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Update

MGM/UA sues D&O insurers for settlement with shareholders

LOS ANGELES—MGM/UA Communications Co. is suing a group of its directors and officers liability insurers for bad faith for reaching a $20 million settlement with some shareholders over the 1986 sale of company assets to the company's majority shareholder.

The settlement, subject to approval by a Superior Court judge, would leave MGM/UA majority shareholder Kirk Kerkorian and his Tracinda Corp. holding company as the sole defendants in the shareholders'

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Aon bids for Corroon & Black

Offer imperils Willis Faber-C&B link

By LINDA J. COLLINS

CHICAGO—Aon Corp.'s last-minute offer to purchase all outstanding Corroon & Black Corp. stock for $40 per share could derail C&B's proposed merger with Willis Faber P.L.C. of London.

Observers point out that Aon's offer on the surface is a better deal for C&B shareholders. However, merging with Aon, parent of broker Rollins Burdick Hunter Group Inc., would not give C&B management the international link it has sought and which Willis Faber offers.

Directors of New York-based C&B, which approved the proposed merger with Willis Faber months ago, will meet Tuesday to discuss Aon's surprise offer. Shareholders are scheduled to vote on the Willis Faber-C&B merger on Sept. 28.

"We are studying the proposals together with our financial and legal advisers, and we will respond to Aon's letter after our board has adequate opportunity to consider the proposal," said Robert P. Cuthbert, first vp and chief financial officer at C&B.

Other C&B executives would not comment further.

Willis Faber will make no moves until after the C&B board meeting, but is still committed to the proposed merger and is not ruling out any options to make the deal succeed, said Chairman Roger Elliott.

With more than $150 million in cash on its balance sheet, Willis Faber could sweeten its offer with cash. However, Willis Faber's stock price fell sharply last week, which could deter the broker from increasing the offer.

In a letter last Wednesday to Richard M. Miller, his counterpart at C&B, Aon Chairman Patrick G. Ryan said he considers Aon's offer "superior" to Willis Faber's.

Mr. Ryan said in an interview last week that merging C&B and Rollins Burdick Hunter would benefit clients of both brokerages.

"We think that, by adding C&B, we can reach a level of size and earnings contribution so that. . . Aon will take on more of the characteristics of a brokerage, with the balance and stable earnings of (accident and health) and life business as well as tremendous cash flow," Mr. Ryan said.

Aon, a Chicago holding company with gross revenues of more than $2.3 billion in 1989, owns large life, accident and health and some specialty property/casualty underwriting operations.

"We think of this as a long-term position that would enhance our shareholder value and service to our clients," Mr. Ryan said. "We have some strengths that are complementary to one another and our combined market power would certainly provide us with a big advantage."

"When Aon bought RBH (in De-

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IRS to allow firms to 'restructure' for 401(k) tests—at least for 1990

By JERRY GEISEL

WASHINGTON—Employers for now can continue to "restructure" their 401(k) plans to make it easier to pass non-discrimination tests, but the Internal Revenue Service may ban the new technique next year.

The IRS last week said employers would be able to use—with certain restrictions—a new technique known as restructuring when running non-discrimination tests this year. The announcement eliminates employer concerns that the IRS would ban restructuring only months after it was first permitted.

IRS regulations issued in May covered a plethora of pension issues. But the regulations may have opened the door to this new way of running 401(k) non-discrimination tests that many employers find much more attractive than previous methods.

Restructuring a 401(k) plan for testing purposes could mean the difference between passing and failing the non-discrimination tests, benefit experts have said (*BI*, July 9). And restructuring could allow highly compensated employees to contribute as much as several hundred dollars a year more to their 401(k) plans.

The 401(k) non-discrimination tests compare contributions made by high- and low-paid employees. The Tax Reform Act of 1986 toughened the rules, making the tests extremely difficult to pass.

As a result, many employers have been forced to cap contributions by highly compensated employees or return contributions, which was an administrative mess.

However, under the new IRS rules, employers running 401(k) non-discrimination tests no longer would have to compare, on a plan-wide basis, average deferrals by highly compensated employees—generally those earning at least $57,000 a year—with those by other employees.

Instead, a plan could be "restructured" just for testing purposes into separate components or groups of participants. Under this approach, a 401(k) plan could be broken down into separate plans covering employees at different locations or in separate job categories. These components would then be separately tested.

That would be allowed under the new IRS rules as long as the percentage of non-highly compensated employees covered by a component plan was at least 70% of the percentage of highly compensated employees covered by the plan.

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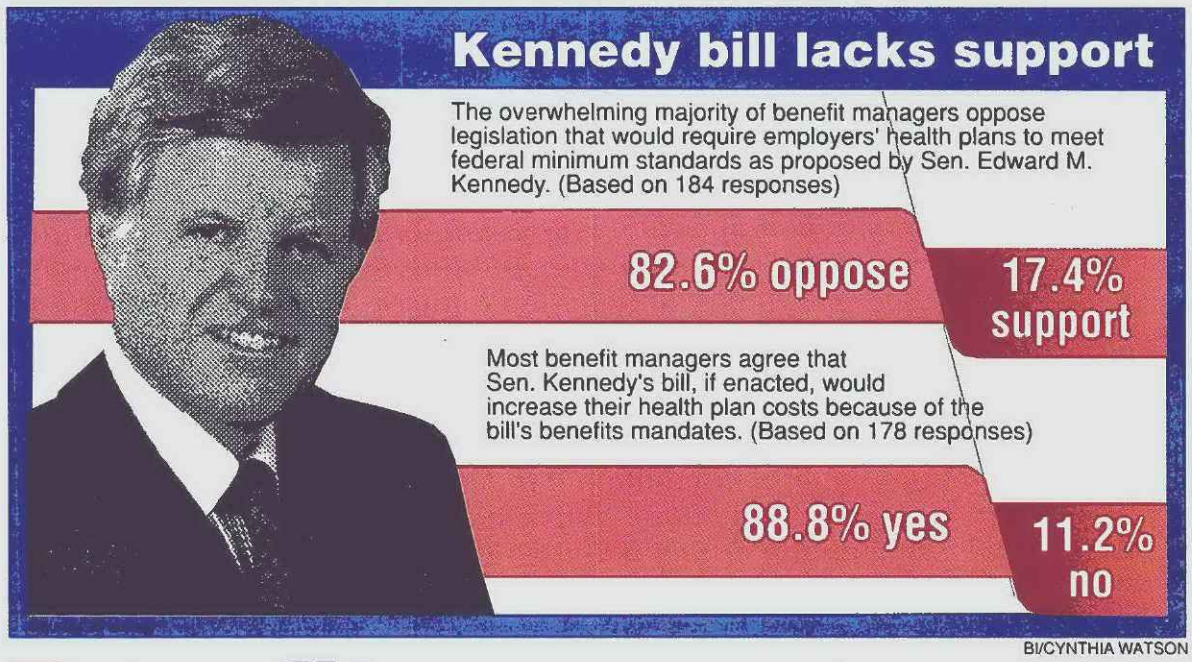

BI/CYNTHIA WATSON

Benefit managers see health plan mandate

By DAVE LENCKUS

It may take from three to 10 years, but federally mandated employer-provided health care benefits and accompanying increases in health care costs are inevitable, employee benefit managers say.

And once Congress begins mandating benefits, the list of required benefits likely will expand continually, says an overwhelming majority of respondents to the latest *Business Insurance* Employee Benefits Board survey.

"It would be a perfect way for legislators to respond to special interests, gain votes and not have to be concerned with the cost," observed the manager of U.S. employee benefits for a computer manufacturing firm in the Northeast with $13 billion in annual sales and 75,000 employees.

"Once they get started, it's hard for them to stop," said the assistant manager of employee benefits for an electric utility in Missouri with 3,000 employees.

However, benefit managers say there are no mandated employee benefit proposals they could support to achieve universal health care coverage, even though the vast majority of survey respondents say their employers' health care plans already comply with most provisions of the universal health care bill introduced by Sen. Edward M. Kennedy, D-Mass.

Benefit managers say they oppose such mandates on the grounds that they interfere with free markets and make employers responsible for solving a societal problem.

Benefit managers also oppose requiring employers to offer health insurance that is worth a certain economic value, as a health care plan in Massachusetts would.

But many respondents who oppose employee benefit mandates say they would support expanding

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Dispute over health benefits triggers strike at university
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Weak first-half results do not surprise reinsurers
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Update

Settlement sparks bad-faith suit

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class-action suit.

MGM/UA sued its excess D&O insurers Aug. 30 to halt the settlement, charging they acted in bad faith to "sabotage" a "global settlement" of the shareholders' suit with all defendants.

The shareholders' suit, which seeks unspecified economic and punitive damages, claims that fiduciary duties to minority shareholders were breached in 1986 when MGM/UA was sold to Turner Broadcasting Systems Inc. and then assets of United Artists were sold back to Mr. Kerkorian for an inadequate price.

Harbor Insurance Co. wrote the $5 million primary layer of D&O coverage and is participating in the shareholder settlement but is not named in the MGM/UA suit. MGM/UA explains in its suit that it does not believe Harbor sabotaged a global settlement.

MGM/UA names its excess D&O insurers, which wrote a total of approximately $85 million of limits excess of $5 million. The insurers are Forum Insurance Co., Associated International Insurance Co. and National Union Fire Insurance Co. of Pittsburgh, Pa.

Under the settlement, Harbor and Forum will pay $8 million to minority shareholders of record before the sale. All four D&O insurers also agreed to place a total of $12 million in an escrow account as a guarantee of payment for the remainder of the settlement if shareholders cannot recover losses from Mr. Kerkorian and Tracinda.

Fireman's Fund sale protested

SAN FRANCISCO—Mutual Fire, Marine & Inland Insurance Co.'s rehabilitator is asking California regulators to block Allianz A.G. Holding's proposed $1.1 billion acquisition of Fireman's Fund Insurance Co. until they hold hearings on her claim that an Allianz unit failed to pay more than $100,000 in reinsurance owed to the Mutual Fire estate.

Allianz Syndicate Inc., a syndicate on the now-shuttered New York Insurance Exchange, reinsured Mutual Fire in 1983 and 1984 on a book of limited partnership financial guarantee bonds, according to papers submitted to California regulators by Mutual Fire's rehabilitator, Pennsylvania Insurance Commissioner Constance B. Foster.

Allianz Syndicate and other reinsurers sued Mutual Fire in 1987 seeking recision of the treaty. An arbitration panel's refusal to grant that request was later affirmed by a federal judge.

However, Allianz Syndicate will not pay the more than $100,000 it owes the Mutual Fire estate and has not posted a letter of credit to secure future losses under the treaty, Ms. Foster charges.

A Fireman's Fund spokesman called the matter a "thunderstorm in a thimble." He said he is confident that the majority of the Pennsylvania Department of Insurance recognizes Allianz is "one of the strongest and most reliable insurance organizations."

Mutual Fire's dispute is a "completely separate matter," he said.

Allianz attorney Dick Barger of Barger & Wohlan in Los Angeles, agreed, saying Ms. Foster has "picked the wrong forum" to litigate.

Minimum benefits relief

SPRINGFIELD, Ill.—A new Illinois law allows insured health care plans offered by small firms to provide a smaller benefits package than insured plans offered by large companies are required to provide.

Gov. James Thompson last week signed the Small Employer Group Health Insurance Law, which allows plans offered by firms that have 25 or fewer workers and have not provided health coverage in the last year to provide only basic coverage, including hospital and physician charges and the cost of mammograms for women over age 35. Those companies will be exempt from requirements to provide mental health and substance abuse coverage.

The law allows insurers to offer incentives to workers to obtain health care from certain doctors or hospitals, but insurers may not require the workers to obtain care from certain providers.

The State Chamber of Commerce supported the bill, H.R. 3528, as a way to cut health care costs for many businesses. Nearly 20 benefits now required by the state account for 15% to 20% of employers health insurance costs, the Chamber estimates.

Washington and Virginia earlier this year reduced mandated benefits for small employers (*BI*, April 2; March 26).

Retirement incentives at stake

WASHINGTON—Early retirement incentive programs are still in jeopardy under a new version of legislation—to be taken up by the full Senate this week—intended to overturn a controversial Supreme Court decision on age discrimination.

While a cover letter says the new version of the so-called Betts legislation would protect early retirement incentive programs, the actual legislation is virtually unchanged from an earlier version that cleared the Senate Labor and Human Resources Committee and was denounced by business groups (*BI*, April 30).

Under the latest version, early retirement incentive programs still would have to "further the purposes" of the Age Discrimination in Employment Act. Benefit experts note that the purpose of early retirement incentive or window programs is to encourage older workers to retire early. That is the opposite goal of ADEA, which has the defined purpose of encouraging the employment of older workers.

Unless the legislation, S. 1511, is modified on the Senate floor, "there would be a lot of potential for challenges" of early retirement incentive programs, said Frank McArdle, a consultant with Hewitt Associates.

Insurers appeal treasure ruling

RICHMOND, Va.—U.S. and London insurers are appealing a federal judge's ruling that awarded a group of underwater explorers three tons of gold they are recovering from a sunken ship.

The insurers, which filed their appeal last week in the 4th U.S. Circuit Court of Appeals, contend they have paid about $1.5 million in claims on the gold bullion, which was lost when the steamship Central America sank off the South Carolina coast during a hurricane in 1857.

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Guaranty fund dispute

Judge blocks cover for cleanups

By JUDY GREENWALD

SAN FRANCISCO—Aerojet-General Corp. and a subsidiary are appealing a California court ruling that the state's property/casualty insurance guaranty fund does not have to provide a defense or indemnification for insurable government-mandated hazardous waste cleanups.

At the heart of the dispute is language in the guaranty fund's enabling legislation that the guaranty fund and Aerojet are interpreting differently.

California's guaranty fund law states: " 'Covered claims' shall not include any obligations of the insolvent insurer arising out of any reinsurance contracts. . .nor any obligations to any state or to the federal government."

The California Insurance Guarantee Assn. says the language means the fund will not indemnify policyholders of insolvent companies for the cost of government-mandated cleanups.However, La Jolla, Calif-based Aerojet, a subsidiary of GenCorp Inc., says the language means that the fund will not indemnify state and federal governmental agencies when their insurers become insolvent.

California is the only state whose guaranty fund law includes the controversial language, according to Aerojet attorney Scott DeVries with San Francisco-based Lasky, Haas, Cohler & Munter.

Unlike most states, California has not adopted the National Assn. of Insurance Commissioners' model law, which does not include that language.

If upheld, the decision could have broad implications because of the growing number of insolvent insurers as well as the number of state and federal hazardous waste cleanup orders against policyholders in the state, Aerojet court papers say.

Forty-two California insurers were in conservation or liquidation as of year-end 1988, the court papers note.

And, although California is the only state whose guaranty fund law includes the controversial language, the ruling in the case could have an impact on guaranty funds in other states, said Dale Stephenson, president of the National Con-

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Arbitrations save money, not time, study reports

By CHRISTINE WOOLSEY

Arbitrating civil disputes, like personal injury claims, can save litigants money, but arbitrations typically take as much time as resolving disputes through the legal system, according to a new study.

In addition, the study found that mandatory referral of civil cases to non-binding arbitration before a lawyer-arbitrator left litigants and attorneys with a positive view of the process and apparently did not change case outcomes.

But, while alternative dispute resolution mechanisms, including arbitration, are often touted as a solution to the massive amounts of money and time spent on litigation, experts warn that arbitration is not a panacea.

And, they point out that the study's conclusions apply only to a court-administered, non-binding arbitration program and should not be broadly associated with all arbitration programs, including arbitrations of insurance and reinsurance policy disputes.

The findings are the result of a four-year joint study by Santa Monica, Calif.-based Rand Corp.'s Institute for Civil Justice and the Private Adjudication Center of the Duke University School of Law.

The study, "Arbitrating High-Stakes Cases: An Evaluation of Court-Annexed Arbitration in a United States District Court," examined the outcomes of 350 corporate and individual breach of contract and personal injury cases heard by the U.S. District Court for the Middle District of North Carolina. Rand examined disputes in which plaintiffs were seeking monetary damages of $150,000 or less.

Under a program set up by the North Carolina court, cases that seek damages of less than $150,000—not including punitive damages, statutory multiple damages, court costs or interest—are automatically referred to non-

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Poisoning victims' survivors seek damages

Tylenol suits headed to trial

By MEG FLETCHER

CHICAGO—A jury will decide whether the manufacturer of Extra-Strength Tylenol is liable for damages sought by survivors of seven people who died in the Chicago area in 1982 after ingesting cyanide-laced capsules, a Cook County Circuit Court judge ruled last week.

At issue is whether McNeil Consumer Products Inc. and McNeilab Inc., divisions of Johnson & Johnson, should have been able to foresee that the product's packaging would allow someone to tamper with the product, resulting in harm to consumers.

The tainted capsules were sold in capped plastic bottles packaged in cardboard boxes with tuck-in flaps.

After the deaths, the company adopted "a tamper-evident and tamper-resistant" triple-seal safety system, consisting of multiple seals and printed warnings.

The tainted capsules apparently were laced with lethal potassium cyanide after they left the control of McNeil and were placed on retailers' shelves.

The 8-year-old investigation is still open.

Johnson & Johnson had at least $80 million in liability insurance at the time of the poisonings. J&J unsuccessfully sued its liability insurers for coverage for the cost of its massive recall of Tylenol products following the poisonings (*BI*, Sept. 22, 1986).

Plaintiffs allege that McNeil ex-

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- Older workers' demands for security could lead to more defined benefit plans, a researcher says at the second Corporate Benefits Management conference. **PAGE 18**
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- West Germany has barred a Delaware-based company from issuing policies there, although the company contends it is following E.C. law. **PAGE 35**
- Brokerage stock values are uncharacteristically low in the soft market, says analyst Leonard Wilson. **PAGE 47**

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Walkout over health plan stops classes at Temple

By CHRISTINE WOOLSEY

PHILADELPHIA—Unionized professors, librarians and other academic professionals at Temple University walked off their jobs earlier this month following an attempt by the university to require all employees to contribute $260 per year toward their health insurance premiums.

University officials said at least 50% of the classes at Temple were not meeting late last week as a result of the Sept. 4 strike by about 70% of the 1,162-member Temple Assn. of University Professionals.

At issue is the university's request that all Temple employees—both union and non-union—begin contributing to their health insurance premiums.

While more and more unionized plans are accepting the idea of cost-shifting, many unions are still violently opposed to that particular cost containment strategy, noted Michael Carter, a senior vp in the Philadelphia office of benefit consultant Hay Huggins Co. Inc.

For example, while American Telephone & Telegraph Co. and some of the regional telephone companies increased deductibles and copayments last year during contract negotiations, unions at some of the so-called "Baby Bells" initially balked at the changes (*BI*, Sept. 4, 1989; Aug. 14, 1989; May 29, 1989).

James J. Mohan, assistant vp of personnel services at Temple, said the university's health care "premiums have skyrocketed over the last several years." He said Temple currently spends about $4,400 per year on health care benefits for each faculty member and estimated the university's annual health care budget at $30 million.

Mr. Mohan said the university, like other employers, tried implementing cost containment strategies in an effort to address increasing expenses, but those techniques "had no impact close to what was predicted."

As a result, the university is requiring each of its approximately 9,500 employees to contribute $5 per week—$260 per year—toward their health care benefits. Approximately 800 non-union university employees will begin paying the $260 per year on Jan. 1, 1991, he said.

Michael S. Wirtz, Philadelphia Inquirer

Donald Rackin, who teaches English literature, and other Temple University strikers rally outside the Paley Library.

The remaining employees are members of 14 different unions operating at the university, including TAUP, the union representing professors and academic professionals.

Of the six unions that have negotiated contracts with the university

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Employer poll finds 55% test for drugs, or plan to

By LAURA MAZZUCA

More than 50% of employers now test or plan to test job applicants and employees for use of illicit drugs, according to a recent survey.

A national survey of 681 corporate human resources executives found that 55% of their companies, or 374, test or plan to test job applicants and employees.

The benefits of drug testing programs were improved quality of job applicants, a safer work environment and a better image in the community, according to the survey, "Corporate Experiences with Drug Testing Programs," conducted by The Conference Board, a business information service based in New York.

However, employers with drug testing programs also cited problems with such programs, such as labor union challenges, conflicting interpretations of policy and employee resentment.

A drug testing program is typically part of a comprehensive strategy that includes a written substance abuse policy, an employee assistance program, and a drug education and awareness program, according to the survey.

And, the decision to initiate a drug testing program is not made hastily, the surveyed executives reported. Employers took from several months to two years or more to reach such a decision, they said.

A total of 2,675 questionnaires were mailed in the spring of 1988 to the senior human resources officers at the largest national corporations in the manufacturing, gas and electric utility, finance and insurance, transportation, wholesale and retail trade and other industries. Survey results were based on 681 written responses, a 25.5% response rate.

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Seeks $400 million for botched launch

Intelsat sues satellite launch firm

By MARK A. HOFMANN

BALTIMORE—Telecommunications consortium Intelsat is seeking at least $400 million in compensation from Martin Marietta Corp. for the botched launch of a communications satellite last March.

The International Telecommunications Satellite Organization claims in a breach-of-contract suit that Martin Marietta should pay for the cost of the $145 million satellite, among other things, because the aerospace firm did not fulfill the terms of its launch contract.

The consortium self-insured the value of the satellite and the $115 million cost of the launch, an Intelsat spokesman said.

However, Bethesda, Md.-based Martin Marietta argues in its own suit against Intelsat that the launch contract specifically absolved it from financial liability if the launch failed to properly deploy the satellite.

In addition, the aerospace firm claims that commercial space launches could become so expensive that it and other space launch contractors could be forced out of the market if Intelsat wins its case.

Both actions were filed in the U.S. District Court in Baltimore.

The litigation involves the March 14 launch of Intelsat's F-3 communications satellite (*BI*, March 19).

To function correctly, the Intelsat satellite must orbit about 22,300 miles above the earth's surface in a geosynchronous orbit. In such an orbit, the satellite would appear stationary to an earth-bound observer.

Both Intelsat, a consortium of national communications companies, and Martin Marietta agree that the aerospace firm failed to detect a key wiring error before the launch.

They also agree that the error caused the satellite, launched from a Titan III rocket owned and operated by Martin Marietta, to orbit far too low to operate correctly.

The wiring error prevented "a signal sent to activate the payload separation" from reaching the system, according to a Martin Marietta spokesman.

The satellite is now orbiting about 300 miles above the earth, and it is not maintaining a geosynchronous orbit.

The satellite can maintain that orbit until a planned space shuttle rescue mission by the National Aeronautics and Space Administration in 1992, the Intelsat spokesman said.

Prelaunch procedures have since been revised to prevent such wiring errors, according to the Martin Marietta spokesman.

Intelsat, which filed suit Aug. 31, charges Martin Marietta with breach of contract, negligence, gross negligence and misrepresentation, and failing to disclose material information.

"Martin Marietta has breached its obligations under the contract, including its obligations to use its 'best efforts' in providing launch services to Intelsat and to carry out its obligations under the contract by 'diligently working in a good and workmanlike manner as a reasonable, prudent manufacturer of launch vehicles and provider of launch services,'" Intelsat charges, quoting from its launch contract with the firm.

Intelsat seeks compensatory damages of at least $400 million.

Those damages include the $145 million value of the satellite, the $115 million that Intelsat paid Martin Marietta for the launch, the approximate $140 million cost of the space shuttle rescue attempt and as-yet-undetermined revenues it has lost because the satellite is inoperative. The suit also seeks reimbursement for attorneys' fees and court costs, all interest provided by law and any other appropriate relief.

Martin Marietta, fearing Intelsat's litigation, had filed a preemptive suit July 6.

In its suit, Martin Marietta seeks a court ruling that Intelsat as-

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Weak results don't surprise reinsurers

By DOUGLAS McLEOD

NEW YORK—U.S. reinsurers hoping for a change in the stubbornly soft property/casualty market remain disappointed as mid-year results show no signs of improvement.

Underwriting results for many reinsurers continued to slide and industry observers remain pessimistic about prospects for a quick turnaround.

Sixty-eight property/casualty reinsurers surveyed by the Washington, D.C.-based Reinsurance Assn. of America reported an average combined ratio of 107.2% for the first half of 1990. This represented a slight deterioration from 107.0% for the first quarter and a more marked decline from 104.0% reported for the first half of 1989 by a similar group.

First-half net written premium volume for the 68 companies, meanwhile, rose a meager 4.5% to $5.1 billion from $4.9 billion in 1989.

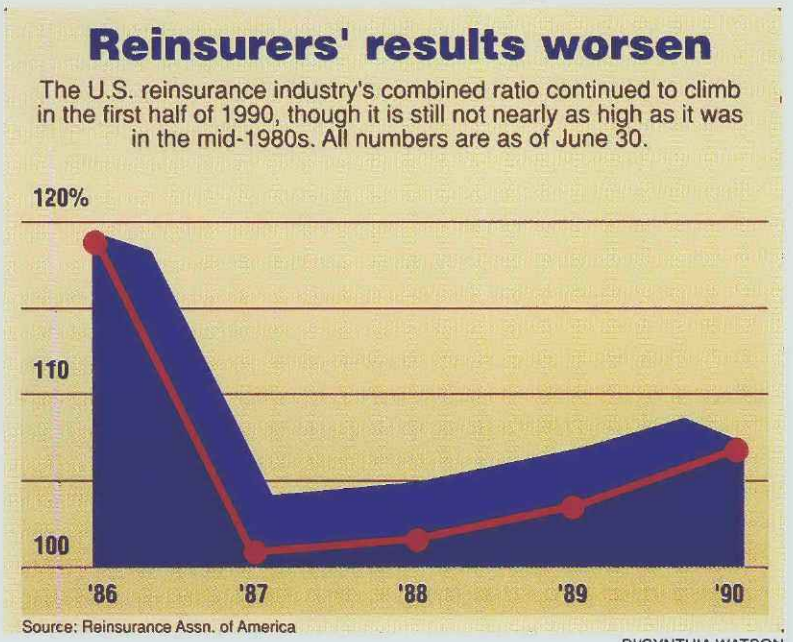
The RAA labeled the results "ambiguous," noting that while premium volume is up, the continued weak underwriting performance reflects the impact of the ongoing soft market.

Other comments were more pointed.

"No change is bad news," observed Paul Ingrey, president of F&G Re Inc. in Morristown, N.J., a unit of USF&G Corp.

The chance of a turnaround in the next 12 months is small, barring a huge drop in the stock market, another major catastrophe loss or some other unforeseen event, Mr. Ingrey added.

"We are obviously in a continued slide and it's going to get worse before it gets better," predicted Bard E. Bunaes, chairman and chief executive officer of Constitution Reinsurance Corp. in New York.



Competition actually has grown more intense and less "responsible" in the last six to 12 months, Mr. Bunaes said.

"Reinsurers are starting to write business that will not produce a profit," he said, adding that he sees no letup in the immediate future and that a turn in the market is not likely until reinsurers' combined ratios reach 112% or 115%.

"It's just not bad enough yet," Mr. Bunaes lamented. "We are going to have to see negative cash flow" before reinsurance pricing begins to firm.

Even though reinsurers' own retrocessional coverage has become dramatically more expensive and less plentiful in recent months, that tightening has had virtually no impact on reinsurance prices or availability so far, Mr. Ingrey and others report.

Overcapacity in the reinsurance marketplace also will not be dented by the withdrawal last week of U.S. International Reinsurance Co., the 17th-largest U.S. reinsurer based on six month net written reinsurance premiums of $109.8 million (see story, page 43).

"There's just oodles of capacity," noted Michael E. Rothpletz, execu-

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Guaranty fund

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ference of Insurance Guaranty Funds in Indianapolis.

"Any legal suit that goes into a guaranty fund situation does have the potential for rolling over, if you will, into other locations, simply because it's going to be cited in cases in other locations," Mr. Stephenson said.

Aerojet and subsidiary Cordova Chemical Co. claim they are entitled to $163 million in excess liability coverage written for most years between 1961 and 1984 by several insolvent insurers to pay for government-mandated cleanups.

The amount of coverage written by the insolvent insurers in any given year during that period varied between $500,000 and $30 million, Aerojet court papers say.

The coverage was written by Mission Insurance Co., Midland Insurance Co., Integrity Insurance Co. and Transit Casualty Co., all of which are insolvent.

In addition, the guaranty fund says in a footnote in court papers that Aerojet asserts that its claims against Pine Top Insurance Co., which also is insolvent, should be covered by the guaranty fund.

However, Pine Top was not an admitted insurer and therefore the fund would not indemnify any California policyholders of Pine Top, the guaranty fund says.

The Aug. 2 summary judgment for the guaranty fund by San Mateo County Superior Court Judge John J. Bible is part of broader litigation involving Aerojet and more than 50 of its general liability insurers over tens of millions of dollars in coverage.

In April 1989, the California 1st District Appellate Court overturned a decision by Judge Bible and ruled that hazardous waste cleanup costs are covered by comprehensive general liability policies.

The state Supreme Court later declined to review that decision (*BI*, Sept. 18, 1989; May 1, 1989).

A trial to determine whether Aerojet is entitled to the coverage is scheduled to begin in March.

Attorneys for Aerojet filed a writ of mandate with the 1st District Appellate Court on Aug. 30 seeking to vacate Judge Bible's latest order.

The guaranty fund has until Oct. 2 to respond to Aerojet's writ, said guaranty fund attorney James B. Clapp, with San Francisco-based Carroll, Burdick & McDonough.

Mr. Clapp said he has never seen a decision on the issue of the language of the guaranty fund law, but added that part of the reason is that the language of the statute is so clear.

"I think the statute's abundantly clear" that the legislation's "true intent" is that the guaranty fund does not have to indemnify policyholders for the cost of government-mandated cleanups, Mr. Clapp said.

However, Aerojet applies a different interpretation to the language.

"As we told the court this language refers to the obligations of the insolvent insurer to the state or federal government," Mr. DeVries said.

The concept behind the legislation is that if a government agency's insurer becomes insolvent, the government would be "more than capable" of absorbing the loss or spreading it "among the people as a whole," he said.

The guaranty fund, though, did suffer a setback under another ruling by Judge Bible: The judge denied the guaranty fund's motion for summary judgment that it is not obligated to defend or indemnify a policyholder of an insolvent insurer that faces third-party claims if there is any other insurance available.

As a result, the guaranty fund remains a defendant in the larger Aerojet coverage dispute case over the issue of coverage for the cost of settlements of property damage claims that Aerojet has made with private citizens.

Mr. Clapp noted that less than $1 million in coverage written by insolvent Aerojet insurers is involved in connection with these claims. ■

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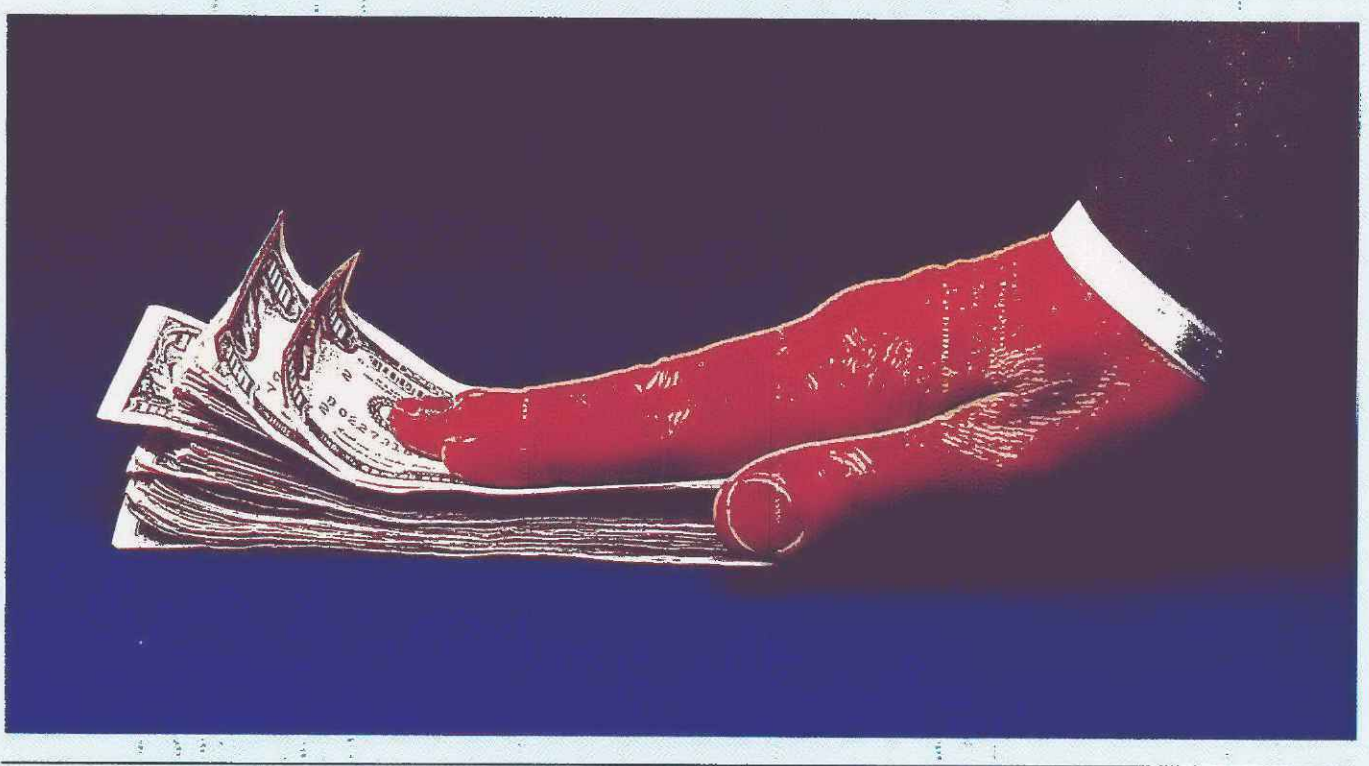

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AIA invites federal role in regulation

By JERRY GEISEL

WASHINGTON—Increased federal involvement is one of several new approaches that should be considered to improve state regulation of insurer solvency, says the president of the American Insurance Assn.

