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Update

Rostenkowski plan would ease employers' Section 89 burdens

WASHINGTON—Comprehensive Section 89 overhaul legislation introduced last week by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., would significantly ease employers' administrative burdens, benefits experts say.

H.R. 1864, co-sponsored by a majority the committee members, would replace Section 89's multiple and complex nondiscrimination tests with a more streamlined testing procedure.

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Kennedy bill draws criticism despite changes

By DEBORAH SHALOWITZ

WASHINGTON—Employers are not embracing Sen. Edward Kennedy's latest legislative effort to require all employers to offer group health insurance, despite the addition of provisions that would trim employers' costs.

The latest bill to mandate health care coverage, introduced last week by Sen. Kennedy, D-Mass., strongly resembles legislation passed last year by the Senate Labor and Human Resources Committee, which the senator chairs (*BI*, Feb. 22, 1988).

Under Sen. Kennedy's new bill, S. 768, all employers would be required to offer employees who work at least 17.5 hours per week and their dependents group health care coverage that meets minimum federal standards, just like last year's proposal, and employers generally would be required to pay 80% of the premium for health care coverage for their employees.

However, under the latest version of the bill, a portion of the cost of providing coverage for some small employers would be partially subsidized by the federal government.

And, all employers could contribute less than 80% of the cost of premiums for some part-time workers.

Sen. Kennedy estimates the new plan would cost about $18 billion annually, about 80% of which would be borne by employers and the remainder by employees. This is $7 billion less than the plan he first introduced in May 1987 (*BI*, May 25, 1987).

In addition, besides mandating that all employers offer health care coverage to their workers, the new Kennedy proposal also would establish a government-

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Split decision issued in Agent Orange case

By DOUGLAS McLEOD

MORRISTOWN, N.J.—Diamond Shamrock Chemicals Co. is considering appealing a New Jersey state court judge's ruling that it has no insurance for the multimillion-dollar cleanup of a polluted Newark plant site.

Meanwhile, Diamond Shamrock's insurers may appeal an order in the same decision requiring them to pay the chemical company's $23.3 million share of a $180 million settlement of a class action suit brought by Vietnam veterans exposed to the toxic defoliant Agent Orange (*BI*, Oct. 1, 1984; May 14, 1984).

Morris County Superior Court Judge Reginald Stanton found last week that Diamond Shamrock's operation of the Newark chemical plant was "unacceptably wrong and irresponsible" and that many of company's hundreds of liability policies should not respond because the pollution damage was both expected and intended by Diamond Shamrock.

Coverage under numerous other Diamond Shamrock policies is explicitly barred by the policies' pollution exclusions, the judge also found.

Diamond Shamrock, an Agent Orange producer, used the Newark plant to manufacture an intermediate chemical needed for production of the defoliant. The plant was later found to be contaminated with dioxin, a toxic byproduct of the Agent Orange manufacturing process. Cleanup efforts may cost $20 million and possibly much more.

Dallas-based Maxus Energy Corp.—which sold Diamond Shamrock to Occidental Petroleum Co. in 1986—established a $75 million reserve for any Diamond-related liabilities including the Newark plant cleanup. Maxus had agreed to indemnify Occidental for prior Diamond-related liabilities at the time of the sale.

A lawyer for Diamond Shamrock said the company is pleased with the Agent Orange product liability ruling but disappointed with the Newark plant cleanup decision.

"What it comes down to is whether it is fair to judge a plant operating in 1951 by 1981 standards," said Michael P. Tierney, a lawyer with Cahill, Gordon & Reindel in New York. "We knew we had a problem on that side."

Lawyers for the insurers, meanwhile, say they are happy with the cleanup ruling

"We couldn t have asked for a better decision. It was everything we wanted," said Stephen D. Cuyler, a partner with the firm of Cuyler, Burk & Matthews in Morristown, representing several excess insurers.

The insurers, however, are considering appealing the Agent Orange product liability decision, he said.

"I think it's more significant than Shell," said Robert Bates, a lawyer representing two of Diamond's excess insurers, referring to the December 1988 jury verdict that Shell Oil Co. has no insurance for the $2 billion to $4 billion cleanup of the Rocky Mountain Arsenal near Denver (*BI*, Dec. 26, 1988).

Where the Shell verdict included no explanation of the reasons for the jury's decision, "here you have 35 pages of explanation" for the denial of coverage, noted Mr. Bates, who is with the Chicago firm of Phelan, Pope & John.

Mr. Bates added that the two decisions are a warning to corporations that they may find themselves without insurance if they knowingly dumped hazardous chemicals over periods of years or decades, even if they did not realize the full extent of their liabilities.

"This, as did Shell, demonstrates that they are going to have some coverage problems," Mr. Bates predicted.

Diamond Shamrock may be further hurt by the precedent set by Judge Stanton's ruling: The chemical company has another lawsuit pending before the judge over coverage for cleanups at other contaminated sites in New Jersey, Mr. Bates noted.

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Managers blamed for Transit failure

By DOUGLAS McLEOD

WASHINGTON—Transit Casualty Co. management ignored warnings about operational flaws and concealed Transit's deteriorating financial condition while funneling large financial benefits to the insurer's parent company, Transit's receiver told a House subcommittee last week.

In the second of a series of hearings on the 1985 Transit collapse, the House Oversight and Investigations Subcommittee last Tuesday focused on the extent to which top officials of Transit and its parent company, Beneficial Standard Corp., were responsible for the insurer's insolvency.

Testimony centered specifically on the actions of former Transit Chairman George P. Bowie and former Beneficial Standard President Joseph N. Mitchell.

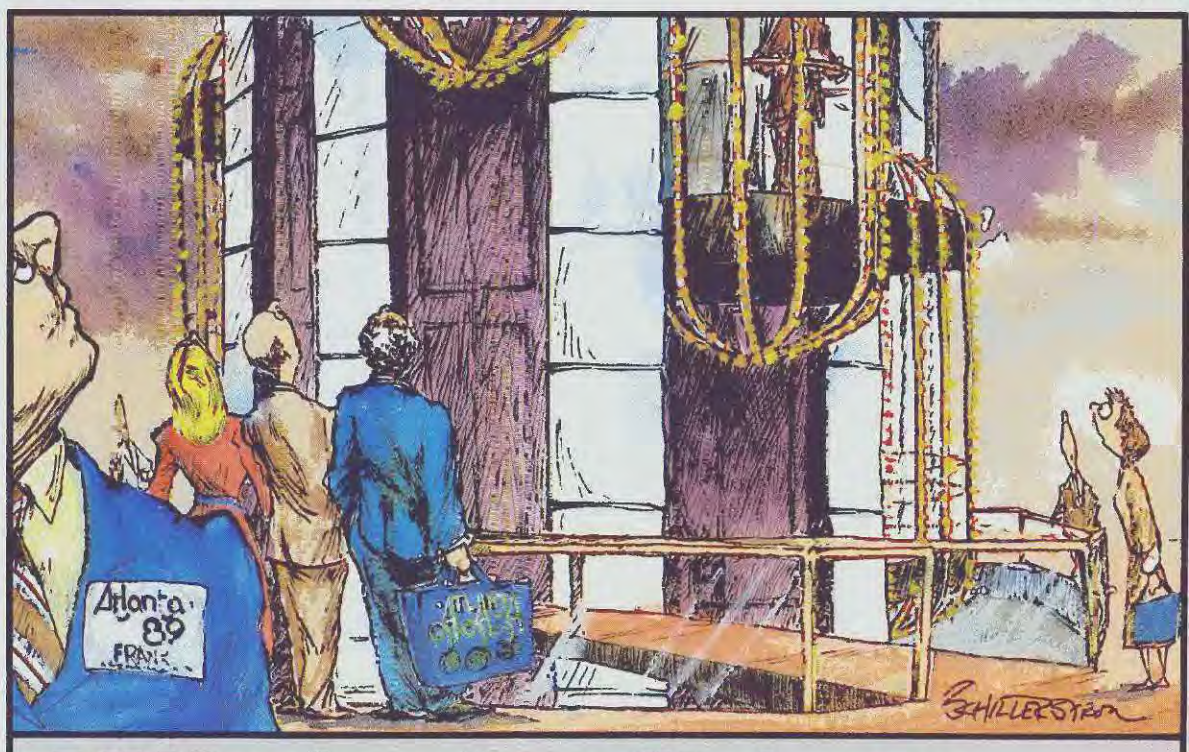
Messrs. Bowie and Mitchell "knew or should have known what kind of financial trouble they were leading Transit into," Missouri Special Deputy Receiver J. Burleigh Arnold told the subcommittee.

"Both Mr. Mitchell and Mr. Bowie were in the cockpit of this plane," he said, referring to Transit. "They were in the cockpit and flying Transit when it crashed."

Transit management overlooked repeated warnings from several quarters—including some of its own employees—that it had no systems in

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Benefits community opposes try by Medicare to recoup payments
Page 2



RIMS raises benefits issues

When not riding up and down the glass elevators that are a hallmark of Atlanta's major hotels, risk and employee benefit managers considered some of the toughest employee benefit issues now confronting their companies and Congress during the 27th annual Risk & Insurance Management Society conference, held last week in Atlanta. Reports on employee benefit sessions begin on page 3. Reports on risk management sessions will appear in next week's issue.

Update

Section 89 overhaul introduced

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Under the proposal, an employer's health care program would pass Section 89 if:

- The plans are available to 90% of non-highly compensated employees.
- Employee premium contributions do not exceed $10 a week for individual coverage and $25 a week for family coverage.
- The amount of employer-paid premiums for highly compensated employees does not exceed 133% of the premium paid by employers in a plan made available to 90% of non-highly compensated employees.

The legislation also would raise the number of hours an employee would have to work to be included in the non-discrimination test to 25 hours a week from the current 17.5-hour standard.

In addition, special excise taxes would be imposed on employers that violate Section 89(k)—that part of the law detailing how employers must document and communicate their plans. Currently, employees are penalized for employer violations of Section 89(k).

The legislation, if enacted, would take effect next year. However, in 1989 only, employers would have a choice of using the current Section 89 testing procedures or the rules contained in the legislation.

A Ways and Means Committee hearing on the Rostenkowski legislation is set for May 2.

"The legislation will be a major starting point in the drive to overhaul Section 89," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Retiree health care funding bill

WASHINGTON—Employers would have some tax incentives to fund future retiree health care and long-term care expenses under legislation introduced in Congress last week.

However, the proposal would bar companies from recovering excess assets when they terminate overfunded defined benefit plans.

The bill, H.R. 1866, which was introduced by Rep. Rod Chandler, R-Wash., and Rep. Ronnie Flippo, D-Ala., is virtually identical to legislation Rep. Chandler introduced last year (*BI*, Aug. 8, 1988).

The latest proposal would allow employers with defined benefit plans to make annual tax-deductible contributions to fund up to $2,500 in annual premium costs for retiree health care benefits and another $2,500 in annual premium costs for long-term care coverage. Sponsors of defined contribution plans would be allowed to make tax-deductible contributions of up to $825 annually per employee to fund retiree health care benefits and could contribute an equal tax-deductible amount to fund long-term care benefits.

However, any tax-deductible contributions made to retiree health care and long-term care plans for current employees would apply against the defined benefit and defined contribution plan funding limits now imposed under the tax code.

The bill also would allow employers to transfer from a defined benefit pension plan assets exceeding 125% of plan liabilities—without terminating the plan—to fund retiree health or long-term care costs.

However, the bill would impose a 100% excise tax on reversions of excess assets when overfunded defined benefit pension plans are terminated. The current excise tax is generally 15%.

In addition, to ensure sound funding of defined benefit pension plans, the proposal would rescind a provision of the Omnibus Budget Reconciliation Act of 1987 that limits employers' annual maximum tax-deductible contributions to their defined benefit pension plans to 150% of the plan's current liabilities.

Reps. Chandler and Flippo also introduced H.R. 1865, a limited version of H.R. 1866, without the pension provisions. Sen. David Pryor, D-Ark., introduced an identical version in the Senate.

Judge remands PRMC award

LOS ANGELES—A federal judge has declined to either confirm or set aside a $94 million arbitration award against six reinsurers of the insolvent Mission Insurance Co.

Instead, U.S. District Judge Terry J. Hatter remanded the award to the three-member arbitration panel for further consideration.

The award included certain damages, the amount of which was to be determined by a later audit. Until the amount of these damages is calculated, the award will not become final and cannot be confirmed by the court, sources familiar with the arbitration say.

A status conference on Judge Hatter's order has been scheduled for May 1, according to lawyers involved in the case.

In a 2-1 vote last October, the panel ordered the six reinsurers to pay $94 million to Pacific Reinsurance Management Corp., the defunct reinsurance pooling subsidiary of Mission. The reinsurers had argued that PRMC was fraudulently managed and that their liabilities should be voided (*BI*, Nov. 7, 1988; Oct. 17, 1988).

The reinsurers are: Ohio Reinsurance Corp.; Abeille-Paix Reassurances; Hamburg International Reinsurance Co.; Hassneh Insurance of Israel Ltd.; Seguros America S.A.; and Compagnie Transcontinentale de Reassurance.

Oil spill suit coordination eyed

ANCHORAGE, Alaska—Attorneys representing most of the growing number of plaintiffs who are suing Exxon Corp. over the massive Alaskan oil spill have formed a committee to coordinate the lawsuits.

A single, coordinated lawsuit would be more advantageous for plaintiffs than trying to recover damages from Exxon and other defendants separately in several courts, explained attorney Kenneth Adams of Dickstein, Shapiro & Morin in Washington, D.C. Mr. Adams estimated that more than two dozen suits have been filed against Exxon and other defendants so far.

Mr. Adams, who represents commercial fishermen, tour boat operators and fish processors, has filed two lawsuits in state Superior Court and two in U.S. District Court in Anchorage. All of the suits seek class-action status.

Prominent San Francisco plaintiffs' attorney Melvin Belli sup-

Continued on page 65

Medicare payment snafu sets stage for legal battle

By STACY ADLER

WASHINGTON—Self-insured employers, insurers and third-party administrators are aligning themselves against the federal government in what could become a giant legal and political battle over who should pay hundreds of millions of dollars in Medicare mispayments.

Medicare is trying to recoup money it says it mistakenly paid for health care claims for older workers and spouses that, under federal laws, should have been paid by employer-sponsored group health care plans.

However, employers, insurers and TPAs contend that the government should bear the burden of any mistakes that were made because the government failed to issue timely regulations on how to implement federal laws regarding Medicare-eligible workers. These laws mandate that Medicare be the secondary source of health care coverage for workers and spouses aged 65 and older who are covered by an employer-provided group health care plan.

To date, lawsuits have been filed by the government, a claims administrator and an older worker in at least three federal courts seeking to determine whether the government or the private sector is liable for health care claims erroneously paid by Medicare for older workers and spouses.

In addition, the federal government is suing Blue Cross & Blue Shield of Michigan, which administers Medicare in Michigan, for paying claims on behalf of Medicare that should have been paid by group health care plans (*BI*, April 3).

If the government is successful in passing this liability on to the private sector, litigation among employers, insurers and third-party administrators over exactly who should pay the claims is almost certain to explode, experts say.

In the end, Congress might have to step in and provide a legislative solution, the experts add.

"It is a national disgrace that you have the government pushing a policy of letting Medicare pay improperly and then chasing after someone they feel should have paid," said Charles W. Havens, an attorney who represents Provident Life & Accident Insurance Co. of Chattanooga, Tenn. The government is suing Provident to recover erroneously paid Medicare claims.

"There ought to be a single, national solution to this problem rather than picking on certain insurers," said Mr. Havens, who is with LeBoeuf, Lamb, Leiby & MacRae in Washington, D.C.

"If Medicare decides to play hardball, there are going to be numerous political and legal battles," predicted Frederick D. Hunt, president of the Society of Professional Benefit Administrators in Washington, D.C. "The benefits community—insurance companies, employers and administrators—is lining up against the government and nailing it to the wall because there has been gross negligence," he said, adding that "Congress might step in."

According to a 1987 study by the U.S. General Accounting Office,

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RIMS, APIW commend *Business Insurance* editor

Business Insurance Editor and Associate Publisher Kathryn J. McIntyre is the recipient of the 1989 Dorothy and Harry Goodell Award, presented last week by the Risk & Insurance Management Society Inc.

The Goodell Award, RIMS' highest honor, recognizes outstanding continuing achievement in furthering the goals of risk management.



Ms. McIntyre

Separately, the Assn. of Professional Insurance Women last week announced that it has selected Ms. McIntyre as the 1989 Insurance Woman of the Year.

Ms. McIntyre will receive the APIW award at a June 15 reception in New York.

Ms. McIntyre was presented with the Goodell Award at RIMS' annual membership breakfast last week during RIMS' 27th annual conference held in Atlanta.

In presenting the award, RIMS' outgoing President Richard C. Heydinger cited Ms. McIntyre's quick grasp of the complex issues and problems facing risk and employee benefit managers and insurance professionals, leading to an in-depth analysis of how the business works.

"Through these efforts, much of the mystique has been demystified," said Mr. Heydinger, risk management director at Hallmark Cards Inc. in Kansas City, Mo.

In announcing Ms. McIntyre's selection as Insurance Woman of the Year, APIW President Marsha A. Cohen said: "Ms. McIntyre was selected based on her professional achievements and personal qualities which reflect the goals of the APIW. She has been substantially responsible for developing *Business Insurance* and has brought new ideas into the industry and in many ways has changed our perceptions of the industry."

Business Insurance Publisher Alfred Malecki said, "It is significant that Kathryn is the first non-RIMS member to receive the Goodell Award."

And, "While Kathryn is not a practitioner of insurance, the APIW has recognized her clear and concise reporting and analysis of topics in the insurance industry," Mr. Malecki added.

Ms. McIntyre joined *Business Insurance* in January 1977 as an associate editor. She was promoted to news editor in November 1978; to managing editor in July 1979; to editor in June 1980; and to the additional post of associate publisher in August 1987.

Ms. McIntyre is a magna cum laude graduate of Syracuse University in Syracuse, N.Y., and is a member of Phi Beta Kappa. She also has earned the Associate in Risk Management designation.

The APIW reception will be held from 5:30 to 7:30 p.m. on Thursday, June 15, at the City Midday/Drug & Chemical Club, 140 Broadway, in New York. For information, contact Catherine Ancone at 212-785-2500.

Inside

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- Exposure to catastrophic risks is the greatest force affecting today's property/casualty insurance industry, an industry executive says at a symposium. **PAGE 51**
- Reinsurance executives must learn how to adapt in a radically changing reinsurance environment, executives agree at a seminar. **PAGE 53**
- Separate workers compensation and insurer reform bills await the Indiana governor's signature. **PAGE 56**
- Risk managers at the nation's smallest companies have more diverse responsibilities than their counterparts at larger firms, a new survey shows. **PAGE 57**
- Insured commercial property losses resulting from a cyclone that belted the Queensland coast of Australia early this month could amount to more than $24 million. **PAGE 61**

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RIMS benefit report



Congress confronts myriad of tough issues

By JERRY GEISEL

ATLANTA—The debate on some of the toughest benefit issues now confronting Congress is destined to intensify in the years ahead, a panel of experts agrees.

Those issues—mandated health care coverage, taxation of employee benefits, non-discrimination rules for welfare-type plans and pension portability—will be at the front and center of future congressional sessions.

How legislators will deal with this maze of benefit issues was discussed last week at a special session, "Employee Benefit Issues—The Next Four Years," during the 27th annual Risk & Insurance Management Society conference in Atlanta.

Those experts, representing private industry, the Bush administration and Congress, included Frank McArdle, a consultant and manager of Hewitt Associates' Washington, D.C., office; David Walker, assistant U.S. secretary of labor for pension and welfare benefits; and Win Froelich, a minority staff member of the Senate Labor and Human Resources Committee.

One of those issues—mandated health care coverage—was vigorously debated during the last congressional session when Sen. Edward Kennedy, D-Mass., introduced legislation to require employers to offer health care plans that would meet minimum federal standards (*BI*, April 27, 1987).

While the proposal died last year after clearing the Senate Labor and Human Resources Committee, Sen. Kennedy last week introduced a new version of the legislation and vowed to keep up the fight for a federal health care mandate (see story, page 1).

While the chances of this latest Kennedy bill clearing Congress this session are slim, Hewitt Associates' Mr. McArdle believes the issue of mandated health care coverage will not go away.

"With 35 million people uninsured for health care coverage, it is hard to see that employers will not be brought into the picture" to reduce the ranks of the uninsured, he said.

In fact, the concept of requiring employers to extend health care coverage to their employees is popular among the American public, Mr. McArdle said, citing a poll that found that seven out of 10 voters who supported George Bush also backed mandated health care coverage.

Atlanta 89

Both Mr. Froelich, the congressional staffer, and Mr. Walker, the Bush administration official, sharply criticized Sen. Kennedy's proposal.

"Sen. Kennedy wants to mandate the benefits you must offer. It is an extremely detrimental approach," Mr. Froelich said.

"Congress should leave the freedom to employers to design their plans," Mr. Walker added.

Mr. Froelich said one force pushing the Kennedy bill is the large federal budget deficit.

With a high deficit and public resistance to more taxes, mandating health care coverage is a way of assisting workers without adding to the deficit.

"It is very ingenious of Sen. Kennedy," Mr. Froelich said.

But Mr. Froelich said the Kennedy bill does nothing to ease the biggest problems in the nation's health care delivery system—soaring costs.

Indeed, Mr. Froelich said there is plenty that legislators can do to put the brakes on health care costs without reducing the quality of care.

One possible approach would be to pre-empt state laws that require group health care plans sold by insurance

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Corporate and government employee benefit experts (clockwise from center) Win Froelich, David Walker, Judy Lindenmayer and Frank McArdle go 'round the issues.

Claims data can help control health costs

By DONNA DiBLASE

ATLANTA—Health care claims data is the key to understanding and managing benefits costs, health care benefits experts assert.

Collecting and analyzing claims data can help employers identify health care cost problems, as well as help them implement programs that will specifically address those problems, the experts said. In addition, this data can help employers identify health care utilization problems, they said.

"Data is the beginning, the middle and the end of managing health care costs. Data makes you a better-informed purchaser of health care," said Daniel S. Brunner, president of Affordable Health Care Concepts Inc. of Sacramento, Calif. The firm specializes in collecting and analyzing employer health claims data and designing and implementing preferred provider organizations.

The importance and function of claims data in health care cost management was discussed during a session at the 27th annual Risk & Insurance Management Society conference last week in Atlanta.

Employers need claims data for many reasons, Mr. Brunner explained.

"Health care payers are faced not only with rapidly rising health care costs, but also with a perplexing number of strategies to deal with costs. There is a real morass of programs and ideas that you, the payer, have to sift through," he observed.

Claims data is important for identifying problems and designing cost management programs and for monitoring their effectiveness, he said.

"The health care environment changes so rapidly that solutions that are useful today might not be useful tomorrow. So, you need to re-evaluate the effectiveness of programs and make changes," he explained.

Employers can build a health claims data base from several sources, according to Mr. Brunner.

"The primary source of information is your indemnity insurer or claims administrator," he said. Employers also may be able to obtain some utilization data from the health maintenance organizations with which they contract.

In addition, employers can obtain normative data with which to compare their own experience from state public health data commissions or from some health care data vendors, he pointed out.

With data, "you can identify problems and think about how you want to solve them," he explained.

"Data can help an employer to answer some basic questions," Mr. Brunner said. These include:

- What kinds of services are employees receiving and where are these services being rendered?
- For which types of illnesses or conditions are employees being treated?
- How much is being paid for these services?

Once problem services are identified and programs are implemented to solve them, the employer should use updated data to make any necessary corrections to prevent or eliminate future problems, he said.

"Data can provide sound and accurate documentation for recommendations of new programs. And, data can provide employers with the flexibility to address new questions as their sophistication in costs management increases," Mr. Brunner said.

Data also provides employers with a basis from which to negotiate with selected health care providers. Employers then can negotiate prices and utilization controls with these providers in return for channeling their employees and their dependents to those providers, he said.

Continued on next page

Spotlight report

Cost control

Continued from previous page

Health care claims data also can be used to accomplish other benefits management goals, the experts said.

A study of health care claims data helped Minneapolis-based Control Data Corp. analyze the connection between poor health habits and the high health care costs of some of its employees.

The company collected claims data from its claims administrator and merged it with health risk information on its employees collected through its wellness program, explained David R. Anderson, a vp with StayWell Health Management Systems Inc., a Minneapolis subsidiary of Control Data.

The study was conducted from 1981 to 1984 with the help of Milwaukee-based benefit consultant Milliman & Robertson Inc. It included information on 15,000 employees in 27 locations nationwide, Mr. Anderson said.

The results showed that the health care costs of employees who smoked were 18% higher on average than those of employees who did not smoke.

And, the health care costs of employees who did not exercise regularly were 14% higher than those who exercised, he said.

"These results lead us to the inevitable conclusion that poor health habits are driving a lot of the health care costs," he said.

To illustrate, Mr. Anderson provided examples from the Control Data study. The study found that annual health care costs were:

- $1,282 for a 40-year-old male employee who smokes two packs of cigarettes daily, is sedentary, 30% overweight and does not wear a seat belt.
- $631 for a 40-year-old male employee who does not smoke, exercises regularly, maintains a normal weight for his height, and wears a seat belt.

"The real solution to the problem of health care costs is good health. A lot of these risks can be managed," Mr. Anderson asserted.

For example, Control Data has offered its employees smoking cessation programs and information on the benefits of wearing a seat belt and on getting exercise. The company offers incentives such as 100% coverage of costs related to an automobile accident if employees were wearing a seat belt.

As a result of these programs, smoking by Control Data employees is down 40%. When the StayWell program began in 1980, 35% of employees smoked; today only 21% smoke, he said.

In addition, seat belt use is up 229%, and 28% more employees are exercising regularly, Mr. Anderson pointed out.

Control Data estimates that it avoids $79 in annual health care costs per employee because of improved employee health, he said.

Health claims data analysis also can be used to identify specific health care utilization problems in a benefit plan. Employers then can use this information to select and implement utilization review programs, said David K. Barton, vp of sales for Control Data Benefit Services, a third-party claims administrator in Richardson, Texas.

The traditional concepts of UR programs are hospital preadmission review and precertification, concurrent review and second surgical opinions, he said.

However, as employers have identified other cost and utilization problems, the traditional forms of UR have been expanded, he added. "Today, there are large case management programs, which when triggered early in a case, can produce substantial savings."

These programs involve a nurse or physician case manager who works with a patient's physician to arrange the best care in the most appropriate health care setting. Case management usually begins when a case involves a catastrophic illness or injury, or when the costs of a case reach a certain dollar amount.

In addition, "outpatient utilization review now is getting a lot of attention as outpatient costs continue to escalate," he said.

Another enhancement of UR services is prenatal review, which can begin when a patient first submits a claim that includes a diagnosis of pregnancy, he explained.

One employer client of Control Data Benefit Services decided it needed a prenatal UR program after its claims data revealed that 33% of its expenses were for maternity care, he illustrated.

"These programs can identify a potential high-risk pregnancy early on" and then ensure that the mother receives care and counseling to prevent problems, he said.

Also, dental UR programs can help employers to manage dental services costs and utilization, Mr. Barton noted.

Claims data can be used by employers to study inpatient and outpatient utilization patterns and common diagnoses in their groups. It also can be used to help employers compare their experience with national health care cost and utilization norms and to identify gaps in cost control programs, he said.

"Data will allow you to determine whether you need all of the components of a utilization review program, or whether you need only specific features," he said.

Once specific programs are in place, employers can use claims data to determine whether adjustments are needed to improve the effectiveness of cost management, he said.

For example, "do you need a hospital utilization review that is generic and applies to all admissions? Or do you need one that is focused on certain types of admissions or conditions. And, does the utilization review vendor need to speak with the employee's physician in every case," Mr. Barton suggested.

In terms of second surgical opinion programs, employers can determine whether they need to go to the expense of paying for a second opinion for a large number of elective procedures, or only for certain commonly performed surgeries, he added.

Employers also can compare their claims data with the reports they receive from their UR vendor. "With this comparison, you can ask whether the program really is working to your advantage," he noted.

And, "you can ask the vendor what your real savings are and what your cost is under the program," he added.

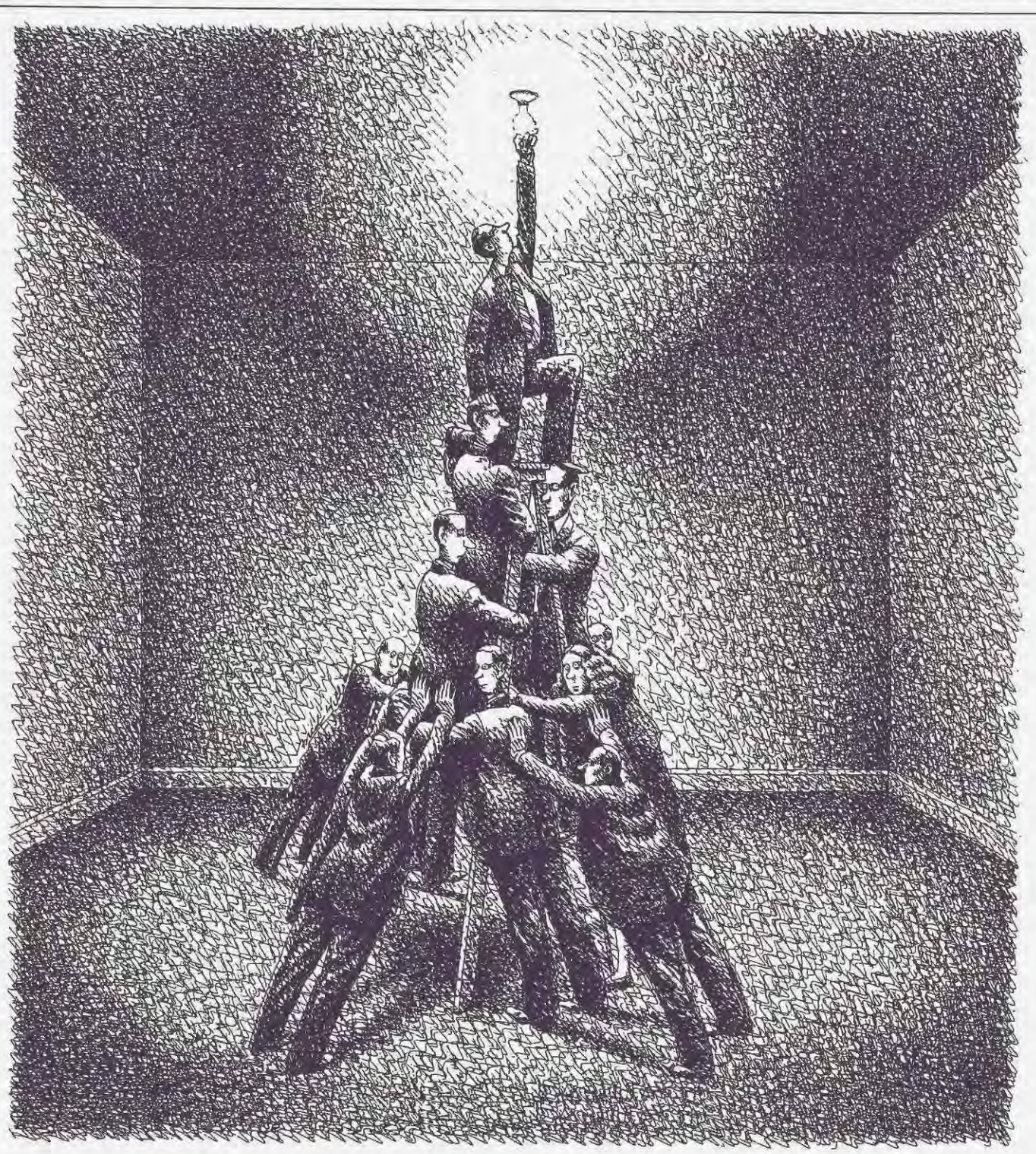
Health care claims data has enabled employers to make leaps in managing the costs of their benefits plans, the experts agreed.

In the early 1980s, "we were paying a lot of money for health care, but we didn't know specifically what we were paying for. But, we went from having poor data to having excellent data," noted Mr. Anderson of StayWell Health Management Systems.

"We're all out there spending millions of dollars on health care. Years ago, the dollars went out the window and we had no idea where they were going," said Mr. Brunner of Affordable Health Care Concepts.

"Now, we are much more sophisticated. And, data will help improve that sophistication as time goes on," he predicted.

James Chapman, director of risk management for Voluntary Hospitals of America in Dallas moderated the session. ■



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Employers feel pinch of retiree health costs

By JERRY GEISEL

ATLANTA—Employers are facing the real costs of retiree health care benefits as proposed accounting rules and soaring health care costs force corporations to review their plans, an expert says.

Recent changes proposed by the balance sheets, are raising corporate awareness about the true costs of retiree health care programs, said W. Leon Smith, a partner in the Dallas office of Touche Ross & Co.

"There is the recognition that these are expensive benefits," Mr. Smith said last week at a session at the 27th annual Risk & Insurance Manage-

pendents to pick up part of the health care coverage premium.

• Linking contributions paid by retirees to length of service.

While imposing or increasing premium contributions will produce grumbling, retirees will prefer more cost sharing to a cutback in benefits, Mr. Smith said. In addition, employ-

Indeed, efforts by employers to alter retiree health care plans has triggered considerable litigation during the last several years, said Harry Burton, a partner in the law firm of Morgan, Lewis & Bockius in Washington, D.C. Much of the litigation has centered on retiree health care benefits that companies may have

they always warned employees that they reserved the right to amend retiree health care plans.

It can be difficult, though, for a company to prove to a federal court that it had warned employees that it reserved the right to change benefits.

"Defenses can be complicated. A company may have distributed five

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Opinions

Kennedy proposal redux

TO PARAPHRASE a now-famous motion picture advertisement: "It's back!"

The "it" in this case is Sen. Edward M. Kennedy's proposal mandating that employers offer a so-called minimum health care plan.

Although the goal of providing Americans with access to affordable health care coverage is a worthy one, we never liked the Massachusetts Democrat's original proposal. And, despite some bells and whistles added primarily to appease small employers, we do not like the revised proposal unveiled last week (see story, page 1).

Under one portion of the new proposal, employers—similar to the previous legislation—would have to offer a health care plan that includes certain mandatory benefits to all employees working more than 17.5 hours a week. Employers generally would pay 80% of the premium, and individual and family deductibles could not exceed $250 and $500, respectively. The maximum out-of-pocket expense would be capped at $3,000 annually.

However, to make his new proposal more appealing to business, Sen. Kennedy has added some concessions. For instance, the federal government would subsidize 75% of plan costs that exceed 5% of revenues for employers with 25 or fewer workers. And, under the new proposal, employers would be allowed to contribute a smaller amount toward plan costs for part-time employees working between 17.5 and 25 hours per week.

While both of these new provisions represent improvements over the previous legislation, they in no way will change most businesses' attitudes.

The sad truth is that during the year since a Senate committee approved his original proposal, Sen. Kennedy has refused to listen to cries from business groups that the proposal is not fair.

And, we still fear that once the government mandates that employers offer certain types of health care coverage, powerful medical provider groups will convince Congress to add a laundry list of benefits—like chiropractic care—that must be covered.

We also oppose Sen. Kennedy's vague proposal that would extend health care coverage to all Americans. Our reason is simple: The senator has not yet stated the total cost of this proposal. And, we fear that by funding this program through general revenues, employers that already provide health care employee benefits will foot a good portion of the bill for covering the unemployed through higher corporate income taxes.

Well-deserved recognition

ON PAGE 2, we report that the Risk & Insurance Management Society Inc. has bestowed its prestigious Dorothy and Harry Goodell Award on *Business Insurance* Associate Publisher and Editor Kathryn J. McIntyre, A.R.M.

At the same time, the Assn. of Professional Insurance Women has announced that Kathryn has been named 1989 Insurance Woman of the Year.

To those of us who have been among her longtime associates and close co-workers, this double recognition of Kathryn's outstanding service to the risk management and insurance profession comes as no surprise.

These splendid awards honor Kathryn for the very best in editorial excellence, integrity and independence and also symbolize the longstanding commitment of this newsmagazine to serve corporate risk and employee benefits management.

As publisher of *Business Insurance,* I join our entire staff and the directors of Crain Communications Inc. in congratulating Kathryn for these well-deserved honors.

Kathryn, we are very proud of you.

Alfred Malecki
Publisher
Business Insurance
New York

Letters

Fairness must come from within industry

To the editor: The article about *Brown-Spaulding vs. ISLIC* highlights the problem that besets our industry: We simply fail to regulate ourselves to the standards of fairness and reasonableness that the public demands.

The result typically is a decision such as Brown-Spaulding (*BI,* March 20; March 6; Jan. 16). Some claims-made policies contain "a trap" for unwary policyholders and set up the opportunity for predatory insurers to enjoy windfall profits from an unfair advantage.

Our company could not exist without a claims-made form of coverage. In direct response to the Brown-Spaulding case, we have instituted an automatic 60-day extended reporting period with no additional premium charge. Of course, we offer extended discovery options for appropriate premiums. This is *fair.*

Why doesn't "the industry" ever advocate curing problems that arise? If we don't, the courts do. Their solutions are predictable and, very often, unacceptable. Unfortunately, the forthcoming antitrust mania will encourage the opposite behavior by insurers. I fear the worst.

Peter B. Hawes
President and Chief Executive Officer
Design Professionals Insurance Co.
Monterey, Calif.

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611.

Auto insurance sales show group potential

To the editor: With the passage of Proposition 103 in California, the auto insurance "affordability" issue has once again reared its ugly head and caused insurers across the country to scurry for cover. There is hardly an adversary so fearsome as a consumer advocate with a cause—and auto insurance affordability is a cause that rivals such one-sided issues as whale preservation in its potential for grass-roots support.

So far, the insurance industry has generally assumed a defensive posture. A flurry of educational-type news releases have been offered to explain the rationale behind auto insurance rating and to suggest that price increases are beyond the control of the industry.

While it is true that the loss cost portion of the auto insurance premium dollar bears a direct relationship to what the medical, law and auto repair communities are charging, there is an expense portion of the premium dollar that comes under the direct control of insurance companies. As much as 30% of premiums can be eaten up by sales costs, servicing costs and other related company expenses. There is room for considerable improvement in this area with savings being passed on to the consumer.

One alternative with the potential for immediate, positive impact on expenses is mass merchandising. Many years ago, health insurers discovered that it was much more efficient and profitable to sell to groups of people rather than to individuals. Anyone who has tried to buy health insurance can attest to the cost benefit of buying as a member of a group.

The differences probably outnumber the similarities when comparing auto and health insurance, but the fact remains that sales economies do exist in distributing commodity-type products to a group with the strong support of a sponsor. Further economies are possible in the billing and collections area if payroll deduction or automatic transfer techniques are utilized.

Over the years, auto insurers have experimented with sales to employees and association groups. "True group" rating

Continued on page 10

backlash by retirees to the higher taxes they will have to pay under the recently expanded Medicare program may make Congress more cautious about imposing new taxes to pay for expanded benefits in other areas, Mr. McArdle said.

Under legislation enacted by Congress last year, middle- and upper-income retirees will face up to $800 in new federal taxes ($1,600 for retirees filing joint tax returns) this year to pay for an expanded Medicare program.

The expanded program by 1990 will place a $2,000 annual, out-of-pocket limit on covered medical ser-

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At issue

Would you support retiree health benefits vesting if given tax incentives to prefund them?



Anthony J. Limina
director-employee benefits
Sterling Drug Inc.,
New York

I would not support mandated "vesting" of retiree health benefits with or without tax incentives unless there was some assurance by the federal government that Medicare would continue to be the primary carrier for retired employees.



Gerald Rudd
senior vp-human resources
Albertson's Stores,
Boise, Idaho

Yes, but the question defies a simplistic answer. I would think a vesting schedule entitling a retiree to a percent of plan benefits based upon years of service, and then prefunding that obligation, just like a pension plan, would make a lot of sense in reducing the magnitude of corporate liability. It would require a lot of work to make it fair to all parties.



Hugh E. Becker
director-human resources
Robbins & Myers Inc.,
Dayton, Ohio

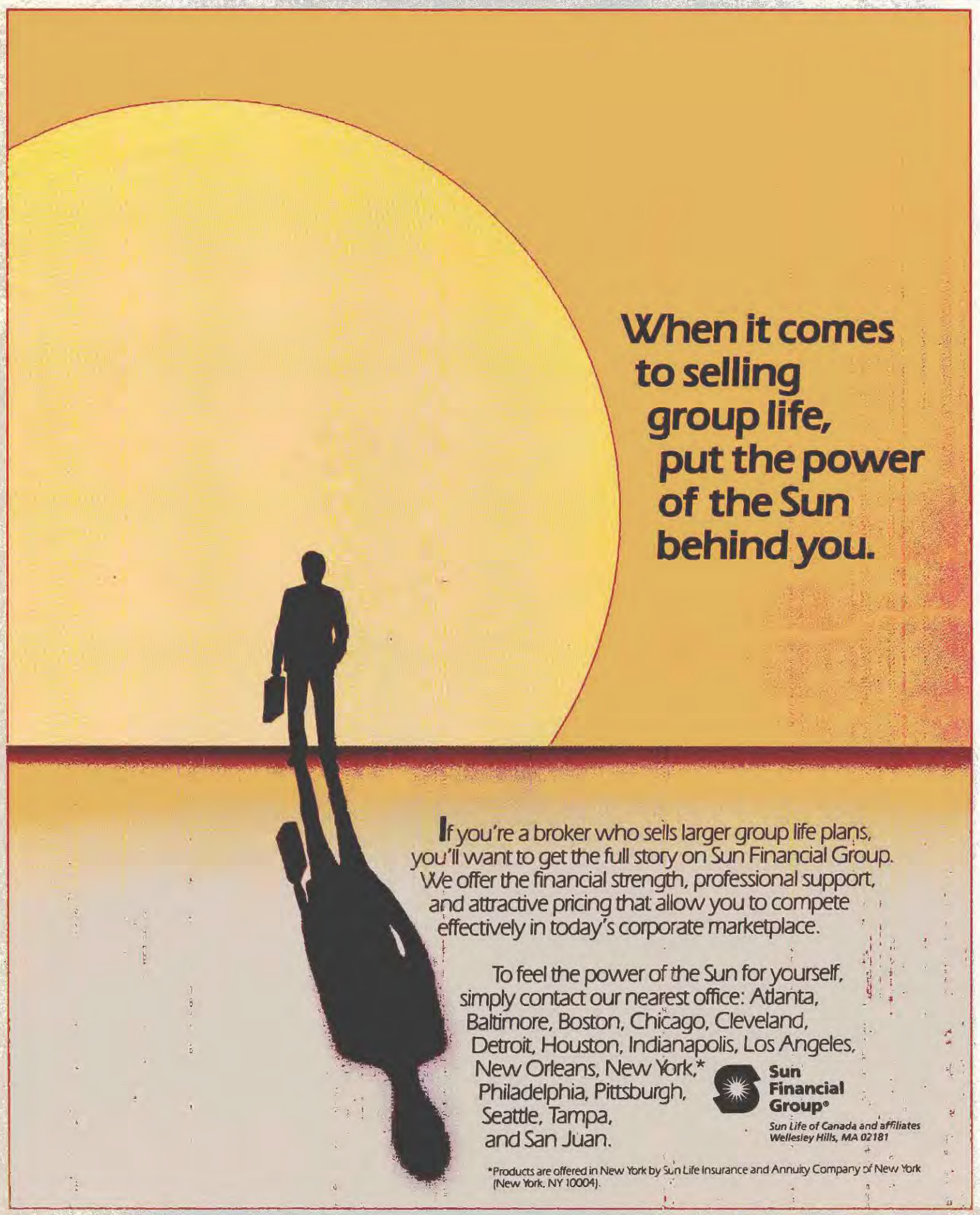
Yes. Vesting of retiree health benefits is an acceptable trade-off for sound legislation providing appropriate tax incentives for prefunding such benefits. The significance of the issue is recognizing such liability demands legislative relief. Vesting is an appropriate compromise; the alternative, discontinuance of benefits, is not socially acceptable to the U.S. today.



Linda Roskosky
employee services representative
Polychrome Corp.,
Yonkers, N.Y.

Yes, if the tax benefits adequately offset the cost of providing such benefits. This is a good social cause, but some factors must be considered. For example, will an employer be able to provide these benefits long-term? Smaller and medium-sized corporations may not have the funds to provide these benefits despite the tax breaks.

Compiled by Christine Woolsey



Letters

Continued from page 8

with required employer contributions to premium cost is a concept that, for the most part, has been scrapped by auto writers. Since the contribution cannot be considered a deductible expense, demand has never fully materialized. And other less structured mass merchandising approaches have always been the first to go when auto results become unbearable. In spite of all the obstacles, however, mass marketing of auto insurance has managed to survive.

Today, an insignificant fraction of the millions of auto insurance consumers are covered by programs that provide for reduced premiums and convenient payment terms. A groundswell of consumer interest can correct this situation. Employees, association members, etc., have the power to demand that their organization sponsor an auto insurance program. Such concerted action could result in needed premium relief and would help remove the necessity for consumers in other states to seek political intervention to halt escalating auto insurance costs.

Robert P. Hughes
VP
North American Specialty Insurance Co.
Manchester, N.H.

Prop. 103 issue speaks to quality

To the editor: Has anyone who runs an insurance company focused on the basic issue that prompted Proposition 103? The consumer is telling the seller in the most unambiguous terms that the *quality* of its product nowhere near approaches what the buyer demands and expects.

Isn't this the same reason so many other U.S. businesses have lost market share to others, especially to foreigners? Maybe the proof is that more than 30% of the insurance market has abandoned the traditional insurance industry for forms of self-insurance. Instead of making excuses, maybe it is time for insurers to get back to basics and find out what their customers expect and give them what they want instead of fighting with them.

Stephen W. Scammell
Director, Risk Management
GAF Corp.
Wayne, N.J.

1976 Eagle, a Hall unit, stops writing

BRUSSELS, Belgium—1976 Eagle Insurance Co., a Brussels, Belgium-based facultative reinsurance underwriting unit of New York-based Frank B. Hall & Co. Inc., stopped writing business effective April 1.

The company, which is solvent, is running off its business.

The reinsurer, which primarily wrote short-tail property reinsurance ceded by the London market, wrote roughly $10 million in gross premiums in 1988, translated into U.S. dollars.

The reinsurer wrote no U.S. business.

Hall wrote off the unit as a discontinued operation in 1986 when it decided to withdraw completely from insurance underwriting, and had been looking for a buyer since then.

—By Linda J. Collins

EVER TRY TO PUT A LID ON RISING DENTAL COSTS?



In recent years, the cost of dental care has risen dramatically.

Fact is, expenditures for dental services in the U.S. are increasing at three times the Consumer Price Index, and will soon reach over $42 billion a year.

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

What does all this mean to an employer?

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

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CIGNA

Many measures can cut AIDS-related costs

By KARI BERMAN

ATLANTA—Proper case management and workplace safety procedures can help control AIDS-related health costs, experts say.

"The best way to reduce the costs of treating an AIDS patient is to keep them out of the hospitals where acute care costs are significantly higher than other forms of medical services," said Dr. John J. Mahoney, a vp at Health Strategies Group in Westport, Conn, a unit of The Alexander Consulting Group Inc., an Alexander & Alexander Services Inc. subsidiary.

Dr. Mahoney and other experts advised employers on how to contain costs related to employees with acquired immune deficiency syndrome during a session at the 27th annual Risk & Insurance Management Society conference in Atlanta last week.

"Case management will help employers get employees with AIDS the quality care that is necessary at the lowest cost," Dr. Mahoney commenpted in an interview after the session.

"In the issue of hospital vs. home care, the employer saves money, and employees with AIDS, who often would rather be at home, are able to get their wish," Dr. Mahoney explained.

Dr. Mahoney estimated that one day of acute hospital care costs $698, while one day of home care costs $94.

An estimated 83,000 AIDS cases have been reported since 1980, according to Mark G. Doherty, director of research at the Schaumburg, Ill.-based Society of Actuaries.

'The best way' to reduce AIDS-related costs is trimming hospital stays, Dr. Mahoney says.

Other panelists said that employers can help protect their workers from the disease by implementing some workplace safety measures.

The Occupational Safety and Health Administration is expected to issue an expanded draft rule on blood-borne infectious diseases later this month, according to David P. Maslen, a research attorney in the Newburyport, Mass., office of The Alexander Consulting Group.

A preliminary draft of the rules were released earlier this year, according to Mr. Maslen.

"OSHA's standards will have a major impact on virtually all occupations where employees are exposed to blood or other potentially infectious materials," Mr. Maslen said.

"Under the OSHA's standard, all blood is considered infected, and protective measures should be taken to protect employees," he added.

According to Mr. Maslen, key components of OSHA's draft rule will probably include:

- Exposure determination. Employers will have to identify which employees are at risk and what kinds of exposures threaten their health.

While this measure would obviously include most health care professionals, it also would apply to workers in many other industries, such as laundry service personnel who come in contact with soiled hospital sheets and undertakers, Mr. Maslen explained.

- Procedure modifications. If a potential risk is identified, changes in the way a task is performed should be made to reduce the possibility of contamination.

Modifications might include additional protective clothing.

- General housekeeping rules for disinfecting workplace equipment and for properly disposing of infectious waste.

This provision also cautions against storing food in the same refrigerator used to preserve blood.

- Special rules for researchers creating AIDS viruses in the laboratory.

For example, all employees working in facilities where the virus is made must be specially trained, and areas where the virus is tested or stored must be clearly marked.

- Mandatory AIDS education for employees.

More employers also can expect to be hit with litigation if they do not protect the rights of employees with acquired immune deficiency syndrome, a benefit expert warns.

As the number of AIDS cases continues to rise, "employers can expect to see an explosion of AIDS litigation in the coming year," said Mr. Maslen.

"As the numbers of AIDS cases increase daily, we are beginning to also hear about new litigation involving AIDS," Mr. Maslen pointed out.

A significant amount of the litigation brought against employers involves the termination of an employee solely because the employee has contracted the disease, he said.

However, AIDS patients are protected under the Rehabilitation Act of 1973, and they cannot be fired for having the disease, Mr. Maslen said.

The Rehabilitation Act of 1973 protects handicapped employees from being fired because of their impairment. The U.S. Supreme Court extended the law in 1987 to include AIDS patients.

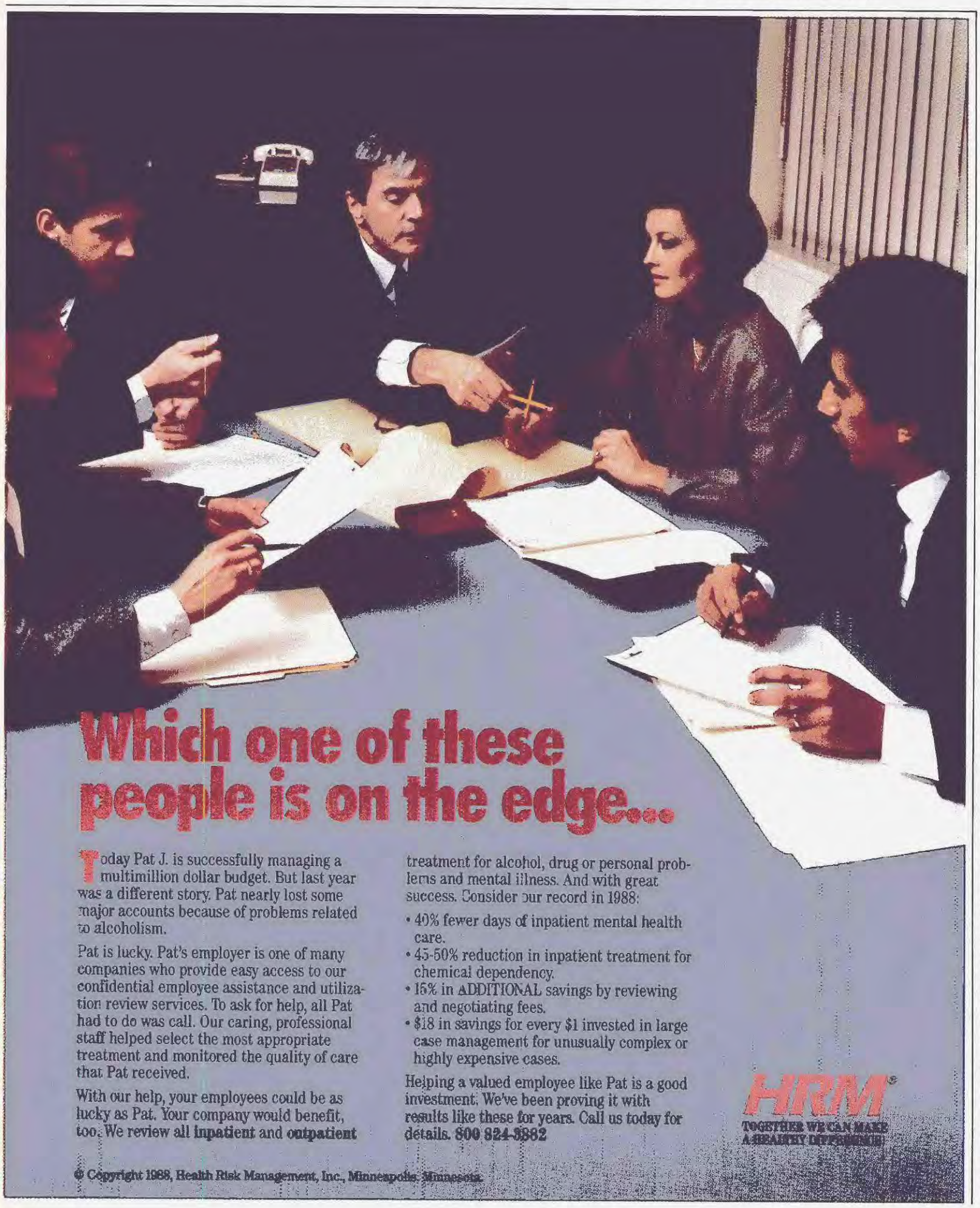
Illustrating the kinds of AIDS-related issues that can result in lawsuits, Mr. Maslen cited a 1988 Kansas Civil Rights Commission order as a landmark.

In that case, Mr. Maslen explained, an employee brought suit against his employer, charging he was fired because his employer feared the worker would transmit AIDS to other workers.

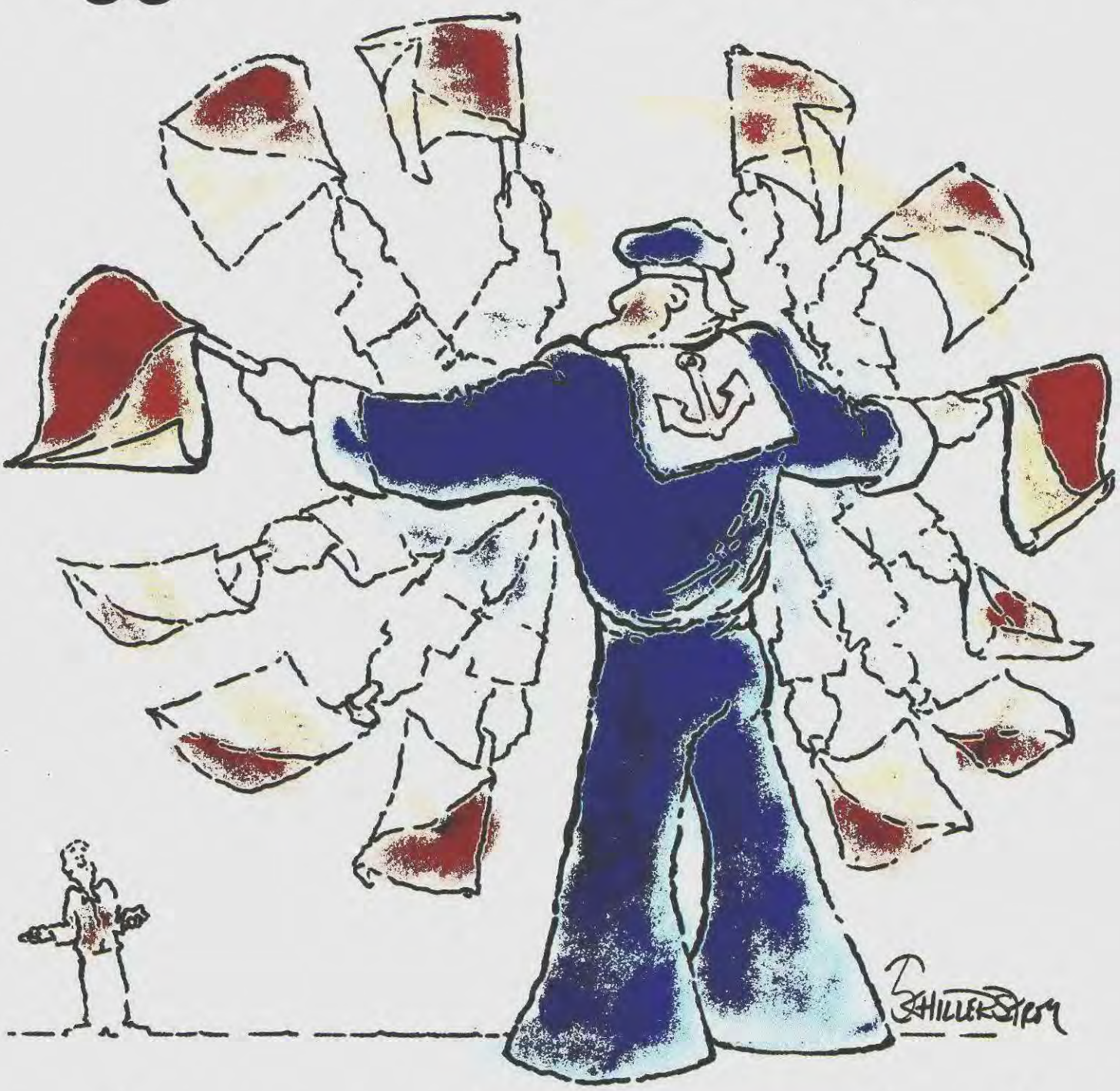
After the employee presented medical evidence that AIDS was not communicable in a workplace environment and showed that he still could carry out all of his job-related duties, the Kansas Civil Rights Commission ordered the employer to pay the worker $22,000 in damages and reinstate him.

The underlying implication is that "if employees with AIDS can perform their jobs, then they should be treated like any other employee and not be discriminated against," Mr. Maslen stressed.

Also on the panel were Yvonne Norton Leung, risk manager for the Nebraska office of Risk Management in Lincoln, Neb., and Ron Bryant, insurance manager for The Southland Corp. in Dallas who moderated the session. ■



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Plan sponsors' fiduciary liabilities rising

By JUDY GREENWALD

ATLANTA—Employee benefit plan sponsors face increasing fiduciary liability exposures, an insurer and an attorney warn.

Class-action suits brought by plaintiffs' attorneys, plan changes caused by mergers and acquisitions and the use of employee stock ownership plans as financing vehicles for leveraged buyouts are all potential problem areas, according to John P. Coonan, assistant vp at Warren, N.J.-based Chubb & Son Inc., a subsidiary of Chubb Corp., and attorney Robert C. Christenson, of Atlanta-based Fisher & Phillips.

Messrs. Coonan and Christenson discussed potential problems with benefit plans regulated by the Employee Retirement Income Security Act at a session during the 27th annual Risk & Insurance Management Society conference in Atlanta last week.

"There is always kind of a shifting focus of plaintiffs' law," Mr. Coonan pointed out. Because of tort reform that discourages personal injury suits, plaintiffs' attorneys are beginning to find the area of fiduciary liability increasingly attractive, he said.

Companies with large numbers of employees seem to be particularly popular litigation targets, Mr. Coonan noted.

For example, in one case, a lawsuit filed against a retailer by part-time employees because the part-timer did not receive the same benefits as the company's full-time employees eventually cost the company about $4 million, he said.

Plaintiffs' attorneys are "just beginning to wake up" to this type of litigation, Mr. Christenson agreed.

One factor likely to encourage their interest is the Feb. 21 U.S. Supreme Court decision in *Bruch vs. Firestone Tire & Rubber Co.*

The court ruled that federal courts should not automatically give deference to decisions by pension and welfare plan administrators when reviewing cases involving denial or reductions of benefits (*BI*, Feb. 27).

The decision probably will make it much easier for a plaintiff to prevail against a benefit plan or a plan's fiduciaries in litigation, Mr. Christenson said.

Another potential source of increased employer liability stems from defined benefit pension plan terminations following a merger or acquisition.

A company is often left with little equity and a large amount of debt after a merger or acquisition, and "that causes a lot of these plan terminations" and subsequent suits, according to Mr. Coonan.

Employers also face a potential problem when ESOPs, which are regulated under ERISA, are used to finance leveraged buyouts.

And, as ESOPs become an increasingly common tool in takeover defenses, fiduciary problems are emerging more often.

Although a fiduciary may be a company employee, his first responsibility is to the ESOP, not the company, Mr. Christenson noted. "It's absolutely against the law for a fiduciary to take the company line with an ESOP," he said.

But employers can follow some loss-prevention guidelines to reduce their fiduciary liability exposure and enhance their plans' administration, according to Mr. Coonan.

He advised employers to:

- Make sure fiduciaries are aware of their basic duties under ERISA.

Fiduciaries must be aware of the standards they are to uphold as well as what transactions are prohibited under ERISA.

They also should be given a "full familiarity" with plan documents, Mr. Coonan said.

And, employers should be more careful in selecting capable plan fiduciaries, Mr. Coonan said.

- Hold regular meetings of fiduciaries. Meetings should be held at least quarterly, not annually, which is "ridiculous," Mr. Coonan said.
- Pay attention to support services.

For example, problems can be avoided if an employer's communication material is "readable and clear."

Claims by plan beneficiaries often result because of poor communication, according to Mr. Coonan.

"If you have a proper and understandable response to benefit claims, it will undoubtedly reduce the (liability) claims you get," Mr. Coonan said.

In addition, outside benefit plan administrators with large employee turnovers should be avoided, Mr. Coonan recommended, because such changes in personnel will lead to "certain errors," he said.

It is also critical to hire an outside counsel with expertise in employee benefits, and "not a generalist," Mr. Coonan recommended.

Even attorneys who specialize in employee benefits confess there are parts of ERISA they do not understand, he added.

Advice from outside administrators, counsel and investment advisers, among others, also is useful in avoiding the appearance of a conflict of interest, Mr. Coonan pointed out.

For example, if an employer wishes to use an ESOP as a defense in a hostile takeover attempt, it is important that decisions are made with the advice of people who are "totally independent," Mr. Coonan said.

Legal compliance is also important, Mr. Coonan noted. The employer must be sure his plan conforms to any changes in the law.

- Clearly delineate investment guidelines.

Mr. Coonan also recommended that employers give themselves the buffer of a "reasonable" period of time to complete investment transactions on employees' behalf.

Despite the potential liability problems employers face over their benefit plans, fiduciary liability coverage is still relatively cheap and readily available, according to Michael J. Robinson, assistant vp at Johnson & Higgins of Georgia in Atlanta.

Rates in the market, he said, are a "pleasant surprise" when compared with the directors and officers liability market.

"Deductibles are relatively small," and in some cases there are no deductibles at all, he said.

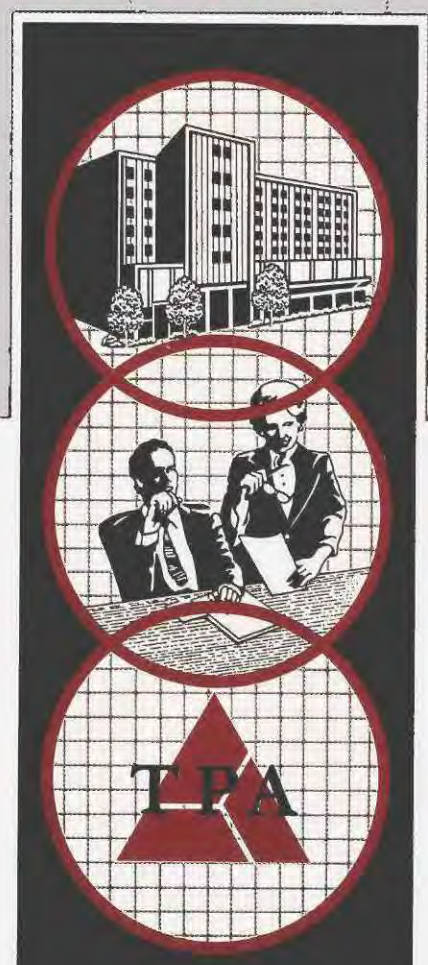
"You don't have to run up to that $150,000 level before you get coverage for it," he said.

"There's no real way to tell" how much coverage should be purchased, Mr. Robinson said. That depends on claims "and how well you want to sleep at night."

Also speaking at the session were Kristian P. Moor, vp of New York-based National Union Fire Insurance Co. of Pittsburgh, Pa., a subsidiary of American International Group Inc.

The session was moderated by Donald E. McGuffey, assistant vp-risk management for Atlanta-based Equifax Inc. ■

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Section 89 repeal unlikely: Consultant

By JERRY GEISEL

ATLANTA—Employers shouldn't count on a congressional repeal of Section 89's complex non-discrimination rules for welfare-type plans, a benefit consultant says.

While small employers have been waging a fierce battle to rescind the controversial law, repeal is opposed by the congressman who controls the fate of Section 89: House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill. (*BI*, March 6).

"Nothing will happen without (support) from Rep. Rostenkowski," said Ede Baker, a consultant in the Dallas office of The Wyatt Co.

"And, up until now, Rep. Rostenkowski has been adamantly opposed to repeal" of Section 89, Ms. Baker added.

Speaking last week during the 27th annual conference of the Risk & Insurance Management Society in Atlanta, Ms. Baker noted that lobbying to scrap Section 89 has been heavy.

And, this lobbying effort has convinced many members of Congress that Section 89 is in need of changes.

For example, a healthy majority of the members of the House of Representatives have signed on as cosponsors of Section 89 repeal legislation introduced by House Small Business Committee Chairman John LaFalce, D-N.Y. (*BI*, March 27).

Yet despite this show of support, repeal of Section 89 remains unlikely, Ms. Baker said.

While many members may support the LaFalce bill, the fate of any major tax-related legislation, such as changes to Section 89, rests with Rep. Rostenkowski, she explained.

While the complexity of Section 89 has aroused widespread anger in the business community, congressional staffers who drafted Section 89, as part of the Tax Reform Act of 1986, had some specific tax and social policy objectives, Ms. Baker said.

One objective was to raise additional revenue by taxing highly compensated employees—generally those earning more than $54,000 annually—on a portion or all of their employee benefits.

There was a feeling that if highly compensated employees received more benefits than the lower paid, then they should be taxed on those benefits, Ms. Baker said.

But critics of Section 89, such as Rep. LaFalce, say that the additional tax revenue generated by Section 89, at least initially, will be more than offset by the tax-deductible administrative expenses employers will incur collecting data and running the various non-discrimination tests.

Another congressional objective in enacting Section 89 was to encourage employers to broaden coverage in their health care plans, Ms. Baker said.

Section 89 drafters had thought that employers might broaden coverage to prevent their health care plans from failing the various non-discrimination tests, she said. Those tests are used to compare, among other things, the percentage of highly compensated and non-highly compensated employees that are covered under a plan or are eligible for benefits.

The second objective has, so far, not been met, Ms. Baker noted.

"Most employers are not broadening their plans. Things have not worked out that way," she said.

"If the intent of Section 89 was to broaden coverage, then the law has failed miserably," added Chris Sande, a consultant in Wyatt's Detroit office, who spoke at the session.

Mr. Sande said that it may be a lot cheaper for companies to "gross up"—boost salaries to cover the additional taxes highly compensated employees would face by being in a "discriminatory" plan—than to broaden coverage for the rest of the company's employees.

Mr. Sande stressed that grossing up is not a legal requirement under Section 89. But, "it should be considered an option," he said.

Indeed, grossing up may set an uncomfortable precedent, Mr. Sande said.

"You set up an expectation among the highly compensated employees that every time the tax law changes, they will be protected" by their employer from any adverse tax consequences, he said.

While it remains to be seen what, if any, changes Congress will make to Section 89, employers at least for now have to figure out and comply with perhaps the most complex benefit statute ever enacted by Congress.

For starters, Section 89 imposes a maze of non-discrimination tests that employers must run on their welfare-type plans.

These tests are intended to measure whether benefit plans discriminate in favor of highly compensated employees.

The first major test is known as the 80% coverage or "alternative coverage" test. This test is described as an alternative because if the test is satisfied, an employer does not have to run the other, far more complicated eligibility and average benefits non-discrimination tests (*BI*, March 13).

Under this test, a plan is considered non-discriminatory if it covers 80% of a company's non-highly compensated employees.

However, the 80% coverage test really isn't much of an alternative for most employers, Mr. Sande says. Instead, it is aimed at small companies with simple benefit arrangements, such as those offering a single health care program throughout the workforce.

"I'm down on the 80% test" as a meaningful option for most employers, he said.

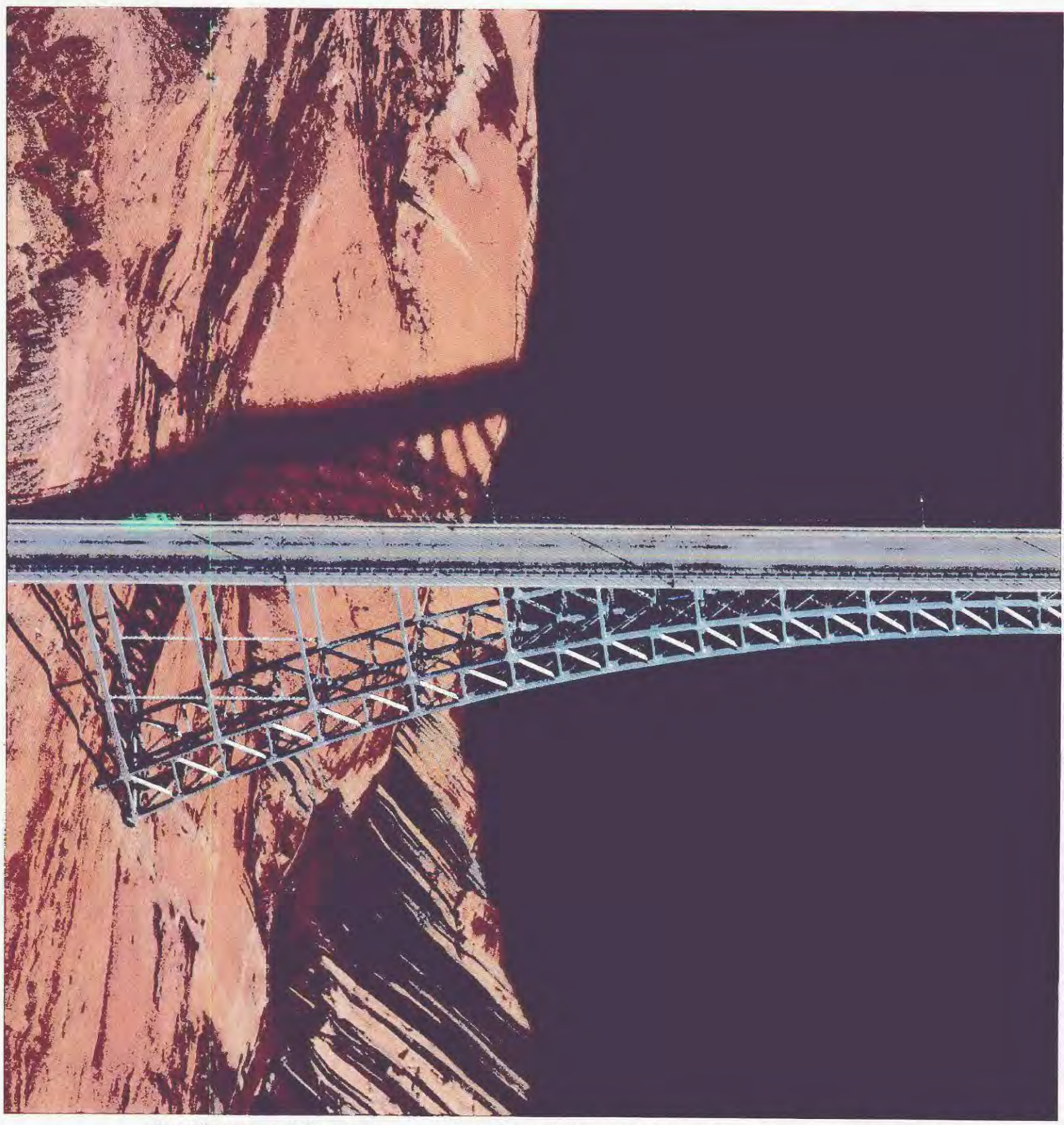
The company offers three health care plans: an executive-only plan, a plan for salaried employees and a plan only for hourly employees.

The 5,000 salaried and hourly employees are all non-highly compensated.

The example also assumes that all 100 highly compensated employees are covered by the executive-only

Continued on next page

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Continued from previous page
plan, while the 1,000 salaried employees are covered by the salaried plan and the 4,000 hourly employees are covered by the hourly medical care plan, Mr. Sande said.

The executive-only plan would clearly fail the 80% coverage test because 0% of non-highly compensated employees are covered, he noted.

In addition, the salaried plan also would fail because it only covers 20% of the company's 5,000 non-highly compensated employees (the number of employees in the plan—1,000—divided by 5,000).

In this example, only the hourly plan would pass the 80% test. That is because it covers 80% of the company's non-highly compensated employees (4,000 divided by 5,000).

Because the company failed the 80% test, it then must run three additional, generally more complicated and more difficult tests to pass Section 89 non-discrimination requirements.

These tests are:

- The 50% eligibility test. Under this test, at least 50% of employees eligible for welfare plan benefits must be non-highly compensated employees.

Under the 50% test, plans can be aggregated if the least valuable plan has a value of 95% of the most valuable plan.

- The 90%/50% eligibility test. Under this test, at least 90% of non-highly compensated employees must be eligible for a benefit worth at least 50% of the most valuable benefit available to any highly compensated employee.

Wyatt's Ms. Baker noted that companies with a lot of part-time employees can find it difficult to pass the 90%/50% test.

That is because under Section 89 employees working at least 17.5 hours a week must be counted when running the non-discrimination tests. However, employees working fewer than 20 hours a week rarely are eligible for benefits coverage.

As a result, companies with a lot of part-time employees would have too low a percentage of non-highly compensated employees eligible for coverage to pass the 90%/50% test.

- The 75% benefits test. Under this test, the average benefit for non-highly compensated employees eligible for a plan—regardless of whether they participate—must be at least 75% of the average benefit for highly compensated employees.

However, a transition rule proposed last month by the Internal Revenue Service would give employers a temporary reprieve from running the 75% test.

The IRS says that in lieu of running this test, employers—in 1989 only—can elect to have the top 20% of highly compensated employees taxed on the full value of their health care benefits. In 1990, the 75% test could be skipped if the top 40% of highly compensated employees were taxed on the full value of their health care benefits.

In addition, employers taking this option of avoiding the 75% test would be allowed to use a modified version of the 90%/50% eligibility test.

Under the modification, known as the 80%/66% test, 80% of non-highly compensated employees must be eligible for a health care plan that is at least 66% of the value of the most generous plan available to highly compensated employees. This modified version of the 90%/50% test can only be used in 1989.

While the IRS officials have described the "20% alternative" transition rule as offering some temporary administrative relief, Ms. Baker says the rule really is of modest benefit to employers.

She notes that employers opting for the 20% alternative still have to run Section 89's other non-discrimination tests. And, if those tests are failed, highly compensated employees face taxes on all or a portion of their benefits.

"We are looking for a transition rule that does away with all the tests," Mr. Sande said, somewhat in jest.

While much attention has been focused on the non-discrimination tests, Section 89 also includes tough rules on how employers must communicate and document their welfare plans.

Most of these rules are covered under Section 89(k) of the statute.

For example, a plan must be maintained for at least 12 consecutive months unless there is a bona fide business reason for terminating the plan.

Ms. Baker noted that this was designed so that an employer could not, for example, set up a dental plan for a few months and then cancel the plan as soon as the wife of a company president received reimbursement for certain dental services.

In addition, a plan can't be designed so that the only beneficiaries would be highly compensated employees or their dependents, Ms. Baker said.

In addition, benefits must be put in writing and communicated to all employees.

For example, a plan would fail Section 89(k) if company owners decided to reimburse an employee's spouse for cosmetic surgery without notifying all employees of this added benefit, Ms. Baker said.

And, Section 89(k) penalties are much tougher than Section 89.

If a plan fails Section 89(k), all employees who use the "discriminatory" benefits are taxed on the amount—not the cost—of the benefit they use. ■

Congressional staff is blamed for law

ATLANTA—The complexity of Internal Revenue Code Section 89 can be blamed on overzealous and unsupervised congressional staffers, a benefit manager says.

"This is a case where congressional staffers were allowed to act on their own," Dick Bowen, director of benefit planning at Enserch Corp., a diversified Dallas-based company, said during the Risk & Insurance Management Society conference in Atlanta last week.

One example of Section 89's complexity is that it requires employers to consider every employee benefit option, such as plans with different deductibles, as separate plans.

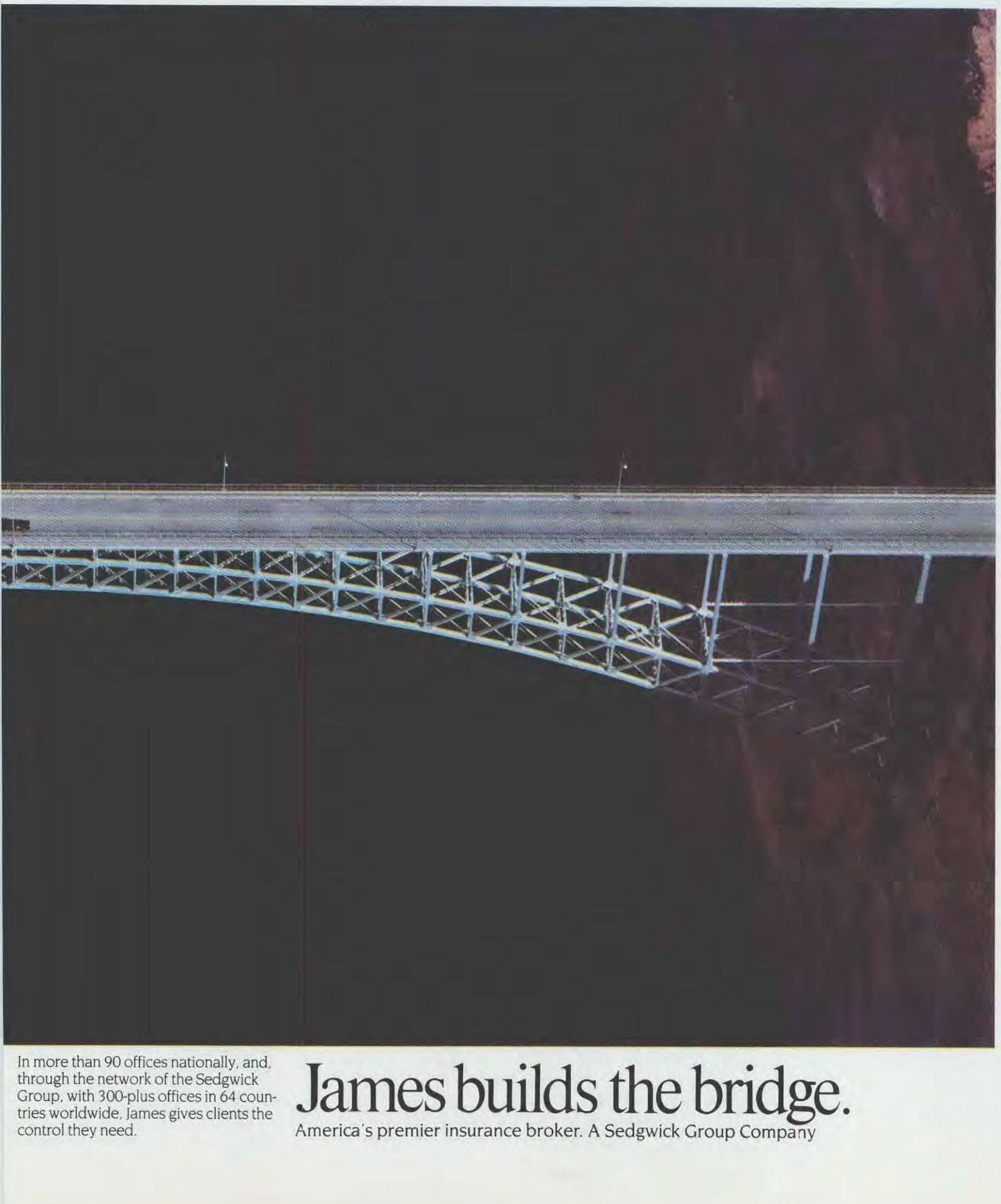
"If you had asked me a few years ago how many medical plans we had, I would have said four or five. But, at last count under Section 89, we had 76 plans," he said.

Mr. Bowen said it appears that Enserch's health care plans will pass the major non-discrimination tests.

But the cost of collecting data and running the tests has been high. Mr. Bowen said data collection and running the tests have cost between $25,000 and $50,000 in company computer time alone.

—By Jerry Geisel

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Flex plan design can help minimize cost

By DONNA DiBLASE

ATLANTA—Flexible benefits plans can help employers better manage their benefit costs while also providing employees with a choice, according to some benefit experts.

However, employers must consider certain plan design aspects to minimize benefit costs resulting from adverse selection in flexible plans, the experts said.

"From an employer's perspective, a flexible benefits plan meets diverse needs, maximizes tax advantages of providing benefits and achieves the direct involvement of employees in benefits selection," said Ganne DeSomery, director of risk management for Data General Corp. in Westboro, Mass., at a session held during the 27th annual the Risk & Insurance Management Society conference last week.

And, flexible benefits plans "provide a better structure for employers to control costs because employers define how much they are going to spend on each employee," she said, referring to the allocation of credits or benefit dollars under the plans.

From an employee's perspective, flex plans increase satisfaction with benefits and give them the opportunity to choose benefits that best meet their needs, she said.

Adverse selection in a flexible benefits plan occurs when each employee is permitted to choose without limitations the options that best meet his or her needs, said William Lamb, a principal in the Boston office of the actuarial, benefits and compensation consulting practice of Coopers & Lybrand.

Flexible benefits provide a 'structure for employers to control costs,' says Ganne DeSomery.

For example, employees who typically utilize a lot of health care services usually opt for the richest health plan, while employees who do not often utilize health care choose less coverage, he said.

"Selection costs cannot be completely eliminated from a flexible benefits plan. But, the key is to manage this cost through plan design, communication of the plan and the flex credits and option pricing in the plan," Mr. Lamb explained.

In the typical flexible benefits plan, each employee is given a specific number of benefit credits, or "flex dollars." Employees have a menu of benefit options from which to choose, each of which has a certain price tag.

Employees then select their benefit options, and if the total "cost" of those options exceeds the amount of flex dollars provided to the employee, the balance is paid by the employee through pretax salary deductions, said Ms. DeSomery of Data General Corp.

If the cost of the selected options is less than the amount of flex dollars given to the employee, the difference can be refunded in cash to the employee, or the employee can use the remaining amount to "buy" other benefits or vacation days, she explained.

Flex dollars can be allocated to employees in several different ways, said Andreas Hauer, a senior consultant in the New York office of Coopers & Lybrand's benefits consulting division.

"Employers can determine what the average annual cost of benefits per employee is and then allocate the same flat amount to all employees," Mr. Hauer said.

Or, flex dollars can be allocated based on a percentage-of-pay formula, on the employee's years of service or on a combination of these methods, he said.

Some flexible benefits plans are designed so that all employees are offered a core package of benefits. Employees then can buy more coverage or reduce coverage and receive cash.

Other flex plans are designed so that employees receive enough flex dollars to buy back the level of benefits they had under the employer's previous health benefit plan, he said.

When determining the price of the options under a flex plan, employers should "compile data on their current costs and then project the values of the options," Mr. Hauer said.

Employers also should consider their own cost-saving goals, the value of buy-back benefits and how employee waivers of certain benefits—such as life insurance—will affect plan costs, he added.

The factors affecting an employee's choice of benefits options include the price of the option; his or her expected utilization of the benefit; the employee's attitude toward assuming some of the financial risk involved in choosing lower coverage options; and the employee's understanding of benefit trade-offs, Mr. Hauer noted.

Employees who select higher coverage options and are higher utilizers of care minimize their own out-of-pocket costs but drive up the employer's costs under the plan, Mr. Lamb said.

Therefore, employers should include the following plan design features:

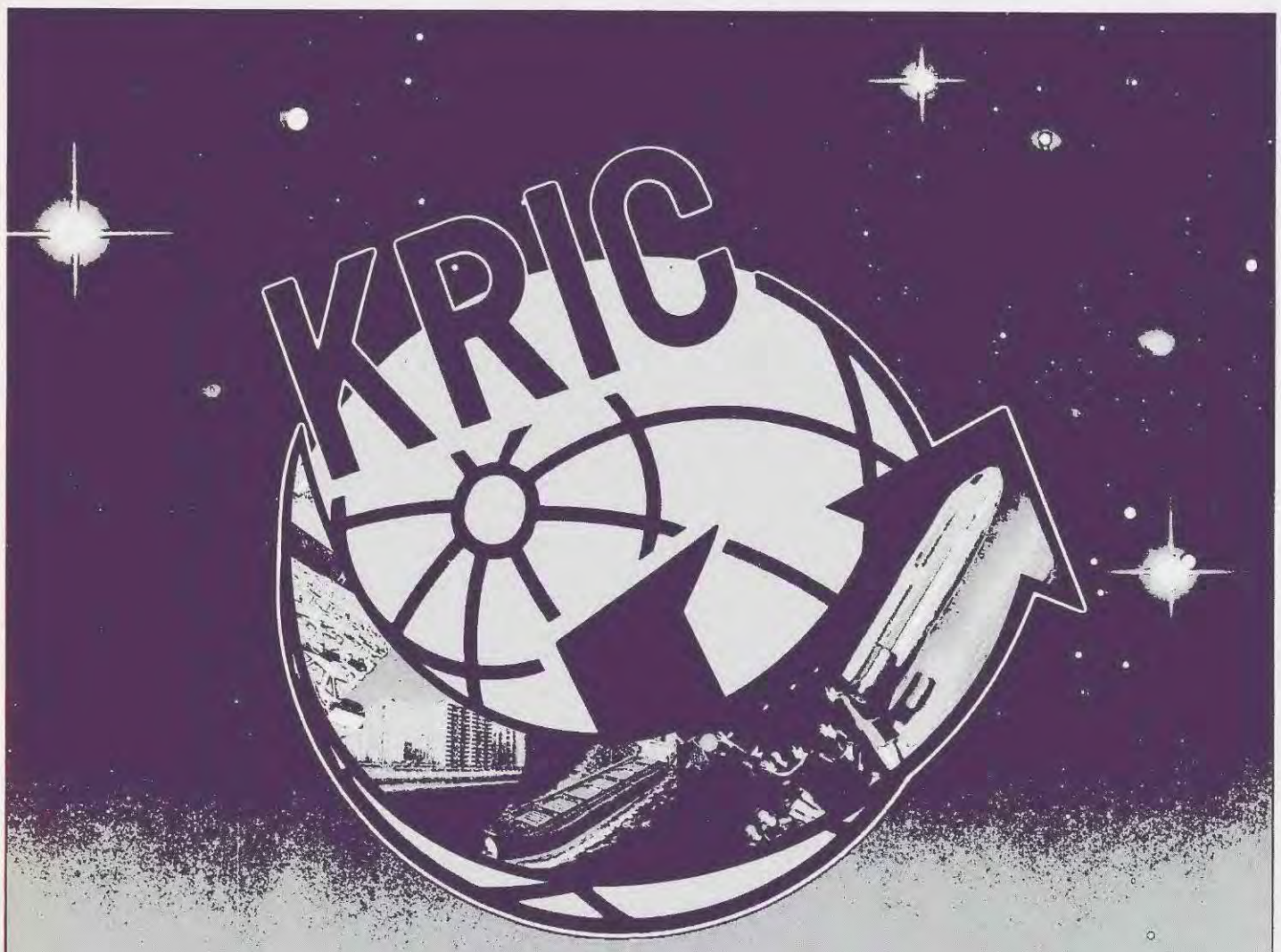
- Limiting employees to jumping only one benefit level each year they re-enroll in the plan after the initial enrollment period. For example, if an employee enrolls in the middle coverage health plan in the first year, he or she can then only move up or down only one level the following year.
- Combining some benefits under the options available in the plan. For example, a high coverage dental benefit can be combined with a low coverage health plan as one option.

However, this technique may reduce meaningful choice so much that the negative impact on employee satisfaction may not be worth the savings in selection cost.

- Requiring longer periods for participation in or exclusion from benefits options, such as two-year lock-in periods for certain coverages.
- Requiring employees to choose a health plan that at least covers catastrophic costs or a disability plan that provides at least 40% coverage.

Along with these plan design considerations, employers must design communications materials that lead employees to make choices that do not create selection costs, Mr. Lamb said.

The panel was moderated by Ms. DeSomery of Data General. ■



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Employer finds 'informal' EAP works best

By JAMES M. BURCKE

ATLANTA—Actively working with employees who need substance abuse or mental health treatment helps the worker obtain high-quality care while saving the employer money, a benefit manager says.

An "informal" program at Minneapolis-based Genmar Industries Inc. that includes employee assistance and utilization review programs as well as negotiated contracts with preferred providers has paid dividends to the company and its workers, said Ed Laginess, vp of employee relations for Genmar, a unit of Minstar Corp.

Through the program, "we can save money and help employees to a better recovery," he said.

Mr. Laginess moderated a seminar on managing mental health and substance abuse costs at the 27th annual Risk & Insurance Management Society conference last week in Atlanta.

Mr. Laginess stressed that the 18-month-old program is not formally structured, though employees seeking non-emergency mental health or substance abuse treatment must contact Genmar's utilization review firm or risk a 50% cut in benefits.

"Employees are more likely to use an EAP if it is informal," he said.

The program, especially as it applies to substance abuse patients, is founded on the principle that the company cares for its workers and wants them to recover from their problems, Mr. Laginess explained.

Under the program, the company encourages workers with substance abuse problems to notify an EAP coordinator in their local plant. The EAP coordinator, usually a member of Genmar's employee benefits department, is available to discuss the employee's problems and available options. However, only a utilization review expert—not the EAP coordinator—makes specific recommendations about what type of treatment the employee should seek.

In addition, the EAP will provide support services to a substance abuse patient's family to help it cope while he or she is seeking treatment.

To encourage employees to seek help from the EAP, the company stresses that no disciplinary action will be taken against an employee with a substance abuse problem who seeks treatment.

"We will give them all the support they need," Mr. Laginess said. "We will guarantee them their jobs."

"It's a matter of gaining their trust, explaining to them that they are not going to be penalized," he said. This strategy works, he said, noting that "employees are now coming to the program for advice."

However, while Genmar is willing to help substance abusers find treatment, the company's compassion only goes so far, Mr. Laginess added.

"We will become very supportive and take him through the (detoxification) program once—not twice or one and a half. If he doesn't remain clean, he is terminated," Mr. Laginess said. "We invest too much time and money to play games with the employee."

"I feel, like many of our employees, that (substance abuse) is a self-inflicted problem," he said. "We do not have the responsibility to take them through the program more than once."

However, Mr. Laginess again noted that Genmar's policy is flexible, explaining that the company would help an employee who actively requests treatment even if he has already completed a detoxification program.

Genmar's program not only encourages employees with substance abuse problems to seek treatment, but the UR portion of the program helps them find the most appropriate care, Mr. Laginess pointed out.

For example, utilization review doctors and nurses discuss treatment alternatives with health care providers and, in turn, relay information to the employee.

He said that UR staffers often recommend that substance abusers seek outpatient—rather than the more traditional inpatient—detoxification treatment. In fact, 70% of Genmar's employees and dependents in Florida who seek substance abuse treatment are enrolled in outpatient care programs, he said.

"We have shifted a great deal of cases to outpatient care and it has been very successful," he noted.

However, Mr. Laginess noted after the session that it is important for an employer to subject outpatient care to the same stringent UR procedures as inpatient care since health care providers are inflating outpatient costs to make up for decreased inpatient utilization.

And, when inpatient treatment is required, it is not necessary for a patient to spend the traditional 28 to 30 days in an inpatient facility, he noted.

"Once a person is detoxed, I do not see any reason for hospitalization. We won't stand for needless hospitalization," Mr. Laginess said, adding that many detoxification programs last 28 days because that is the maximum length of stay covered by many employer's health care plans.

He pointed out that keeping a substance abuse or mental health patient in a facility for too long can hurt chances for recovery.

Referring to "teen-age crisis cases," Mr. Laginess said that often an adolescent is "locked up for eight months. Then, they let him go home with the stigma of 'Where have you been?' "

While conceding that Genmar's program has not reduced the company's costs, "we have put a hold on cost increases," Mr. Laginess said.

That in itself is a success because mental health and substance abuse treatment costs are rising 30% to 35% annually, said Jeff V. Aycock, assistant vp with Compass Health Management in Savannah, Ga., a unit of Crawford & Co. Compass is Genmar's UR vendor.

Mr. Aycock pointed out that 20% to 30% of all inpatient hospital days are related to mental health or substance abuse problems, "but this may only be the tip of the iceberg."

Another panelist, Richard C. Groepper, a national account executive for Crawford in Atlanta, stressed that employers, health care providers and managed care professionals such as UR vendors and EAP administrators must work together to help control mental health and substance abuse treatment costs. ■

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No 'simple solution' for outpatient costs

By JERRY GEISEL

ATLANTA—Simple approaches to control soaring outpatient health care costs are doomed to failure, a health care management expert says.

"Health care is an enormously complex service. It is impossible to come up with a simple solution to control costs that will work in the long run," said Leslie Michelson, president of Santa Monica, Calif.-based Value Health Services Inc.

The most popular approaches to controlling health costs—health maintenance organizations, diagnostic related groups and preferred provider organizations—are only partial remedies to rising costs, Mr. Michelson said during a session last week at the 27th annual Risk & Insurance Management Society conference in Atlanta.

HMOs and DRGs, for example, are intended to put the brakes on costs by putting the provider at risk, he said. Also, in many PPO arrangements, participating hospitals and physicians will discount the medical services provided.

But none of these arrangements takes aim at improving the quality of care while controlling the volume of services, he stressed.

"There are larger issues to consider in managing care. You need to look at value—is the care appropriate? Were the services performed appropriate?" he asked.

Indeed, in some cases, DRG-type programs have been abused, another health care expert said.

"You find that there is 'DRG creep,' " where physicians may diagnose patients in categories that provide the greatest reimbursement, said Dr. Richard Huset, president of HealthDecision Inc., a St. Paul, Minn., health care management firm.

The most promising approach to controlling the volume of health care services, especially on the outpatient side, while improving the quality of care, is the development of clinically based standards on appropriate standards of care, Mr. Michelson said.

"Clinically based guidelines can play an important role in determining appropriate standards of care," he said.

In fact, Value Health Sciences is now marketing to insurers and other utilization review vendors a software package that uses a clinically based approach to determine if medical care for a certain illness or condition is appropriate (*BI*, Feb. 20).

This program, known as Value Health Sciences' Medical Review System, was developed after years of research during which Value Health Sciences consulted top medical experts, physicians in the field, as well as medical literature, to come up with appropriate standards of care for 36 different outpatient procedures, including cataract extraction and knee arthroscopy. These standards have been incorporated into a computer software program that can be used by review service nurses and insurers to discuss patient information with attending physicians.

If there is agreement that the services to be performed are appropriate, the work is precertified; if there is a disagreement, the case would be turned over to a review physician who contacts the attending physician.

However, if an agreement still cannot be obtained, outside specialists then would be called in for an independent medical exam.

While these types of review or precertification programs are relatively new, especially for outpatient procedures, Mr. Michelson doubts that there will be significant opposition to their use from the medical community.

"Doctors will not oppose reviews as long as the clinical standards on what is appropriate are developed objectively," he said.

There seems little doubt in the medical community that many services now being delivered are unnecessary or inappropriate, he said.

For example, Value Health Sciences' researchers found that as many as 17% of upper gastrointestinal tests may be inappropriate. "Billions of dollars are being wasted," he said.

And, despite widespread publicity that coronary bypass surgery is being inappropriately recommended, the number of operations almost tripled between 1979 and 1986, Mr. Michelson said, citing information compiled by the National Center for Health Statistics.

At the same time, researchers have found huge variations in the rate of medical services performed around the country, for no apparent medically justifiable reasons, Mr. Michelson said.

"There is a wide variation in health care services. And, there is a lot that can be done about it," he said.

Until recently, though, little attention has been paid to controlling medical care costs on the outpatient side through precertification programs, said Patty Armocida, director of utilization management for Blue Cross & Blue Shield Assn. in Chicago.

Employers and insurers may have felt that UR programs, such as precertification, would not produce enough savings to justify the cost of installing and operating the programs. Indeed, employees often were encouraged by their employers to use health care services on an outpatient basis, she noted.

For example, believing it made sense to give employees an incentive to stay out of high-cost hospitals, some employers often gave greater coverage for services performed on an outpatient basis than for inpatient work.

But such a strategy may be backfiring, health care management experts say. Some even suspect that hospitals are increasing fees for outpatient services to compensate for falling inpatient revenues.

In fact, as much as 50% of health care dollars now are going for outpatient care, up from 20% a few years ago, Ms. Armocida said.

In addition, the cost of an average outpatient visit has increased by 88% since 1984, while the volume of visits also has increased substantially, she said.

Outpatient precertification programs can be successful in controlling costs, but only if they are tightly focused, she said.

For example, an employer would want to design its program to focus on costly medical procedures where there is a wide variation in practice patterns, she noted.

"In setting up review programs, the programs must be focused on specific procedures that are causing the greatest problems," Ms. Armocida added. ■

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Assessing LTD claims takes careful hand

By MICHAEL SCHACHNER

ATLANTA—Assessing disability claims poses unique problems for employers, says a group disability insurance underwriter.

"Disability is not a medical issue, and it's not a legal issue," said James S. Mishizen, director of group disability for EQUICOR-Equitable HCA Corp. in Pittsburgh.

"Disability is an administrative issue that falls somewhere between medical and legal" Mr. Mishizen explained.

Long-term disability benefits generally are intended to replace a reasonable portion of income lost because of serious illness or injury during a worker's career, but defining what is "reasonable" may not be the same in any two cases, noted Robert G. Ostrander, regional sales manager in New York for Portland, Maine-based UNUM Life Insurance Co.

And, nobody can determine what constitutes a serious injury in all cases, Mr. Ostrander said.

Messrs. Mishizen and Ostrander spoke about managing long-term disability insurance at the 27th annual Risk & Insurance Management Society conference last week in Atlanta.

"All disabilities are not created equal. That's what makes this whole business of evaluating disability so difficult," Mr. Mishizen said.

For example, determining disability claimants' level of impairment is difficult, he said.

Social Security laws governing disability insurance say that if an injured worker is capable of using his or her existing job skills in another position, the worker no longer is eligible for disability compensation, Mr. Mishizen pointed out.

But, it is difficult to prove, for example, that a highly skilled worker, such as a nuclear physicist, can use his or her job skills to drive a taxicab, he said.

"It's much easier to establish transfer-of-skills among the semi-skilled category of workers," Mr. Mishizen said.

Employers should do their utmost to control the disability evaluation, Mr. Mishizen said.

Challenging a questionable claim or terminating a disability complaint that appears to be unjust is simply part of the evaluation process, he said.

And, employers should not rely on physicians to determine the extent of a worker's disability, Mr. Mishizen stressed.

"Doctors are called on to provide medical information and medical information only," he said.

In fact, he noted, an American Medical Assn. book titled "Guides to the Evaluation of Permanent Impairment" advises physicians to avoid making disability determinations.

In his remarks, Mr. Ostrnader noted that although a large portion of the workforce is not covered by long-term disability insurance, it is unlikely the government will mandate employer-sponsored LTD benefits for all workers.

Approximately 40% of the U.S. labor force have employer-sponsored insured or self-insured group LTD coverage or purchase private coverage, he said.

That leaves 60% of the labor force and their dependents relying strictly on Social Security for disability payments if they suffer a severe injury, according to Mr. Ostrander.

And, due to inflation, "workers need more money now than they did 10 or 15 years ago," Mr. Ostrander said.

"Replacement income needs to come up even though there would be financial implications for the employer," he noted.

'Disability is not a medical issue, and it's not a legal issue,' says James S. Mishizen, director of group disability for EQUICOR-Equitable HCA Corp. in Pittsburgh. 'Disability is an administrative issue that falls somewhere between medical and legal.'

Mr. Ostrander cited a UNUM survey of 26,000 of its group LTD policyholders that found 12% of employers provide LTD benefits that replace 70% of income; 70% of employers provide benefits that replace 60% of income; 15% of employers provide benefits that replace 66% of income; and 3% of employers provide benefits that replace 50% of income.

Despite his call for increasing disability replacement income to offset inflationary pressures, Mr. Ostrander warned employers not to make disability replacement income profitable to the disabled worker.

He reiterated that the benefit is designed only to replace a "reasonable" portion of lost income.

Also speaking at the seminar was Gordor. M. Sherman, regional commissioner of Social Security administration for the U.S. Department of Health and Human Services in Atlanta.

Anne M. Zug, corporate director of insurance for Radnor, Pa.-based Main Line Health Inc., moderated the session. ■

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Intervention through an EAP pays off

By KARI BERMAN

ATLANTA—Employers unwilling to allocate funds for employee assistance programs will pay the price in the long run, according to employee benefits experts.

"If an employee has any kind of a problem that goes unrecognized and untreated it will develop into a crisis, which increases the employer's costs across the board," said Scott J. Pontier, director of Summit, N.J.-based Resources in Employee Assistance & Corporate Health.

Employees with untreated problems are unhappy employees and are usually unproductive, Mr. Pontier explained. And unproductive employees also typically have higher health care costs and are absent more than other employees, Mr. Pontier pointed out at a session at the 27th annual Risk & Insurance Management Society conference last week in Atlanta.

He estimated that one of every four employees suffers from either stress or substance abuse-related problems that hinder job performance.

In addition, Mr. Pontier reported that 76% of chemically dependent individuals are full-time employees, illustrating the huge financial losses that employers could incur if troubled employees do not have a source for obtaining help.

Employers without EAPs often end up absorbing a heavy loss because employee problems can result in tragedies.

Often, the catastrophe that triggers employer interest in implementing an EAP occurs in the workplace, adding workers' compensation claims to the long list of financially draining costs directly linked to some type of personal employee problem, according to Leo Kiebala, a vp at Applied Risk Control Corp. in Atlanta.

Employees who are consumed by either their personal problems or by a substance addiction are often preoccupied and more likely to be involved in a workplace accident, Mr. Kiebala said.

"Having an EAP and getting employees the help that they need can help reduce the potential for accidents in the workplace, avoiding additional costs in workers compensation," Mr. Kiebala pointed out.

Mr. Kiebala told attendees that an estimated 10% to 15% of the workforce are substance abusers and 10% of them are involved in workplace accidents.

Mr. Pontier of Resources in Employee Assistance said he believes more employers are finally realizing the financial toll that ignored employee problems can take on their businesses. He reported that an estimated 70% of Fortune 500 companies now have EAP programs as part of their employee benefit packages.

"Employers are finally getting on the ball and realizing that employee problems are going to effect productivity and cost them in the end," Mr. Pontier said.

However, he stressed that the key to a successful cost-effective EAP is employer understanding of how the EAP works and how it can best service employees.

Typically, EAPs are employer-funded and provide troubled employees with a place to go for confidential and professional help in solving their problems.

The structure of the EAP depends on the employer and the demographics of the company.

Some employers that operate out of one location establish EAPs on-site and select the counseling staff.

Other employers with several branch offices often contract with an independent EAP service provider and pay an annual fee per employee and dependent who use the program.

Mr. Pontier advised employers to train all managers and supervisors to:

- Identify potentially troubled employees through job performance evaluations. Unpredictable roller-coaster performance is a telltale sign of emotional or substance abuse problems, according to Mr. Pontier.
- Recognize the warning signs of emotional distress. Those signs include sudden angry outbursts and irrational emotional behavior.
- Recognize the warning signs of chemical substance abuse. Those signs include frequent absenteeism and general irresponsibility.
- Properly intervene. The manager should not attempt to act as the EAP professional by trying to help solve the employee's problem, but rather should refer the employee directly to the EAP office.

Mr. Pontier also stressed that employers should provide employees with comprehensive communication packages explaining the benefits of having an EAP. He suggested using brochures, posters, payroll stuffers, educational meetings and video programs.

However, Mr. Pontier cautioned employers about representing EAPs as mainly programs to treat problems related to substance abuse.

"Employees need to know that an EAP can be used for any kind of problem and not feel that others will think they have a drug problem if they seek help," he explained.

Employees also can use EAPs for help with marital problems, depression, anxiety, eating disorders and financial pressures.

M. Adelle Spradely, corporate insurance-risk manager at K. Hovnanian Enterprises Inc. of Red Bank, N.J., was the moderator for the session. ■



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RIMS exhibit hall provides one-stop benefit shopping

By DONNA DiBLASE and KARI BERMAN

ATLANTA—Employee benefit managers know their jobs aren't all peaches and cream.

In fact, most benefit managers deal with an array of daily challenges, such as new regulations governing benefit plan administration, escalating health care costs and their employees' need for data and information about their benefit plans.

But, benefit managers last week found a one-stop shopping mall full of products and services to help them sweeten their management tasks.

At the 27th annual Risk & Insurance Management Society conference last week in Atlanta, exhibitors presented benefit managers with a variety of products and services designed to simplify benefit plan administration and health care cost containment.

For example, benefit managers can take the law into their own hands with a new software package that performs the Section 89 non-discrimination tests.

POWERPACT now is available from Naperville, Ill.-based Resource Information Management Systems Inc. and can be used to collect and maintain data on benefit plans, plus test the plans for compliance.

The system, which operates on a personal computer, costs $3,000 and includes one year of service and support from Resource Information Management Systems, explained Robert A. Hass, director of account management.

Resource Information Management Systems, which traditionally has focused on mainframe or minicomputer-based employee benefit information systems, also is offering a personal computer software product —known as POWERFLEX—that administers cafeteria benefit plans.

Employers with self-insured benefit plans also learned about a new electronic claims processing system being developed by Dyer Wells Computations Inc. of Marietta, