speaker phone on the desk of her downtown office.

One staff member, tired of talking to an empty chair, drew a caricature of Ms. Metzroth, which was placed behind her desk until she returned.

By the end of May, Ms. Metzroth was back in the Salomon Brothers' office. But she notes she made extensive use of the group health coverage she negotiated during her pregnancy.

Her son Alexander was born four weeks ahead of schedule and spent the first 10 days of his life in the hospital's intensive-care nursery.

Ms. Metzroth also had undergone surgery and was hospitalized twice to prevent premature labor. The total health care claim for mother and son: $25,000. ■

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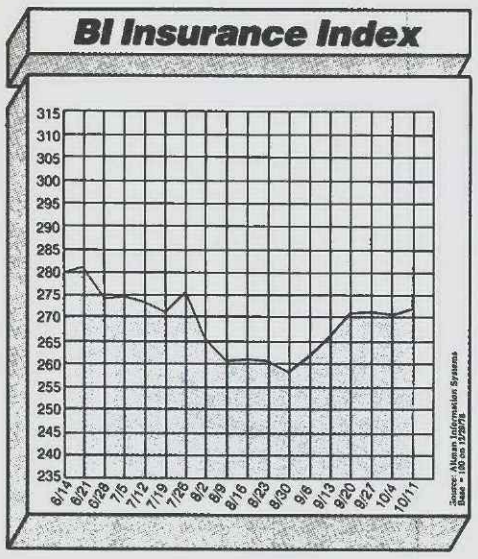

The *Business Insurance* stock index rallied during the five-day trading period ending Oct. 11, gaining 2.9 points to 273.7 from 270.8. Thirty-five issues posted gains, 17 were unchanged and 12 closed down. The largest gains were reported by General Reinsurance Corp., 8.9%; American National Insurance Co., 8.2%; Kemper Corp., 7.9%; American Bankers Insurance Group, 6.3%; and Statesman Group Inc., 5.7%. The largest losses were posted by Aneco Reinsurance Co. Ltd., 11.5%; Avemco Corp., 7.4%; Mission Insurance Group Inc., 6.0%; Frank B. Hall & Co. Inc., 5.8%; and Optimum Holding Corp., 3.8%. The *BI* index reported a 1.1% increase, which was bested by a 2.3% rise in the Dow Jones 30 industrials. The gain follows a decline by insurance industry stocks in the previous period.

British Issues

11 Oct Companies	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Comml Union	154	154.0	16.86	10.9	160	154
Eagle Star	463	16.5	24.29	6.0	480	463
Genl Accident	420	10.9	24.29	6.3	432	420
Gdn Royal Exch	463	11.6	27.26	6.6	470	463
Phoenix	324	14.1	25.00	8.0	332	324
Royal	493	12.3	37.86	8.0	513	493
Sun Alliance	1188	13.7	68.57	6.6	1225	1188
Brokers						
CE Heath	285	7.1	21.07	8.0	290	285
Hogg Robinson	115	8.8	8.57	8.2	115	112
JH Minet	129	9.9	6.50	5.9	131	129
Sedg Grp	216	10.8	10.00	5.3	217	211
Stenhouse Hldg	101	9.2	7.86	8.2	103	101
Stew Wrightson	250	8.3	20.43	9.0	260	245
Willis Faber	567	11.8	25.00	5.3	572	567

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Insurers' path could lead to trouble, ISO official says

By LEN STRAZEWSKI

THE INSURANCE industry has passed the crossroads and is now steaming steadily down the road to a permanent soft market for commercial lines, according to a leading industry researcher.

Fred R. Marcon, senior executive vp and chief operating officer of the Insurance Services Office, recently told the Independent Insurance Agents of America Inc.'s annual meeting in San Francisco that agents and brokers, insurers and corporate buyers could expect little change in commercial insurance pricing for the next several years.

And, despite greatly increased investment income, individual insurers could be heading for great trouble, depending upon their reaction to contemporary market trends, he added.

"Last year, when we were privileged to speak to your annual meeting in New York City, we said our industry was at a crossroads," Mr. Marcon told the agents. "At that time, we proved quantitatively that the poor correlation of the premium companies charge and their underlying loss costs was the culprit in causing the industry's disastrous commercial lines underwriting results. We said that continuing to rely on investment income is a dangerous answer to the industry's underwriting problems."

Commercial insurers have not changed their ways in the last year, Mr. Marcon noted.

In the most recent 12-month reporting period, ending June 30, the insurance industry's overall combined ratio for all lines of coverage continued to climb, increasing to 109% from 108% for the corresponding period last year, he reported. During this latest period, the insurance industry sustained $10 billion in underwriting losses, 10% higher than the previous year.

Combined ratios and the industry's variance from ISO's advisory rates also continued to increase in most major commercial insurance categories, he said:

- In commercial auto insurance, the industry's combined ratio increased to 119% in 1982, up from 112% in 1981. ISO forecasts a 120% combined ratio for 1983 and says 1984 underwriting results will be at least as bad.

"From 1980 through June 1 of last year, ISO advisory rates went up 23% while premiums didn't increase at all," he remarked. "In the year ended June 1983, our advisory rates went up another 14%, again with no increase in premiums. That puts the difference between increases in advisory rates and premiums at 40 percentage points for the 2½-year period. The gap has widened in the past 12 months."

- In general liability lines, the industry-wide combined ratio grew to 129% in 1982 from 116% in 1981 and ISO forecasts a 130% combined ratio for 1983 with no improvement in 1984.

From 1980 through the middle of last year, ISO's advisory rates for general liability increased 5% while industry premiums fell off 10%, Mr. Marcon noted, and from June 1982 through June 1983, ISO rates increased 7% while premiums fell off another 5%, leaving a gap of 27 percentage points between changes in advisory rates and premiums for the past 2½ years.

- In commercial multiperil coverages, the industry's combined ratio jumped to 116% in 1982 from 107% in 1981, with ISO forecasting 117% for 1983 and beyond.

"From 1980 through the middle of last year, the combined impact of advisory rate changes would have boosted commercial multiperil premiums 16%, but premiums rose only 2%. Then, in the year ended in June, rating programs and advisory rate changes were worth another 12% but premiums went up just 1%," Mr. Marcon said. "The gap between growth in advisory rates and premiums for the 2½-year period stands at 27 points. Again, the gap has widened in the past 12 months."

The underwriting losses caused by premium growth lagging behind advisory rates, however, were balanced by significant pretax investment income gains totaling $17 billion, 15% more than the previous year.

Overall, the industry's net aftertax income for the latest 12-month period was more than $7 billion, up 24% from last year.

"These overall results do not tell the real story. They mask the turmoil and changes in the pieces that make up the whole—changes that vary by line of insurance, by company marketing strategy, by distribution channel, by investment strategy, by geography," Mr. Marcon remarked.

"It's clear that insurers are choosing many different roads to reach their goals of growth and prosperity. It's also clear that individual companies must adjust promptly to the realities of a new insurance/financial world and not wait for an improvement in the traditional underwriting cycle, which for many of the commercial lines may never again happen in the traditional sense.

"Frankly," he continued, "at least for some of the commercial lines, where we are now is probably as good as it will get for the next several years. This soft, highly competitive commercial lines market in this new insurance/financial world has achieved a degree of permanence—a permanent soft market that each individual insurer and producer has to accept and adjust to."

Although ISO, a statistical and ratemaking organization funded by the insurance industry, has always touted the combined ratio as the best measure of insurer performance, Mr. Marcon says that a true evaluation of an insurer's success or failure now demands more complex measuring tools.

"The combined ratio is still a very valid indicator of performance in one critical area of our business—underwriting. But—and this is key—with the more competitive insurance/financial world that's here and the increasing importance of investment income, the more there is a demand for additional techniques," Mr. Marcon said.

"Each insurer's profitability or unprofitability will depend upon how that insurer adjusts to the realities of a soft, shrinking market and the aggressive competition for market share.

"Therefore, the magic turn in the underwriting cycle, when and if it finally comes, will come slowly and unevenly company by company, by variable mix of personal and commercial lines business and be tied to the efficiency and effectiveness of company operations and distribution channels."

So far, a financial measurement of insurer results indicates that underwriters have been relatively efficient in their respective areas and are continuing to turn a profit. Even with adverse underwriting results, the insurance industry's net aftertax income went up 24% in the 12 months ending June 30, according to Mr. Marcon, and the industry's 9.6% return on net worth was comparable with a 10.2% average return by the Fortune 500 companies.

"While insurance, as a risk business, should have a higher return on net worth, our industry's present performance cannot be characterized as disastrous," he says. "The industry's nearly 10% return, achieved in the face of persistently poor underwriting results, is another indication that the traditional underwriting cycle, as measured by the combined ratio, no longer tells the full story.

"If we are going to see a firming of commercial lines prices, that firming will be driven by a drop in return on net worth and not by worsening combined ratios. This does not appear to be in the cards immediately, since the industry's return on net worth is benefiting from high interest rates and a healthy stock market that is producing solid investment gains."

Mr. Marcon warned, however, that all is not smooth on the road the insurance industry has chosen.

"First, the industry is relying on an unreliable source for improving investment results. In the first six months of this year, half of the industry's increase in investment gains came from realized capital gains—gains which are notoriously volatile," he explained.

"Second, as insurers adjust to the new financial world, they'll have to keep a watchful eye on loss reserves. The ratio of loss reserves to earned premiums has been showing healthy increases over the years, primarily because of the increase in long-tail liability exposures and the lack of vigorous premium growth. But the ratio of loss reserves to paid losses fell noticeably last year.

"The last time the ratio of loss reserves to paid losses showed a similar decline in 1974 when it was widely believed that the industry, in the aggregate, was under-reserved." ■

BI Industry Stock Report

OCT. 11, 1983 — 9/5/83 THRU 10/11/83

Insurance Cos.		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	38.38	3.0	9.3	2.64	6.9	39.00	37.13	1,017.0
American Bankers Ins Group	OTC	12.63	6.3	9.9	0.50	4.0	12.63	11.88	219.4
American Gen Ins Co	NYSE	21.75	2.4	7.9	0.80	3.7	21.88	21.25	565.9
American Indty Finl Corp	OTC	17.63	0.0	12.2	1.12	6.4	17.63	17.63	5.6
American Intl Group Inc	OTC	69.75	2.6	11.7	0.44	0.6	70.88	68.00	637.4
American Natl Ins Co	OTC	21.38	8.2	8.5	0.84	3.9	21.38	20.38	55.7
American Sts Life Ins Co	OTC	41.25	1.2	11.3	0.88	2.1	41.25*	41.00	2.0
Aneco Reins Ltd	OTC	2.88	-11.5	71.9	0.00	0.0	3.13	2.88	36.4
Avemco Corp	AMEX	20.38	-7.4	11.0	0.58	2.8	22.13	20.38	18.3
Banks Iowa Inc	OTC	49.50	2.1	18.1	1.52	3.1	49.50*	48.50	2.9
Bitco Corp	OTC	20.00	0.0	8.6	1.33	6.7	20.00	20.00	16.6
Carolina Cas Ins Co	OTC	9.25	0.0	0.0	0.32	3.5	9.25	9.25	2.5
Chubb Corp	OTC	67.13	5.1	8.3	3.12	4.6	67.13*	64.13	205.9
Combined Intl Corp	NYSE	38.75	2.6	12.3	2.00	5.2	39.75*	38.75	303.6
Continental Corp	NYSE	31.00	4.2	19.0	2.60	8.4	31.50	30.00	337.4
Crawford & Co	OTC	16.25	-1.5	12.1	0.60	3.7	16.25	16.25	4.9
Crown Life Ins Co	OTC	125.00	0.0	8.2	3.10	2.5	125.00	125.00	0.4
Employers Cas Co	OTC	34.50	0.7	7.0	1.20	3.5	34.75	34.50	8.2
Equifax Inc	NYSE	32.50	-1.5	13.8	1.40	4.3	33.00	32.50	40.0
Excelsior Ins Co	OTC	20.50	0.0	17.2	0.00	0.0	20.50	20.50	0.1
Farmers Group Inc	OTC	40.13	2.2	10.1	1.36	3.4	40.13	39.25	434.8
Foremost Corp Amer	OTC	31.00	0.0	9.5	0.83	2.7	31.00	31.00	174.8
Fremont Gen Corp	OTC	13.88	2.8	63.1	0.48	3.5	13.88	13.50	489.3
Great West Life Assurn Co	OTC	250.00	0.0	9.0	11.00	4.4	250.00	250.00	0.4
Hanover Ins Co	OTC	61.75	2.5	7.7	0.88	1.4	61.75	60.50	6.9
Hartford Steam Boiler Inspctn	OTC	54.00	1.9	8.5	3.00	5.6	54.00	53.00	4.2
Jefferson Natl Life Ins Co	OTC	43.50	3.6	13.5	0.76	1.7	43.50	42.50	31.5
Kemper Corp	OTC	41.00	7.9	7.6	1.80	4.4	41.00	38.38	139.0
Lincoln Natl Corp Ind	NYSE	57.00	1.1	9.0	3.00	5.3	57.50	56.50	89.4
Mission Ins Group Inc	NYSE	29.50	-6.0	11.0	1.00	3.4	31.00	29.50	292.5
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT TRADE	
Northwestern Natl Life Ins	OTC	37.00	0.0	24.5	1.50	4.1	37.00	37.00	115.7
Ohio Cas Corp	OTC	49.75	1.8	9.1	2.52	5.1	49.75	48.88	160.2
Old Rep Intl Corp	OTC	33.63	1.9	7.8	0.90	2.7	33.63	33.13	147.7
Orion Cap Corp	NYSE	29.25	3.1	14.6	0.66	2.3	29.25	28.50	88.1
Preferred Risk Life Ins Co	OTC	20.13	3.2	8.1	0.67	3.3	20.13	19.50	1.6
Provident Life & Acc Ins Co	OTC	65.50	0.0	8.3	2.60	4.0	65.50	65.50	25.2
St Paul Cos Inc	OTC	60.25	5.2	6.9	2.80	4.6	60.50	57.38	276.3
SAFECO Corp	OTC	58.50	3.5	12.0	2.40	4.1	58.50	56.88	264.8
Sri Corp	OTC	20.25	0.0	7.5	0.56	2.8	20.75	20.25	145.9
Seibels Bruce Group Inc	OTC	25.00	-3.4	14.8	0.80	3.2	25.50	25.00	24.7
Statesman Group Inc	OTC	11.50	5.7	8.0	0.15	1.3	11.50	10.88	139.2
Tokio Marine & Fire Ins Co	OTC	109.25	2.8	17.5	0.96	0.9	109.25	106.50	7.4

OCT. 11, 1983 — 9/5/83 THRU 10/11/83

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Travelers Corp	NYSE	32.38	4.4	8.3	1.80	5.6	33.00	31.75	1,135.4
United Fire & Cas Co	OTC	32.25	0.0	11.6	0.88	2.7	32.25	32.25	1.1
United States Fid & Gty Co	NYSE	56.25	1.4	11.1	3.84	6.8	58.00*	56.25	292.3
United Svcs Life Ins Co	OTC	23.00	2.2	6.6	1.06	4.3	23.00	22.50	19.0
Uslife Corp	NYSE	26.38	-0.9	7.3	0.88	3.3	26.88	26.38	207.9
Washington Natl Corp	NYSE	27.25	0.9	12.1	1.08	4.0	28.63	27.25	123.9
Zenith Natl Ins Corp	OTC	16.50	1.5	11.8	0.60	3.6	16.50	16.25	21.3
INSURANCE COMPANIES	AVERAGE			10.0		3.7			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	20.75	-1.8	0.0	1.00	4.8	21.25	20.75	211.6
Baldwin & Lyons Inc	OTC	38.50	0.0	12.4	0.80	2.1	38.50	38.50	0.6
Corroon & Black Corp	NYSE	24.00	0.5	16.6	1.80	7.5	24.25	23.88	28.6
Crump E H Cos Inc	OTC	9.75	-1.3	14.1	0.40	4.1	9.88	9.75*	4.3
Emett & Chandler Cos Inc	OTC	10.63	0.0	0.0	0.00	0.0	10.63	10.63	0.1
Hall Frank B & Co Inc	NYSE	24.50	-5.8	19.1	1.70	6.9	26.25	24.50*	135.1
Integrated Res Inc	AMEX	37.63	0.0	14.0	0.00	0.0	39.00	37.63	166.5
Marsh & Mclennan Cos Inc	NYSE	43.75	-1.1	12.7	2.20	5.0	45.00	43.75	318.4
Poe & Assoc Inc	OTC	6.00	0.0	0.0	0.00	0.0	6.00	6.00	3.6
Reed Stenhouse Cos Ltd	OTC	13.50	-2.7	22.5	0.60	4.4	13.63	13.50	144.4
AGENTS/BROKERS	AVERAGE			18.0		3.7			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	38.88	10.3	11.4	1.28	3.3	39.63	36.63	3,421.5
Anderson Clayton(Ranger/PanAm)	NYSE	28.50	0.0	16.3	1.32	4.6	28.75	28.00	24.3
Armco Inc	NYSE	19.50	-3.1	0.0	0.40	2.1	20.00	19.50	279.8
Baldwin Utd Corp	NYSE	3.13	-7.4	1.5	0.00	0.0	3.38	3.13*	1,162.3
CIGNA Corp	NYSE	46.50	4.5	7.5	2.48	5.3	47.25	45.63	671.1
City Investing Co. (Home Ins.)	NYSE	36.75	2.4	11.3	1.80	4.9	37.63	36.75	988.8
CNA Finl Corp (CNA)	NYSE	22.38	1.7	7.7	0.00	0.0	22.50	22.25	109.1
Control Data (Comml. Credit)	NYSE	51.50	1.0	12.6	0.60	1.2	53.50	51.50	1,041.1
General Re Corp	NYSE	67.50	8.9	14.0	1.28	1.9	68.50	63.00	466.6
Gulf Utd Corp	NYSE	28.13	0.0	8.5	1.32	4.7	28.38	28.13	286.9
ITT (Hartford Group)	NYSE	44.63	1.1	9.5	2.76	6.2	45.00	44.50	1,210.1
Optimum Hldg Corp	OTC	6.25	-3.8	20.2	0.00	0.0	6.25	6.25*	6.9
Sears Roebuck & Co. (Allstate)	NYSE	40.30	7.4	12.8	1.52	3.8	40.50	38.13	3,201.9
Teledyne Inc (Argonaut)	NYSE	167.75	2.1	14.9	0.00	0.0	168.75	162.63	487.2
Transamerica Corp (Occidental & Fred S. James)	NYSE	29.00	4.0	9.9	1.56	5.4	29.13	28.00	426.7
CONGLOMERATES/HOLDING COS.	AVERAGE			13.6		2.6			

*Record high/low since Jan. 1, 1983

System design: Altman Information Systems

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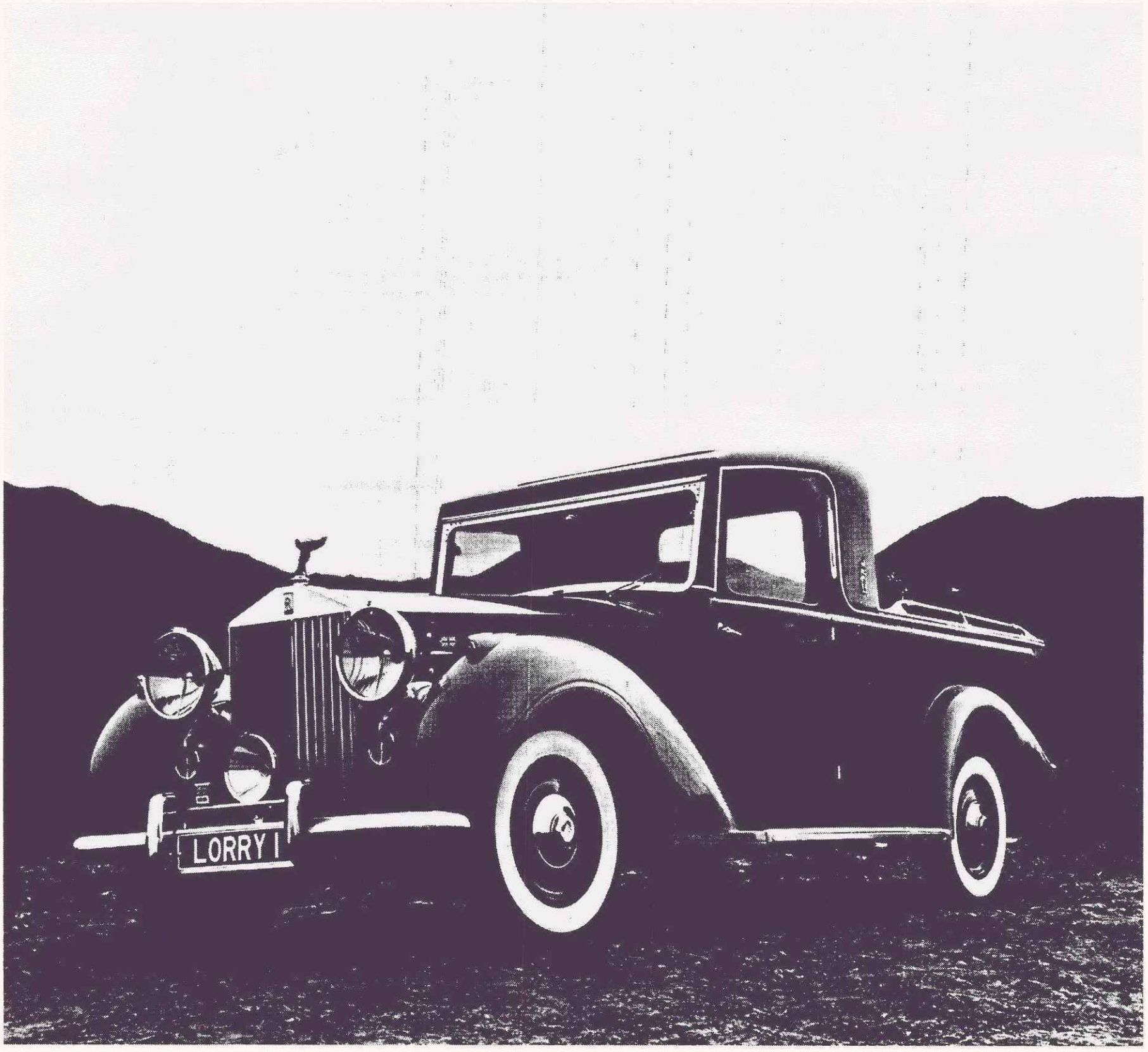

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