Robert Vagley says the trade group is "wide open" in considering ways to improve solvency regulation.

"We are not saying that we only can the fix the problem within the confines of the existing (regulatory) structure," Mr. Vagley said last week.

"We are not sure that the states, without some federal assistance, can make solvency regulation as effective as it needs to be," he added.

Mr. Vagley emphasized that he advocates not federal regulation of insurance, but rather federal "involvement" in solvency regulation.

For example, in written testimony presented Friday before the House Oversight and Investigations Subcommittee, Mr. Vagley said one idea to consider was a federal law enhancing the National Assn. of Insurance Commissioners' authority to regulate solvency.

"Perhaps the NAIC, through the force of federal law, would be able to enforce its directives on states. If the NAIC issued an order, it would be backed through a federal grant of authority," said David Pratt, AIA's vp-federal affairs in Washington, D.C.

Mr. Vagley cites another possible avenue of federal involvement: Federal minimum standards for solvency regulation that states would follow.

"Obviously, many details would have to be considered, ranging from the substance of the federal standards to the process for assuring compliance," Mr. Vagley said.

Another possible role for the federal government would be for a government agency to step in and warn state regulators that unless they took action to shut down a failing insurer within a certain period of time, the federal agency would intervene, Mr. Pratt said.

Such a federal agency could say to regulators, "You have 90 days to shut it down or we will because you are not meeting federal standards for taking action in terms of failing companies," Mr. Pratt said.

The AIA also is proposing making state guaranty fund protection unavailable to commercial insurance buyers.

Doing so would make "sophisticated purchasers of commercial and excess levels of insurance. . .more concerned about the solvency of their insurers and would not necessarily purchase coverage from the insurer which offered the lowest price. This would mitigate the effects of unscrupulous rate cutting and, in effect, discourage purchasers from exacerbating the condition of financially troubled insurers by unknowingly buying underpriced coverage," Mr. Vagley said in his written testimony.

The AIA testimony comes amidst growing concern about insolvency. The AIA, for example, notes that the number of property/casualty insurer insolvencies more than doubled last year to 43, up from 21 in 1988 and just two in 1981.

Insolvencies, as a percentage of all property and casualty insurers, reached a record 1.14% last year, eclipsing the previous mark of 0.78% in 1984. ■

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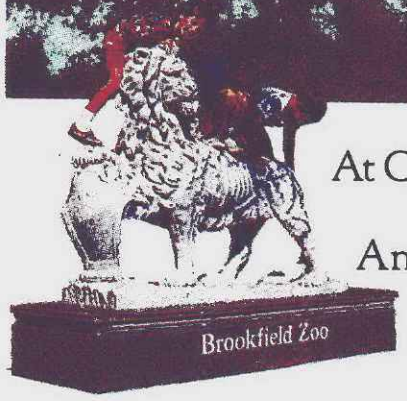

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Lesbian partner sues AT&T for benefits

The surviving lesbian partner of a deceased American Telephone & Telegraph Co. employee is suing the communications conglomerate for not providing her and her two children death benefits.

The woman claims that she and her children are entitled to the benefits under city and state law as well as AT&T's employment policy.

In what is believed to be the first domestic partnership benefits case filed in federal court, Sandra Rovira of New Rochelle, N.Y., sued AT&T Aug. 22 in U.S. District Court for the Southern District of New York. She claims that the company discriminated against her by not paying death benefits routinely paid to surviving family members of AT&T employees.

Benefit beat

For 12 years, Ms. Rovira maintained a committed relationship with Marjorie Forlini, who was an AT&T sales and marketing manager from 1980 until her death from cancer in 1988. Ms. Rovira is seeking $133,000 in benefits and damages, plus attorneys fees.

AT&T is guilty of discrimination, the suit alleges, because its employee benefits committee denied the benefits to Ms. Rovira and her two sons on the grounds that Ms. Rovira and Ms. Forlini were not legally married and that the children were not Ms. Forlini's natural or adopted children.

The lawsuit asks the court to order AT&T to pay Ms. Rovira a death benefit of $58,000—an amount equal to Ms. Forlini's annual salary—as well as $75,000 for three counts of discrimination.

Ms. Rovira, whose children moved in with her and Ms. Forlini in 1978, says AT&T's Management Pension Plan "provides for the payment of a benefit equal to one year's pay to 'mandatory' beneficiaries and payment of a benefit in an amount to be determined by AT&T to 'discretionary' beneficiaries," according to court papers.

The AT&T personnel guide describes mandatory beneficiaries as spouses and unmarried children under age 23. Discretionary beneficiaries are "other relatives who are dependent on the employee participant prior to his or her death who demonstrate financial need after death."

Ms. Rovira, the lawsuit claims, is entitled to mandatory benefits and her two sons are entitled to discretionary benefits, based on Ms. Rovira and Ms. Forlini's relationship. The two exchanged wedding vows and rings and acted as most married couples do, according to court papers.

AT&T's personnel guide also says the company "would not discriminate on the basis of sexual orientation or marital status" in granting benefits, according to the lawsuit.

In addition, the lawsuit contends that AT&T violated the New York City Human Rights Law, which makes it illegal to discriminate because of actual or perceived sexual orientation. The New York State Human Rights Law also prohibits marital status discrimination in employment.

"This case is a good example of a phenomenon that goes on far too frequently," said Paula L. Ettelbrick, legal director with Lambda Legal Defense and Education Fund Inc., a non-profit gay and lesbian rights group in New York that represents Ms. Rovira. "Companies have passed policies that, in name, provide equal treatment for lesbians and gay men in the workplace. But in reality these protections are seldom enforced and almost never translate into equal pay for lesbian and gay employees."

Another lawyer for Ms. Rovira—Lee F. Bantle of Beldock Levine & Hoffman in New York—said, "The denial was blatantly discriminatory and violates AT&T's own promise to provide equal benefits to employees regardless of their sexual orientation or marital status."

AT&T not only ignored city and state laws prohibiting discrimination, "but also the federal law which mandates that employers provide benefits promised to employees," Mr. Bantle said.

An spokeswoman in Basking Ridge, N.J., said: "AT&T does not discriminate on any basis, including sexual preference." She said the company's benefits committee rejected Ms. Rovira's claim because "state law guides us, and no state, including New York, recognizes homosexual marriages. Therefore, the claim has no merit."

—By Michael Schachner

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Common-law marriage

Employer-paid health insurance for an employee's domestic partner can be excluded as taxable income if the state in which the employee lives recognizes common-law marriage, the Internal Revenue Service has ruled.

But in states that do not recognize common-law marriage, such benefits will be taxed as income to the employee unless the domestic partner meets the federal tax code definition of dependent, according to the IRS.

The private letter ruling was requested by the city of Seattle, which recently extended health care benefits to city employees' domestic partners.

Domestic partners of Seattle city employees on May 1 were given the option of receiving fully paid medical coverage from either the city's indemnity plan or from one of two health maintenance organizations (*BI*, May 14).

The decision to offer health insurance to domestic partners followed the city's adoption last fall

Continued on page 12

"What the best and wisest parents want for their children is that which society must want for all its children."

John Dewey

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Opinions

OSHA needs helping hand

TO MANY CORPORATE executives, the two dirtiest words in the English language may well be "OSHA inspection."

And while there likely are overzealous Occupational Safety and Health Administration inspectors who have nit-picked over alleged workplace hazards that amount to no more than a puddle on the floor, we think OSHA has come a long way in the 20 years since it was established.

Unfortunately, OSHA still has a long way to go: Too many workers still are being injured on the job.

In particular, as we reported last week, the number of reported cases of cumulative trauma disorders—illnesses of the musculoskeletal and nervous systems that are caused by repeated motion—are skyrocketing. More than 115,000 reports of cumulative trauma disorders were filed with the federal government in 1988, compared with only 23,000 in 1980 (*BI*, Sept. 10).

OSHA now is attempting to tackle this problem, but more work is needed.

The Labor Department late last month released long-awaited ergonomic guidelines for the "red meat" industry and announced that OSHA will target slaughterhouses, and other facilities where cumulative trauma disorders can run rampant, for special inspections.

These steps were long overdue. The pain and suffering posed by cumulative trauma disorders have been recognized for years. We hope that employers in the meat industry will follow the ergonomic guidelines and that they will reduce cumulative trauma disorders among workers in that industry.

However, we do question the Labor Department's decision not to immediately extend these guidelines to other industries. While cumulative trauma disorders are widespread in the meatpacking industry, other companies—like automobile manufacturers and parts companies—also have high incidences of cumulative trauma disorders among their workforces. And any employees who work at a keyboard all day—be they secretaries, telephone operators or newspaper reporters—face the risk of cumulative trauma disorders unless work stations and duties are ergonomically designed to prevent them.

While critics of industrywide ergonomic guidelines say that the problem is too large to be addressed by one set of rules governing all types of employers, we believe that simple, general rules that all employers can follow would be better than no rules at all.

And we recommend that those who believe that any wide-ranging ergonomic guidelines from the Labor Department would hurt employers should work with OSHA and the Labor Department to make sure that these rules are fair to employers but still protect workers from injury. We urge them to respond to Labor Secretary Elizabeth Dole's request for information about ergonomic hazards in all industry and to work with the government to use that information to develop fair and equitable rules governing ergonomic hazards.

Finally, we salute those employers that are taking steps to reduce the risk of cumulative trauma disorders among their workforces. While such disorders are very complex medical conditions, preventing them can be as easy as making sure a warehouse worker knows proper lifting techniques or raising secretaries' chairs to make sure they're at the proper level in relation to typewriter or computer keyboards.

Smart employers know that taking the steps to prevent ergonomic injuries will save them millions of dollars in workers compensation costs and keep them out of hot water when the OSHA inspector finally decides to pay a visit.

Letters

Nader defends need for expansion of tort law

To the editor: Walter Buce's word processor seems to have run away with him.

In an Aug. 27 letter to the editor, "Nader Reached Nadir at ATLA Meeting," he criticizes my position that expansion of tort law is needed and then immediately launches into a tirade against plaintiffs' trial lawyers.

Not so fast, Mr. Buce.

Let's first focus on the millions of victims who receive no or too little compensation from wrongdoers or perpetrators of their harm. That is a fact. Tort law and its advocates and adjudicators need to face up to that fact and make the law and its administration more embracing.

Greater court and lawyer efficiencies are necessary to fulfill the basic ideal of American law, which is that those who engage in willful or negligent injury to innocents must be required to compensate them for their injuries, pain and suffering.

That is both just and a deterrent to future careless behavior.

Turning to lawyers and Mr. Buce's venom, I looked for similar criticism of defense lawyers who get paid whether they win or lose and who make more money the more they delay litigation with interminable motions. Could it be that Mr. Buce doesn't like lawyers who represent victims and get paid only if they prevail, but looks the other way at the inefficiencies of fixed costs imposed on the system by corporate defendants and their counsel?

And what implicit disparagement on the courts and juries, who provide a check against insubstantial cases that reach these tribunals and their appellate overseers, does Mr. Buce heap! Does he really think it is easy to win a toxic tort or product liability case? Look at the data, oh ye of little faith.

Tort law has restrained the marketing of dangerous technologies: IUDs like the Dalkon Shield, Pinto-type gas tanks and, finally, asbestos. Reasonably safe technologies need not fear the law of torts, which is finally decided by judges, most of whom were formerly corporate or business lawyers.

Mr. Buce goes off the deep end when he assumes that lawyers take 50% of the recovery. In my address, I stated that no contingency fee should ever be over 33% even in the most difficult or drawn-out cases.

As David Schrager, former president of the Assn. of Trial Lawyers of America, said: that should be tops. If Mr. Buce knows any lawyers charging a 50% contingent fee for victims, I would be pleased to denounce them.

Ralph Nader
Washington, D.C.

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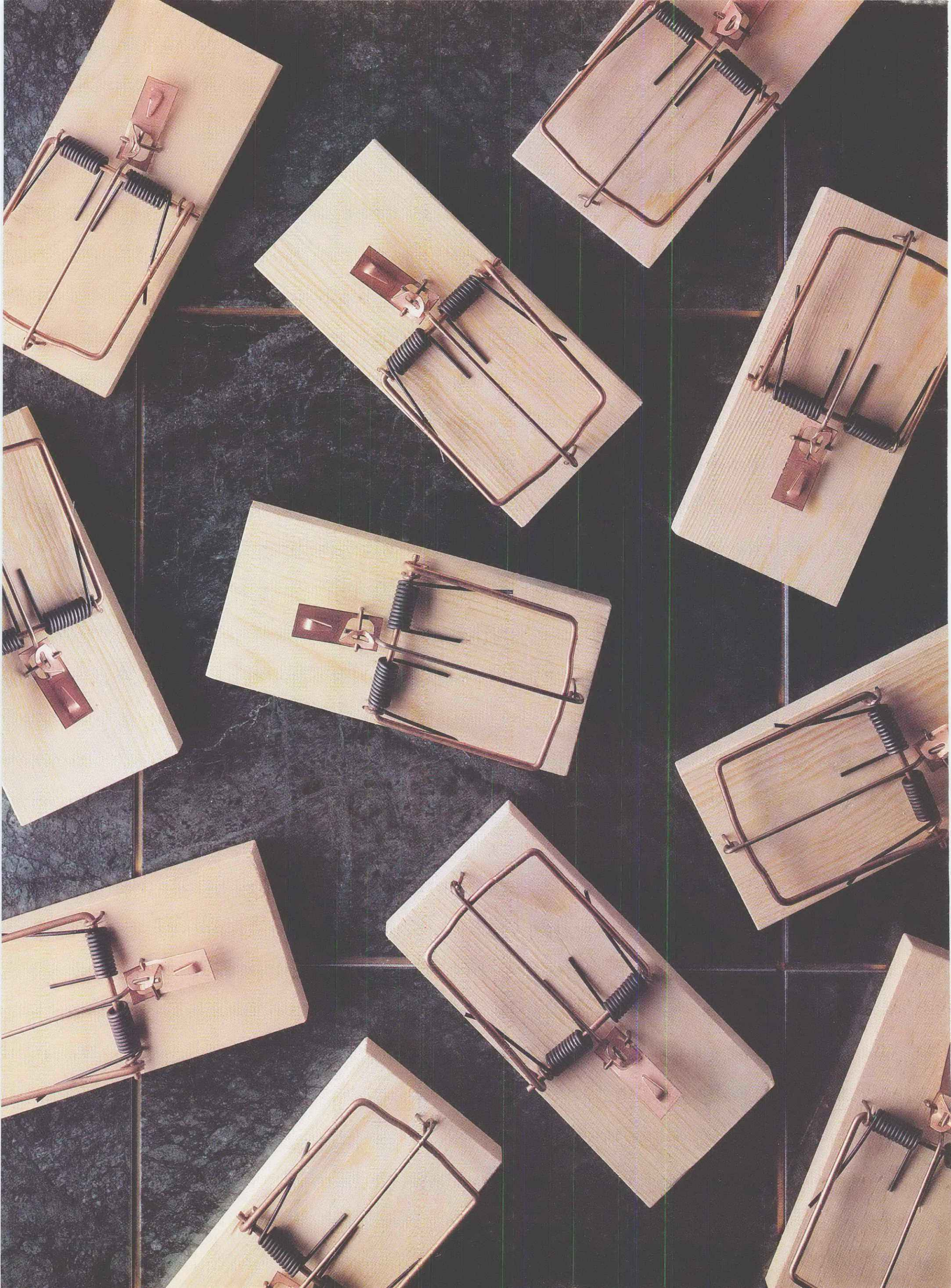

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Benefit beat

Continued from page 6

of an ordinance that prohibits discrimination by employers on the basis of marital status.

So far 194 of the 318 city employees eligible to receive domestic partner coverage have enrolled in the program, which is underwritten by the city.

But because Washington state does not recognize common-law marriage, Seattle employees receiving benefits for their domestic partners will have to pay taxes on those benefits as if they were regular income, explained Sally Fox, the city's benefits manager.

Only 13 states and the District of Columbia recognize common-law marriage, according to Georgetown University School of Law researchers.

Seattle is one of several employers that have begun extending health care benefits to the domestic partners of their employees. These include Santa Cruz County, Calif.; the cities of West Hollywood and Berkeley, Calif., and Madison, Wis.; and the Village Voice newspaper in New York.

In addition, the city of San Francisco recently completed a study on the cost of providing health benefits for domestic partners. According to the study, published June 13, it would cost the city $1.1 million a year to extend health insurance to city employees' domestic partners.

Approximately 12%, or 3,701 of the city's 31,000 active employees have a domestic partner, the study estimated.

However, in a November referendum, San Francisco voters rejected expanding the definition of family to include domestic partners.

—By Joanne Wojcik

Flexible benefits

Forty-two percent of the respondents to a recent survey by accountant Coopers & Lybrand report that their companies offer a flexible benefits plan.

And 55% of those firms that do not currently have flex plans indicated that they are likely to start one within the next five years. Another 6% of respondents said they would probably offer flexible benefits before the year 2000, while 39% said flexible benefits were not under consideration at all.

The survey of 264 Chicago-area human resource executives also questioned employers on the types of work and family programs they currently offer employees.

Fifty-two percent said their company offers flexible work schedules and 36% said they provide parental leave.

One-fourth of the survey respondents said their companies have a job-sharing program designed to accommodate part-time employees, especially working parents.

Some form of adoption program is offered by 14% of the responding companies. Among those who said they do have an adoption policy, 83% said they offer parental leave; 33% said they reimburse a portion of adoption fees; 3% offer financial incentives for adopting hard-to-place children; and 3% said they provide some sort of other adoption plan.

Only 6% of respondents offer elder care or a long-term care plan for convalescing dependents, but 43% provide some other type of dependent care coverage.

Of those companies offering a dependent care program, 85% of respondents said they allow employees to pay dependent care expenses on a pretax basis. In addition, 33% have dependent care resource and referral services; 14% reimburse a portion of child care expenses; 8% offer a sick child service; 4% have on-site child care facilities; and 8% offer some other dependent care program.

For those companies not offering dependent care programs, 36% said they will offer some type of program within the next 10 years, while 64% said plans for dependent care are not under way.

Forty-eight percent of the executives surveyed said their single biggest human resource concern is recruiting experienced workers. Retaining quality workers once they have come on board was cited by 29% of the survey respondents. Only 14% said recruiting entry-level workers was their primary concern.

For a free copy of "Emerging Human Resource Issues—Balancing Work and Family," contact Iris Goldfein, Partner in Charge, Actuarial, Benefits and Compensation Consulting Group, Coopers & Lybrand, 203 N. La Salle St., Chicago, Ill. 60601; 312-701-5618.

—By Michael Schachner

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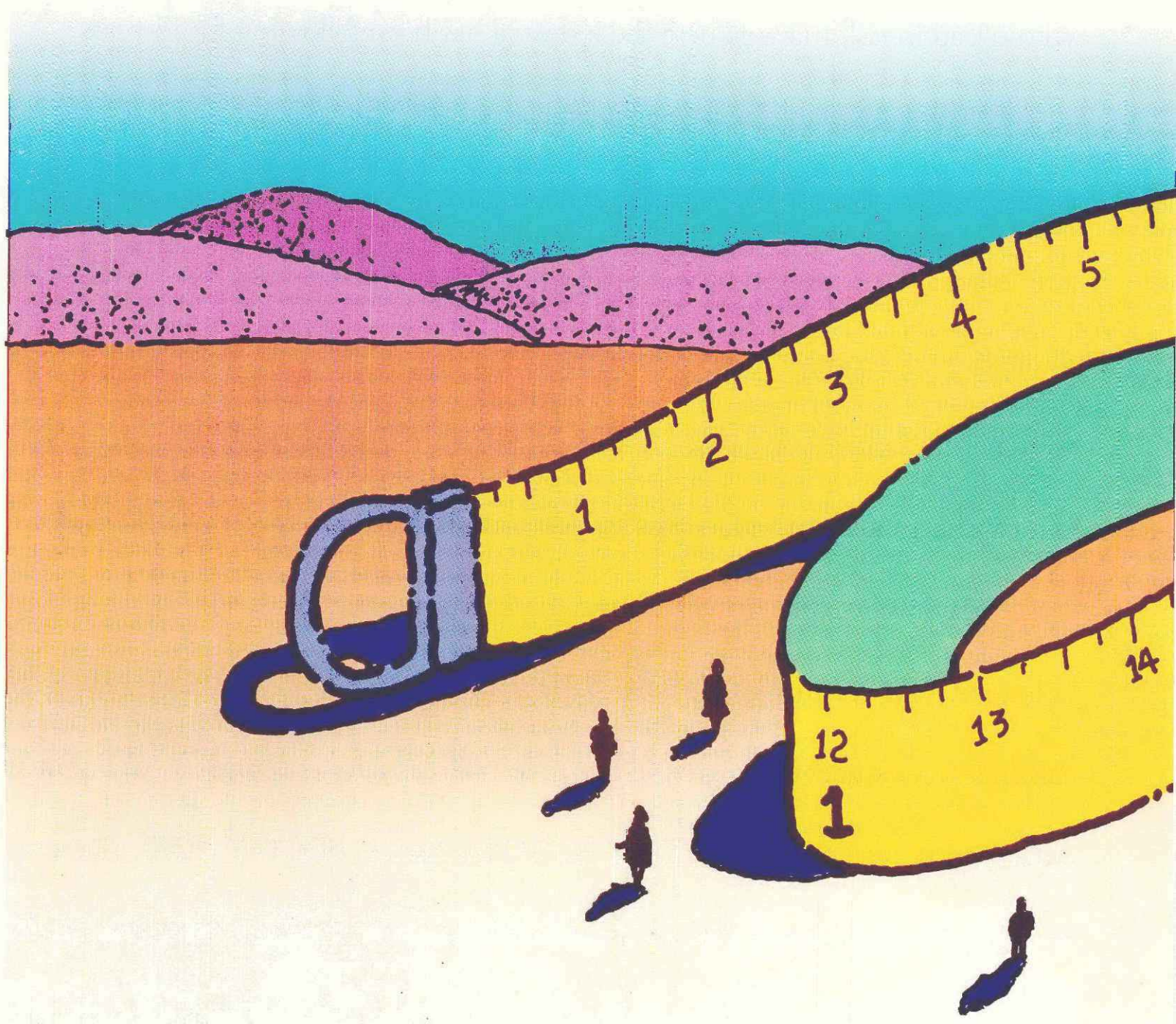

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Continental unit offers cross-border cover

Canadian employers with U.S. operations can now cover their property/casualty exposures on both sides of the border in one integrated insurance package.

Continental Insurance Management Ltd. of Toronto and New York-based parent Continental Corp. have formed a Cross Border Unit in response to the Canada-U.S. Free Trade Agreement, which is providing Canadian businesses with new expansion opportunities in the United States.

The unit will provide full account coverages, specifically commercial property/casualty package policies and specialized products and services, for Canadian companies' operations in both Canada and the United States.

Policies are written for all of a company's sites, combining experience from each location, rather than just insuring risks for one site, explained a Continental spokeswoman in Canada.

The new unit will issue policies for U.S. risks, including workers compensation, and will put Canadian brokers in touch with U.S. brokers for countersigning and servicing purposes, she explained. All billing will be handled in Canada, she said.

For more information about Continental's Cross Border Unit, contact Susan C. Nahley, Corporate Communications, Continental Corp., 180 Maiden Lane, New York, N.Y. 10038; 212-440-7728.

Markets

Joint venture

Mutual Risk Management Ltd., a captive management company in Bermuda, has formed a joint venture with Coyle Hamilton Group, an insurance and reinsurance brokerage that is based in Dublin, Ireland.

The new company, called Mutual Coyle Hamilton Managers Ltd., will be based in Dublin and will combine Mutual Risk Management's captive management services and Coyle Hamilton's brokerage capabilities.

The firm will offer captive management services to companies worldwide.

Employers may benefit from the tax advantages in the region, said John Kessock Jr., chairman of Commonwealth Risk Services Inc., a subsidiary of Mutual Risk Management.

The Irish government is in the process of creating the International Financial Services Centre in Dublin, he explained. The IFSC buildings will house reinsurance, insurance and captive management service companies from around the world.

The center has been designated a low tax area by the Irish government. Companies housed there will be subject to a maximum Irish tax of 10% on profits, including investment income, Mr. Kessock explained. That would be among Europe's lowest corporate tax rates and the European Community has approved it through at least the year 2000, he said.

Double taxation treaties between Ireland and E.C. and other nations will ensure captives that pay Ireland's 10% tax on profits are typically not retaxed when the captive's profits are returned to parent companies, he said.

For more information, contact John Kessock, Chairman, Commonwealth Risk Services Inc., 1 Penn Square West, Suite 1900, Philadelphia, Pa. 19102; 215-981-1404.

Aetna health plans

Aetna Life Insurance Co. plans to consolidate and market its line of group health benefits and services under the name Aetna Health Plans.

The Hartford, Conn.-based insurer's indemnity insurance, preferred provider programs and some health maintenance organizations managed by PARTNERS National Health Plans will be incorporated under the new name. Irving, Texas-based PARTNERS became a wholly owned subsidiary of Aetna in May.

"Aetna Health Plan will also encompass the core program of medical management services we've established," said Charles T. Bell, senior vp in Aetna's employee benefits division.

The insurer "can now coordinate all medical benefit programs for employers, including indemnity, HMO, PPO and point-of-service plans," he said.

HIAA reorganizes

The Health Insurance Assn. of America, a Washington, D.C.-based trade group for 320 commercial insurers, is reorganizing to emphasize managed care and member company services.

Individual departments are being established to handle different areas of concern.

The Department of Managed Care and Insurance products will handle issues of managed care, group, individual and disability insurance.

The Member Services department will coordinate services and resources for the health insurance industry, including the Prevailing Health Charges System—the association's physician reimbursement database.

The Department of Provider Affairs will maintain relationships with health care professional organizations and provider institutions.

In addition, the Legal/State Affairs Department will be further enlarged, adding two lobbyist positions to represent the association at the state level. ■

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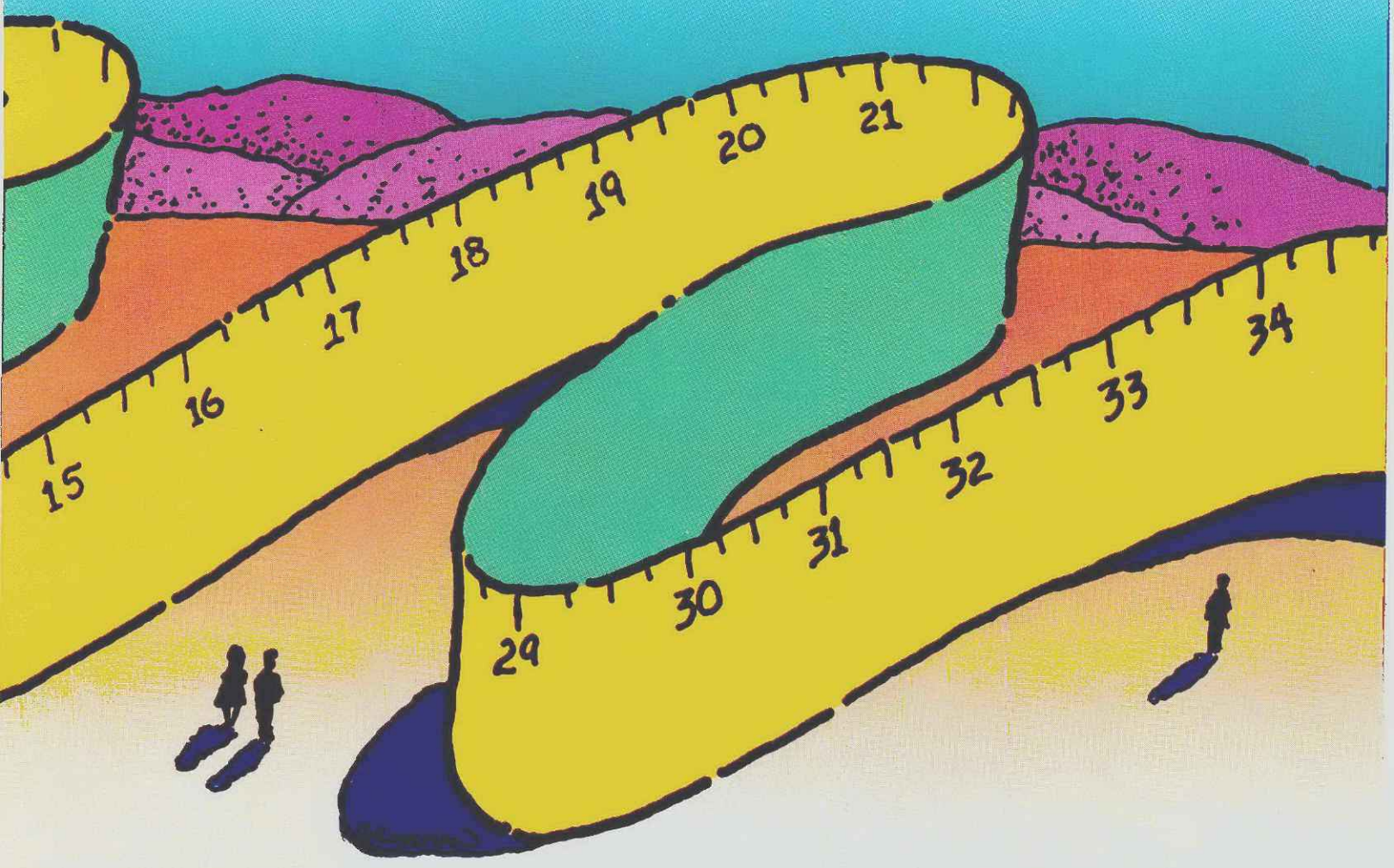

Arbitration

Continued from page 2

binding, pretrial arbitration. However, some cases—like class actions and disputes that involve unusually complex legal issues—can be excluded from the program. Either side can still demand a trial after the arbitrator reaches a decision.

E. Allan Lind, the study's principal researcher, concluded that the arbitration program was successful in reducing the private cost—or the plaintiffs' and defendants' own legal and other costs—of litigation. For example, of the 210 cases that went through arbitration, litigants paid an average of $19,972 in total legal fees and costs, while legal fees and costs for non-arbitrated cases totaled about $25,047—a difference of about 25%.

But, the study found the arbitration program did not save public costs—like court costs—nor did it speed up the duration of legal proceedings.

"Public costs weren't that different," Mr. Lind said. The public cost of each arbitrated case was $1,209, compared with $1,240 for each case handled traditionally.

Mr. Lind pointed out that, unlike other forms of arbitration in which lawsuits are never filed, these cases had already been filed with the court. And, because litigants had the option of refusing the arbitrated settlement and continuing with a trial, most cases still incurred typical administrative and court costs, he said.

And, he explained, because this particular program was characterized by a "formal and measured arbitration process and because the court was concerned that no one feel rushed," arbitrated cases took just as long to adjudicate than those tried traditionally.

Arbitrated cases took an average of 285 days to adjudicate, compared with 282 days for cases handled conventionally.

Most litigants who could not reach a settlement were more than willing to try the arbitration program, Mr. Lind said. "If you have a case in court and there has been no good settlement offer, you would be willing to wait the six to seven months and try arbitration" before proceeding to trial.

The study also noted that parties to the disputes rated the arbitration process favorably.

"Arbitrated hearings were viewed very favorably by attorneys and litigants," said Mr. Lind. The study noted that this was likely because there was greater opportunity for some form of adjudication in cases that were arbitrated than cases that were handled through traditional means, often involving a pretrial settlement.

Currently, more than 200 metropolitan trial courts and at least 20 federal district courts in 22 states operate these kinds of arbitration programs, said Deborah Hensler, researcher for Rand's Institute of Civil Justice.

And, Mr. Lind said he expects mandatory referral of civil cases to non-binding arbitration before a lawyer-arbitrator to become increasingly common in both state and federal courts.

However, he stressed that the Rand study's conclusions apply only to court-administered arbitration. "This isn't traditional arbitration like one might see in" disputes between insurance companies or between policyholders and their insurers, he said.

In fact, advocates of arbitration are quick to point out that there are disputes that can be settled much more quickly through pretrial, binding arbitration than non-binding arbitration programs like the North Carolina federal court's program.

The Rand study "has no application to any kind of traditional final and binding arbitration like insurance companies use," noted Robert Coulson, president of the American Arbitration Assn. in New York.

Mr. Coulson said his association's arbitration system, frequently utilized by insurers and policyholders involved in coverage disputes, does save time.

"Court-administered arbitration is not arbitration at all; it's an appraisal or neutral evaluation system," Mr. Coulson said.

"On the whole, (reinsurance) cases in arbitration are settled in less time and more cheaply" than cases litigated in court, agreed W.J. Gilmartin, president of Brokers & Reinsurance Markets Assn. in Olympia Fields, Ill. BRMA is a educational organization for reinsurers and reinsurance brokers.

Arbitration "is something that is in the best interests of insurance companies and policyholders" when they are involved in a dispute, said Joseph Decaminada, executive vp and general counsel at Atlantic Mutual Insurance Co. in New York. The process "benefits the claimant because he gets his money sooner and with a lot less aggravation," he said.

And insurance companies benefit because, although they may be paying out the same amount to the claimant, they are not running up administrative and legal expenses, Mr. Decaminada said. Insurance company "defense costs are growing at a faster rate than claims costs, so if we can reduce those costs, why not" try arbitration?

"I'm not at all surprised at the results because it's my own experience," said Lawrence Zelle, an attorney with Zelle & Larson in Minneapolis.

However, he pointed out, "you can't use arbitration, mediation or any form of (alternative dispute resolution) and paint with a broad brush because, on average, you don't save time or money" by arbitrating cases.

"There are, however, select disputes where, in my view, arbitration, mediation or some other form of ADR is tremendously advantageous," Mr. Zelle said.

For example, contract disputes involving highly complex or technical issues and characterized by multiple documents often can benefit from arbitration. Setting up a "blue-ribbon" panel of experts to hear the dispute can help speed up the process, he said.

However, "efforts to use arbitration as a panacea or a substitute for litigation are misguided," Mr. Zelle said, stressing that the specifics of the dispute should be examined before choosing any type of ADR mechanism.

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Copies of the report, numbered R-3908-ICJ, are available for $10 from Rand's Publication Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90406-2138; 213-393-0411, extension 6686.

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INTRACORP

Court blocks further hikes of pension tab

By ADRIENNE C. LOCKE

NEW ORLEANS—Champion International Corp. may not further increase a group of retirees' health care coverage contributions pending a federal court's interpretation of the labor agreement that established contribution levels, a U.S. appeals court ruled in overturning a lower court's summary judgment.

A panel of the 5th U.S. Circuit Court of Appeals has sent the case back to the U.S. District Court in Houston for trial on whether Champion can increase the retirees' contributions whenever the government increases Medicare Part B premiums.

The case involves between 70 and 100 early retirees from a Pasadena, Texas, plant Champion sold in 1987.

Champion contends that, under a 1986 collective bargaining agreement, the monthly contributions the retirees must pay toward the cost of health care coverage under Champion's self-insured plan equal the premium for Medicare Part B, which covers physician services.

Therefore, Champion claims, it can increase those retirees' contributions whenever the federal government increases Medicare Part B premiums.

However, the United Paperworkers International Union, which filed suit in March 1988 along with three retirees, argues Champion should have made this intention clearer in its collective bargaining agreement.

It argues that under the agreement, the retirees' monthly contributions must equal the Medicare Part B premium in effect when the agreement was approved but that the retirees' contributions would not have to keep pace with future increases in Medicare Part B premiums.

The union also pointed out that Champion did not increase the retirees' contribution during 1987 to correspond with an increase in Medicare Part B during that same year.

The 1986 bargaining agreement set the retirees' monthly contribution at $15.50. Since 1987, Champion has increased the retirees' monthly contributions to $31.90.

A federal district court judge in Houston granted a summary judgment in September 1989 allowing Champion to increase the retirees' health care coverage contributions to match Medicare Part B premiums.

But, in its Aug. 16 ruling, the 5th Circuit ruled that the collective bargaining agreement was "ambiguous" on the amount of the early retirees' monthly contribution.

The court ruled that Champion's and the union's arguments are equally plausible but that it could not determine whether both parties had a "meeting of the minds" when the bargaining agreement was approved.

However, because the contract outlined a specific amount that the early retirees would pay, the court said it could, as did the union, "easily conclude that both parties intended that the agreement designate completely what the retirees' future premiums would be."

Champion was surprised by the 5th Circuit Court's ruling, said company attorney L. Champman Smith of Baker & Botts in Houston.

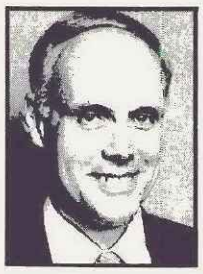
"The District Court granted us a summary judgment, and it's always a little surprising when the appeals court sets one of those aside," he said.

Mr. Smith said Champion will not ask the U.S. Supreme Court to review the 5th Circuit ruling.

Plaintiff's attorney Bruce Finkman of Houston, a solo practitioner, was not surprised by the 5th Circuit's decision. He said the appellate court's ruling confirms the retirees' belief that the issue should be decided during a trial. ■

At issue

What has been your most effective health care cost containment strategy?



John J. Ryan
Vp-Human Resources & Administration
Parsons, Brinckerhoff, Quade & Douglas Inc.,
New York

We put in hospital pre-admission review about two years ago. Our sense is, if it hasn't achieved lower admissions, it's convinced us that the admissions aren't so arbitrary as they once were. Our main concern was with providers who were shifting our employees into more expensive treatments when there were less costly alternatives available.

Paul I. Newman II
Human Resources Manager
Transit Mix Concrete Co.,
Colorado Springs, Colo.

Self-insurance and scrutinizing hospital bills. I closely examine hospital bills covered under our self-insured indemnity plan to spot inappropriate charges and over-billing. We've got a chain of hospitals here that is well-known for overcharging. When I see an error in a bill and tell the hospital we will not pay for that charge, they usually say they've made a mistake.

Evon Wedemeier
Director-Human Resources & Employee Benefit Administrator
Clay Equipment Corp.,
Cedar Falls, Iowa

The most dollars have been saved through effective case management of catastrophic claims. In managing their care, we help our employees select where they can receive the most cost-efficient and high quality health care services. Also, we have been performing in-house claims administration since 1974 and scrutinizing claims more closely saves money.

Robert F. Carniaux
Director-Compensation & Benefits
Hasbro Inc.,
Pawtucket, R.I.

There have been two for us: the move to self-insurance and case management. We try to make a difference from both a dollar and a quality point of view for catastrophic claims and claims that can go on for years. We cover about 6,000 employees and only get an opportunity for case management two or three times a year. But it's had a major impact.

Compiled by Christine Woolsey

Corroon & Black names 2 benefits execs

Comings & goings: buyers

Gary Sindler, 44, has been named senior vp-administration of Corroon & Black Corp. in New York. In this newly created position, he is responsible for compensation, employee benefits, corporate communications, professional development and corporate office administration. Mr. Sindler reports to Richard M. Miller, chairman and chief executive officer. Prior to joining Corroon & Black, Mr. Sindler served as vp-business automation at Alexander & Alexander Insurance Services Inc. in Baltimore. He holds a bachelor's degree in accounting from the University of Baltimore. Also at Corroon & Black, **Jacob J. Hays II**, 41, named vp-compensation and benefits. He replaces **Rita Hebel**, who left the company. Mr. Hays, who reports to Mr. Sindler, is responsible for development and administration of salary, benefits and incentive packages. Prior to joining Corroon & Black, Mr. Hays was a director of corporate compensation and human resource systems for Continental Corp. in New York. Before that, he was vp and manager of executive and expatriate compensation at Chemical Bank in New York. He holds a bachelor's degree in political science from Dickinson College in Carlisle, Pa.; a master's degree in business administration from Monmouth College in West Long Branch, N.J.; and a law degree from New York University. He is a member of the New Jersey Bar Assn. as well as the American Compensation Assn.

* * *

Jeffrey E. Brandon, 32, has been named assistant vp and risk manager of Old Kent Financial Corp. in Grand Rapids, Mich. Mr. Brandon is responsible for administering the general insurance and employee benefits programs for Old Kent and its affiliates. He replaces **Sharon Wilson**, who left the company. Mr. Brandon reports to R. Jay Palmer, senior vp. Prior to joining the bank holding company Mr. Brandon was insurance manager for the North Dakota Bankers Assn. in Bismarck. He also was an account representative at Norwest Insurance Agency in Jamestown, N.D. He holds a bachelor's degree in business administration from Sioux Falls College in Sioux Falls, S.D. In addition, he is a deputy member of the Risk & Insurance Management Society Inc.

Mr. Brandon

* * *

Philip S. Renaud, 39, has been named assistant vp-risk management services of Hills Department Stores Inc. in Canton, Mass. In this newly created position he is responsible for property/casualty insurance as well as pension and deferred savings plans. He reports to Stephen A. Feldman, treasurer. Mr. Renaud joined Hills as manager-risk management and pension administration in 1983 and was promoted in 1986 to risk manager. Prior to joining Hills, he was director of risk management at Scoa Industries, a holding company in Columbus, Ohio. He holds a bachelor's degree in business administration from Johnson and Wales University in Providence, R.I., as well as a master's degree in business administration from Hood College in Frederick, Md. He also has completed post-graduate work in insurance at the University of Rhode Island in Kingston. Mr. Renaud is a deputy member of the Risk & Insurance Management Society and has earned the Chartered Property & Casualty Underwriter designation.

Mr. Renaud

* * *

Donna I. Carr, 43, has been named loss control supervisor for the city of San Antonio, Texas. In this newly created position, she is responsible for administering liability, workers compensation and safety programs. Ms. Carr reports to Scott Wyatt, the city's risk manager. She previously served as risk management supervisor for Spohn Hospital in Corpus Christi, Texas. Ms. Carr holds a bachelor's degree in sociology as well as a master's degree in finance with an emphasis on safety and risk management from the University of Arizona in Tucson. is a deputy member of the Risk & Insurance Management Society and holds the Associate in Risk Management designation. She also is a member of the American Society of Safety Engineers, the American Conference for Government Industrial Hygienists, the National Society for Risk Analysis and the Public Risk Management Assn.

* * *

Vicki L. Gerken, 39, has been named vp-risk management of Adams Communications Inc. in Wayzata, Minn. In this newly created position, she is responsible for property/casualty insurance and risk management programs, including loss control administration. She reports to Wayne Boysen, insurance coordinator. Ms. Gerken was assistant risk manager at Super Valu Stores Inc. in Eden Prairie, Minn., before joining Adams Communications—an advertising, radio and television firm—as corporate risk manager in 1989. She holds the Chartered Property & Casualty Underwriter, Associate in Claims and Associate in Risk Management designations. Ms. Gerken was a 1989 director of the Minnesota Chapter of the Risk & Insurance Management Society and currently serves on the RIMS national continuing education committee.

* * *

Kenneth Gerrity, 33, has been named risk manager of Genstar Stone Products Co. in Hunt Valley, Md. In this newly created position, he is responsible for the company's property/casualty insurance, claims administration and safety programs. He reports to Jim Underwood, director of human resources. Prior to joining Genstar Stone Products, Mr. Gerrity was risk manager for Forsyth County, N.C. Prior to that, he was director of risk management for Pilot Freight Carriers Inc. in Winston-Salem, N.C. He also was a claims supervisor at Peerless Insurance Cos. in Charlotte, N.C. He holds a bachelor's degree in business administration from Wake Forest University in Winston-Salem, as well as a master's degree in business administration from the University of Richmond in Richmond, Va. Mr. Gerrity is a deputy member of the Risk & Insurance Management Society Inc. and holds the Chartered Property & Casualty Underwriter designation.

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Call one...

Defined benefit plan revival foreseen

By JERRY GEISEL

WILLIAMSBURG, Va.—Older workers' demands for retirement income security could lead to a resurgence of defined benefit pension plans, the head of a benefits research organization predicts.

As workers near age 50 and realize they have not made sufficient contributions to 401(k) plans and other defined contribution plans, they may demand a secure, promised retirement benefit, said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C.

"Employees will demand some kind of benefit security so they think they can afford to retire," Mr. Salisbury said last month at the second Corporate Benefits Management conference in Williamsburg, Va., sponsored by the International Foundation of Employee Benefit Plans.

Mr. Salisbury also discussed the possible conflicts between flexible benefit programs and managed health care arrangements.

A rise in the popularity of defined benefit plans, which promise a specific benefit—usually based on a combination of employee salary and length of service—would reverse long-standing trends.

Between 1984 and 1987, the most recent year for which complete statistics are available, the number of defined benefit plans in operation increased 8.3% to 234,000 from 216,000.

By contrast, the number of defined contribution plans, which include 401(k) programs, leaped 19.7% in those years to 638,000 from 533,000, according to U.S. Labor Department data analyzed by EBRI.

Some observers have blamed excessive regulation for the slower growth among defined benefit plans. Government rules have been less of a burden on defined contribution plans, they say.

More predictable costs also make defined contribution plans popular among employees. A company with such a plan promises to make a specific contribution rather than deliver a specific benefit.

Employees also have clamored for defined contribution plans, especially 401(k) plans, which offer features such as employee pretax contributions, loan provisions, a choice of investment options and hardship withdrawals. Those features are not available in defined benefit plans.

But Mr. Salisbury foresees a possible employee backlash against defined contribution plans if the stock market continues to fall, which could lower the value of equity investments in employees' 401(k) and defined contribution plan accounts.

"Let's assume the market continues downward—lump off another 500 points. How enthusiastic will employees be when they get their next quarterly statement? Will they still say that 401(k) plans are God's gift to the world? What will they say? What will they do?" Mr. Salisbury asked.

What older employers—those nearing age 50—will do is demand that employers add defined benefit plans, Mr. Salisbury said.

"When employees are 48, 49 or 50, they may be back at the employer's doorstep saying, 'It is time for you to put in a defined benefit plan,' " Mr. Salisbury said.

And costs, he pointed out, may make some employers reluctant to do so.

"Employers will kick and scream. They will recognize that they don't want the (pension) liabilities. They really don't want to pay (pension termination insurance premiums) to the PBGC," Mr. Salisbury said. But employers will be in a difficult position. With labor shortages expected, they will find it hard to resist such employee demands, he said.

An employee may say to an employer: "I'm 50. I'm in a fairly important job. You've invested a lot in me. If you don't put in a defined benefit plan, I'm going to walk down the street to another company," Mr. Salisbury said.

Down the road, Mr. Salisbury envisions potential conflict between flexible benefit plans, one of the fastest growing benefit programs of the 1980s, and employer efforts to control health costs through managed care programs like health care networks.

'Will employees still say that 401(k) plans are God's gift to the world?' asks EBRI's Dallas Salisbury.

"Managed care in health care is clearly a trend. . .Yet it is at conflict with the other major trend of the 1930s and moving into the '90s —flex plans, which offer multiple options and multiple choices," Mr. Salisbury said.

Surveys indicate, he said, that employers will continue to provide flexibility in benefit choices. Yet, managed care networks, which have proven the most effective in controlling health care costs, work by limiting employees' choice of health care providers, he noted.

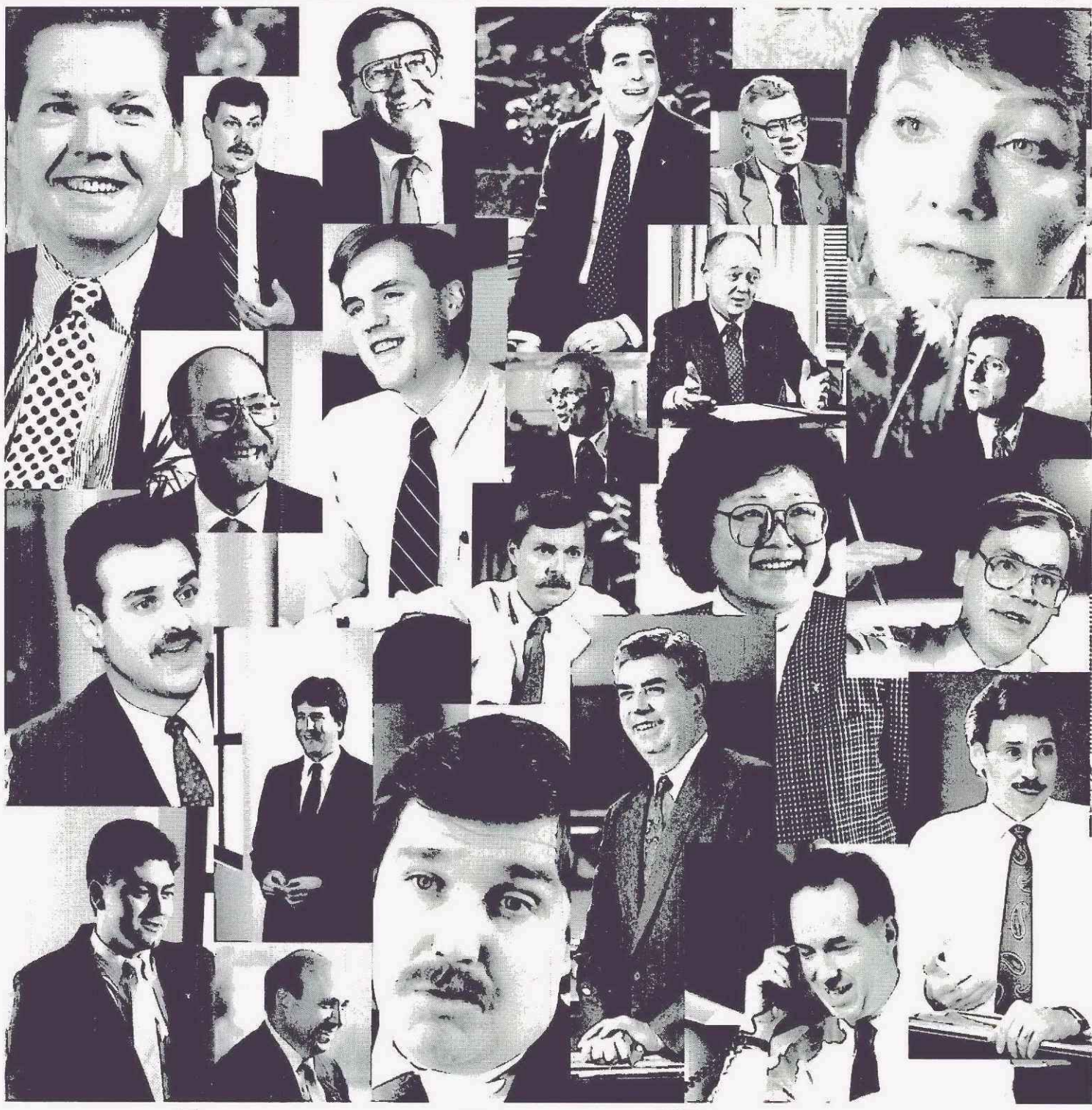
"Will we be able to make that reconciliation? Or have we gone too far down the road in flexible benefit programs and choice to accommodate true managed care. . . and better control health care costs?" Mr. Salisbury asked.

At the same time, employers in the future may have second thoughts about allowing employees to choose flexible benefit plan options that provide only scanty levels of health care coverage, Mr. Salisbury said.

"Employers face some tough questions in the 1990s. Is it in the interest of employers to even provide the choice to individuals to have less than a level of medical care that the employer has deemed to be desirable for the maintenance of healthy productive employees unburdened by the fear of illness for themselves and their families?" he asked.

While there has been much discussion of the growing importance of child care programs, Mr. Salisbury notes that employees continue to rank health care plans as the most important employee benefit provided by their companies, a trend that is likely to continue.

Indeed, a new survey that the Gallup Organization conducted for EBRI found that 61% of respondents ranked health insurance as the most important employer provided benefit, while only 3% said child care topped their list, he noted. ■



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Expert calls for simpler benefit message

By JERRY GEISEL

WILLIAMSBURG, Va.—Employers need new strategies to better explain benefit programs to employees, a consultant says.

"The No. 1 problem for an employer is not 'I need to explain more.' The problem is you probably are explaining too much,'' said George Heiring, a partner and communications group manager with Hewitt Associates in Lincolnshire, Ill.

At the second Corporate Benefits Management conference in Williamsburg, Va., sponsored by the International Foundation of Employee Benefit Plans, Mr. Heiring said employees complain that they're being buried with too much detail about benefits.

"Employees say: 'Things are so thick or so difficult to understand.' Over and over again we see that and hear that,'' he said.

In fact, company messages about benefit programs have become almost too much to comprehend.

An employer may, in effect, be saying to employees " 'Here is your flex plan, there are 12 different plans and 32 different choices available to you. . .savings plans. . .pretax. . .aftertax, FSAs. . .dependent care. . .health care.' The messages are increasingly complex,'' Mr. Heiring said.

Even as plans become more complex, communication could be simplified, he said.

"Our research with employees has told us to approach communications differently,'' Mr. Heiring said.

'The No. 1 problem for an employer is not "I need to explain more." The problem is you probably are explaining too much,' says George Heiring, a partner and communications group manager with Hewitt Associates in Lincolnshire, Ill.

One of the easiest, but most important, communications steps companies can take is to revamp benefit booklets, he said. Employers could, for example, add a table of contents or thumb tabs to enable employees to get information quickly, he said.

More graphs and charts could also be used. "One simple graph, if well done, can replace five paragraphs. A graph can show the relationship of things much clearer'' than words, Mr. Heiring said.

"People creating benefit books too often don't think of how to visualize. Instead, they think of how to verbalize'' something which we have done too much, he said.

Employers could also put less print on each page of a booklet, Mr. Heiring said. "We have grown up with the idea that more print on the page is better. True? Wrong.''

Employers can learn from the catchy graphics and layout techniques used by USA Today, he noted.

He also advised employers to use examples liberally when illustrating points about their benefits.

"Pick a variety of examples. Don't use dated figures, like the employee making $12,000. Pick some average salaries, some typical situations. Use real employees (deleting the actual name). Say, 'This is a real employee.' People will accept that,'' Mr. Heiring said.

Before distributing a new benefit booklet, Mr. Heiring says employers should have a few employees read it.

"Pick a few employees. Tell them you would like them to look at the booklet and read it. If there is a great distance between what you want it to mean and what they think it means, it is time to go back and rethink it,'' he says.

Aside from revamping benefit booklets, employee meetings can be an effective way to explain benefit programs or changes, Mr. Heiring said.

The perceived downside of meetings is that corporate managers may feel that the cost of time off from work to attend such a forum is too great.

But that downside can work to a company's advantage, Mr. Heiring said.

"The meeting is a major expense in terms of time away from work. Because of that, though, it has a psychological lift. The employees say: 'It must be important if they are bringing me to a meeting.' It initially underscores the importance of the message,'' Mr. Heiring said.

Meetings also have the advantage of capturing employees' attention, if only for a short time.

"Unlike print, the doors are shut. You can't escape. I have your attention. You will get attention that you can't get with print,'' Mr. Heiring said.

Unfortunately, many employers don't spend enough time deciding who will be the most effective speaker at a meeting or rehearsing speakers.

"The live speaker still is one of the most effective mechanisms of getting sensitive information across. If the speaker can command the interest, attention and respect of the audience that speaker can be very effective,'' Mr. Heiring said.

But too often speakers are poorly trained and their performances are not monitored, he said.

Rather than selecting speakers for their technical expertise, Mr. Heiring suggests using people known for their ability to communicate and having a technical expert nearby to answer questions.

Video also is a natural communications medium employers should consider using to explain benefit programs, Mr. Heiring said.

"Video can be less boring because it has emotion, it has motion. . .it lets you see things you can't see in any other way. It is an excellent tool for stressing concepts,'' he said.

Video can also deliver a uniform message with the same intensity and clarity.

Employers should consider having their chief executives in their benefit videos, Mr. Heiring said.

"There is a logical, universal spokesman: the chief executive. With the enormity of those messages—managed health care, flex, changing retiree health benefits—the CEO often is the only credible spokesman,'' Mr. Heiring said.

While many chief executives are not comfortable in front of a camera, with the proper training they can be very good, he said. ■

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Legislation to protect PBGC pondered

By JERRY GEISEL

WILLIAMSBURG, Va.—The Bush administration is considering legislation to make the Pension Benefit Guaranty Corp. less vulnerable to big claims, a top PBGC official says.

Some of the proposed changes being considered were outlined by PBGC Executive Director James B. Lockhart III before the International Foundation of Employee Benefit Plans' second Corporate Benefits Management conference in Williamsburg, Va., last month. They include:

- Increasing the annual minimum contributions employers must make to pension plans.

Congress strengthened the minimum funding rules considerably in 1987. But pension plans that comply with the new rules can still be seriously underfunded because of lump sum payments and increases in past service liability, Mr. Lockhart said.

- Improving the status of PBGC claims in bankruptcy court. Earlier this year, a federal bankruptcy court ruled that the PBGC should not be given priority over LTV Corp.'s unsecured creditors (*BI*, June 4).
- Reducing PBGC guarantees of so-called contingent benefits, such as benefits companies pay when they shut down plants.
- Giving the PBGC better protection when a company with different units attempts to spin off an underfunded pension plan to a financially weaker unit.

Mr. Lockhart said these changes remain necessary despite the pension agency's somewhat improved finances and a Supreme Court ruling that removed the threat that the PBGC might have to assume responsibility for more than $2 billion in pension benefits LTV Corp. promised to workers and retirees but did not fund.

"At PBGC, we've passed through some stormy seas and now we're trying to avoid the gale-force winds. We're hopeful we, too, can move toward calmer waters and a safe harbor," according to Mr. Lockhart.

In the last year, higher revenues from the premiums paid by employers and increased investment income have reduced the PBGC's deficit to $1 billion from $1.5 billion.

And in June, the Supreme Court ruled that the PBGC had the authority to return to LTV three previously terminated pension plans with $2.3 billion in unfunded liabilities. The PBGC took its action after LTV set up a new low-cost "follow-on" pension program that would have supplemented benefits in terminated plans that the PBGC had earlier taken over (*BI*, June 25).

PBGC officials said that if LTV had prevailed, other financially distressed companies would have dumped their pension liabilities onto the PBGC and then would have established new low-cost supplemental or follow-on plans.

And once they did, the pension agency, facing billions of dollars in new liabilities, would have had to seek congressional approval to once again raise termination insurance premiums on employers.

The Supreme Court decision in the LTV case was "a victory for us and the 40 million workers and retirees that we cover, but also for our premium payers. The decision certainly will help discourage unwarranted terminations and encourage better funding," Mr. Lockhart said.

While the LTV case removed the specter of the agency being hit with a $2 billion claim—as well as claims from other companies that would have followed in LTV's footsteps—the PBGC's road to a more solvent state is still, as Mr. Lockhart puts it, "strewn with rocks and pitfalls."

For example, a U.S. Bankruptcy Court decision that the PBGC does not have priority status as a creditor could affect the agency if financial troubled Eastern Air Lines Inc. terminates its pension program. Eastern, which filed for Chapter 11 protection from its creditors last year, has unfunded pension liabilities of about $800 million, according to Mr. Lockhart.

And Eastern is not the only company whose pension plans are massively underfunded. In all, the PBGC faces a potential exposure of $20 billion to $30 billion if companies—mainly in the steel, auto and airline industries—terminate underfunded programs.

To reduce underfunding and its exposure to big claims, the PBGC—aside from seeking legislative changes—is using other loss prevention techniques, the PBGC chief said.

As part of its loss prevention strategy, the PBGC earlier this year released a list of the 50 largest underfunded pension plans sponsored by publicly held companies. Negative publicity generated by the list has put pressure on companies to improve funding, Mr. Lockhart said.

"Despite the complaints generated from some of the listed companies, release of the list has raised awareness. Shareholders, workers, retirees and even creditors are calling on companies to better fund their pensions," Mr. Lockhart said.

At the same time, the PBGC through what was described by Mr. Lockhart as "tough negotiation" and litigation, is seeking the best possible recovery when companies do terminate underfunded plans.

Meanwhile, Mr. Lockhart took issue with comparisons of the problems in the nation's pension system—such as the PBGC's continuing exposure to big claims—and the savings and loan crisis.

"Let's be honest, there are similarities between the S&L industry and the pension industry. But I think the differences are far more compelling," Mr. Lockhart observed.

Many thrifts, for example, used self-deceptive accounting procedures, while "conservative accounting is the norm for pensions," he said.

In addition, while officers and employees of S&L have been charged with fraud and other criminal activities, "almost no such people can be found in the pension industry," he said.

Mr. Lockhart said that while the S&L crisis began almost invisibly and out of the public eye, pension problems will not be swept under the table.

Congress, the Bush administration and the media all will assure that pension problems will be aired before they become a national disaster, he said. ■

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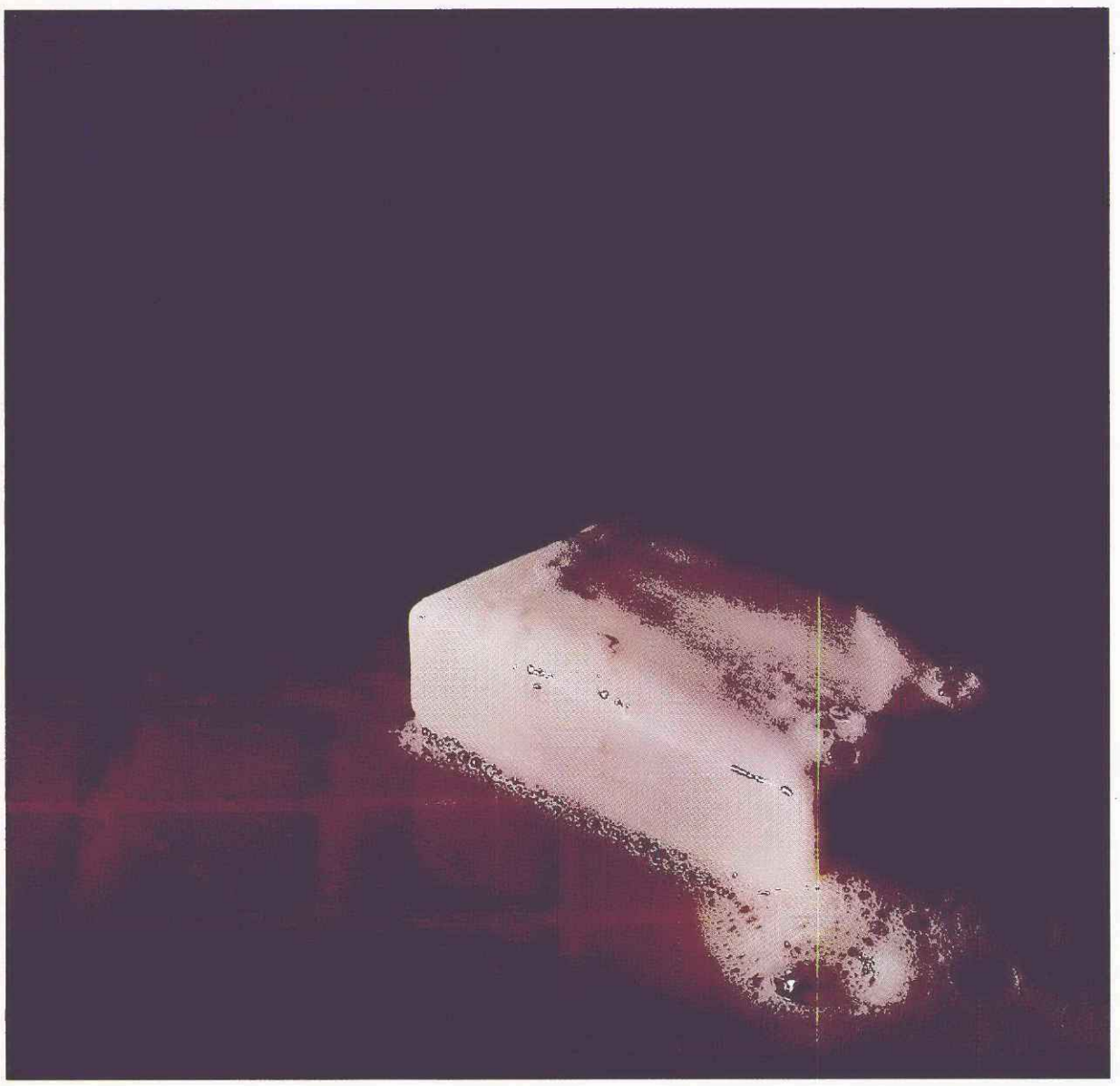

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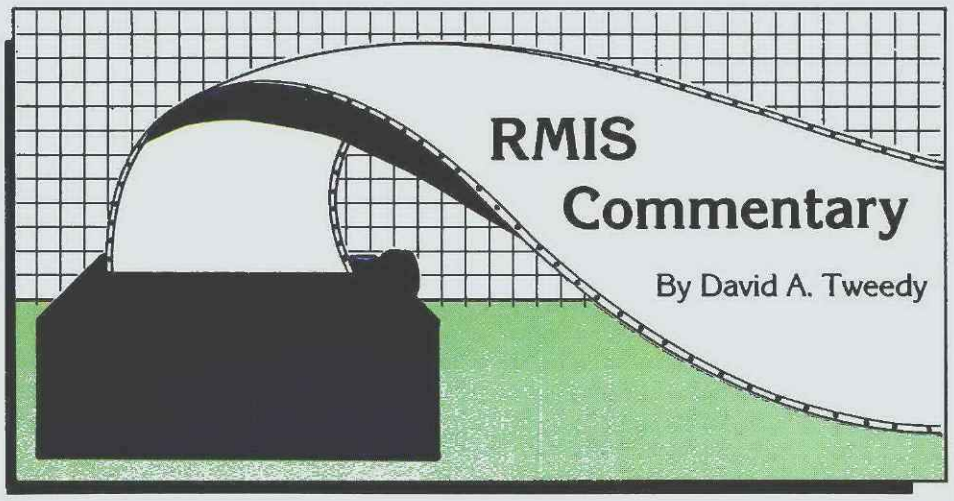
Request for proposals

An RFP is final step in RMIS needs identification



A GOOD REQUEST FOR proposal is quite important in the selection of a risk management information system. Last month, we discussed the development of user specifications as the final step in the RMIS needs identification process (*BI*, Aug. 20). Now, these needs and specifications must be proposed to several bidders before the actual system selection can be made.

Essentially a good request for proposal will help to identify and weed out vendors that are not really qualified—either from technical or service vantage points—to handle your system needs.

Also, the risk manager would not want to relax his or her efforts at the point of purchase, having completed the exhaustive need determination and specification development steps. A poorly designed RFP will mislead bidders and cause an unwanted—and expensive—breakdown in the system selection process.

How does one devise a good RFP? There really are no standard formats; they will vary depending on the particular situation. But all proposals should present, clearly and definitively, what the risk manager wants in a system.

The RFP sets the proper direction and emphasis for bidders. It is meant to modify and emphasize (or de-emphasize) parts of the specifications.

For smaller systems—such as for an in-house, personal computer-based system—the RFP may include the specifications, combining the general objectives with the specific details. For custom-built or large vendor-supported systems, the RFP should provide general guidance and overall concepts. The specifications will be attached to the RFP to provide the details.

Generally, an effective RFP should contain the following elements:

✔ Clear objectives.

Above all, the RFP is meant to clearly instruct the participating vendors on what is desired by the organization. The objectives must be clearly stated to prevent the vendor from following up on less significant points in the specifications.

The objectives should be prefaced by a brief description of your organization. For example, describe claims volume, number of employees and current system environment. Objectives indicate the amount of time the vendor should spend on describing how its systems can respond to those stated objectives. The specifications, if done properly, will provide exact details.

✔ Vendor credentials.

The next section in the general format for an RFP concerns the vendors' own capabilities to provide systems and services to the client.

Your specifications package should comment on your hardware requirements in detail. For example, a complete identification of your organization's hardware environment and available capacity—if internal hardware is to be used—is necessary.

For purposes of the RFP, the vendor should comment on the type of hardware it utilizes, whether it sells hardware and whether it can provide software "bridges" between your firm's hardware and operating environment and that of the vendor. Vendors must clearly state their system's hardware requirements, such as storage and processing needs, necessary ancillary equipment, upgrades of existing microcomputers, communications equipment, etc.

Documentation provides a good test of the vendor's capabilities. At past Risk & Insurance Management Society conferences, several new vendors had terrible documentation (or none at all), which should immediately create suspicion in the mind of any potential buyer.

Documentation of software also should be a basic component of any RFP. Solid documentation of the system's structures, codes and regular updates provides a good foundation for the client to begin to understand how to use this new system. Also, it provides a good test of the vendor's capabilities. At past Risk & Insurance Management Society conferences, several new systems and vendors have had terrible documentation (or none at all), which should immediately create suspicion in the mind of any potential buyer. This documentation can be reviewed by your internal data processing department for an expert opinion.

Another very important consideration is the vendor's references on similar projects and clients. The risk manager will want to speak with each of these references to determine the nature of the system's readability and servicing abilities. It would be even better if the potential buyer could speak to a number of former users of this potential vendor to get a feel for the system.

✔ Implementation.

The RFP should request specific information on the length of time required to fully implement the system. You must be clear in identifying your time frame in getting your system fully operational.

Depending on the complexity of the RMIS, personnel training costs and time become critical factors. You should ask for a clear statement of initial training costs for the person in your department who will need to know how this system operates.

Also, information on availability and cost of regular update training seminars should be received. Some of the questions normally asked pertaining to personnel training are: Where does the training take place? Is there a training manual? How often is the manual updated? Is there a contact person at the vendor if things go wrong?

The ability of the vendor's system to integrate with other systems is another important factor. More often than not, the RMIS is not a stand-alone system but must relate with other existing RMIS or other corporate systems. The RFP will specify what degree of flexibility in integrating the systems is necessary. Additionally, users want to utilize data in popular spreadsheet, data base or graphics packages with an RMIS. The vendor should comment on this possible integration.

✔ Management issues.

Because much of the information contained in your system may be sensitive, you should require a confidentiality agreement between you and the vendor. This obviously is essential if the vendor is managing your system and handling claims and personnel data on your behalf. A reputable vendor will have no problem in signing this confidentiality agreement. If a vendor objects, you should wonder about the quality and professionalism of that vendor.

Although servicing was touched on under the implementation section, it is important as an ongoing concern. After all, you have not only invested in an RMIS, but a service provider. The system may be only as good as the people backing it up. Systems change over time, new features are added, modifications are made and problems occur. For these and other related concerns, good solid servicing agreements should be part of any relationship between a risk manager and an RMIS vendor. This is especially true with a vendor support system, but is also important for a stand-alone system. Even a stand-alone system changes, and bugs will occur from time to time. It is recommended that the risk manager have easy access to the original providing vendor for service, if necessary.

✔ Price.

Last, but certainly not least in the minds of buyers, is the price being charged for the system and related services. Because each vendor may offer the pricing in different forms (price per claim added to the system, price per module, price per 1,000 claims, price per hours of time sharing, etc.), the risk manager is advised to clearly delineate how he or she would like the price quoted.

For instance, a good method is to devise a bid tabulation sheet identifying how you would like the quote to be made. You may desire to have a price per 100 claims added to the data base, or as broad as a price per monthly usage of the system. Obviously the pricing methodology for stand-alone systems is simpler in that you can ask for a price per module (i.e., claims administration) and a yearly servicing fee estimate.

The important point is to aid the bidder in conforming to your pricing structure so that you may be able to compare the proposals on an equal basis.

In summary, a well-designed RFP will assist vendors to properly interpret the specifications and provide the type of proposal sought by the risk manager. Although there are no set standards for an RFP, it should be structured with clear objectives, concise questions about the vendor's qualifications, description of training and servicing abilities and system documentation. ■

David A. Tweedy is a senior consultant for Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.

One company's health care solution

By Robert J. Andreoni and Daniel W. Hurley

IT IS A PROBLEM facing all American business and it has no simple solution. Can the ever-rising cost of employee health care be managed without significantly reducing the benefits employees currently enjoy? Our company, Cookson America Inc., recently took on the challenge of solving this problem.

Our initial review found Cookson America's cost for providing health care benefits to our 6,500 employees—who are located in 45 different companies throughout Rhode Island, New Hampshire, Pennsylvania, New Jersey, New York, Georgia, Ohio, Minnesota, Illinois and California—had risen to approximately $14 million annually. It was projected that our costs would reach approximately $30 million per year in about five years if we didn't act now. We realized a unified plan of action was necessary and, considering Cookson America's philosophy of autonomy, we knew it wasn't going to be an easy task.

Our first step was to assemble a benefits team to work on the project. The team's immediate task was to assess the current state of the company's health insurance. The benefits team then developed a working relationship with a group of outside consultants that specialize in employee benefits. Together, they determined exactly what type of coverage was in place throughout all of Cookson America's companies.

This involved an enormous amount of data gathering and analysis. Once the review process was complete, we could then start discussing the type of benefits programs that were most compatible with Cookson's goals for providing employee coverage.

Given all the available data, we determined that the most efficient way for Cookson to manage its share of health care costs was to consolidate plan coverage and consider alternative financial arrangements. We would design our own program and collect our own premiums. A major insurer would be selected to provide the claims administration.

When it came to designing a benefits program, the Cookson executive committee was influential in stressing a program that would involve choice. Discussions with the benefit consultants had convinced us that we didn't have the administrative resources to offer each Cookson employee a choice of plans. However, mandating one benefit program for all subsidiary companies did not fit the Cookson philosophy of autonomy.

According to the experts, our solution to this dilemma was unique. While they argued that one plan was easier to implement, we felt that was too restrictive. Our plan was to offer our subsidiary companies a choice of three medical plans and that each company choose one plan that would be available to all of its employees.

The final consolidated coverages offered through three medical plans was the result of evaluating more than 60 medical plans previously offered by 40 subsidiaries. According to the outside consultants, each of the three new plans provided high-quality coverage. However, the structure of the three new plans was different from the previous plans in a significant way.

Each plan provides Cookson employees, on average, with a 25% responsibility for medical costs, either through claims sharing or premium contributions. The remaining 75% is paid by the Cookson subsidiary. Most of our employees have never shared in the cost of medical coverage and therefore we at headquarters were concerned with the initial communication of this concept.

In addition to their concerns regarding employee acceptance, the Cookson executive committee also wanted assurances that the 25% to 75% ratio was competitive within the industry.

Our benefits team realized that it had to sell this program to the executive committee before anyone else. After several meetings, the committee recognized that the program provided high coverage at a competitive price. They were interested in learning from our statistics, that employee cost sharing is the norm with medical care benefits, not the exception. This arrangement provided flexibility to our subsidiary companies in selecting an out-of-pocket maximum for their employees.

It was also important to note that our philosophy would allow the subsidiary companies to continue offering health maintenance organizations if currently available. Newly acquired companies would be given time to integrate into the Cookson program and, to minimize the impact of employee contributions, payroll deductions are made on a pretax basis. The benefits team also explained projected benefit costs and how these costs would be managed not only through employee cost sharing but also through efficient plan design and administration. Other cost containment features, such as preadmission certification and second surgical opinions, were also included in the plan's design, as well as some generous wellness and preventive care benefits.

The executive committee's concerns with employee acceptance were well taken. To facilitate understanding of the new program among employees, a two-step training program was formulated for all subsidiary company personnel managers and human resources directors, which totaled about 75 employees. They participated in two day-long training sessions at our company headquarters.

During the first session, participants learned of the specific benefit coverages so that they would be able to communicate the program in depth to their co-workers. The second session covered the procedures necessary for implementation and ongoing administration. In addition, brochures describing the benefits of the particular program that had been selected were made available for employee distribution. Brochure formats were printed in both English and Spanish.

We at Cookson felt that it was extremely important for our employees to feel comfortable with our health care administrator. Initially, eight major insurers were asked to present proposals. The interviewing and selection process narrowed the field down to three candidates. Although impressed with all three, we ultimately decided to use Blue Cross & Blue Shield of Rhode Island to administer the medical and prescription drug plan. Since nearly half of the Cookson companies already relied on some type of Blue Cross/Blue Shield plan, the feeling was that the employees would have the security of dealing with a familiar organization on a national basis.

About the time that Cookson decided to make a change in its medical coverage, BC/BS of Rhode Island was examining ways to effectively handle central claims processing for large national accounts that were headquartered in Rhode Island. At that point, its biggest account was just beginning to phase in employees from Massachusetts and Rhode Island, but had not yet brought in employees located in 12 other states. In order to satisfy that demand, BC/BS implemented a new system that allows enrollment, claims management and claims payment through a single site. By the time the Cookson bid arrived, BC/BS of Rhode Island was ready to take on claims handling for an account with employees located across the nation.

BC/BS of Rhode Island made a significant commitment of resources to the Cookson program. It maintained an employee on-site at Cookson during the nearly year-long implementation process. In addition, changes were made in the way claims were handled. Phone lines that normally closed at 4:30 p.m. remained open to accommodate West Coast subsidiary companies. Also, a portion of claims handlers are fluent in Spanish.

On March 1, 1990, coverage under the new medical plans became effective. The Cookson benefits team will review plans on a yearly basis. At that time, changes to the program can be made and, thanks to up-to-the-minute administrative reports, our rates can be adjusted based on actual claims experience, not just projections.

Although it took nearly two years of planning, meetings, calculations, consulting and development of customized software, Cookson America has achieved its goal. We have all the advantages of benefit consolidation without giving up freedom of choice. Combine that with the fact that we expect to save almost $17 million over the next five years, while providing high-quality employee health benefits, and we would say that Cookson America has found the best solution to our problem of containing rising health care costs. ■

Robert J. Andreoni is director of administration and Daniel W. Hurley is vp and chief administrative officer for Cookson America Inc., a subsidiary of Cookson Group P.L.C. in Providence, R.I.

Mr. Andreoni

Mr. Hurley

Incontestability clause bars coverage denial

Legal briefs

A Pennsylvania appellate court ruled that an incontestability clause in a group life insurance policy barred an insurer from asserting the defense that the policyholder was ineligible for coverage.

In November 1982, SAFECO Life Insurance Co. issued a policy of group insurance to The Kaplan Co. on the lives of full-time employees who worked a minimum of 30 hours each week.

Michael Groll filled out an enrollment card in which he designated his wife as his beneficiary. In 1986, Mr. Groll was shot and killed in a home burglary. Premiums had been paid until his death.

The employer submitted a notice of claim to SAFECO in January 1986, requesting the insurer to pay $10,000 in basic coverage plus an additional $10,000 for accidental death.

SAFECO rejected the claim asserting that Mr. Groll was not a full-time employee. Mrs. Groll sued claiming the policy's incontestability clause precluded SAFECO from denying coverage. The trial court ruled for the beneficiary.

On appeal, SAFECO argued that its act of accepting Mr. Groll's insurance premiums should not be construed as a waiver of its right to subsequently assert his employment status as a defense.

However, the appellate court disagreed and said that eligibility could have been discovered by a simple investigation. As a result, the court said the defense of ineligibility was barred by the incontestability clause.

Groll vs. SAFECO Life Insurance Co., Superior Court of Pennsylvania, Nov. 2, 1989 (*BI*/03/June-$10). ■

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a $10 check payable to Cases Unlimited to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

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College of Insurance to use $150,000 grant to attract minorities

By MARK A. HOFMANN

NEW YORK—The College of Insurance will use a three-year $150,000 grant announced late last month to recruit students—primarily minority group members—to study insurance, risk management, actuarial science and finance.

In the past few weeks, the New York college also received a three-year $69,000 grant to launch a magazine and $15,000 in initial funding for a memorial scholarship, said President Ellen Thrower.

A spokeswoman said 1990 donations total about $1.2 million—including the 1990 portions of the new multiyear grants.

Aetna Life & Casualty Co. provided the $150,000 recruiting grant. Rich Wackenreuter, manager-corporate public involvement, said Aetna has donated $8,000 to $10,000 a year for several years, but "we thought it was appropriate now to address some of the needs that were important to us" through a larger grant.

The money will go toward scholarships and financial aid, Mr. Wackenreuter said. He said Aetna management believes more must be done to bring minorities into insurance.

Roughly one-third of the workforce early in the next century will consist of minorities, including African-Americans, Hispanics and native Americans, Mr. Wackenreuter said. To have a well-trained workforce and to maintain the customer base, the industry must reach out to minority entrants, he said.

In addition, Aetna wants to help the college reach a pool of qualified minority job applicants beyond the New York metropolitan area.

"This particular grant allows the college to extend its recruiting efforts to other cities, including Hartford," he said.

"The grants certainly will help us continue recruiting minority students," said Ms. Thrower. About 20% of the school's students are minorities, but she added that "we still want to do better."

Mr. Wackenreuter noted that this is not Aetna's first effort to draw minority students to insurance education. He said Aetna gave about $50,000 to the Insurance Center at Drake University in Des Moines, Iowa, in 1987 to aid in minority recruitment.

The Long Grove, Ill.-based James S. Kemper Foundation, which is supported by Kemper Corp. and Kemper Group's national insurance companies, announced a three-year grant of $69,000 to start a College of Insurance magazine.

The foundation decided to make its first grant to The College of Insurance because the college has strengthened its educational program and adopted "a much stronger strategic direction" since Ms. Thrower assumed its presidency about two years ago, said John Barcroft, executive director of the foundation. "More than most colleges, The College of Insurance needs some kind of publication to promote itself," he said.

Ms. Thrower agreed. "We very much need to be telling people what the college is. We're not just a New York college."

Both stressed that the magazine will not be "fluff," but rather contain serious articles on the college's programs and insurance industry issues. The first issue of the magazine, which will be distributed to insurance industry leaders, is expected to be published by year-end, said a spokeswoman for the college.

The third August grant came from New York-based broker Frenkel & Co. Inc. in memory of James J. Costa, its former president and chief executive officer. Mr. Costa, who began his 42-year career at Frenkel as a messenger in 1946, died June 28.

According to Frenkel President Alan S. Samuels, Frenkel made an initial $15,000 donation to the James J. Costa Memorial Scholarship Fund in the hope that other donations will follow. The scholarship will be administered by the college, he said.

Ms. Thrower said this is one of several memorial scholarships begun in the past two years.

"It's such a lasting remembrance," she said of the Costa scholarship. "If companies knew how easy it was to establish these memorial scholarships, there'd be more of them." ■

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Benefit board

Continued from page 1

poor people's access to health care by creating a federal catastrophic and preventive coverage program funded with general revenues or new taxes.

Others favor creating state pools funded by general revenues, a tax on insurers, or both, to underwrite coverage for the uninsured (see story, page 33).

And some benefit managers—though clearly a minority—say they support Sen. Kennedy's proposal and the Massachusetts health plan (see story, page 31).

The total number of uninsured non-elderly Americans declined to 33.3 million in 1988 from 37 million in 1986, but the number of uninsured working adults has increased to 18.5 million from 18.1 million during the same time, reports the Employee Benefit Research Institute in Washington, D.C. (*BI*, Aug. 6).

Nearly all benefit managers oppose mandated benefits. But they also believe it is only a matter of time before employers are required to provide minimum benefits.

Of the 184 survey respondents, 173 ventured to predict the fate of universal health care in the United States. Of these, 80.9% believe that the federal government will begin requiring minimum health care benefits within 10 years.

And, 58.4% expect the Kennedy bill or similar legislation will be enacted by the year 2000.

About 21.4% said they expect Congress to pass such legislation within three years.

And one respondent—the director of human resources for a machine tool manufacturer in the Ohio area with annual sales of $28 million and 152 employees—expects to see such a law passed within a year.

Among other things, the Kennedy legislation would require employers to:

- Provide coverage for certain types of care, like prenatal care.
- Limit individual deductibles to $250 and family deductibles to $500 annually.
- Cap employee premium contributions at 20% for both individual and family coverage.
- Limit each employee's out-of-pocket expenses to $3,000 annually.
- Offer coverage to employees who work at least 17.5 hours per week.

Sen. Kennedy estimates that upgrading or adding plans to comply with such a law would cost employers $18 billion a year. He also estimates that the coverage mandate would cost employers $1,295 per employee for indemnity plan coverage and $1,100 per employee for health maintenance organization coverage.

Since the Labor and Human Resources Committee passed the bill in July 1989 (*BI*, July 17, 1989), the Senate has taken no further action.

About 19.1% of the respondents, do not expect Congress to mandate health care coverage.

A majority also said S. 768 or similar universal health care proposals would increase health care costs.

Of the 174 respondents who answered this question, 86.8% predicted that the Kennedy bill would not help reduce health care costs for employers that already provide health care benefits by reducing the costs of indigent care shifted by hospitals to third-party payers.

"The legislation would shift those health care costs to a small number of retailers and other service industries, and those costs will ultimately be reflected in consumer prices," said the manager of employee benefits and property/casualty insurance for a national retail store with 410 full-time and 800 part-time employees and $120 million in annual sales.

"Government intervention does not reduce overall costs; it only adds another layer of administration that must be paid," said the controller of a manufacturer in Oklahoma with 150 employees and $9 million in annual sales.

"The problem encompasses more than one factor," said the benefits manager for an electrical contractor in Florida with 850 employees and $50 million in annual sales.

"You have doctors who defraud the system because of greed. You have new procedures at teaching hospitals that are expensive, so they have to charge more for everything to cover the cost of research. You have a welfare system that doesn't encourage people to find good jobs that come with benefits," that respondent added.

Indeed, a sizable number of those responding to the survey said they believe mandating benefits would increase—rather than help control—their health care costs.

Of the 178 respondents who predicted the impact of Sen. Kennedy's bill, 88.8% said it would raise the cost of their health care plans.

Ironically, though, a large majority of respondents say their plans already comply with most provisions of the bill.

Nearly 66% of the 179 respondents to this question said their employee health care plans already comply with most provisions, while 26.8% say their plans comply somewhat. Only nine respondents—5%—said their plans did not comply at all, and the remainder were unsure.

"Regulation always costs more," observed the director of human resources for a manufacturing company in the Midwest with 400 employees and more than $50 million in sales annually.

The company's health care plan complies with most provisions of the Kennedy bill, the human resources director said.

"All mandates increase costs," agreed a director of human resources for a textile manufacturer on the East Coast with 1,700 employees and $252 million in annual sales.

The company's health care plan complies with most provisions of the Kennedy bill, the director said.

"Our own in-house analysis indicates a cost increase of more than 70% if the Kennedy bill were made law today," noted the vp of employee benefits for a national hospitality and contract food service company with 200,000 employees and $7.5 billion in annual sales.

That respondent said his company's plan somewhat complies with the Kennedy bill.

Many of those who said that the bill would increase employers' health care costs said some companies would be hurt more than others.

"Most large employers already provide more than this package. The 'moms and pops' that do not provide coverage now will definitely see costs increase," said the vp of human resources for a financial services company in the Midwest with 350 employees, whose health care plan somewhat complies with the Kennedy bill.

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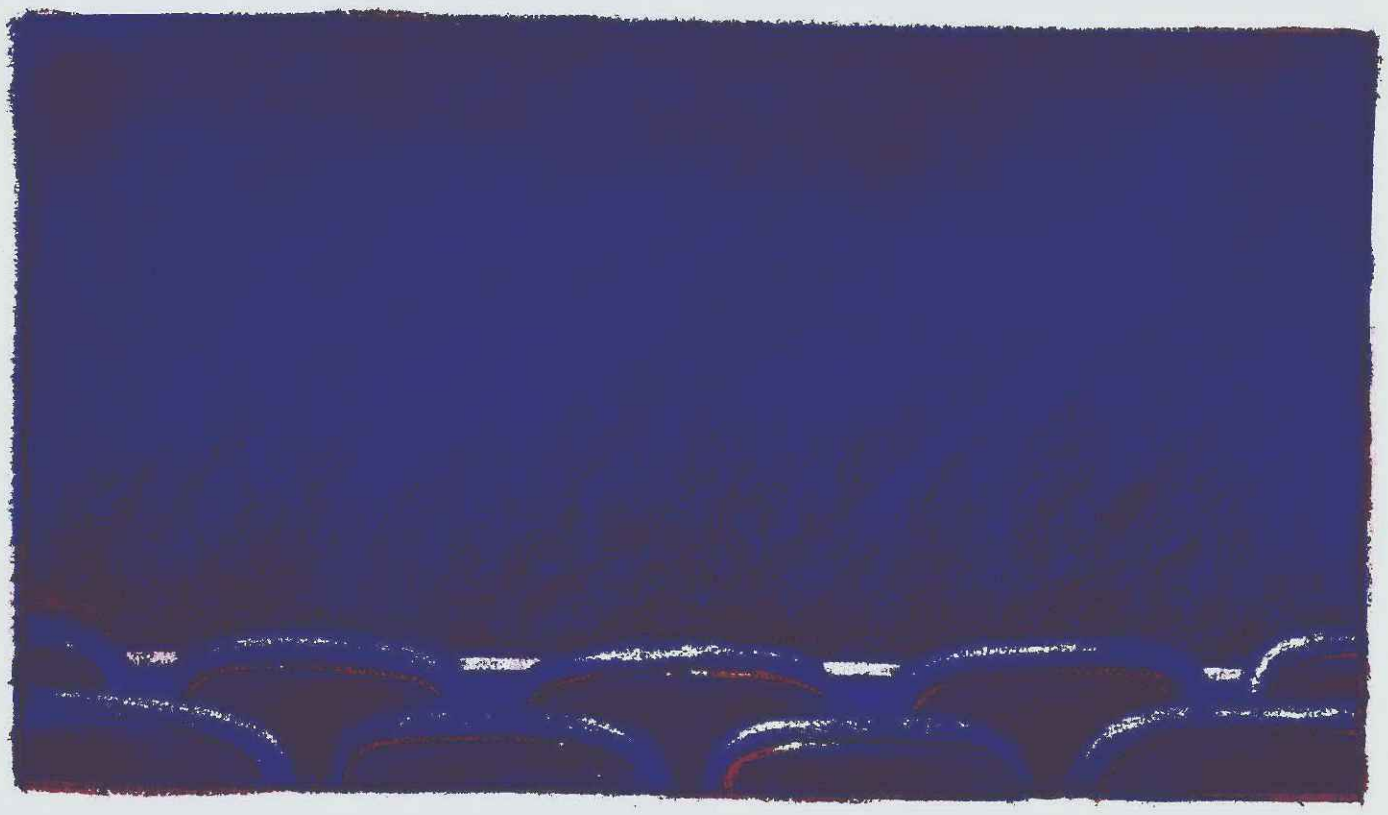

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Benefit board

Continued from previous page

"It depends on a company's current benefit structure and premium contribution," said the executive vp of a national systems integration and management consulting firm with 3,000 employees and $225 million in annual sales.

The Kennedy bill "would increase our costs, unless we chose to require employees to pay for a share of the premium to offset increased company costs. The company currently pays 100% of the employee premium."

The company's health care plan complies somewhat with the Kennedy bill, the executive vp pointed out.

"If an employer is not currently providing the exact same level of coverage as mandated, yes, costs would increase," commented the manager of human resources administration for a service company in the Mid-Atlantic states with 3,500 employees.

The company's health care plan complies with most provisions of S. 768, the manager said.

"Some employers' costs would be increased. Others already provide more" than would be required, said the manager of employee benefits for a retail department store in the Southeast with 25,000 employees. The store's health care plan complies with most provisions of the Kennedy bill, he said.

However, he noted: "My concern is primarily with the growth of the mandate" in the future.

Indeed, nearly all benefit managers said they believe Congress would continue to expand the list of required benefits once it approves an initial bill.

Among the 179 survey respondents who made a prediction on the future of mandated employee benefits if such a bill ever became law, 98.3% predicted Congress would expand the list of mandated benefits.

"Their foot would be in the door," observed the manager of benefits administration for a Midwest bank with more than 10,000 employees and $23 billion in assets.

"Once the ice is broken, I believe many mandates will be forthcoming," said the manager of benefits planning for a financial services firm in Minneapolis with 10,000 employees.

"Just look at COBRA," noted the benefit manager of Midwest and West Coast distributor with 2,000 employees and $3 billion in annual sales.

Under 1989 budget reconciliation legislation, Congress allowed employees to keep their health care continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 to pay for pre-existing medical conditions for which a new employer's plan denies coverage.

In addition, Congress extended the COBRA eligibility for individuals who receive Social Security disability benefits to 29 months from 18 months, although employers are allowed to charge up to 150% of the group rate for the additional 11 months of coverage (*BI*, Jan. 15; Nov. 27, 1989).

And legislation introduced recently in the House would require employers to extend COBRA health care continuation for up to 15 years to dependents of former employees who were at least 50 years old when they became COBRA beneficiaries (*BI*, Aug. 20; July 30).

"Congress would probably add to the list in areas of dental, vision, life, child care, etc.," predicted the human resources officer for a bank in California with 108 employees.

"Special interest groups would continue to push for expanded benefits," predicted the benefits coordinator for a Midwest university with 6,500 employees.

"Washington has never missed an opportunity to expand any legislation. Without a clear national policy commitment by the major political parties, Kennedy's bill, if enacted, would be doomed to the vagaries of the lobbies," said the director of compensation and benefits for a toy and game manufacturer in New England with 8,200 employees and $1.4 billion in annual sales.

Two-thirds of the survey respondents say they would not support any kind of mandate on employers to provide employee benefits.

Of the 155 respondents who answered the question, 67.1% oppose any type of mandated employee benefits plans.

Many survey respondents say mandating benefits goes against the grain of a free market system.

"Employers have provided health coverage as an incentive. It's not government's responsibility to mandate what business does in this area," asserted one respondent.

"Benefits should not be mandated but left to the competitive marketplace," said the manager of compensation and benefits for a national health care firm with 10,000 employees and $800 million in annual sales.

Employee health care coverage "should be between employers and employees—not mandated from government. Market conditions and collective bargaining should dictate, as in the past," said the director of human resources for a Midwest manufacturer with 400 employees and $50 million in annual sales.

"Coverage should be offered on an individual, competitive basis," said the director of employee benefits for a consumer products company in the Northeast with 5,000 employees and $1 billion in annual sales.

"Is health insurance an inalienable right? Of course not. Health care may be, but health insurance is not," said the senior benefits analyst for a chemical refining company in Texas with 1,000 employees.

Other respondents were more blunt.

"Government should stay out of the private sector's business," said the director of compensation and benefits for a financial lending institution in the Midwest with 930 employees and $3.5 billion in assets.

Many other respondents argued that employers should not have to shoulder the societal responsibility of universal health care coverage.

"If universal health care coverage is a social 'right,' then society should pay via the tax revenue system," said the director of personnel administration and benefits for a Midwest manufacturer with 7,500 employees and $750 million in annual sales.

•

Employee benefit managers and buyers of employee benefit plans are invited to join the Business Insurance Employee Benefit Board. Just send a card with your name, title, company and address to Kathryn J. McIntyre, Associate Publisher/Editor, Business Insurance, 740 Rush St., Chicago, Ill. 60611. You will receive several surveys during the year on benefit issues.

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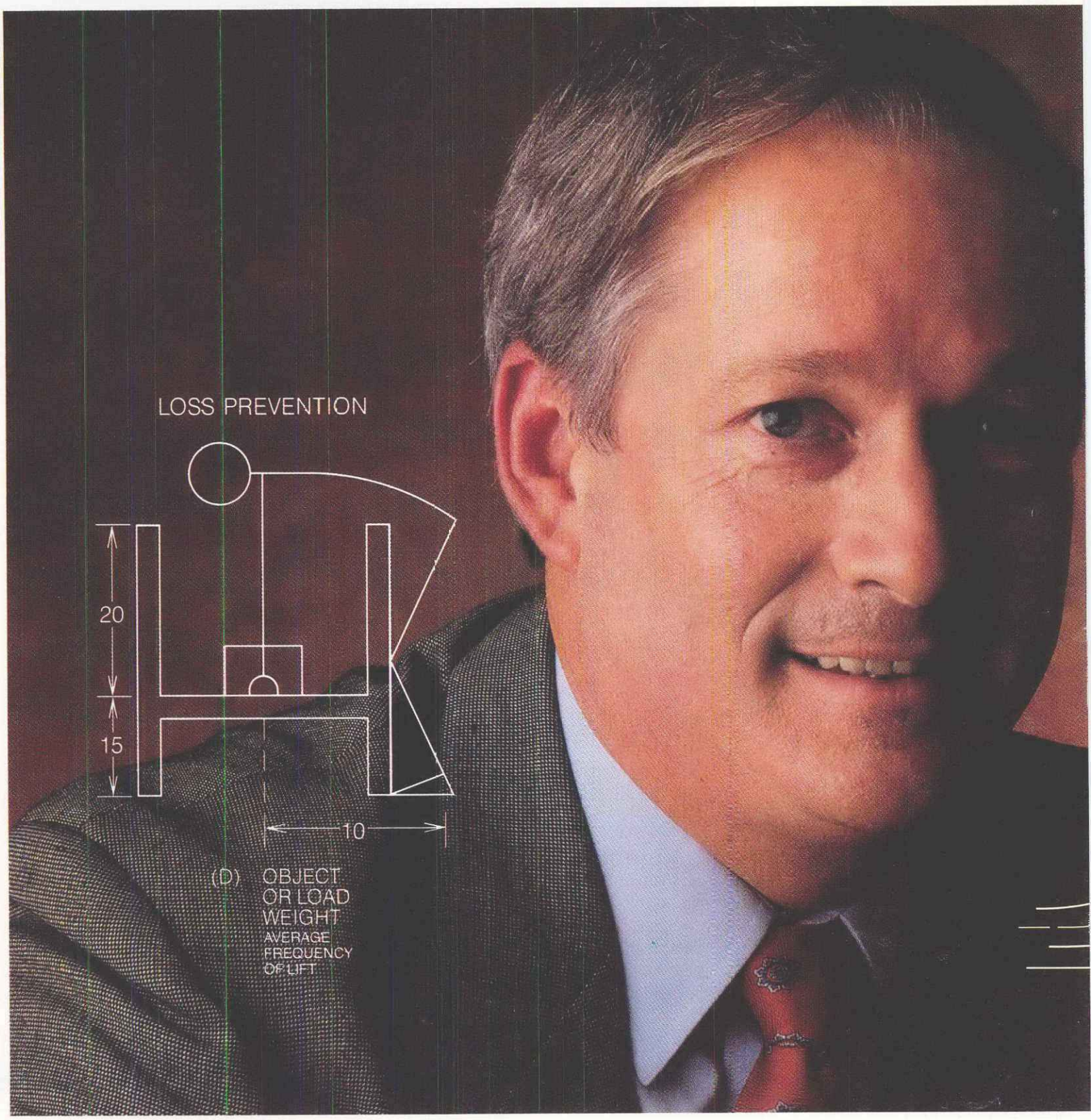

OLD PROS ON

Some benefit managers favor mandates

By DAVE LENCKUS

Forcing employers to offer health care benefits is a good first step toward universal health care coverage, some employee benefits managers say.

Although they are a clear minority, a segment of benefits managers responding to a *Business Insurance* Employee Benefits Board survey say that either requiring employers to provide employee health care benefits that meet federal minimum standards or that have a certain value would be a good first step toward ensuring that all Americans have access to health care.

Among 184 survey respondents, 17.4% supported a universal health care bill, S. 763, introduced by Sen. Edward M. Kennedy, D-Mass., that would require employers to provide health care coverage that meets certain minimum standards.

And, among 180 respondents who commented on the landmark universal health care statute enacted in Massachusetts in 1988, 11.5% supported that plan.

The problem of uninsured Americans has to be addressed, and Sen. Kennedy's bill is a viable solution, according to some survey respondents.

"The number and percentage of citizens without health coverage is a national disgrace. It is causing serious social problems and has implications for the quality of our future workforce," asserted the director of employee benefits for a sales and marketing representation firm in the Northeast with 950 employees and $75 million in annual ales.

The benefits director, who says the company's health care plan complies with most provisions of S. 768, also believes the bill would help reduce health care cost for employers already providing health care benefits by reducing the costs of indigent care shifted by hospitals to third-party payers.

"Companies should at least offer health care to their employees. The employee should have the option to accept or refuse coverage," said the human resources officer for a bank in California with 108 employees.

However, the respondent, who says the bank's health care plan complies with most provisions of the Kennedy bill, does not believe the bill would help reduce health care costs by reducing the costs of indigent care shifted by hospitals to third-party payers.

Another respondent, the human resources director of a manufacturer in Iowa with 93 employees and $6 million in annual sales, said S. 768 should be enacted "to avoid a federal health plan or national health care insurance."

Some survey respondents who support Sen. Kennedy's legislation say it seems like the most equitable solution for providing more Americans with health care coverage.

"We all pay one way or another, through higher rates for those who are insured or through taxes; this seem to be the best way to have the cost absorbed more equitably," said the vp of finance for a physicians' professional trade association in Pennsylvania with 100 employees.

However, the executive, who said the association's plan complies with most provisions of the Kennedy bill, does not believe S. 768 would reduce employers' health care costs by reducing the costs of indigent care shifted to third-party payers.

Other survey respondents said they would support Sen. Kennedy's bill if it exempted small employers.

Currently, for employers with fewer than 25 workers, the Kennedy bill calls for the federal government to subsidize 75% of health care costs that exceed 5% of gross revenues.

The bill also would allow employers with fewer than 10 workers and that have been in business for less than four years to offer an unspecified "low cost" health plan.

And, the legislation would give employers with fewer than six workers five years to comply.

However, S. 768 should apply only to employers with "50 or more employees," said the employee benefits manager for a national consumer goods company with 9,000 employees and $3 billion in annual gross sales.

An employer should have to comply with the Kennedy bill "if the company has more than 100 full-time employees," said the manager of human resources administration of a service firm in the Mid-Atlantic states with 3,500 employees.

The Kennedy bill should apply to "only employers of a certain size—100 or more employees. Small employers would find it difficult to impossible to afford it, but all employers should thereafter 'share the burden,' " said the manager of compensation and benefits of a national primary metals company with 3,200 employees and $502 million in annual sales.

A smaller group of respondents said they would support the universal health care plan enacted in Massachusetts, and many of them oppose the Kennedy bill.

The Massachusetts law will impose on employers a tax that could total $1,680 per employee. An employer with a health care plan can offset the tax by each health care dollar spent per employee. Employers whose annual health care expenses exceed $1,680 per worker will be exempt from the tax.

In addition, the Massachusetts plan on Jan. 1 began to require all employers with at least six workers to pay a tax equal to 0.12% of the first $14,000 of each employee's wages, up to an annual per-employee maximum of $16.80. This tax is used to finance coverage for the unemployed.

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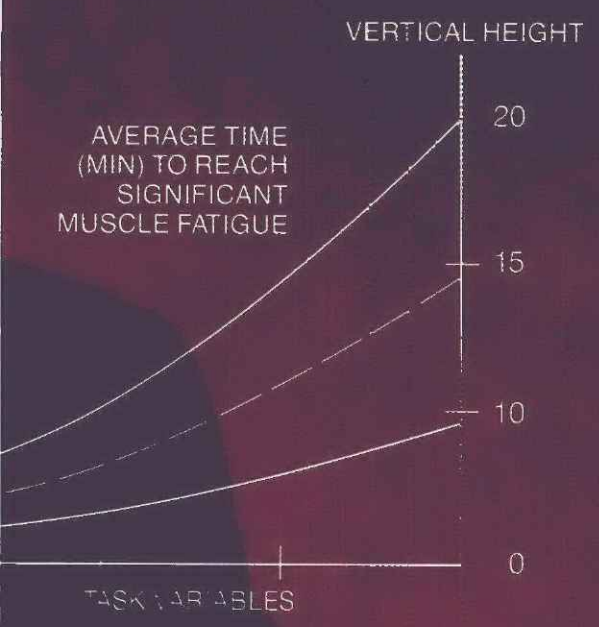

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Massachusetts Gov. Michael Dukakis earlier this summer vetoed amendments approved by the Legislature that would have delayed key provisions (*BI*, Aug. 13).

The director of human resources for the manufacturer in Iowa would support the Massachusetts universal health care plan on a national level because there is a "need to finance health care of the uninsured."

The Massachusetts plan "reduces the number of 'uninsured' or 'underinsured' employees. It spreads health care costs over a larger group of paying users," said the benefits coordinator of a Midwestern university with 6,500 employees, who also supports the bill.

"This approach will continue to allow employers to design plans reflecting their particular philosophy and not be a plan designed by the government," said the U.S. employee benefit programs manager for a computer manufacturer in the Northeast with 75,000 employees and $13 billion in annual sales. The manager opposes the Kennedy bill.

"If a company elects not to provide coverage, society bears the risk. Companies making such an election should pay a tax representing a portion of the risk they would have assumed had they offered coverage," said the director of benefits administration for a national manufacturer with 4,000 employees and $40 million in annual sales who also opposes the Kennedy bill.

A universal health care plan like the one enacted in Massachusetts would "spread the burden more evenly," said the manager of group insurance for a national manufacturer of beer and related food products with 42,000 employees, who opposes the Kennedy bill.

Some survey respondents gave the Massachusetts plan their qualified support.

For example, a proponent of the Kennedy bill, the director of employee health benefits for a carpenters welfare fund in New Jersey, said the Massachusetts plan "would probably be the next best solution" after the Kennedy bill.

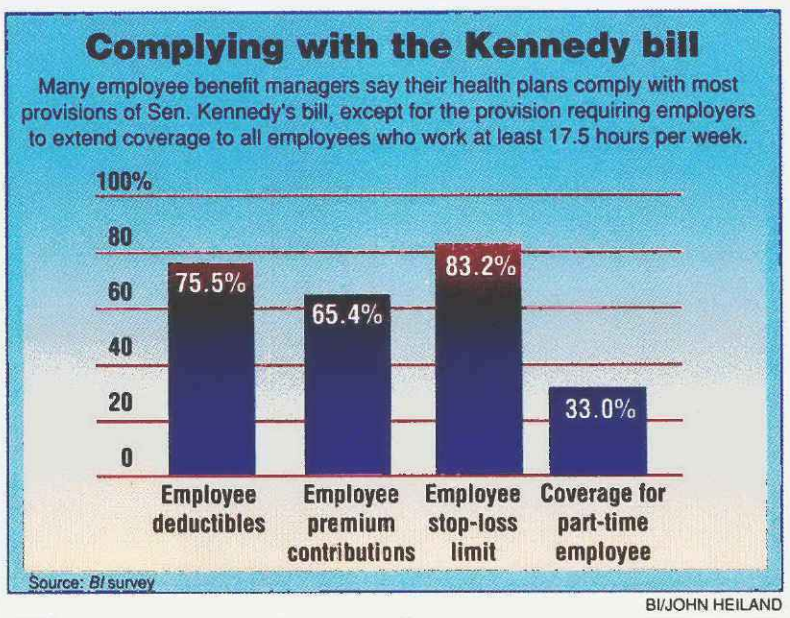
And, the director of employee benefits for the sales and marketing representation firm in the Northeast said: "I would prefer a 'minimum benefits' approach rather than an 'economic value' approach, but I support an alternative tax."

And, as with the Kennedy legislation, some survey respondents said they would support a universal health care plan like the one in Massachusetts if small employers were exempted.

For example, the manager of human resources administration for the Mid-Atlantic service firm said that a plan like the one in Massachusetts should be enacted nationwide for employers with more than 10 workers.

And, the manager of employee benefits for a Midwest electric utility with 4,000 employees and more than $1 billion in gross sales said: "I have no problem with this concept as long as the level of coverage is reasonable."

However, the manager added: "It should be catastrophic coverage only." ■



BI/JOHN HEILAND

Few extend coverage to part-time workers

Many employers say their health care plans would comply with most provisions of Sen. Edward M. Kennedy's bill requiring companies to offer workers health care coverage that meets federal minimum standards, according to a new survey.

However, many of those benefits managers said their plans would not comply with a provision of the bill that would require employers to extend coverage to part-time workers, according to a *Business Insurance* Employee Benefits Board survey.

Among 179 respondents, 65.9%, or 118, said their plans comply with most provisions of the Kennedy bill, S. 768. And, 26.8% more, or 48, said their plans comply somewhat.

Only 5%, or nine respondents, said their health care plans do not comply at all. The remaining 2.2% said they were unsure.

However, most benefit managers said their plans fail to meet at least one standard of the Kennedy bill: Most employers would be tripped up by a requirement that they offer coverage to employees who work at least 17.5 hours each week. More than two-thirds of the respondents, or 120, said they do not offer health care coverage to part-time workers.

Many others fail on a requirement to cap employee contributions for individual and family coverage at 20% of the total premium: 34.6% of the survey respondents, or 62, said their health plans do not cap employee contributions.

Less than one-fourth of the survey respondents—23.5%, or 42—said their plans do not comply with Sen. Kennedy's proposal to cap individual deductibles at $250 and family deductibles at $500 annually.

The provision that would cause problems for the fewest number of employee benefits managers would require health care plans to cap employees' annual out-of-pocket expenses at $3,000. Only 16.8%, or 30 respondents, said their plans' annual employee stop-loss limits exceed $3,000.

—By Dave Lenckus

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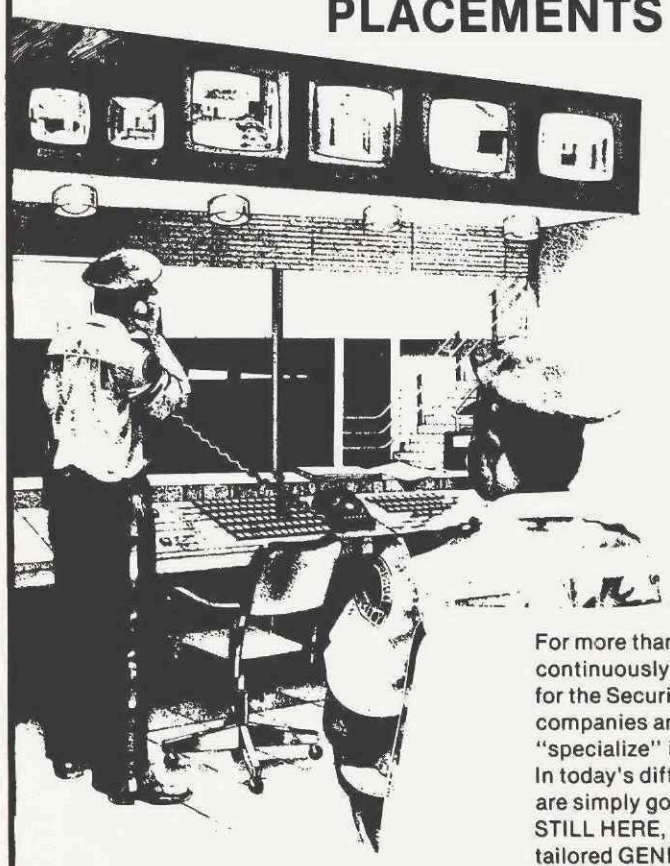

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Some say idea is OK, Kennedy bill is not

By DAVE LENCKUS

Many employee benefit managers say they could support federally mandated employee benefits legislation—under certain conditions.

Nearly one-third of the benefit managers responding to a *Business Insurance* Employee Benefits Board survey said they could support mandated employee benefits legislation but not in the form proposed by Sen. Edward M. Kennedy, D-Mass., or already enacted in Massachusetts.

For example, many benefit managers would support mandated employer-provided catastrophic health care coverage.

Many respondents also suggested the establishment of federal- and state-administered health care plans funded by general revenues or other taxes.

Among 155 survey respondents who answered the question, 32.9%, or 51, said they could support mandated employee benefits plans other than the Kennedy bill or the Massachusetts law.

The Kennedy legislation, S. 768, would require employers to offer health care coverage that meets federal minimum standards (see stories, page 1 and 32).

And, a 1988 universal health care law in Massachusetts will require employers in 1992 to pay a special tax that could be totally offset if they spend $1,680 per employee for health care coverage.

Beginning last Jan. 1, that plan also required employers with at least six workers to pay a tax of up to $16.80 per employee annually to finance coverage for the unemployed.

But, there are better solutions, and some could involve mandated employee benefits, benefits managers say.

For example, if the federal government itself "provides for federal minimum coverage, then employers could offer supplemental coverage, much like Medicare and private insurance now works," suggested the human resources manager for a Midwest direct marketer of office products with $150 million in annual sales.

The benefits manager for a national paper manufacturer with more than 2,200 employees and $2 billion in annual sales offered a similar recommendation: "Let's take a closer look at the Canadian health care system."

Many employers in Canada offer coverage to supplement government-sponsored health care programs administered by Canada's 10 provinces and two territories.

The manager of group insurance and provider services for a national paper and forest products company with 22,000 employees and $5.5 billion in annual sales suggested another type of mandated employee benefits catastrophic plan.

That plan should be "a minimum benefit plan that is in no way administered by the federal government. The plan should be catastrophic protection—perhaps with a $1,000 deductible. Insurers should be required to offer such a plan to all, especially small, employers."

The corporate manager of benefits and insurance for an oil refining company in the West and Southeast with 1,500 employees and $2 billion in annual sales suggested a similar plan. The plan should mandate "limited major medical with a good deductible and copayment limit. And it should make it mandatory for doctors and hospitals to allow people to pay bills over time."

Noting that the Kennedy legislation would cap individual deductibles in employer health plans at $250, the assistant vp of human resources for an insurer in Connecticut with 2,000 employees said: "Increase the federal minimum so that it is more of a catastrophic approach rather than a first-dollar approach. Some may say a $250 deductible is not first-dollar, but we offer employees a choice of an $800 deductible plan that has an increasing following."

Among other recommendations, the manager of health benefits for a multinational company with 14,000 employees and $500 million in annual sales suggested eliminating some provisions of S. 768 that businesses say are especially burdensome.

This respondent's ideal plan would include "minimum standards that are more reasonable. Covering part-time employees is not an employer 'responsibility.' As costs continue to rise, the employees must recognize their own individual needs and be willing to contribute as such."

The director of compensation for an oil and gas company in Texas with 2,000 employees and $2 billion in annual sales explained he would support the Massachusetts law if it also taxed employees to finance their health care coverage after retirement, "an arrangement similar to Social Security."

The general manager of employee services for an electric and gas utility in New Jersey with 13,000 employees and $4.6 billion in annual sales complained that the Massachusetts universal health care plan does not go far enough to "meet the needs of the unemployed. A broad-based tax is probably the best answer. If universal coverage is a social need, then we should all participate in its financial support."

Mandated employee health care coverage should take the form of "leaves of absence or sick pay (short-term disability)," said the personnel manager/benefits ad-

Continued on next page

1990 Results* **RLI** Even Stronger

Consolidated Statutory Financial Information

RLI Insurance Company and Mt. Hawley Insurance Company

STATUTORY SURPLUS (000 Omitted)	COMBINED RATIO
1985 — $37,037	1985 — 99.7
1986 — $53,063	1986 — 84.1
1987 — $57,243	1987 — 84.2
1988 — $60,024	1988 — 97.1
1989 — $68,864	1989 — 98.0
1990 — $66,837*	1990 — 91.3*
	5 YEAR COMBINED RATIO: 91.5 (1985-1989)

ASSETS (000 Omitted)	LOSS RESERVES (000 Omitted)
1985 — $105,993	1985 — $22,784
1986 — $159,568	1986 — $46,243
1987 — $168,859	1987 — $59,712
1988 — $176,876	1988 — $71,091
1989 — $216,619	1989 — $96,368
1990 — $228,899*	1990 — $96,639*

* Six months results ended June 30, 1990.

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issue:	September 17
closing:	September 5
demographic section:	Insurer Topics: Conferences & Exhibits
issue:	September 24
closing:	September 11
editorial feature:	Reinsurance: Monte Carlo Rendez-Vous Report
conference report:	IAIABC; ISCEBS; NAPSLO
issue:	October 1
closing:	September 19
demographic section:	Agent/Broker Topics: Customer Service & IIAA Conference Report
issue:	October 8 — Reader Service Bonus Distribution: SIIA; NACSA-NACSE; CPCU
closing:	September 25
editorial feature:	Specialty Risks: Environmental Liability — Directory: Environmental Consultants

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Business Insurance
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Mandated cover

Continued from previous page

ministrator for a manufacturing company in the Southwest with 150 employees and $13 million in annual sales.

Some of the survey respondents suggested that the federal government should give employers more incentives to offer health care coverage to employees.

"I think employers should be encouraged through tax incentives to offer needed cover. There could be a national reinsurance pool for the uninsured to purchase coverage through; possibly partially tax-subsidized but not to a large degree," said the employee benefits manager of a national building products manufacturer with 7,500 employees and $1.2 billion of annual gross sales.

The survey also asked benefit managers whether they would support other ideas for expanding Americans' access to health care.

Among the 117 responses to that question:

- 55.6% would support creating a federal catastrophic and preventive coverage program to provide health care to the poor. The program would be funded through general revenues or new taxes.
- 42.7% would support creating state pools to underwrite coverage. The pools would be funded by general revenues, a tax on insurers or both.
- 28.2% would support creating a national health insurance system like those in Canada or the United Kingdom, which largely eliminate private insurance.

The percentages do not total 100 because respondents could select more than one choice.

Other respondents, though, asserted that other factors that enter into the equation of providing universal health care—such as spiraling medical costs—must be addressed before a workable plan can be hammered out.

"The problem is not the number of those without coverage or the quality of care but rather the price spiral. Until that is solved, government and business are stupid to expand coverage," asserted the employee benefit manager for an electrical equipment manufacturer with 70,000 employees.

Several issues need to be addressed that contribute to "high, unnecessary costs," said the vp of employee benefits for a national hospitality and contract food services firm with 200,000 employees and $7.5 billion in annual sales.

The executive recommended "malpractice tort reform; eliminating unethical, poor quality, inefficient health care providers; and arranging for health care consumer education."

In addition, "Congress should address the barriers that exist for employers to voluntarily offer health care protection: pre-empt state-mandated benefits for insurance contracts, encourage legitimate multiple employer trusts," the executive commented.

Others, though, said the government is part of the problem, not the solution.

"I believe it has been proven . . .that government involvement and administration evokes a wasteful and totally inefficient means of getting dollar value out of an endeavor," said the director of human resources for an energy and mining company on the Gulf Coast with 2,000 employees and $155 million in annual sales.

Other respondents said that employers should not be held accountable to resolve the problem of the uninsured.

"Employers cannot remain competitive if they continue to underwrite health care for the entire population," said the human resource administrator for a multinational electrical products company with 19,000 employees and $1.6 billion in annual sales.

"Most people should be made to realize that they have to pay for their own routine health care," said the executive vp of a national systems integration and management consulting firm with 3,000 employees and $225 million in annual sales.

The executive, who would support a bill similar to S. 768 but with higher minimum deductibles, continued: "For a family with a $40,000 income, it's not too much to expect them to pay 5% ($2,000) of their pretax income on health care. Look what they pay for autos, housing, clothes, food and drink outside of the home. Low-income households should have preventive and catastrophic coverage provided by the government, not the employer."

And, the employee benefit manager of a West Coast bank with 5,000 employees and $18 billion of assets summed up: "We take pains to provide competitive quality health benefits to our employees, whom we value a lot. Our health cost subsidy is running at about $14 million annually. What more should we be expected to pay?" ■

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INTERNATIONAL

Germany kicks out unlicensed insurer

By DON KIRK and STACY SHAPIRO

BONN, West Germany—The West German federal insurance authority has issued an injunction to bar a Delaware-based company from selling life and health insurance policies in West Germany.

The government last month warned consumers that the insurer, United Insurance Co., was not authorized to sell insurance in West Germany.

In addition, UIC also is not licensed in the state of Delaware to write any form of insurance, according to Delaware insurance regulators.

However, UIC President Friedhelm Brusermann claims that, under current West German insurance legislation and a proposed European Community directive, his company is doing nothing wrong.

Under West German insurance law, "correspondent" insurers that are incorporated in another E.C. nation can write coverage in West Germany without being licensed there as long as they don't "actively market" their coverage to insurance buyers.

This principle is also incorporated in the proposed E.C. second life directive, which is currently being considered by the European Parliament (*BI*, Dec. 4, 1989).

The second life directive—which will govern a wide range of group life/health insurance plans, including private pension plans—would allow insurance buyers in one E.C. nation to purchase insurance policies from a correspondent of an insurer that is licensed in another E.C. member state. Like the West German law, however, the E.C. proposal would prevent the correspondent insurer from actively marketing its policies.

However, the West German insurance authority claims that UIC has gone beyond the bounds of the West German law and the proposed E.C. directive because it is neither licensed in Delaware nor in another E.C. country.

In addition, the federal authority, the Bundesaufsichtsamt fur das Versicherungswesen, contends the insurer is actively marketing its policies through agents, contrary to the laws governing correspondent insurers.

UIC, though, maintains that brokers are bringing business to it.

At a meeting in Berlin last week, representatives of the BAV met with UIC representatives to discuss the dispute and informed the insurer that an injunction had been issued to prevent it from selling policies in West Germany.

"The way we see it, the BAV is acting like we're a non-existent company trying to cheat people of their money," said Mr. Brusermann. "It's just not that way."

At the meeting, the BAV requested proof from UIC that it is licensed to sell insurance in Delaware, said Alex Glusa, UIC's general counsel.

He said the insurer intends to apply for a license in Delaware as well as to set up an office somewhere within the European Community to meet the law's requirement for correspondent insurers. Afterward, the insurer plans to return to the West German market, Mr. Glusa said.

Questions about the legitimacy of UIC arose in June when the BAV wrote to the Delaware Department of Insurance in Dover to inquire whether UIC was authorized to write insurance there.

The BAV's letter to the Delaware Insurance Department said that the West German regulatory authority was informed of "cases where the above company offered and sold health and life insurance policies through agents and brokers in the Federal Republic of Germany. The company has not been granted the necessary authorization to do insurance business in the Federal Republic of Germany. It is even doubted whether the above company has been properly authorized as an insurance com-

Continued on next page

BERMUDA

J&H's Hall hits government spending

By ROGER SCOTTON

HAMILTON, Bermuda—Johnson & Higgins (Bermuda) Ltd. President Brian Hall is calling for the careful monitoring of any Bermuda government spending that could drive up the cost of conducting international business on the island.

In a forceful speech at a community meeting earlier this month in Hamilton, Mr. Hall warned that Bermuda was walking a fine line with a vital sector of its economy—international business, including the insurance business.

"We cannot become complacent," he cautioned. "Government expenditures which directly impact our costs of doing business must be monitored. Unnecessary bureaucratic infrastructures must not be allowed to go unchecked and salary increases should be fair but not lead the market. And capital projects must be carefully planned to be within our means."

The president of Bermuda's largest captive management firm said Bermuda companies must differentiate themselves from competitors by providing value-added services.

"We can no longer compete on price," he said, referring to a new 5% payroll tax that is to be phased in over five years (*BI*, March 5). Local companies have paid the tax for years, though their foreign counterparts have been exempt.

J&H (Bermuda) earlier this year announced that senior managers would temporarily forego a pay increase to avoid increasing clients' fees in the wake of the new taxes (*BI*, April 2).

At the community meeting, Mr. Hall called for a renewed effort to create a "master plan" for the island's economic future.

He said such a plan should take into account the island's limited resources and its market opportunities and help position Bermuda to respond to changes while preserving its integrity and viability.

"Many international businesses have conducted their own strategic planning exercises and now is the time to merge those with others to create a vision and a plan to meet the challenges of the future," Mr. Hall said. "Bermuda is walking a fine line into the future; however, these challenges have been met by many smart Bermudians in the

Continued on page 37

RIMS to co-host meeting on Asian risk management

A risk management conference focusing on problems faced by companies doing business in Asia will be held in Singapore next month.

The conference, titled "Asia Pacific Strategies for the '90s," is being jointly organized by the Risk & Insurance Management Society Inc. and the Risk & Insurance Management Assn. of Singapore.

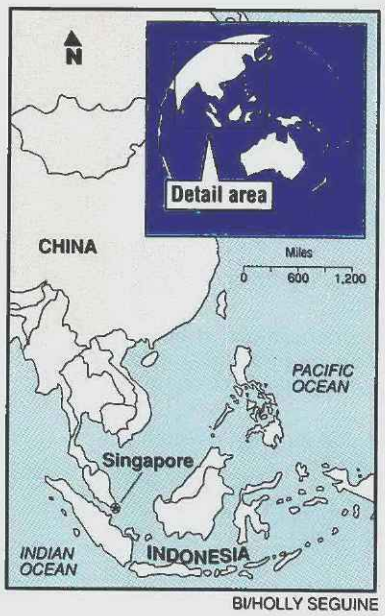
The conference will be held Oct. 28-31 at the Mandarin Hotel in Singapore.

RIMS hosted the first Asia Pacific Risk Management Conference in Singapore in October 1986. RIMAS was formed in 1988, and the conference now is a joint endeavor.

The conference is intended to address issues facing:

- Risk managers of North American organizations operating in the Asia/Pacific Rim region.
- Risk managers of North American organizations looking to expand into the region.
- Risk managers of Asian/Pacific Rim-based businesses expanding overseas.

After registration and an opening reception on Sunday, Oct. 28, the business agenda will begin Monday, Oct. 29, with a session featuring Cheri J. Hawkins, president of RIMS and director of insurance at Weyerhaeuser Co. in Tacoma, Wash., and Michael Wan, president of RIMAS and financial controller at The Getz Corp. in Singapore. Ms. Hawkins will overview global risk management trends, while Mr. Wan will discuss issues particular to the region.



BI/HOLLY SEGUINE

Also on Monday morning will be the conference's first plenary session, which will focus on political risk issues, like political and social upheavals in China, Eastern Europe and Latin America and the ways risk managers can protect corporate assets in such uncertain environments.

The speakers will be John G. Pinner, assistant treasurer at Mattel Inc. in Hawthorne, Calif., and John J. Salinger, president of the political risk division of American International Underwriters in New York. Edith Lichota, president of Lichota & Associates in Norwalk, Conn., will moderate the session.

Following lunch on Monday, two sets of concurrent sessions will be offered. Registrants can attend one session in both sets.

The first set of concurrent sessions will include seminars on:

- The problems facing new risk managers.
- Product liability problems around the world.
- The selection and use of brokers.

The second set of concurrent sessions on Monday afternoon will study:

- Systematic approaches to set-

Continued on next page

Bermuda taps Butterfield as registrar

HAMILTON, Bermuda—Insurance consultant Malcolm Butterfield will be Bermuda's next registrar of companies, succeeding Verbena Daniels.

Ms. Daniels will retire Dec. 14 after 26 years of government service, the last nine in the post that oversees insurer regulation and registration on the island (*BI*, April 30).

Mr. Butterfield, who will work alongside Ms. Daniels for three months, is not a complete stranger to his new job.

He served as inspector of companies for four years under Ms. Daniels before leaving in 1985 to set up Malcolm Butterfield Associates Ltd., an insurance and risk management consulting firm.

"Going back to the registrar's department will be like a homecoming for me," he said. "I'm really looking forward to it, although I've enjoyed working in the private sector which has helped prepare me for this move."

Mr. Butterfield

In addition to his own consulting practice, Mr. Butterfield was managing director of Betterley Risk Consultants (Bermuda) Ltd., an affiliate of Betterley Risk Consultants of Worcester, Mass. Mr. Butterfield held a 20% stake in the Bermuda company.

Richard Betterley, joint managing director of the Bermuda operation, said he will continue to develop the Bermuda company.

"We intend to maintain an active and visible role in the Bermuda business community and to that end will fill the position Malcolm is vacating. In the interim, I will be assuming much of the responsibility for the firm and its client services," Mr. Betterley said.

To avoid perceived conflicts of interest, Mr. Butterfield also resigned as representative of consulting actuaries Milliman & Robertson in Bermuda.

"I have resigned my Milliman & Robertson connection, given up Betterley Risk Consultants and have resigned my position as principal representative in Bermuda for four insurance companies," he said. "Also, I will be divesting myself of management responsibility for Malcolm Butterfield Associates Ltd. . . .Though it will remain a Butterfield family asset, it will no longer be involved in transacting any insurance business whatsoever."

Mr. Butterfield said the registrar of companies can have a key bearing on the island's reputation as an international business center. Too rigid an approach to the 1978 Insurance Act and regulations could discourage the industry, he said, while too soft an attitude would also be misleading.

"There's not just a policing role to be played. That might have been sufficient for how it used to be in the early days, but now the registrar has to be a listener and decision-maker, as well as a corporate midwife and undertaker," Mr. Butterfield said.

The registrar's function is an integral part of what he calls the Bermuda government's "unwritten partnership agreement" with the international insurance industry. Mr. Butterfield says that highly workable arrangement has helped Bermuda to emerge as the world's leading captive insurance center and will be vital to continued stability.

"As a domicile, Bermuda will continue to offer the best possible package for getting things done. But, we'll have to successfully guard our position," he said.

—By Roger Scotton

German dispute

Continued from previous page
pany in the United States," the letter continued.

The BAV asked Delaware regulators to confirm:

- Whether UIC was authorized to write insurance in Delaware.
- What branches and subsidiaries did the company have.
- And, whether Christian Stahnke and/or Friedhelm Brusermann were directors of the company.

Catherine S. Mulholland, director of company regulation at the Delaware Insurance Department, says she "never heard of United Insurance Co." before the letter arrived.

Ms. Mulholland found that UIC was indeed incorporated in Delaware under a certificate of incorporation dated July 18, 1989. The director on the certificate was Mr. Stahnke in Berlin.

However, UIC "is not authorized to do business in Delaware" as an insurer, Ms. Mulholland wrote in a July 26 letter to the BAV. And, "we have no knowledge of Christian Stahnke and/or Friedhelm Brusermann," she wrote.

Although UIC is incorporated in Delaware, she continued, "when any company uses the word 'insurance' in its title, it is sent a letter by the Delaware Insurance Department informing it that it may not transact insurance without authorization from the Delaware Insurance Department. United Insurance Co. never sought authorization."

Following Ms. Mulholland's reply, the BAV published warnings against buying insurance policies from United Insurance Co.

"We can't guarantee these policies are good," said a BAV spokesman. "The problem is that those who do sign policies can't get out of them that easy. They have to take the insurer to court."

Meanwhile, Peter Jansen, state attorney for the West German state of Hannover, said he is investigating whether United Insurance Co. is involved in a 9.6 million deutsche mark ($6.1 million) investment scam involving illegal stock trading.

"UIC operates within the framework of a Luxembourg investment company called Save & Safe," said Mr. Jansen. "We have evidence United sold insurance without a license in several cities and we believe that Save & Safe is involved in the fraud."

Complaints against Save & Safe are also being investigated by Mr. Jansen, he said.

UIC and Save & Safe maintain that the allegations by Mr. Jansen and the BAV are false. They say that they are not involved in any "scam" involving illegal stock trading, and that UIC had been conducting insurance business in West Germany within the scope of that nation's laws, as well as the proposed E.C. life insurance regulations.

Under West German and proposed E.C. correspondent insurer regulations, "United does not fall under the jurisdiction of the BAV," contends a spokesman for Save & Safe in Ludenscheidt, West Germany. "It's a correspondent insurer. Brokers can recommend United and it (United) can sign policies legally."

"The (European) market is opening and we're taking advantage of the fact," added Mr. Brusermann. "The conflict with the BAV is a misunderstanding. We are offering life and health insurance at a lower price than other insurers, which angers the competition. We are a correspondent insurer (and as such) we don't need a license from the BAV to do business in here. Any German can have a policy with an American company. It's perfectly legal."

A spokesman for the BAV, however, said that German law and the E.C. proposal require an insurer from a country outside the European Community with business in West Germany to be licensed with the BAV.

Mr. Glusa, UIC's counsel, was critical of the regulatory authority's actions.

"As we see it, the BAV is out to protect German insurers. They want to regulate the way we administrate our finances, and that's not in our interests. Our investment policy is our business," he said.

Clearing up this issue is critical for United Insurance Co.'s future since the company has only written between 50 and 100 policies so far in West Germany and plans to expand across Europe, says Mr. Brusermann. ■

Singapore conference

Continued from previous page
tling business interruption claims.

- The resources risk managers can tap, including publications and educational courses and seminars.
- Loss prevention programs.

Tuesday morning, Oct. 30, will feature two plenary sessions.

The first, titled "Environmental Risk and Issues," will discuss the state of technology available to identify and reduce pollution risks and the action the risk managers should take in controlling these exposures.

Speakers will include T. Ramanan, risk manager for Hindustan Lever Ltd. in Bombay, India; Paul F. York, international risk manager for Union Carbide Corp. in Danbury, Conn.; Jaswant Singh, senior vp and manager of Pacific operations for Clayton Environmental Consultants in Cypress, Calif.; and Myra L. Tobin, managing director at Marsh & McLennan Cos. Inc. in New York.

The second plenary session on Tuesday morning will focus on "Self-Insurance and Asia-Domiciled Captives." The session will feature a case study on self-insurance.

Speakers will include Gerald Vincer, company secretary at Sembawang Shipyard Ltd. in Singapore; Law Song Keng, insurance commissioner with the Monetary Authority of Singapore; Ross Bovill, managing director-Asia/Pacific with Sedgwick James Ltd. in Singapore; and Richard Chua, assistant general manager of Alexander Stenhouse Ltd. in Singapore.

Tuesday afternoon will feature industry sessions, which are risk manager-led discussions of topics of interest to risk managers of companies in specific industries. Sessions will be held for risk managers in the agricultural and fishing, manufacturing and processing, hotel and food services, as well as the transportation industries. In addition, a session will be held for risk mangers involved in joint ventures in the Asia/Pacific Rim region.

Following the industry sessions will be three more concurrent workshops. Registrants will be able to attend one of these sessions, which will focus on:

- Personal computer applications.
- Non-insurance risk management techniques.
- Risk management problems created by mergers, divestitures and acquisitions.

Wednesday morning, Oct. 31, will kick off with three more concurrent workshops focusing on:

- Surviving a major loss.
- Export risks involving goods bound for the United States.
- Risks associated with human resources, including safety management and drug and alcohol abuse.

The conference will conclude with a plenary session, in which a series of video vignettes of risk management problems will be shown in which participants will be able to outline what they would do in such a situation. The session will be moderated by Rita Epstein, director of communications for RIMS, and Andrew Marr, managing director of Trim Risk Management and Frank B. Hall & Co. Inc. in Sydney, Australia.

In addition to the seminars, the conference also will feature an exhibition of products and services available from insurers, brokers, consultants, adjusters and other vendors.

Registration for the conference costs $1,000 Singapore ($563.40 at current exchange rates). The cost for three or more registrants from the same company is $900 Singapore ($507) each.

To obtain a conference program and registration form, contact Barbara Parker, RIMS, Singapore Conference, 205 E. 42nd St., New York, N.Y. 10017. ■

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GLOBAL BRIEFS

Danes reconsider flood coverage

COPENHAGEN, Denmark—Violent storms that hit Europe in January and February have renewed a call in Denmark for a new system of financing flood losses, according to the Danish Insurance Assn.

More than 100,000 storm-related claims cost Danish insurers about 575 million krone ($95.1 million at current exchange rates), the DIA said, citing figures from the Danish Insurance Information Service.

But because only a few well-known and limited areas are considered at risk for flooding, insurance does not cover flood damage in Denmark, according to the DIA. Losses instead are covered by public funds.

After severe flood losses in the early 1980s, insurers suggested developing some form of flood coverage and financing it through additional premiums on property policies, the trade group said. However, a debate in the Danish Parliament on the problem ended with an agreement in 1985 that public funds continue to cover such losses.

Following the January and February storms, the government was asked to look into some other financing arrangement to cover flood losses. The Ministry for Industry approached the Danish Insurance Assn., which pointed to the proposal to add additional premiums to property policies to cover flood losses.

The insurance group is serving on a committee that will draft legislation to establish private flood coverage that will be introduced in the 1990-91 session of parliament, the DIA said. It had not yet determined whether the proposed coverage would be voluntary or compulsory.

—By Paul D. Winston

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Hudig opens in Berlin

ROTTERDAM, The Netherlands —Hudig-Langeveldt Group bv, the world's 17th-largest insurance brokerage, is opening an office in East Berlin.

The new office, called Hudig-Langeveldt Berlin GmbH, became operational last month and is the Dutch broker's first venture in Eastern Europe.

The East German office joins a network of offices throughout continental Europe. In addition to the Netherlands, Hudig also maintains offices in Spain, Austria, France, Belgium and West Germany (*BI*, June 18).

—By Paul D. Winston

BERMUDA

Continued from page 35

past and, being an eternal optimist, I am confident that with the right stuff, Bermuda will take the necessary initiatives to flourish into the 21st century."

Separately, the Bermuda government last week said that it is canceling plans to create about 100 new jobs over the next 18 months. The move is intended to check government expenditures without raising additional taxes.

"The government cannot afford to spend between $17 million to $20 million per year on salaries," a government official said.

The Bermuda government is operating with a budget deficit of $30 million.

Aneco's demise

The chairman of Forum Re Group (Bermuda) Ltd. blames the demise of its Aneco Reinsurance Underwriting Ltd. subsidiary on its former president, Jonathan Crawley.

Mark Hardy closed Aneco early this month after key staff members defected to Sphere Drake Underwriting Management (Bermuda) Ltd., a new firm headed by Mr. Crawley that, like Aneco, will specialize in reinsurance for Bermuda captives (*BI*, Sept. 10).

In a prepared statement after the creation of Sphere Drake, Mr. Hardy said: "Mr. Crawley, on behalf of Sphere Drake, had only last week announced that his new agency would be competing with Aneco but that the market is big enough for both companies. This statement flies in the face of the now known facts that Mr. Crawley was actively soliciting the services of Aneco's key personnel at this same time, thus destroying Aneco's future business."

Mr. Crawley declined to comment on Mr. Hardy's remarks.

Mr. Hardy said that Mr. Crawley had done a marvelous job of turning Aneco around in its early days. However, he complained that under Mr. Crawley's presidency, Aneco had built up not only a highly profitable book of captive business, but also a number of disastrous property catastrophe reinsurance claims that resulted in $10 million in new losses.

Aneco announced last month that these losses had forced it to stop writing property and marine reinsurance in the London market (*BI*, Aug. 27).

"Aneco is quite solvent, but the property catastrophe business would have put a lot of red ink over our financials if we had decided to stay in business," Mr. Hardy said.

The company has not yet published its 1989 financial results because of "uncertainties," though it has filed statutory returns with Bermuda regulators, according to Mr. Hardy.

"One uncertainty was Jonathan's proposal this year to buy out Aneco's business, which never took place," he said. "It might have been the answer, but it didn't happen."

Mr. Crawley had attempted to buy out Aneco's business and form a new reinsurer, Ascot Reinsurance. That effort failed to attract capital, leading Mr. Crawley to resign from the company.

Aneco's operational problems were not the only problems affecting Aneco, according to Mr. Hardy.

Mr. Hardy said that he had waged a nearly constant personality battle with Mr. Crawley almost from the day Forum acquired Aneco in 1988 (*BI*, April 18, 1988).

"I was simply never able to get along with him," he said.

Mr. Crawley's proposed buyout of Aneco's captive reinsurance book seemed to offer a solution, Mr. Hardy said.

In a separate interview, Mr. Hardy said his priority now is to consolidate what remains of Aneco with his Forum Re Insurance Co. Ltd. operation. Although Aneco's specialty was underwriting captive business, Forum Re has largely focused on writing financial reinsurance.

Aneco wrote a $1.5 million line for captives, a third of which was reinsured by Forum Re. During 1989, Aneco reinsured 77 captives and recorded gross premiums from this business of $10.5 million.

The runoff of Aneco's business will be handled from Bermuda and the company has $25 million of net reserves for its 1989 portfolio.

Mr. Hardy said he has not yet decided whether he will replace Forum's president and underwriter, David Thirkill, who is resigning at the end of the month for personal reasons.

"I really don't now whether I'll be replacing Thirkill," Mr. Hardy said. "I'm just reviewing my options at the present and trying to sort things out so we can achieve an orderly runoff of the Aneco business and the joint book that Aneco had been writing with Forum."

Though Mr. Hardy would not confirm that Forum will continue underwriting after Mr. Thirkill's departure, the company has retained the services of insurance consultant Julian Ashby to explore the company's options.

"We're now working out Forum's strategic plan for going forward," Mr. Ashby said. "A key part of it is looking at what we need to do to handle the runoff in Bermuda."

Ian Carswell, financial controller of Aneco and one of the few remaining staff members, said he is holding down the fort at Aneco on a temporary basis.

"I'm not sure what my function is going to be," he said. "I have never been involved in a runoff before and I'm not making policy decisions at Aneco. I'm just concentrating on keeping things in order."

Mr. Carswell added that despite the upheaval, he has received "surprisingly few" telephone calls from captive clients worried about the future of the company.

Centre Re results

Centre Reinsurance Holdings Ltd., the Bermuda-based finite risk reinsurer, posted a 4.3% increase in capital and surplus to $276.1 million in the second quarter, up from $264.6 million at year-end 1989.

The results for the six months ended June 30 also show that Centre Re's assets have grown to $1.2 billion, up from $874.3 million as of Dec. 31, 1989.

At the same time, its total liabilities have grown to $955.5 million from $609.7 million at year-end. These liabilities include losses and loss adjustment expenses of $789.6 million, unearned premiums of $81.4 million and funds held on behalf of reinsurance contractholders of $83.4 million.

The results of Centre Re—by far Bermuda's largest financial reinsurer (*BI*, April 30)—include the results of subsidiaries in Barbados and New York. ■

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LONDON

Lockerbie report urges hull improvements

By CAROLYN ALDRED and STACY SHAPIRO

LONDON—Aircraft manufacturers and aviation authorities should improve aircraft strength and resistance to explosion, the British Department of Transport says in a long-awaited report on the December 1988 Pan American World Airways flight 103 tragedy.

Last week, the Air Accidents Investigation Branch published a technical report on the disintegration, over Lockerbie, Scotland, of the Pan Am Boeing 747 bound for New York from London.

The report concludes that the "detonation of an improvised explosive device led directly to the destruction of the aircraft with the loss of all 259 persons on board and 11 of the residents of the town of Lockerbie," the Department of Transport announced.

Aviation authorities and aircraft manufacturers, the report says, should "undertake a systematic study with a view to identifying measures that might mitigate the effects of explosive devices and improve the tolerance of aircraft structure and systems to explosive damage."

Remaining recommendations all concern flight recorders. The Department of Transport, the report says, should fund a study to devise methods of recording violent positive and negative pressure pulses associated with explosions, "preferably utilizing the aircraft's flight recorder systems."

Manufacturers of flight recorders, the report says, should ensure that data remains recoverable if power is lost. And aviation authorities should consider requiring that cockpit voice recover systems contain up to one minute of back-up power "to respond to events that result in the almost immediate loss of the aircraft's electrical power supply."

The investigation also found that:

- The crew were properly licensed and medically fit.
- The Federal Aviation Administration had certified the plane's airworthiness and maintenance met FAA standards.
- There was no evidence of any defect or malfunction in the aircraft that could have caused or contributed to the accident.
- The aircraft's structure was in good condition and minimal areas of corrosion did not contribute to the accident.
- A minor fatigue crack—about three inches long—in the fuselage skin "had not been exploited during the disintegration."

Airport security and the criminal aspects of the accident are the subject of a separate investigation and are not covered in the report.

Copies of "Air Accident Report 2/90—ISBN 0-11-550981-X" are published by Her Majesty's Stationery Office, P.O. Box 276, London SW8 5DT, England; 071-873 0011. The price is 18 pounds ($33.39). Or contact Unipub, 461/F Assembly Drive, Lanham, Md. 20706-4391; 301-459-7666.

Environmental report

Britain must improve the enforcement of environmental legislation and should have one central agency to enforce pollution controls and environmental legislation, a chemical industry trade group says in a briefing submitted to the government.

The Chemical Industries Assn. "firmly believes that enforcement should be in the hands of one inspectorate which would have responsibility for the implementation of all environmental legislation relating to water, air and land," the London-based group says in the report.

Chemical firms prepared the brief to be the industry's position on environmental proposals to be debated in the upcoming session of Parliament.

"A more clearly focused approach to the development and enforcement of environmental legislation has become imperative if the United Kingdom is to play a leading role in the increasingly internationalized debate" on pollution, the group said.

The association favors merging "policy and inspectorate functions into a central executive body, which is made fully accountable to a (government) minister specifically responsible for pollution control and, through the minister, to Parliament."

"Some of the present U.K. systems (of pollution control) are no longer adequate, and standards of performance and enforcement need to be improved. In order to lose the unwarranted title of 'dirty man of Europe,' the U.K. must take a more positive approach and be much clearer about the criteria and standards to be employed," the association adds.

"No legislation will improve the environment unless it is effectively enforced," said the trade group.

However, "it is vitally important that environmental control systems do not impose burdens which make U.K. industry uncompetitive. It would be wrong to institute environmental policies which force relocation of industries simply because the receiving country is more environmentally tolerant," the association warns.

Meanwhile, "there is a trend in new environmental legislation toward greater public access to information and participation in decision-making. Increasingly, failure to meet mandatory standards will lead to private prosecutions," it warns.

Salvage agreement

A revised Lloyd's of London salvage agreement passed by Council of Lloyd's earlier this month aims to reduce environmental damage by quickening the pace of major oil spill, chemical or nuclear cleanups.

Before this new agreement, salvors were paid on a "no cure, no pay" basis—that is, they weren't paid for unsuccessful work. Salvors have hesitated to participate in major cleanups because they wouldn't be paid for dangerous work if the operation was unsuccessful, like in cases where a damaged vessel continued to leak.

Only for oil spill work had there been a "safety net" to pay salvors something even if they failed to recover anything.

That concept is now extended to situations where there is damage or the threat of damage to the environment from substances other than oil in the ship, its cargo or its bunkers.

Known in the market as "LOF 1990," the agreement allows for the first time a minimum payment to a salvor that attempts to salvage a vessel if its cargo "threatens damage to the environment" and the salvor is not likely to earn a reward.

The special compensation can be up to 30% of the salvor's expenses. Arbitration panels or Lloyd's tribunals could increase that compensation in individual cases. ■

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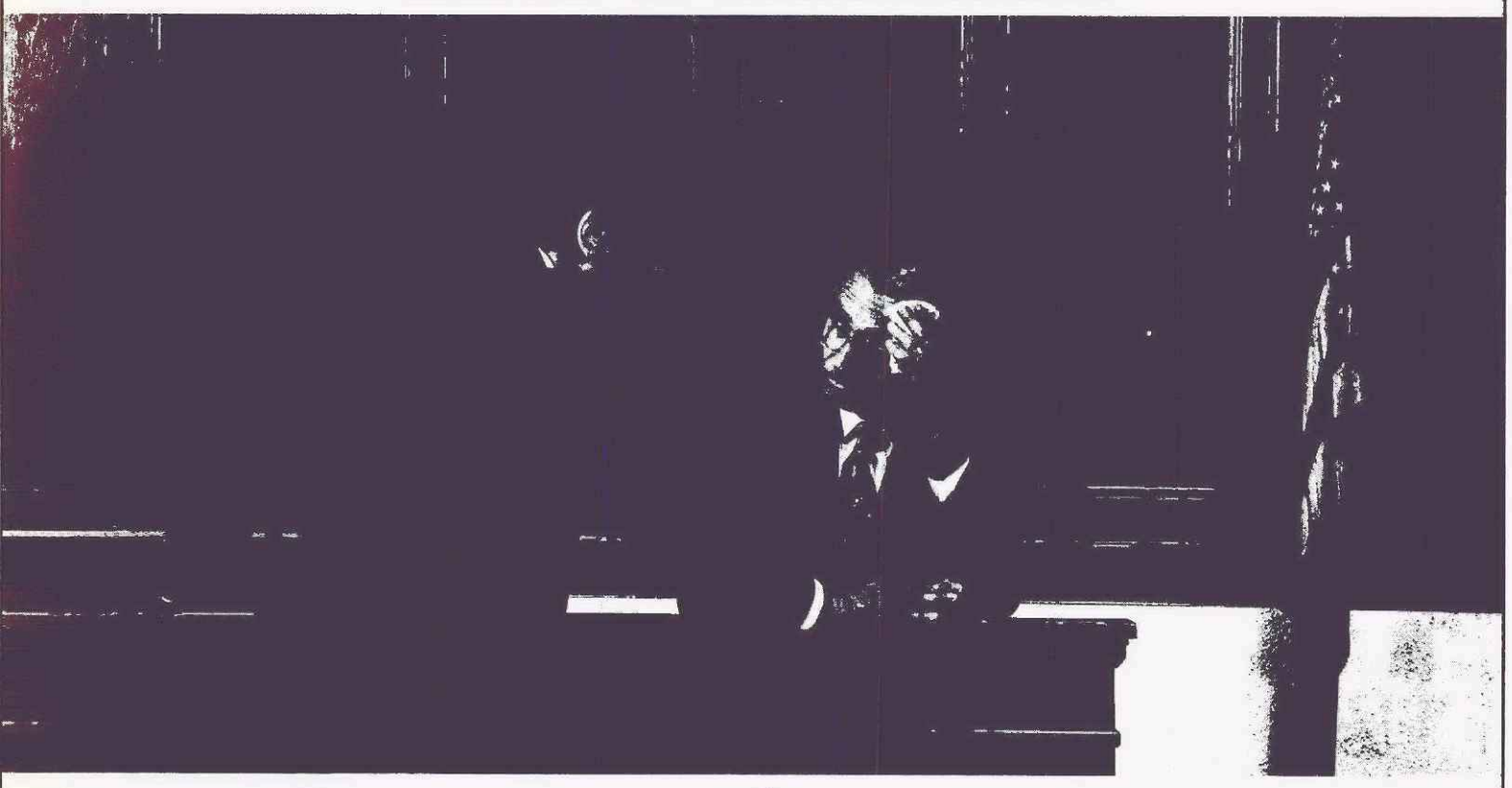

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Temple strike

Continued from page 3

so far this year, all eventually agreed to the premium contribution, Mr. Mohan said.

TAUP is the first union to strike over Temple's demand that employees pay a portion of their health premiums, though two others publicly threatened to strike before signing contracts, said TAUP President Arthur Hochner, an associate professor in human resources administration at Temple.

"We aren't saying co-pay is an evil thing in itself," he said. "We just want to understand why it is necessary."

He said university officials rejected his requests early this year for details about the university's health insurance and claims.

Mr. Hochner said the union may eventually agree to the premium contribution as a valid strategy to control Temple's health care costs, but not until the union is let in on the decision-making process.

"We know there are ways to solve this health benefits issue. But we want to be part of the solution; we don't want a solution imposed upon us," Mr. Hochner explained.

"The university is insisting on the co-pay and we view that as a shifting of costs rather than trying to contain costs," commented Aram Aghazarian, a member of TAUP's executive committee.

One of the union's principal worries is that the premium contribution will increase over time, he said. "Naturally, that $260 won't solve any increasing medical costs problem."

Mr. Hochner said that benefits spelled out in the TAUP contract include a major medical plan underwritten by Prudential Insurance Co. of America. Under the plan, employees are eligible for $1 million in lifetime medical benefits after they pay a $100 deductible. In addition, TAUP members are responsible for a 20% copayment on medical services and a $5 per day copayment for hospital stays for a maximum of 15 days.

Mr. Hochner said about 25% of TAUP members are enrolled in one of six available HMOs.

In addition, TAUP employees receive dental benefits and are eligible for vision benefits if they use the services of Temple's ophthalmology department, Mr. Hochner said. Temple employees are entitled to a free eye exam and a new set of glasses every two years, he said.

No mental health benefits are available to TAUP members, Mr. Hochner said.

Mr. Mohan would not comment on coverage details.

A Temple spokesman said TAUP's two-year contract with the university expired June 30 and talks have been going on all summer. "We presented a package to them and they didn't accept it and said they would strike the first day of class," he said.

The $260 copayment has emerged as a major issue in negotiations, the spokesman said. However, "the board of trustees has remained firm on the concept that all Temple employees should contribute to health care costs."

While the trend toward shifting health care costs to employees is not a new one, educational institutions are somewhat "behind in the cost-shifting aspect," noted Mr. Carter of Hay Huggins.

Most private employers have tried other cost containment strategies like managed care, utilization review and wellness programs. But as health costs have continued to rise, they have resorted to additional cost shifting, Mr. Carter said.

However, colleges and universities have traditionally omitted cost-shifting because their "constituents, who are primarily unionized, were more amenable to cost containment," Mr. Carter explained.

And, academic professionals in particular are especially sensitive to health benefits issues because of the relatively low salaries paid by some colleges and universities, he pointed out.

But, he said, university administrators are now realizing they can no longer foot the entire health care bill for their employees.

Contributing to the problem of rising costs are the traditionally richer benefits packages offered to university employees, Mr. Carter said. Typically, university plans pay 100% of major medical expenses, while private employers are more apt to pay 80% of those expenses, he said.

In addition, "statistics show that university employees are higher utilizers of health care services," Mr. Carter said, noting that highly educated individuals tend to go to the doctor more often. ■

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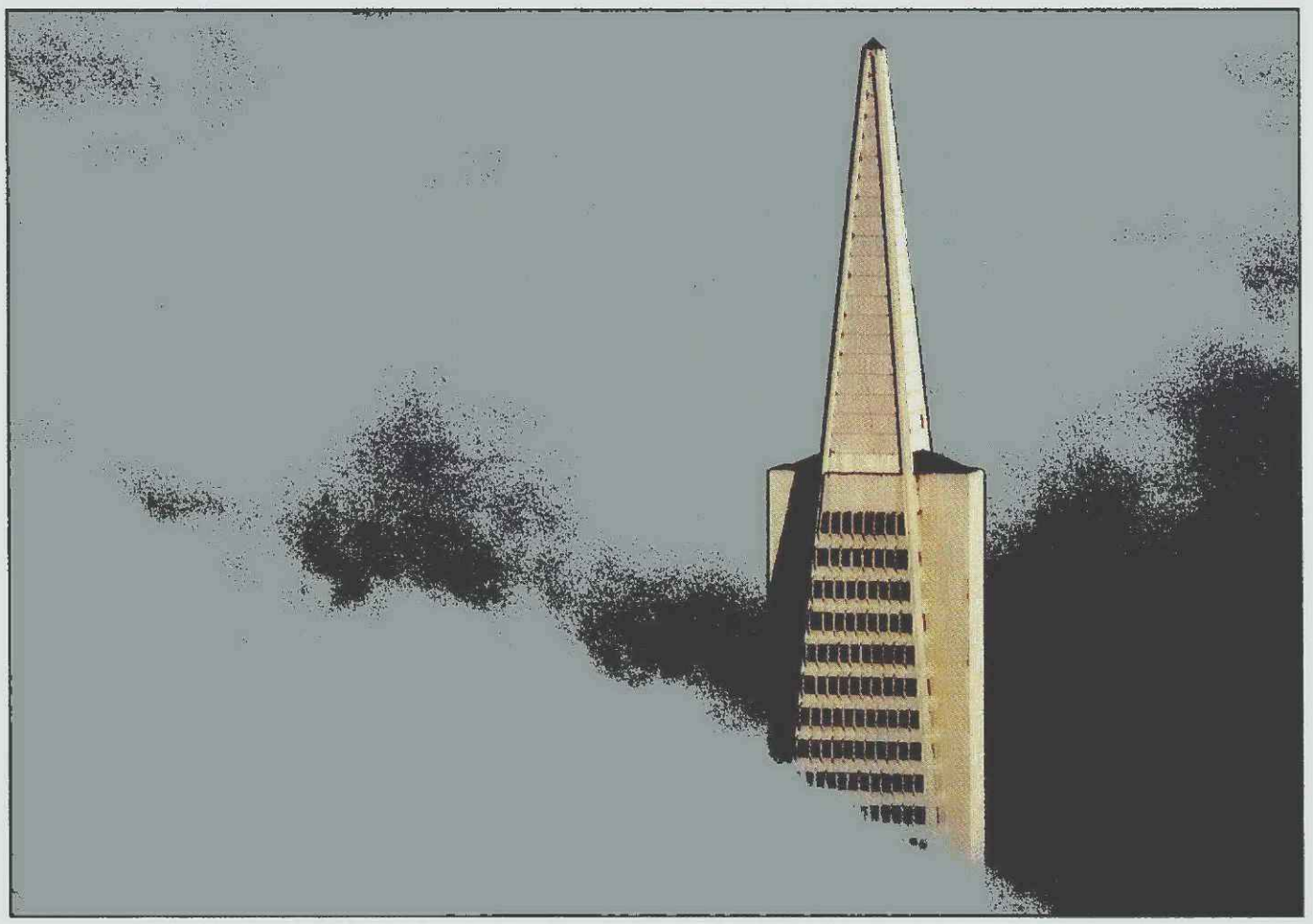

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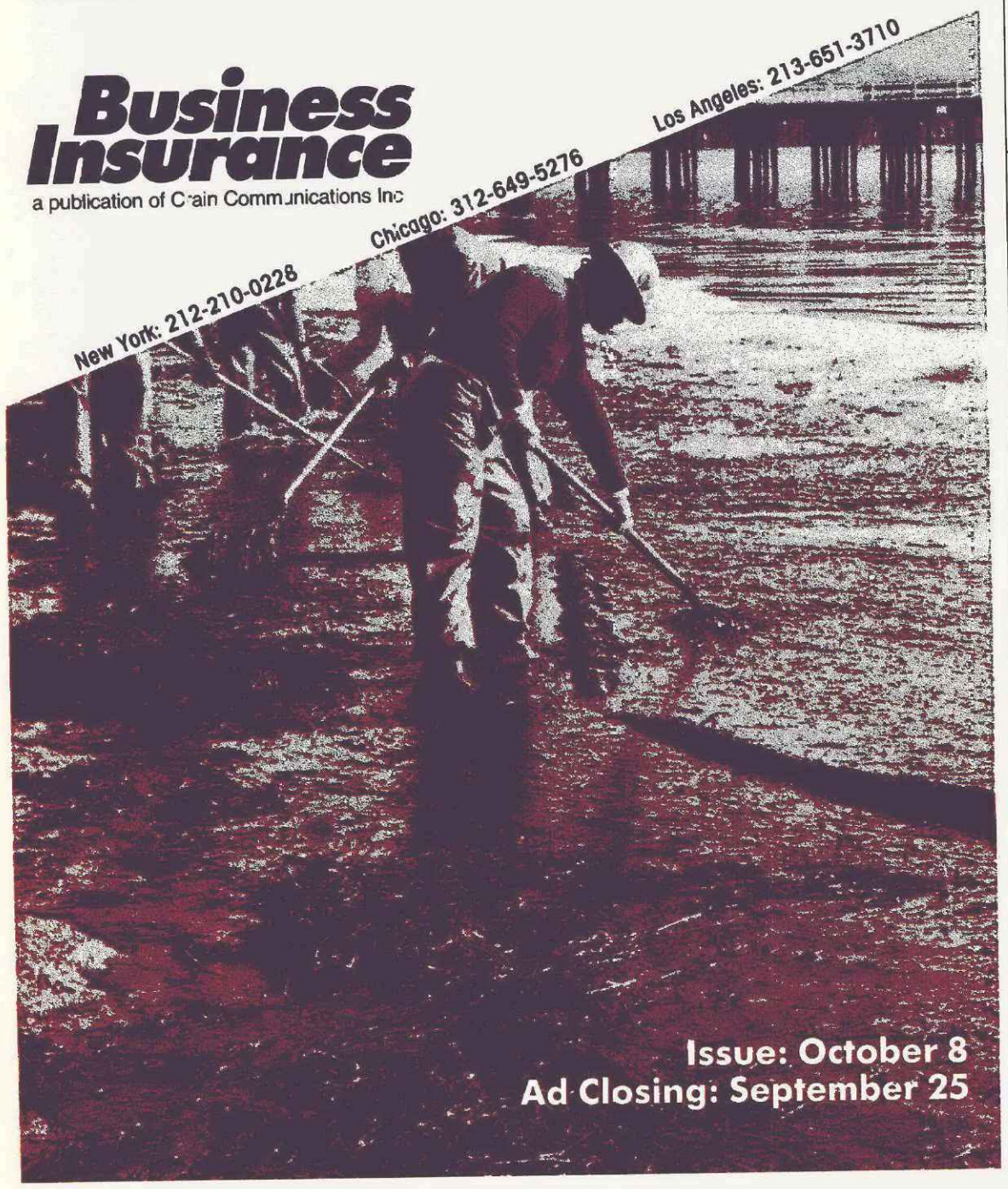

Risk management is vital for students of business: ARIA

By MARK A. HOFMANN

ORLANDO, Fla.—The American Risk & Insurance Assn. is calling for including risk management in the "common body of knowledge" taught to all students in accredited undergraduate business schools.

Knowledge of risk management is "essential for those who hope to be competent organizational leaders. . .Yet thousands of business school students are graduated each year from accredited institutions, without formal instruction in this area," says a position paper from a subcommittee of ARIA's board of directors.

"Arguably, such students are not fully prepared for their future management roles," says the paper prepared by the Orlando, Fla.-based group of insurance educators.

Publication of "Risk Management: An Essential Part of the Common Body of Knowledge for Business" marks the most recent step in the group's long effort to have risk management required in college business curriculums (*BI*, Aug. 29, 1988).

The paper could prove important because the group that accredits university business curricula, the American Assembly of Collegiate Schools of Business, is now reviewing its own standards.

"That's got to be our major thrust this year. The AACSB is currently revising their standards. They're going to be issuing a draft of new standards this month," said Sandra G. Gustavson, the University of Georgia insurance professor who became ARIA president during its annual meeting in Orlando last month.

Insurance educators say they have reason to be slightly optimistic. There is a "hint" at more flexibility in the upcoming standards, says Ms. Gustavson.

The AACSB-recommended core curriculum or "common body of knowledge" currently requires the students at business schools complete courses that touch on five broad areas:

- Production, marketing and finance.
- The economic and legal environment—including ethical considerations—of for-profit and not-for-profit organizations.
- The concepts of accounting and management information systems.
- Work theory, behavior and personal communications.
- Administrative processes.

An AACSB spokesman said 272 business schools, issuing about 55% of all business degrees—including graduate programs—in the country, are currently accredited. Those include heavyweights like Harvard, Stanford and the University of Pennsylvania's Wharton School of Business.

One major problem that has tripped up past efforts by the insurance professors to get risk management included in the core curriculum is the business school accrediting standard that no more than 60% of coursework can be in business-related classes.

Courses required for a business degree often already account for 60% of a student's coursework, so adding risk management would mean eliminating something else.

"We feel that all business students should have some grounding

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Business Insurance

Life industry facing challenges: Experts

By MARK A. HOFMANN

ORLANDO, Fla.—Life insurers, among the strongest performers in the financial services sector, are contending with numerous challenges to their profitability and solvency.

The life insurance industry faces a "lack of public confidence," with some consumers actually thinking that it is next in line for a savings and loan-style debacle, said Mark Puccia, senior vp-life rating division for Standard & Poor's Corp. in New York.

But that is an unfair assessment because life insurers are more sound than many other financial institutions, Mr. Puccia contended during a panel discussion last month at the American Risk & Insurance Assn. annual meeting in Orlando, Fla.

Sandra Gilfillan, executive vp of the National Assn. of Insurance Commissioners, offered another perspective. Life insurer insolvencies are on the upswing, she said, with more life insurers than property/casualty insurers declared insolvent last year.

An NAIC spokeswoman said the group knew of 27 life insurers with multistate operations that were declared insolvent in 1989, compared with 16 property/casualty companies. Those numbers marked a sharp break with preceding years: In 1988, the NAIC said, 10 life and 21 property/casualty insurers were declared insolvent; a year earlier, the figures were 11 and 13, respectively.

The spokeswoman did not know the total amount owed by the insolvent insurers.

Standard & Poor's Mr. Puccia ticked off a list of problems that have bedeviled life and health insurers for several years.

Prices for individual life policies have often been unrealistically low, he said. And the products have been designed poorly by an industry that has to contend with high overhead costs.

Banks and other competitors have squeezed life insurers' profits, Mr. Puccia says.

Banks and other non-insurance competitors have squeezed life insurers' profits in group pension business, Mr. Puccia said. And overcapacity in managed care and longer underwriting cycles have plagued the health insurance sector, he added.

Concerns over many investments also loom over the life insurance industry. Mortgage delinquencies on real estate investments and defaults on junk bond issues both threaten companies, he said.

S&P, in fact, predicts defaults on 10% of high-yield instruments such as junk bonds, Mr. Puccia said.

Despite the problems, Standard & Poor's remains optimistic about the life/health insurance industry, said Mr. Puccia.

"We still see the life and health insurance industry as one of the financially strongest" among financial institutions, he said.

Another speaker on the panel offered four suggestions for insurance regulators.

Joseph M. Belth, an insurance professor at Indiana University in Bloomington, predicted that regulators will be subjected to "unprecedented scrutiny" during the next few years because of consumer concern about insurance.

"Frequently, the insurance regulator is called upon to make crucial decisions" regarding a company's assets, said Mr. Belth, a critic of insurance regulatory practices. Regulators find themselves in a "lonely" position, because, even in the face of legitimate questions, insurers often have persuasive witnesses to attest to their financial strength, he said.

Mr. Belth urged regulators to keep the public informed of their activities; to welcome assistance from wherever they can get it, including from academicians; to screen the directors and officers of insurance companies carefully when granting licenses; and to require that policyholders and possible policyholders receive a prospectus before buying insurance.

Harold D. Skipper Jr., a professor of insurance at Georgia State University in Atlanta, moderated the discussion. ■

Business studies

Continued from previous page

in the principles of risk management," said Ms. Gustavson. She said that preliminary information about the suggested changes, which will be made public this week, indicate that a more liberal interpretation of the common body of knowledge will allow the inclusion of risk management in the business curriculum core.

ARIA has long held that requiring separate risk management courses would be the best way to alter the curriculum. The position paper sticks to that contention, but it also offers several other possibilities.

"In many cases, risk management principles could be integrated into already-required courses in management, finance, accounting, marketing and business law," the paper says.

In an appendix, the authors offer a plan to include "one or more major risk management topics in at least the following five courses: 1. Organizational behavior, 2. quantitative methods, 3. corporate finance, 4. business policy, 5. one or more of the following: accounting, business law, marketing, production and personnel administration."

And at another point, the paper's authors suggest nine major risk management areas for study: nature and function of risk management; theoretical bases, tools and techniques of risk management; identification and analysis of loss exposures; measurement and evaluation of loss exposures; risk control; risk retention; risk transfer; risk management decision-making techniques; and integration of risk management into managerial processes.

The paper also notes that "it likely is impossible and arguably unnecessary to expect all accredited business schools to hire new faculty with risk management specializations. But if existing management, finance, accounting, marketing and business law faculty integrate risk management theories and principles with material already being taught, the need to hire additional faculty is minimized."

After referring to a list of existing risk management texts, the paper says "resource constraints are manageable, especially in light of the urgent educational need to introduce risk management principles to business students who may otherwise never be exposed to the subject." ■

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Single copies are $35. Send prepaid orders for publication TMF-P010-30 to Edward J. Hester, Menninger Return to Work Center, Box 829, Topeka, Kan. 66601; 913-233-2051.

• **"How to Prepare for an Earthquake: A Guide for Businesses,"** is a new publication available from the Insurance Information Institute. Intended to help business owners protect their employees and property if an earthquake strikes, the 52-page book is divided into five sections: protecting employees at the office; protecting employees at home; protecting office/computer facilities; protecting operations; and protecting company assets. The guide was written by John P. McCann, president of McCann Communications, a San Francisco-area consulting firm serving property/liability insurers. The publication also includes lists of national, regional, state and local organizations that provide various types of earthquake-related information and descriptions of responsibilities of agencies charged with responding to an earthquake. Copies are $15 each for brokers, agents and III member companies, and $25 each for all others. Multiple-copy discounts are available. Send prepaid orders to the Insurance Information Institute, Publications Service Center, 110 William St., New York, N.Y. 10038; 212-669-9200.

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2-01-90299-0	09/24/90	11 A.M. EST

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINIOS COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF LIQUIDATION OF) YORKTOWN INDEMNITY COMPANY) NO. 88 CH 9367

NOTICE

PLEASE TAKE NOTICE, that on FEBRUARY 7, 1989 an Order of Liquidation With a Finding of Insolvency was entered against Yorktown Indemnity Company ("Yorktown") by the Honorable Sophia H. Hall, Judge of the Circuit Court of Cook County, Illinois. Zack Stamp, Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Yorktown.

TAKE FURTHER NOTICE, that pursuant to the Order of said Court, all rights and liabilities of Yorktown and of its creditors, policyholders and all other persons interested in its assets are fixed as of February 7, 1989, unless otherwise provided by such other Order of the Court.

TAKE FURTHER NOTICE, that the form of and required content of all Proofs of Claim are described in Illinois Revised Statutes, 1987, Chapter 73, Paragraph 821. Proofs of Claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Special Deputy Liquidator, Yorktown Indemnity Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator Further reserves all rights to any an and all defenses of Yorktown concerning such claim. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR AT HIS ABOVE-MENTIONED OFFICE IS DECEMBER 31, 1990 AT 4:30 P.M., CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS, CONTINGENT OR OTHERWISE, AGAINST YORKTOWN INDEMNITY COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 31, 1990 AT 4:30 P.M. C.S.T.; AND IF ANY SUCH CLAIMS ARE CONTINGENT CLAIMS, THEY MUST BE LIQUIDATED PURSUANT TO SECTION 209 OF THE ILLINOIS INSURANCE CODE (ILL. REV. STAT., 1987, CH. 73, PARA.821) ON OR BEFORE DECEMBER 31, 1991 AT 4:30 P.M. C.S.T.

James W. Schacht, Special Deputy Liquidator, Office of the Special Deputy, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611, (312) 915-4700.

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Circulation Breakdown*

Commercial Consumers

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Financial:	
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Secretaries, Treasurers, contollers and other Financial Personnel	3,562
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	11,566
Sub-total	**24,648**
Associations	539
Government, Unions and Educational Institutions	1,389
Commercial Consumers	
Sub-total	**26,576**
Insurance Agents and Brokers	10,223
Insurance Companies	7,713
Accountants, Actuaries, Attorneys & Consultants	3,353
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,115
Others Allied to the Field	2,149
TOTAL	**51,129**

* Source Business/Occupational breakdown of qualified circulation, November 27, 1989 issue, as submitted to BPA for December 1989 BPA Publisher's Statement.

Largest U.S. reinsurers' first half 1990 results

Ranked by net reinsurance premium written. All amounts in thousands of dollars.

Reinsurers	Policyholders' surplus (reinsurers only)	Net reinsurance premiums written 1990	Net reinsurance premiums written 1989	Net reinsurance premiums earned	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1990	Combined ratio 1989
General Re	$2,804,800	$945,689	$851,310	$919,056	$632,566	68.8%	$285,330	30.2%	99.0%	99.0%
Employers Re	1,460,335	540,262	548,749	543,778	432,389	79.5	136,941	25.3	104.9	105.6
American Re	677,556	389,963	430,325	436,884	305,481	69.9	129,574	33.2	103.1	101.2
F&G Re (USF&G)	N/A	298,178	298,643	221,898	139,482	62.9	99,407	33.3	96.2	97.2
North American/Swiss Re	593,395	290,040	308,168	309,738	211,460	68.3	114,553	39.5	107.8	107.1
Munich Re	582,373	260,106	298,947	259,374	213,111	82.2	86,969	33.4	115.6	101.6
Prudential Re	524,731	247,950	252,812	242,233	207,734	85.8	89,519	36.1	121.9	109.3
St. Paul Cos.	N/A	203,639	197,776	180,363	183,031	101.5	70,818	34.8	136.3	109.0
Constitution Re	195,566	188,358	115,883	156,410	120,912	77.3	55,155	29.3	106.6	102.4
Kemper Re	349,586	168,093	158,144	159,985	143,712	89.8	43,953	26.2	116.0	101.4
Skandia America Group	335,007	163,496	128,897	163,031	131,613	80.7	53,801	32.9	113.6	106.9
Transatlantic Re	207,037	156,379	165,578	153,710	124,681	81.1	40,379	25.8	106.9	106.0
CIGNA Re	190,669	156,055	136,426	143,422	114,681	80.0	37,875	24.3	104.2	104.2
Transamerica Re	175,658	151,497	127,204	151,951	117,101	77.1	43,536	28.7	105.8	104.5
National Re	222,977	118,175	121,293	114,093	87,572	76.8	31,058	26.3	103.0	103.7
NAC Re	195,964	105,777	93,841	104,963	78,451	74.7	36,172	34.2	108.9	106.5
US Int'l Re	109,808	90,015	91,095	91,990	73,447	79.8	32,467	36.1	115.9	105.5
Winterthur Re	157,933	85,206	47,299	53,704	39,966	74.4	29,620	34.8	109.2	108.2
Putnam Re	122,073	74,286	75,504	78,392	61,253	78.1	18,465	24.9	103.0	103.1
Continental Re	151,274	66,588	90,386	68,527	59,755	87.2	21,506	32.3	119.5	108.0
Totals for top 20	**9,056,742**	**4,699,752**	**4,538,280**	**4,553,502**	**3,478,398**	**76.4**	**1,456,738**	**31.0**	**107.4**	**103.5**
Total for all companies	**$12,033,704**	**5,123,233**	**4,903,500**	**5,034,661**	**3,819,485**	**75.9**	**1,604,039**	**31.3**	**107.2**	**104.0**

Source: Reinsurance Assn. of America and *Business Insurance*

Reinsurer results

Continued from page 3

tive vp of G.L. Hodson & Son Inc. of New Hyde Park, N.Y., the reinsurance brokerage unit of Corroon & Black Corp.

Mr. Rothpletz said he sees the softening trend in the reinsurance market slowing, but added that the market is far from tight and that "you are probably talking about 1992 at the earliest" before the market turns.

"From the reinsurance side, there is still a glut of capacity," agreed James Fisher, senior vp and comptroller with American Re-Insurance Co. in Princeton, N.J.

Tightening reinsurance markets have led to past turns in property/casualty prices. But Mr. Fisher predicts that tightening primary rates will actually drive the next change in the reinsurance market.

However, tightening in the primary market also appears to be a long way off.

"We see very few signs of encouragement in terms of pricing on the primary side," noted James F. Dowd, president and chief executive of Skandia America Reinsurance Corp. in New York.

Reinsurers, Mr. Dowd said, have entered a period of "stagnation" in which—unlike earlier years—they are unable to influence primary insurance prices and are hard-pressed to reverse their own deteriorating fortunes.

While this situation could change, Mr. Dowd also guessed that it may be 1992 before the change comes.

This gloomy state of affairs for reinsurers is reflected in the lackluster results in the latest RAA survey.

While net written premiums climbed 4.5%, losses and loss adjustment expenses hit $3.8 billion, producing a loss ratio of 75.9% against earned premiums of $5 billion. This was a slight deterioration from the 73.8% loss ratio reported by a similar but not identical group for the first six months of 1989.

Underwriting expenses for the first half amounted to $1.6 billion, producing an expense ratio of 31.3%, slightly higher than the 30.1% ratio last year.

Overall, the 68 reinsurers surveyed by RAA produced an underwriting loss of $388.9 million. After total investment gains of $1.4 billion, other gains and losses and taxes, the reinsurer group produced net income for the first six months of $785.4 million.

Comparable figures for the same period last year are unavailable.

The 68 reinsurers reported total policyholder surplus of $12 billion at June 30, meaning that as a group, the reinsurers were writing at a net premium-to-surplus ratio of 0.43-to-1 for the first six months of 1990.

Last year at the same point, the net premium-to-surplus for the reinsurer group was 0.46-to-1.

Results for the 20 largest reinsurers were marginally worse. Losses and loss adjustment expenses totaled $3.5 billion, producing a loss ratio of 76.4%. Underwriting expenses, meanwhile, amounted to $1.5 billion, resulting in an expense ratio of 31.0%, slightly better than the group as a whole.

The combined ratio for the largest reinsurers was 107.4% for the first six months, slightly worse than the 107.2% for the group as a whole.

The story was different, though, for the largest of the top 20 companies, according to Michael Smith, vp and insurance industry analyst with Shearson Lehman Brothers in New York.

The combined ratio for the 15 largest reinsurers—who write the bulk of the industry's premiums—deteriorated by about two percentage points from the first half of 1989 to the first half of 1990, he said. By contrast, the combined ratio of reinsurers below the top 15 deteriorated by four to five percentage points, he said.

"The better reinsurance business is continuing to move toward size and security, and price is less of an object," Mr. Smith concluded.

Robert O'Leary, president of New York-based intermediary Willcox Inc., cautioned against comparisons of 1990 and 1989 six-month results.

Premium volume for the first half of this year has in some cases been "artificially inflated" by reinstatement premiums ceding insurers paid reinsurers to re-establish exhausted limits in the wake of last year's large catastrophe losses, Mr. O'Leary noted. Other factors have also affected results, including upward and downward adjustments of reserves for catastrophe claims, he added.

"There are too many things going on" to read too much into a comparison of six-month results, he said.

Some reinsurance observers see disturbing trends in the results, however.

One reinsurance executive noted that 10 reinsurers in the RAA survey reported declines in surplus while 12 others reported increases of less than $1 million.

This means that nearly a third of those surveyed showed declines or only minor increases in surplus, the executive observed.

Meanwhile, five of the reinsurers surveyed reported pretax operating losses and seven reported aftertax net losses.

These and other trends in the results "are signals that some change (in the market) should come," the executive said. "It will come. The only question is when, and the last time I predicted that I was wrong by 18 months." ■

Home closes reinsurance affiliate

NEW YORK—U.S. International Reinsurance Co. has closed its doors to new and renewal business and will run off its existing book, parent Home Insurance Co. announced last week.

The Home, U.S. International Re and Home subsidiary Commonwealth Insurance Co. were put on the block earlier this year by AmBase Corp. AmBase announced an agreement to sell Commonwealth earlier this month and is considering two offers for The Home (*BI*, Sept. 10, Feb. 26).

While The Home conducted "extensive negotiations with potential buyers" of U.S. International Re, the company has rejected an offer for the reinsurance unit, Home President James J. Meenaghan said in a statement last week.

"We believe the inherent value of (U.S. International Re) is greater than the price we could obtain in today's market," Mr. Meenaghan said. "We are now examining several financial alternatives which we are confident will maximize The Home's equity in the net assets of" U.S. International Re.

Net assets of the reinsurance unit include its equity in unearned premium reserves and loss reserves, a Home spokesman noted, adding that financial alternatives being explored by The Home could include financial reinsurance deals covering U.S. International Re's book of business.

U.S. International Re is the 17th-largest U.S. reinsurer based on six-month 1990 net written premium volume of $90 million. The reinsurer's policyholder surplus amounted to $109.8 million at June 30.

Reinsurance industry observers and market competitors welcomed U.S. International Re's exit from a market generally viewed as overcapitalized.

"This is the type of consolidation the industry needs," said Michael Smith, vp and insurance industry analyst with Shearson Lehman Brothers in New York, referring both to the U.S. International Re shutdown and the acquisition of Metropolitan Reinsurance Co.'s business by Skandia America Reinsurance Corp.

"I think it's probably a positive development," added Skandia President James F. Dowd.

Observers also agree, however, that the U.S. International Re shutdown will not put much of a dent in the reinsurance market's abundant capacity.

Asked if the loss of The Home's reinsurance unit will squeeze market capacity, Mr. Dowd replied, "absolutely not."

—By Douglas McLeod

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Drug testing

Continued from page 3

The study was supported in part with funds from the National Institute on Drug Abuse of the U.S. Department of Health and Human Services.

Survey author Helen Axel explained that she proposed the survey because drug testing is "a hot topic" and employers are interested in such programs.

"I've had lots of inquiries about establishing drug testing programs," she said.

"Plenty of companies don't yet have a coordinated strategy, although the Fortune 500 and 1,000 companies are well along," Ms. Axel said.

She also noted that the establishment of drug testing programs is increasing, especially among the larger companies surveyed.

Forty-nine percent of the respondents, or 334 companies, already use drug testing as part of their pre-employment process and to test employees for drug use.

Six percent more, or 40 companies, were in the process of implementing a testing program or studying the feasibility of such a program at the time of the survey.

The survey found that drug testing programs were especially prevalent in the public utility and manufacturing industries.

Of the 104 public utility companies surveyed, 79%, or 82, had drug testing programs.

And, of the 262 manufacturing companies surveyed, 64%, or 167, had drug testing programs.

In addition, 49%, or 63, of the 129 construction, mining and other industries had such programs.

However, only 13%, or 24, of the 186 finance and insurance companies surveyed had programs.

Among the 347 companies that did not have drug testing programs, 339 responded to a question about whether they would consider such programs. Eight percent, or 28 companies, reported they were about to launch a program, and 12 more companies said they planned to explore the feasibility of creating a program in the near future.

Among the reasons cited as "important" or "very important" for initiating drug testing programs were countering drug problems in the workplace, detecting drug use early on, deterring drug use by future employees, improving workplace safety, and minimizing liability in drug-related workplace accidents.

Of the 334 companies with drug testing programs, 92% screen for drug use as part of the employment process; 74% screen for cause; 42% test to monitor treatment; 28% test periodically; 9% test randomly; and another 9% test employees considered for promotions and transfers.

About 90% of the 334 employers with drug testing programs say their procedures are designed to detect recent use of cocaine and its derivatives, marijuana and other cannabinoids, opiates, barbiturates and amphetamines.

In addition, 80% to 90% of the companies test for use of benzodiazepines and phencyclidine, or PCP.

And, 51%, or 171, of the 334 companies with drug testing programs also test for alcohol use, with 12%, or 39 companies, using breath analysis equipment to detect alcohol use on the job.

Job applicants who test positive for drug use will not be offered a job, noted virtually all of the 334 companies.

However, 75% of the companies said they would accept applications after a specified waiting period from job applicants who tested positive for drug use.

And, 17%, or 57, of the 334 companies that require employees to submit to drug tests say they would fire drug users, even those caught for the first time.

Companies with drug testing programs said they have noted several beneficial results since implementing the programs:

- 77% cited improved quality of job applicants.
- 63% said workplace safety has improved.
- 58% believe they have a better image in their respective communities.
- 56% said there were fewer drug problems in the workplace.
- 54% said employee morale has improved.
- 54% said the use of EAPs has increased and the credibility of those programs has improved.
- 43% said job performance has improved.

However, 58 companies of the 334 with drug testing programs acknowledged that despite precautions, variations occur in the testing procedures that can interfere with the successful operation of the program.

For example, companies with operations in more than one state may face varying state regulations on drug testing procedures.

Other problems arose as well. Of the 334 companies with drug testing programs, 37, or more than 11%, reported that they have been challenged in court because of their testing programs.

And 69, or more than 20%, say they were involved in arbitration cases.

'I've had lots of inquiries about establishing drug testing programs,' says Ms. Axel, the survey's author. 'Plenty of companies don't yet have a coordinated strategy, although the Fortune 500 and 1,000 companies are well along.'

Other problems cited by employers include:

- Conflicting interpretations of policy, 21%.
- Employee resentment, 20%.
- Concern about cheating during the testing process, 20%.
- Variable quality in program operation, 14%.
- Inadequate communication of policy and procedures, 9%.
- Problems with confidentiality, 8%.
- Difficulty in justifying cost-effectiveness, 7%.
- Laboratory quality control problems, 6%.
- Lack of management interest and support, 5%.
- Unwelcome publicity, 4%.

More often than not, a drug testing program is part of a more extensive program designed to curb and prevent the use of drugs in the workplace.

Indeed, the 334 companies with drug testing programs were among a group of 480 survey respondents that have formal substance abuse policies.

For example, among the 334 companies with drug testing programs:

- 90% also had a written substance abuse policy.
- 84% had drug education and training programs for supervisors.
- 76% had employee assistance programs.
- 68% offered employees education materials and awareness programs on drug abuse.

The burden for developing such substance abuse programs predominantly falls on the personnel or human resources department, according to the survey.

Of the 480 firms with substance abuse programs—including drug testing programs—94% reported that their personnel or human resources departments were involved in developing the program.

In addition, 75% of the companies reported that their legal departments were involved in developing the programs.

Other personnel or areas of the company involved in developing substance abuse programs included:

- Chief executive officers, reported by 50% of the companies.
- Medical personnel, reported by 50% of the companies.
- Labor relations, reported by 45% of the companies.
- An existing employee assistance program, reported by 44% of the companies.
- Security, reported by 26% of the companies.
- Labor unions, reported by 14% of the companies.

Companies with drug testing programs carefully weighed the decision before launching the programs.

Of the 334 firms with drug testing policies:

- 41%, or 137, deliberated between six and 11 months.
- 25%, or 83, deliberated between a year and 23 months.
- 16%, or 53, deliberated between three and five months.
- 10%, or 33, deliberated less than three months.
- 8%, or 27, deliberated two years or more.

The Conference Board also issued a supplemental booklet with the study titled "Substance Abuse and Drug Testing," which includes specific examples of corporate policies and procedures in the drug testing area.

Corporations whose policies are included in the booklet include FMC Corp., United Airlines, E.I. du Pont de Nemours & Co. and Westinghouse Electric Corp.

•

Copies of "Corporate Experiences with Drug Testing Programs" and "Substance Abuse and Drug Testing" are available from The Conference Board, 845 Third Ave., New York, N.Y. 10022; phone 212-339-0232. The cost of the survey is $20 for members and $80 for non-members. The cost of the supplement is $30 for members and $120 for non-members.

Satellite suit

Continued from page 3

sumed the risk of property loss during the launch, including losses stemming from Martin Marietta's "gross negligence."

Martin Marietta also asks the court to rule that amendments to the Commercial Space Launch Act of 1984 preclude Intelsat from recovering its loss from the aerospace firm.

The 1984 law requires "contractors, subcontractors, customers" and other related parties to waive claims for property damage or personal injury damages that result from launches.

Martin Marietta says in its suit that it met its obligations under the 1984 law by buying about $220 million in liability insurance to respond to any potential losses suffered by third parties.

The Martin Marietta spokesman would not provide coverage details.

If Martin Marietta is held liable for the loss, the aerospace firm would "need to increase substantially the price of its Titan III launch services, which may make the services not competitive or cause Martin Marietta to terminate its commercial launch services business," it claims in its suit against Intelsat.

"It would essentially drive launch companies out of business," said a Martin Marietta spokesman. "If we had to take into consideration the risk factor without insurance, obviously the cost would be much higher."

"Martin Marietta deeply regrets the unsuccessful commercial Titan launch that resulted from the system's failure. But the terms of the launch services contract with Intelsat should be upheld," the spokesman said.

"We're not interested in debating the legal issues with Martin Marietta in the press," the Intelsat spokesman said. "We'll see them in court. We're confident of the strength of our case."

The primary consideration in this case under admiralty law, which is the foundation for many space law rulings, is the freedom to enter into contracts, according to an expert.

"Can parties which are sophisticated, intelligent and which have ample access to legal counsel enter into binding contracts?" asked Richard Robol of Hunton & Williams, a Norfolk, Va., law firm.

The Intelsat spokesman confirmed that Intelsat—which has purchased insurance for previous launches—was not covered for the launch of the F-3 satellite or for the successful launch of the F-4 satellite in June.

"It's all a matter of cost. We thought insurance premiums were too high when we were trying to buy insurance," he said.

Communications Satellite Corp., a Washington, D.C.-based partner in Intelsat, did buy launch insurance to cover its 26% share in Intelsat satellites.

However, the Comsat policy does not respond to the flubbed March 14 launch because it contains a one-loss deductible and the F-3 launch was the first loss under the program.

The insurance was led by Lloyd's of London underwriter Michael Marchant (*BI*, June 25). Corroon & Black Inspace Inc. of Bethesda, Md., and Lloyd's of London broker Crawley Warren & Co. Ltd. placed the coverage. ■

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Aon offer

Continued from page 1

cember 1982), Corroon & Black was the competition for RBH. There has been a feeling for a long time that we have a lot in common," he added.

C&B currently ranks as the fifth-largest brokerage in the world based on 1989 revenues of $456.8 million, and Willis Faber ranked sixth with revenues of $452.1 million when converted to U.S. dollars (*BI*, June 18).

RBH Group ranked as the world's eighth-largest broker with 1989 revenues of $316.4 million. However, RBH Group is expected to report large revenue growth in 1990 because results from Bayly, Martin & Fay International Inc.—which RBH acquired in July 1989—were only included in RBH's 1989 revenues from its date of purchase. BMF reported $74.7 million in revenues in 1988.

Mr. Ryan estimated 1990 gross revenues for RBH at "around $400 million," and C&B's 1990 revenues as "approaching $500 million."

If Aon were to acquire C&B and merge it with RBH, "I think we would clearly become the third-largest brokerage in the United States and the fourth-largest in the world," Mr. Ryan said.

New York-based Johnson & Higgins is currently the world's fourth-largest broker with estimated gross revenues of $785.9 million in 1989. Privately held J&H does not release financial data.

While both Willis Faber and C&B have touted their combined global marketing capabilities as the driving force behind their proposed merger, Mr. Ryan said he believes "in an independent position in Europe so that we can go where the skills are" rather than operating solely through offices of an international partner.

Mr. Ryan also downplays the importance of a U.S. broker having many offices abroad.

"We will open more offices abroad. . .We think flexibility is really important overseas," he said. "However, I don't know that doing business indigenously in Milan should be a goal of a U.S. broker."

RBH already has close ties with Lloyd's of London broker Nicholson, Chamberlain & Colls, in which it holds a 40% stake.

However, Mr. Elliott, Willis Faber's chairman, said in an interview Friday that the Aon proposal makes little sense compared with a Willis Faber-C&B combination, though he added that a rival bid was not surprising.

"I thought another broker (but not Aon) would have made a crack at it by now, because together" Willis Faber & C&B "make the best broker in the world," he said, adding that he wonders whether Mr. Ryan "is up to a bit of mischief" by attempting to spoil the Willis Faber-C&B merger.

Mr. Elliot—who heard about the Aon offer at the annual Rendez-Vous de Septembre, the annual reinsurer gathering in Monte Carlo—noted that an Aon-C&B combination would be a large U.S. broker with little foreign expertise.

"How will they put 3,500 people in America together with another 5,500 people in America?" he asked. RBH reported 3,513 employees at year-end 1989, while C&B reported 4,961.

"It's like the Willis Faber-Stewart Wrightson merger," he said, referring to the turmoil following the 1987 acquisition of Stewart Wrightson P.L.C. that prompted the resignation of more than 100 key Stewart Wrightson executives.

Overlaps between C&B and RBH could prompt the loss of many C&B executives, agreed Russell R. Miller, chairman and chief executive officer of Russell Miller Inc., a San Francisco investment banker specializing in insurance.

Mr. Miller added that C&B's "goal to be an international broker and to have a stock tradable on an exchange would not be achieved through the Aon deal."

But Mr. Ryan stressed that his major attraction to C&B is its "tremendous" professional staff.

"Bringing the two organizations together, we'd become much more formidable," he explained.

Mr. Ryan says the duplication of RBH and C&B offices in many cities would not be a problem, but rather an opportunity. And, he points out that following its purchase of Bayly, Martin & Fay in July 1989, RBH merged several offices in common locations very effectively and profitably with minimum disruption.

He also contends that neither RBH nor C&B has achieved the critical mass needed to excel in New York and other cities. A merger would make the two brokerages much more powerful in those markets, he maintains.

Financial analyst Michael A. Smith, vp with Shearson Lehman Brothers in New York, said that combining offices in common locations would achieve "tremendous economies of scale by reducing duplicate expenses."

Since this is just a preliminary offer, Mr. Ryan said Aon has not determined how management would be restructured, though the merged brokerage would be based in Chicago.

And, Mr. Ryan stressed, "we believe there will be plenty of opportunities for everyone" within the merged organization.

C&B and Willis Faber executives have touted their proposed merger as a good long-range business move that would propel the combined companies into the elite global insurance brokerage arena. But many critics have argued that C&B shareholders would not get a fair price (*BI*, June 11).

Aon's offer, Mr. Ryan notes, guarantees $40 per share.

On the other hand, a Willis Faber-C&B merger is based on an exchange of 7.8 Willis Faber ordinary shares for each C&B common share. Willis Corroon stock would be listed on the London Stock Exchange, but C&B shareholders would receive new shares in the form of American Depository Receipts that would have a restricted listing on the New York Stock Exchange.

Thus, the value of the Willis Faber/C&B transaction to C&B shareholders hinges on the Willis Faber stock prices, which have fallen substantially since the proposed merger was announced June 4.

Willis Faber shares were trading at 289 pence ($5.43 at current exchange rates) on May 31, but fell to 256 pence ($4.81) the week the proposed merger was announced. On Thursday, the day after Aon tendered its offer, Willis Faber shares dropped to 210 pence ($3.94) from 231 pence ($4.34) at close on Wednesday, and the stock fell further to 206 pence per share ($3.87) on Friday.

Based on the Friday closing price, Willis Faber's offer to C&B shareholders is valued at less then $31 per share.

Meanwhile, C&B shares fluctuated last week, though they remained generally higher. C&B stock closed at $37.63 on Wednesday, up from $30.88 on Tuesday. It fell to $36.25 on Thursday.

Aon shares closed at $31.88 Thursday, down from $33 on Wednesday.

Shearson's Mr. Smith said that the drop in Willis Faber stock should be viewed as a "clear message that Willis Faber shareholders will tolerate no further dilution" of their shares if the terms of the C&B-Willis Faber merger need to be renegotiated to salvage the deal.

While Aon's has the higher face value of the two offers, the values are closer after tax considerations.

C&B shareholders have to pay capital gains taxes if they accept Aon's cash offer, though not under Willis Faber's proposed stock swap, noted Mr. Miller of Russell Miller.

Willis Faber's Mr. Elliott said that capital gains taxes effectively lower the value of Aon's offer to $34 per share.

"Nonsense," says Walter Fitzgerald, an investment analyst with Baird, Patrick & Co. in New York, of the tax argument.

He called the Aon offer "a very credible bid and superior to the Willis Faber transaction" and stressed that there are "an awful lot of shareholders for which taxes are not an issue."

Only shareholders retaining the ADRs following a Willis Faber/C&B merger would escape capital gains taxes, he noted. Shareholders selling their ADR would face the same capital gains tax as if they accepted Aon's cash bid.

While about 30% of C&B's shareholders are C&B managers or employees, a large percentage of the remaining 70% are institutional investors, many of which would not be subject to capital gains tax in either transaction, Mr. Fitzgerald said.

Shearson's Mr. Smith likewise played down the importance of capital gains tax to the respective transactions.

Mr. Fitzgerald also noted that while the Willis Faber-C&B merger would create a global brokerage, the value of that "depends upon how effectively the two units could be put together over time. Clearly it's a global market, but that's really irrelevant for the owners of most of the shares.

"The relevant point is which is a superior bid? In my view, Aon has made the superior bid," Mr. Fitzgerald said.

London stock analyst Chris Pountain of Morgan, Stanley & Co.—who has criticized Willis Faber's offer for C&B—noted that the rival offers for C&B can be viewed from two points of view.

From a C&B shareholder's point of view, "it's better to take the $40," Mr. Pountain said. "But from a management point of view, it's better to have the Willis-Corroon merger.

"But the odds are slightly in favor of Aon. Willis Faber can't increase its offer. They don't have the cash and the fall in (Willis Faber's) share prices makes (increasing capital) more difficult," he said.

While Aon's bid would constitute an acquisition of C&B, which C&B executives have long tried to avoid, the Willis Faber/C&B transaction—while billed as a "merger of equals"—would in fact result in Willis Faber shareholders owning 60% of the company. That new entity, Willis Corroon P.L.C., would be based in London, though its board would be composed equally of C&B and Willis Faber representatives.

Shearson's Mr. Smith said that if Willis Faber is forced to sweeten its offer, the London brokerage "would demand full ownership at least."

"The only alternative is for C&B to find someone else willing to pay more than Pat Ryan," said Mr. Smith. In any case, C&B faces acquisition, he speculated.

Mr. Ryan said he sees tremendous advantages for both C&B and RBH in a merger.

While he said he has viewed C&B as "an outstanding company" for several years, and that acquiring such a brokerage "is the sort of thing you fantasize about," he added that "it didn't seem realistic that we would be in a position to even attempt to buy them."

But, when "we saw the deal with Willis Faber and saw that the market had not responded that well to it," Mr. Ryan decided to make his bid.

"We don't know what their reaction is yet, but we thought the board might be interested in an alternative," he said.

"We are trying to make this friendly," Mr. Ryan emphasized. "We don't want to back them against the wall, but we think they should take a good, hard look at our offer.

"They need to step back and objectively look at the two transactions and the strategies behind each one. We both have a strong retail brokerage business with benefits and reinsurance brokerage operations to enhance that," he stressed.

And, RBH and C&B have very similar management structures, Mr. Ryan pointed out.

RBH Group has four primary operating units:

- Rollins Burdick Hunter Co., its retail brokerage operations.
- Aon Risk Services Inc., its reinsurance and wholesale brokerage operations.
- Miller Mason & Dickenson, its employee benefits consulting operations.
- Rollins Specialty Group Inc., which develops and manages specialty insurance programs and captives for financial institutions, associations and affinity groups.

C&B is divided into three primary operating groups: Brokerage Services Group; Benefits and Specialty Sales Group; and Reinsurance Brokerage Group.

Since the brokerages' business segments are already similarly aligned, merging the various operations would be simplified, Mr. Ryan contends.

Both brokerages have stated they want to expand their reinsurance brokerage and employee benefits operations. A merger of RBH and C&B would serve to achieve both of these objectives.

For example, C&B's G.L. Hodson & Son Inc. reinsurance intermediary has struggled with flat revenues over the past three years and has looked for growth through acquisition. RBH's reinsurance brokerage subsidiary—now named Aon Reinsurance Agency Inc.—has grown substantially through acquisitions in recent years.

Combined, the two reinsurance brokers could become the second-largest U.S. reinsurance intermediary, based upon combined estimated revenues of $50 million in 1988 (*BI*, Nov. 6, 1989). Sullivan Payne Co. was the second-largest U.S. intermediary in 1988 based on estimated revenues of $52 million.

Mr. Ryan also pointed out that unlike Willis Faber, which is heavily involved in wholesale brokerage activities, RBH and C&B are "both principally retail brokers. The blend would put us into a position to be a major factor in the U.S."

And, while Aon is engaged in insurance underwriting—a field most insurance brokers have exited over the past few years due to financial uncertainties—its underwriting business is principally confined to life, accident and health insurance, Mr. Ryan pointed out.

Aon has chosen not to write lines of property/casualty business most likely to produce long-tail liability claims, like as environmental impairment and asbestos exposures. However, Willis Faber—which owns nine property/casualty insurers—cannot offer C&B that same assurance, Mr. Ryan explained in his proposal to C&B's Mr. Miller.

Aon's financial advisers are Salomon Brothers Inc. in New York and William Blair & Co. in Chicago.

Corroon & Black's investment banker in the Willis Faber negotiations is Goldman Sachs & Co. in New York.

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International Editor Stacy Shapiro in London contributed to this report.

Comparing the companies

A Willis Faber-Corroon & Black merger would create the world's fourth-largest broker. While a combination of Rollins Burdick Hunter and C&B would create the fifth-largest broker based on 1989 revenues, the merged companies would likely be larger than Johnson & Higgins if a full year of Bayly, Martin & Fay's results are included in RBH's revenues. All numbers in thousands.

[1]RBH's 1989 revenues include only six months of Bayly, Martin & Fay International's results.

Source: Company reports

BI/JOHN HEILAND

Tylenol suit

Continued from page 2

ecutives should have known that safer packaging was necessary because of prior problems with the product, said attorney Bruce R. Pfaff of Corboy & Demetrio in Chicago, who represents two plaintiffs.

"In the three or four years preceding the poisonings, the company received over 200 complaints from individuals writing that something was wrong with their Tylenol," he said.

In addition, other manufacturers of comparable products provided safer packaging during the same time the Tylenol was tampered with, including blister packs and glassine seals over the mouths of bottles, plaintiffs say.

In accord with Illinois law, several of the lawsuits do not specify damages. They seek damages in excess of $15,000, Mr. Pfaff said.

McNeil states in its brief that it should not be liable because the Tylenol capsules were not the proximate or legal cause of the deaths, a McNeil attorney said. The cause was the actions of the unknown person who transformed Tylenol "into weapons for random murder," he said.

The deaths are "an unprecedented event," and the company is confident that it will prevail at trial, said Robert Kniffin, vp-external affairs for J&J in New Brunswick, N.J.

Cook County Circuit Court Judge Donald O'Connell also ruled last week that there was insufficient evidence that the capsules were altered while in McNeil's control.

The trial is set for Oct. 19. ■

401(k) rules

Continued from page 1

For example, a component plan covering 80% of a company's highly compensated employees would have to include 56% of its non-highly compensated employees.

After discovering the restructuring option, benefit experts said that the key to successful restructuring was to identify an average of how much salary is deferred to the 401(k) plan by employees—which is known as the average actual deferral percentage, or ADP—based on job classifications or locations.

Once that was done and component plans were established, highly compensated employees could be shifted into a component plan that covered those non-highly compensated employees with the highest ADP (see related story).

Employer jubilation, though, was cut short when IRS and Treasury Department officials in July said they were having second thoughts about restructuring and might propose certain restrictions (*BI*, July 23).

But under last week's IRS announcement—published as a notice of proposed rulemaking—401(k) restructuring is still alive for at least this year.

"This is good news, at least for the short term and for perhaps longer," said Tom Butterworth, a Hewitt Associates consultant in Rowayton, Conn.

"To me, this is good news. The IRS has not, as some people had feared, completely shut down 401(k) restructuring," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Others, though, are more cautious in assessing the announcement.

"I don't know if I would call this good news. The IRS hasn't killed restructuring outright. But they have not made a final decision yet, either," said Chip Kerby, a William M. Mercer Inc. principal in Washington, D.C.

Certain conditions are now attached to 401(k) restructuring.

The IRS said employers may not restructure on the basis of employee deferral rates. For example, an employer could not create a component plan just for non-highly compensated employees who contribute nothing.

According to the IRS, a 401(k) plan cannot "be restructured into two component plans, one of which consists of employees deferring 5% or more of their compensation and the other consisting of all other employees. Similarly, plans cannot be restructured into components on the basis of whether employees made elective deferrals in the current or prior years."

Instead, restructuring must be done on the basis of employee groups having "common attributes" like geographic location or job classification.

For example, a bank could restructure or split its 401(k) plan into two component plans, one covering tellers and the other covering security guards.

Benefit consultants say many employers will be able to restructure plans to more easily pass the non-discrimination tests even with the restrictions.

"We think there will be considerable opportunities for restructuring," said Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

It remains to be seen, though, how long restructuring will be allowed.

The IRS said it is now considering several options. These options include:

- Banning 401(k) restructuring.
- Banning restructuring, but allowing employers to disregard—when running the 401(k) non-discrimination tests—non-highly compensated employees not needed to satisfy the 70% ratio test.

Under this option, an employer that offered its 401(k) plan to 100% of its non-highly compensated employees could disregard 30% of those employees when running the 401(k) non-discrimination tests.

While benefit experts say this option is very appealing, they say more clarification is needed from the IRS, noting that the option does not make clear which group of non-highly compensated employees could be excluded when running the non-discrimination tests.

- Requiring that employee groups in component plans be designated in advance of the plan year in plan documents.

This option would introduce an element of risk in restructuring. Under current rules, an employer could wait until the end of the year, see which groups of non-highly compensated employees had the highest ADP and then shift highly-compensated employees into that group.

- Defining more precisely the employee groups that can be the basis of component plans.

Benefit experts say that last week's notice doesn't provide any clues as to which option the IRS may be leaning toward.

"The tone of the notice is neutral," said Hewitt's Mr. Butterworth.

In any case, the IRS said any changes would apply to plan years beginning after the date of publication of future regulations.

Because benefit experts say it is unlikely that additional regulations will be published before next year, that could mean that employers likely could continue 401(k) restructuring at least through 1991.

Even if restructuring is allowed for only two years, benefit consultants say it is worthwhile.

"If you had a plan that would otherwise fail, you are spared the hassle of returning contributions" to highly paid employees, said Paul Strella, a Mercer consultant in Washington, D.C.

"This can be good news for highly compensated employees. Why not take advantage of it?" said Leonard Carusi, a Wyatt Co. consultant in Stamford, Conn.

Employers restructuring their 401(k) plans into component plans would face little extra work. The component plans still could be administered as if they were one plan, employees could continue to receive the same benefit booklets and employers could continue to file one Form 5500—the annual report of a plan's financial operations—with the federal government.

The only extra work would be grouping employees into separate components and analyzing the ADPs of these groups to determine whether the restructuring will pass the non-discrimination test. ■

How 401(k) restructuring works

An example of 401(k) restructuring provided by Hewitt Associates when Internal Revenue Service pension rules were published in May still would be bona fide under last week's announcement by the IRS.

In this example, a bank could divide its 401(k) plan into different component plans on the basis of job classification—which the IRS clearly permits.

The bank has 1,000 non-highly compensated employees and 100 highly compensated employees.

Non-highly compensated employees on average put 2% of their pay in a 401(k) plan.

Under the most widely used IRS 401(k) non-discrimination test, the average actual deferral percentage for highly compensated employees cannot exceed the lesser of:

- 200% of the ADP for lower-paid employees.
- The ADP for lower-paid employees plus 2 percentage points.

Before restructuring, highly paid employees at the bank therefore could not on average contribute more than 4% of their annual compensation to the 401(k) plan.

But the bank—for purposes of 401(k) non-discrimination testing—could break down its 1,000 non-highly compensated employees into three separate components:

- Three hundred salaried employees whose ADP is 4%.
- Three hundred hourly security guards with an ADP of 1%.
- Four hundred hourly tellers with an ADP of 1.25%.

The 300 hourly security guards would be placed into one component plan. Meanwhile, the remaining 700 non-highly compensated employees—the 300 salaried employees with an ADP of 4% and the 400 hourly bank tellers with an ADP of 1.25%—as well as the 100 highly compensated employees would be placed into a second 401(k) component plan.

Determining the ADP of non-highly compensated employees in the second component plan involves several steps.

First, the ADPs of the two groups in the second component plan—the salaried employees and the bank tellers—would be multiplied by the number of employees belonging to each group. That result would be added together.

The 4% ADP of salaried employees multiplied by 300 equals 1,200 and the 1.25% ADP of bank tellers multiplied by 400 equals 500. The total—1,700—would be divided by 700, the number of non-highly compensated employees in the second component plan. That would produce an ADP of 2.43% for non-highly compensated employees in the second component plan.

As a result, the average ADP for highly compensated employees at the bank could be 4.43%, compared with an average ADP of 4% without restructuring.

—By Jerry Geisel

IRS corrects error in profit-sharing rule

WASHINGTON—New Internal Revenue Service proposals would correct a technical error in earlier pension regulations that would have made it impossible for many profit-sharing plans to utilize a safe harbor and avoid complex non-discrimination testing procedures.

The IRS recognized its error in its earlier draft.

In the May regulations, the IRS said defined contribution plans, such as profit-sharing plans, would qualify for a safe harbor if contributions made on behalf of plan participants were the same percentage of salary for all participants.

However, the regulations also said that a plan participant's compensation for the entire plan year would have to be taken into account to determine whether the plan qualified for the safe harbor.

In the case of employees who became covered by a plan in midyear, employer contributions on their behalf might only be half—as a percentage—of their annual compensation.

As a result, the plan presumably could not qualify for the safe harbor.

However, the IRS last week said compensation could be measured by the portion of the plan year during which the employee was covered by the plan. ■

Update

Insurers appeal treasure ruling

Continued from page 2

The gold was valued at about $36.7 million late last week. However, because much of the gold is in the form of extremely rare coins and other precious objects, the value of the recovered treasure could rise as high as $450 million, according to the group that discovered the Central America.

U.S. District Court Judge Richard Kellam last month declared the gold is owned solely by Columbus America Discovery Group Inc., a consortium of scientists and investors that discovered the Central America's wreckage in 1986 (*BI*, Aug. 20).

But, insurer attorney Douglas Jacobsen, of Bigham Englar Jones & Houston in New York, said Judge Kellam erred when he ruled that the insurers had abandoned the Central America.

N.J. family leave law challenged

TRENTON, N.J.—Several New Jersey business coalitions are challenging the constitutionality of a state family leave law.

The groups allege in a suit filed last week that the law, which took effect in May, is pre-empted by the Employee Retirement Income Security Act of 1974 and is unconstitutional.

The law requires employers with more than 100 workers to offer male and female employees 12 weeks of unpaid leave with benefits after the birth or adoption of a child or to care for an ill immediate family member. The law eventually will apply to employers with 50 or more workers (*BI*, Jan. 8; Jan. 1).

"ERISA pre-empts any and all state laws insofar as they may relate to any employee benefit plan," the lawsuit charges.

The businesses are asking the New Jersey Superior Court to declare the law null and void. Business groups filing the lawsuit are: the Commerce and Industry Assn. of New Jersey; the New Jersey Business and Industry Assn.; the New Jersey Food Council; the New Jersey Retail Merchants Assn.; and the State Chamber of Commerce. Several employers also joined the suit: Falstrom Co., Fifth Dimension Inc. and George A. Milton Can Co.

ACC bondholders sue insurers

SANTA ANA, Calif.—American Continental Corp. bondholders filed a suit seeking class-action status against 21 of the company's insurers in an effort to recover a portion of nearly $400 million they invested in the failed Phoenix-based financial holding company.

The insurers wrote general liability, directors and officers liability, umbrella and other policies with total limits of about $300 million, said bondholder attorney Ronald Rus of Alvarado, Rus & McClellan in Orange, Calif.

The suit, filed Sept. 5 in Orange County Superior Court, is the latest in a string of suits related to the sale of bonds by the company, which is seeking Chapter 11 reorganization (*BI*, June 11). In separate suits, bondholders have charged former American Continental Chairman Charles H. Keating Jr., who also is the central figure in one of the largest savings and loan failures, and other executives with fraud in the sale of the bonds.

In addition, the federal agency taking over failed thrifts has charged the executives with violating the federal Racketeer Influenced and Corrupt Organizations act in connection with the bond sales.

Mr. Keating also is suing the company's D&O liability insurers, seeking defense cost coverage.

The latest suit by American Continental bondholders names three American International Group Inc. units; two Reliance Group Holdings Inc. units; two units of Fund American Cos. Inc.; two Crum & Forster Inc. units; two Continental Corp. units; American Casualty Co.; Lloyd's of London underwriters; New England Insurance Co.; California Union Insurance Co.; Royal Indemnity Co.; Transamerica Insurance Co.; The Home Insurance Co.; Aetna Casualty & Surety Co.; Zurich American Insurance Co.; and First State Insurance Co.

Some defendant insurers say their policies do not apply, and others claim that defense costs are depleting available limits.

Hotel fire safety bill passes

WASHINGTON—President Bush is expected to sign legislation passed by the House last week that encourages motels and hotels to install smoke detectors and automatic sprinkler systems.

The bill, H.R. 94, introduced by Rep. Sherwood L. Boehlert, R-N.Y., was originally approved by the House last year but needed a second approval after the Senate modified the bill before passing it last month.

The law would prohibit federal employees on government business from staying in hotels or motels that were not on a Federal Emergency Management Agency "master list" of lodgings unless no other rooms are available within a "reasonable distance."

For a hotel or motel to be included on the list, each guest room must be have a smoke detector and an automatic sprinkler and meet other National Fire Protection Assn. guidelines (*BI*, Aug. 27).

Hotels and motels of three stories or less would be exempt. Others would have two years to comply.

Briefly noted

Victims of last year's **Exxon Valdez oil spill** must first seek compensation from the Trans-Alaska Pipeline Liability Fund before trying to pursue their claims in court, under amendments to the Trans-Alaskan Pipeline Authorization Act, a federal judge ruled in a preliminary decision last week. . . .Forty **Westinghouse Electric Corp. property insurers** cannot escape the massive litigation the company filed seeking coverage for cleaning up 135 waste sites nationwide, a New Jersey Superior Court judge ruled last week (*BI*, June 15, 1987). . . .The Transportation Department can force an estimated 116,500 pipeline industry employees to undergo **random drug testing** because the testing program, begun in 1988, does not infringe on workers' constitutional right to privacy, the 9th U.S. Court of Appeals ruled last week (*BI*, Dec. 25, 1989). . . .Wind, hail, tornadoes and flooding in the Phoenix area on Sept. 3 caused an estimated **$20 million of insured property damage**.

Insurance brokerage stocks undervalued in soft market

By LEONARD M. WILSON

Special to Business Insurance

NOT MANY STOCKS have escaped unscathed from the broad stock market decline since July. Investors are worried about recession and the price of oil. Insurance brokerage stocks have also given substantial ground despite their demonstrated ability to sail through economic turbulence without significant adverse effect.

The break in equity prices got us to thinking about the current valuation of insurance brokerage stocks. Valuation is a comparative measure. We usually gauge brokerage stocks against property/casualty underwriters, other financial issues and lastly the broad yardstick of the Standard & Poor's 500 stock index.

Mr. Wilson

Many investors equate brokers and insurance companies as generic investments in the property/casualty industry. We encountered this tendency a number of years ago when Marsh & McLennan Cos. Inc. was selling at around 30 times earnings. We were extolling the long-term fundamentals of the leading broker to an institutional investor. After listening patiently to my comments, he asked, "Why should I buy Marsh & McLennan at 30 times earnings when I can buy St. Paul Cos. at 15 times earnings?"

There were and are good reasons why insurance brokers, also dependent upon the progress of property/casualty premiums, receive higher appraisals than underwriters. Nonetheless, the question had at its core the need to examine the relative valuations of the two groups.

Some current figures are illuminating. On the consensus earnings estimates for 1990, insurance brokerage stocks carry the following price-earnings ratios: Marsh & McLennan, 16 times; Alexander & Alexander Services Inc., 13 times; Arthur J. Gallagher & Co., 13 times. We have left out Corroon & Black Corp., whose appraisal is influenced by the pending merger with Willis Faber P.L.C. (see story, page 1).

Now for the price-earnings ratios of several representative underwriters: American International Group Inc., 10 times; Chubb Corp., 9 times; The St. Paul Cos. Inc., 9 times. It is interesting that, at admittedly substantially lower price-earnings ratios, St. Paul still sells at almost one-half the multiple of Marsh & McLennan.

What accounts for the difference in valuation? First, the brokers are perceived as somewhat less sensitive to the underwriting cycle. In the more extreme phase of competition, brokers seem able to muster flattish earnings comparisons, whereas many insurers post sharp declines.

Second, the brokers, it can be argued, possess higher-quality earnings since they are not faced with the dispute over reserve adequacy, as are the underwriters.

Only time will tell whether there is more profit over the next few years in owning brokerage or underwriting stocks.

Lastly, and perhaps most important, brokers are machines for generating free cash flow. They are not capital-intensive like the underwriters. Free cash flow translates into more generous payouts of earnings and higher dividend yields. Compare two premier companies: Marsh & McLennan now affords a yield of 3.5% vs. less than 1% for American International Group Inc.

Under a popular method of valuing securities, a stock's price is determined by the sum of its future dividends discounted to the present. Accordingly, the brokers with their higher dividend yield coupled with the possibility of modestly greater growth potentials are not currently valued against their underwriter counterparts.

Only time will tell whether there is more profit over the next few years in owning brokerage or underwriting stocks. We would argue that in any well-balanced portfolio, there is room for both. But the loftier valuations of the brokers vis-a-vis underwriters do not put the brokers beyond the pale of sensible investment. Relative price-to-earnings ratios demonstrate a remarkable consistency over a period of years.

Insurance brokerage sales sell at a much wider premium than usual compared with other financial issues. The gap reflects widespread concern over asset quality for a broad spectrum of financial intermediaries. In a period of financial shakiness, the brokers offer a relative haven for investors in the financial sector.

The Standard & Poor's indexes are now selling at roughly 13 times typical earnings estimates for 1990. Brokers historically have sold at 120% to 150% greater than the price-to- earnings ratio for the S&P market index. On this basis, a brokerage stock ought to carry a current appraisal of 16 times at the low end and 20 times at the high end. Insurance brokerage shares, based on our calculations earlier, are seemingly moderately undervalued in today's marketplace.

The undervaluation, at least based on the historical record, can be ascribed to the dogged continuance of the soft market. In a competitive market, earnings growth slows and investor expectations are restrained. Analysis of insurance brokerage valuations illustrates a strong tendency of price earnings ratios, both absolute and relative, to expand when earnings are growing strongly. Similarly, appraisals contract when earnings growth slackens.

When will commercial property and casualty markets firm? This is the fundamental question investors seek to answer before committing to brokerage or underwriting shares. The valuation premium of the insurance brokers against the underwriters and other financial issues seems justified. But until a turn in the insurance markets can be discerned with confidence, the brokers may remain conservatively valued when compared with their past price-to-earnings ratios relative to the Standard & Poor's index. ■

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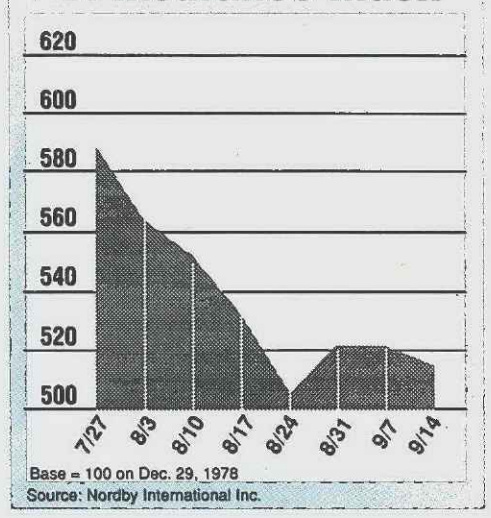
BI Insurance Index



Insurance industry stocks dropped last week as the *Business Insurance* Index fell 6.93 points to 514.52 on Sept. 14, from 521.45 on Sept. 7. Advancing issues were led by Frontier Insurance Group, up 21.6%; Corroon & Black, up 17.0%; and Safeguard Health Enterprises, up 13.6%. Declining issues followed NWNL Cos., down 15.5%; NAC Re Corp., down 11.7%; and Statesman Group Inc., down 10.7%. The most active issue during the week was Corroon & Black, 3.7 million shares traded. The *BI* Index lost 1.3% for the week; The Standard & Poor's 500 lost 2.0%; the Dow Jones 30 Industrials dropped 2.1%; and the New York Stock Exchange Composite fell 1.9%.

British Issues

Sept. 13 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	452	20.8	28.7	6.3	452—445	
Genl Accident	458	13.8	33.4	7.3	462—443	
Gdn Royal Exch	187	16.3	15.3	8.2	192—187	
Royal	398	21.3	34.0	8.5	405—393	
Sun Alliance	283	10.2	16.7	5.9	286—278	
Brokers						
Bradstock	199	13.9	10.0	5.0	199—199	
CE Heath	412	12.1	34.5	8.4	414—412	
Hogg Group	141	9.4	9.7	6.9	142—141	
Lloyd Thompson	283	17.6	9.7	3.4	284—283	
PWS Holdings	70	10.9	3.3	4.7	72—70	
Sedgwick Grp	191	14.4	16.0	8.4	191—186	
Steel Brrl Jones	238	14.3	14.7	6.2	238—238	
Willis Faber	210	15.3	16.0	7.6	232—210	

Source: Philip Olsen, Insurance Industry Specialist London

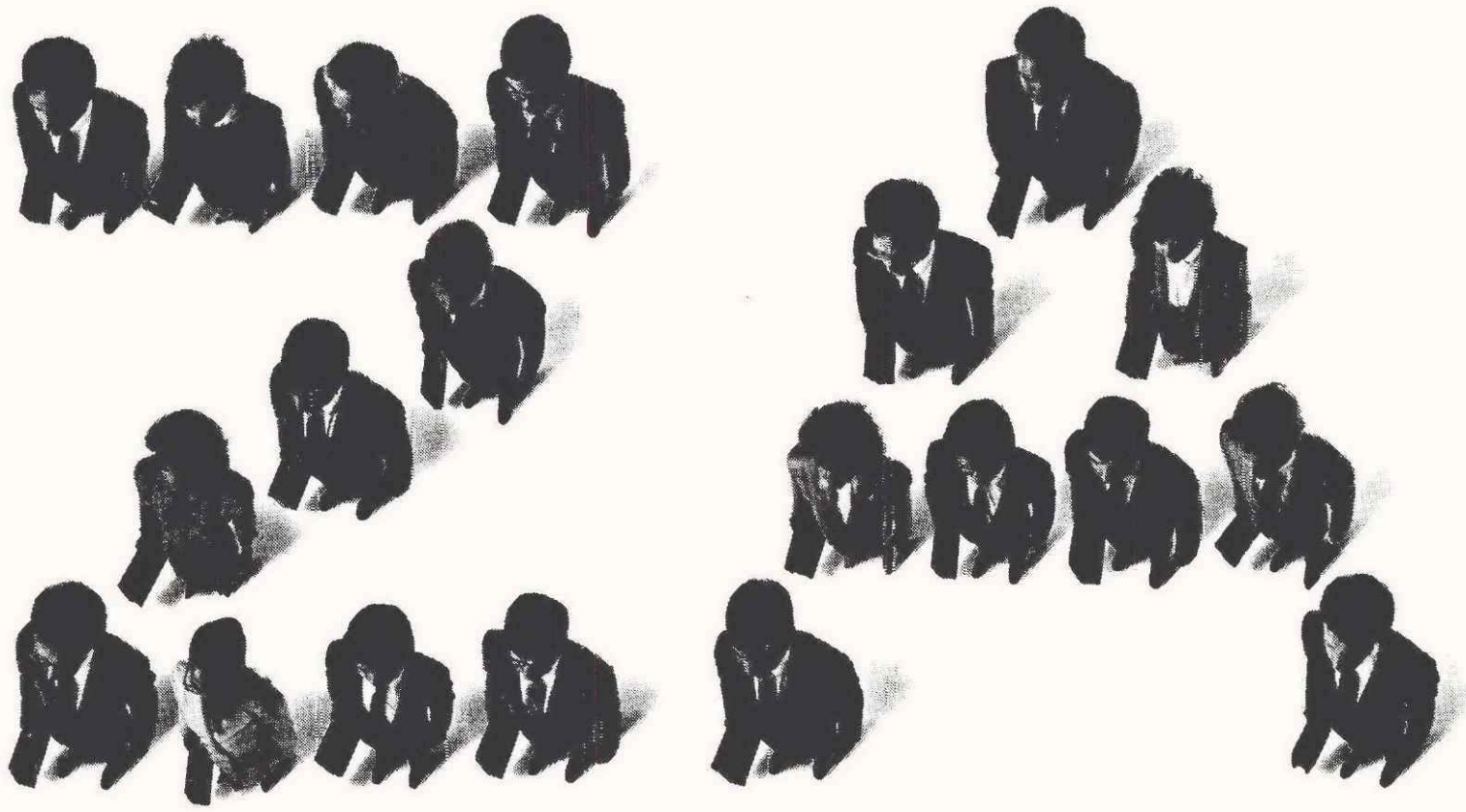
BI Industry Stock Report

SEPTEMBER 10, 1990 THROUGH SEPTEMBER 14, 1990

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	19.75	0.00	-37.30	34.00	19.63	99	1.00	5.06	18	9.18	2.15
Corroon & Black	NYS	36.13	17.00	-5.56	41.00	28.50	3717	1.36	3.76	18	12.73	2.84
Gallagher Arthur J. & Co.	NYS	20.75	0.00	-16.16	26.50	20.25	64	0.60	2.89	16	5.33	3.89
Frank B. Hall	NYS	3.00	0.00	0.00	4.25	2.50	25	0.00	0.00	-2	-2.80	-1.07
Hilb, Rogal & Hamilton	OTC	12.75	0.99	-31.54	20.63	12.25	102	0.28	2.20	17	4.60	2.77
Marsh & McLennan	NYS	67.63	-4.59	-13.30	89.75	66.13	490	2.60	3.84	16	10.56	6.40
Poe & Associates	OTC	11.25	7.14	-15.09	13.00	8.25	0	0.40	3.56	14	1.93	5.83
BROKERS	AVERAGE		2.9	-17.0					3.0	14		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	33.50	-1.83	-19.52	46.50	31.75	17	0.44	1.31	7	25.06	1.34
Berkshire Hathaway Inc.	NYS	6225.00										
			-2.35	-27.83	8900.00	5675.00	0	0.00	0.00	-20	2869.00	2.17
ITT (Hartford Group)	NYS	50.88	-2.16	-15.03	63.75	50.00	810	1.60	3.14	6	56.33	0.90
Sears (Allstate)	NYS	28.00	-2.61	-27.74	44.88	27.63	1960	2.00	7.14	8	37.75	0.74
CONGLOMERATES	AVERAGE		-2.2	-22.5					2.9	0		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	41.63	-3.76	-28.23	62.50	41.88	1443	2.76	6.63	7	58.11	0.72
AmBase Corp.	NYS	1.75	-17.65	-86.14	16.25	1.50	434	0.00	0.00	-1	29.08	0.06
American General	NYS	39.88	-7.27	21.76	50.63	28.13	2715	3.20	8.03	9	34.68	1.15
American Heritage	NYS	20.13	-2.42	-29.39	24.63	20.13	8	1.00	4.97	10	22.60	0.89
American Indemn ty/Fin'l	OTC	4.13	0.00	-48.44	10.75	3.38	3	0.08	1.94	-1	17.38	0.24
American International	NYS	64.25	-4.46	-23.87	89.63	62.63	1000	0.44	0.68	9	41.92	1.53
Aon Corp.	NYS	32.63	-7.12	-23.01	43.25	31.50	489	1.52	4.66	9	19.62	1.66
Argonaut Group	OTC	69.00	0.00	0.18	78.00	63.25	5	1.60	2.32	8	36.83	1.87
AVEMCO Corp.	NYS	23.38	0.54	-4.10	30.13	20.38	1	0.44	1.88	17	9.52	2.46
Baldwin & Lyons Inc.	OTC	20.63	0.61	-4.07	24.00	19.25	44	0.28	1.36	7	20.80	0.99
Belvedere Corp.	ASE	3.38	0.00	-38.64	5.63	3.25	0	0.04	1.19	-4	8.03	0.42
Chandler Insurance	OTC	6.00	-7.69	-48.94	13.25	5.75	11	0.00	0.00	3	9.53	0.63
Chubb Corp.(s)	NYS	41.00	-5.75	-57.24	51.38	38.63	1318	1.32	3.22	8	55.49	0.74
CIGNA Corp.	NYS	40.25	-5.01	-33.20	66.75	40.50	1371	3.04	7.55	11	66.64	0.60
CNA Financial Corp.	NYS	59.75	-8.43	-40.25	108.75	60.63	129	0.00	0.00	10	54.87	1.09
Continental Corp.	NYS	20.75	-10.27	-33.86	36.38	20.63	2084	2.60	12.53	15	41.36	0.50
Durham Corp.	OTC	25.50	-5.56	-17.07	34.75	25.00	5	0.92	3.61	12	26.32	0.97
Fund American Corp.	NYS	46.75	-2.09	32.62	51.88	29.50	502	0.68	1.45	104	32.74	1.43
Fremont General Corp.	OTC	15.00	-1.64	-25.47	22.50	12.88	167	0.80	5.33	4	19.09	0.79
Frontier Insurance Group	NYS	22.50	21.62	21.62	33.00	14.13	66	0.00	0.00	9	7.29	3.09
General RE Corp.	NYS	72.00	-4.79	-20.00	96.25	69.00	544	1.52	2.11	11	29.04	2.48
Hanover Insurance Co.	OTC	23.00	0.00	-24.59	33.00	22.75	300	0.44	1.91	7	32.03	0.72
Harleysville Group	OTC	18.25	-2.67	-33.64	27.38	16.75	63	0.60	3.29	6	18.94	0.96
Hartford Steam Boiler	NYS	47.38	-1.30	-12.67	62.13	43.50	100	1.80	3.80	12	18.94	2.50
Kansas City Life Ins.	OTC	36.00	0.00	0.35	36.25	34.50	16	1.12	3.11	9	39.22	0.92
Kemper Corp.	NYS	27.88	-4.70	-41.01	51.88	27.88	306	0.92	3.30	43	29.97	0.93
Lawrence Insurance Group	ASE	7.00	3.70	-1.75	9.13	6.50	0	0.36	5.14	12	4.40	1.59
Liberty Corp.	NYS	46.75	-2.60	10.00	50.25	35.00	1	0.92	1.97	11	31.82	1.47
Lincoln National	NYS	43.50	-3.60	-28.69	62.88	43.50	200	2.60	5.98	8	49.19	0.88
NAC Re Corp.	OTC	26.50	-11.67	-26.90	41.00	26.25	35	0.20	0.75	12	22.81	1.16
Navigators Group	OTC	31.50	0.00	14.55	33.75	25.25	6	0.00	0.00	12	15.22	2.07
Nobel Insurance LTD.	OTC	3.00	4.35	50.00	3.75	1.50	40	0.00	0.00	-8	7.76	0.39
NWNL Companies	OTC	17.75	-15.48	-55.06	44.13	17.88	515	1.32	7.44	3	37.50	0.47
Ohio Casualty Corp.	OTC	36.00	-10.56	-24.61	52.50	34.75	407	2.32	6.44	11	33.30	1.08
Old Republic Int'l	OTC	24.63	-1.01	-3.90	29.00	21.13	174	0.76	3.09	6	30.70	0.80
Orion Capital Corp.	NYS	17.63	-0.70	-24.19	28.50	17.00	21	0.92	5.22	6	19.72	0.89
Phoenix RE Corp.	OTC	8.25	-2.94	-36.54	15.50	8.00	6	0.20	2.42	-9	12.99	0.64
Protective Life Corp.	OTC	12.38	5.32	-13.16	15.38	10.25	25	0.76	6.14	7	14.54	0.85
Provident Life	OTC	17.75	1.43	-31.40	30.13	17.00	290	0.80	4.51	5	23.24	0.76
Re Capital Corp.	ASE	12.63	0.00	-12.93	15.25	11.25	4	0.00	0.00	10	14.43	0.87
RLI Insurance Corp.	NYS	10.25	-7.87	15.49	14.75	6.88	9	0.44	4.29	5	12.42	0.83
St. Paul Companies	OTC	52.25	-6.07	-12.92	63.50	52.00	520	2.40	4.59	6	43.47	1.20
SAFECO Corp.	OTC	28.50	-2.15	-28.30	42.38	28.25	780	1.36	4.77	7	24.87	1.15
SCOR U.S. Corp.	NYS	9.00	0.00	-36.84	14.50	8.50	7	0.20	2.22	13	10.61	0.85
Seibels Bruce Group	OTC	6.50	-3.70	-40.23	11.75	5.75	56	0.80	12.31	-1	13.75	0.47
Selective Ins. Group	OTC	14.75	-1.67	-22.88	20.25	14.50	59	1.04	7.05	5	15.72	0.94
Statesman Group Inc.	OTC	1.56	-10.69	-43.16	3.31	1.25	70	0.04	2.56	2	4.19	0.37
Tokio Marine & Fire	OTC	38.63	-1.59	-48.76	78.13	36.00	6	0.26	0.67	-	70.93	0.54
Torchmark Corp.	NYS	44.13	-1.94	-22.93	58.75	42.38	226	1.40	3.17	10	13.23	3.34
Transamerica	NYS	29.25	-7.87	-34.45	48.00	29.63	293	1.92	6.56	7	34.63	0.84
Traveler's Corp.	NYS	22.75	-5.70	-38.31	42.38	23.00	1290	2.40	10.55	6	44.85	-
Trenwick Group Inc.	OTC	18.75	2.04	-23.08	26.88	17.25	63	0.48	2.56	8	16.91	1.11
United Fire & Casualty	OTC	34.25	2.24	3.79	35.00	30.50	2	1.20	3.50	9	22.56	1.52
USF&G Corp.	NYS	22.50	-2.17	-24.05	31.63	20.00	1448	2.92	12.98	16	22.87	0.98
UNUM Corp.	NYS	49.50	-2.94	3.66	57.13	39.38	306	0.80	1.62	10	31.20	1.59
USLIFE Corp.	NYS	31.13	-4.96	-31.22	47.75	31.25	96	1.48	4.76	7	54.34	0.57
Washington National	NYS	18.00	0.00	-36.28	28.75	17.88	21	1.08	6.00	20	32.90	0.55
USLICO Corp.	NYS	20.75	-4.05	-12.63	24.75	19.50	15	1.00	4.82	8	27.73	0.75
Zenith National Ins.	NYS	13.50	-0.92	-28.00	19.50	13.38	5	0.88	6.52	8	13.81	0.98
INSURERS/REINSURERS	AVERAGE		-3.0	-21.8					4.1	10.0		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	14.00	-3.45	-34.12	26.38	11.50	114	0.00	0.00	13	3.54	3.95
HMO America Inc.	OTC	5.13	-8.89	-33.87	9.75	4.38	53	0.00	0.00	7	1.12	4.58
Pacificare Health Sys.	OTC	15.50	-3.13	-40.38	30.38	12.00	476	0.00	0.00	11	6.35	2.44
Safeguard Health Enter.	OTC	6.25	13.64	-26.47	12.50	5.13	10	0.00	0.00	11	2.99	2.09
Sierra Health Services	ASE	6.75	-1.82	-23.94	9.63	5.50	16	0.00	0.00	-19	0 62	10.89
United Healthcare Corp.	OTC	18.38	8.89	50.00	20.13	7.88	1440	0.12	0.65	19	0.34	54.04
United Medical Corp.	ASE	7.63	-4.69	27.08	11.38	5.88	6	0.20	2.62	11	5.70	1.34
U.S. Healthcare	OTC	20.13	0.63	41.23	22.25	9.63	0	0.36	1.79	23	3.07	6.56
HMOs	AVERAGE		0.1	-5.1					0.6	9		
ALL COMPANIES	AVERAGE		-2.1	-19.1					3.5	10		

System design: Nordby International Inc.

What Account Team Stands For Better Service?



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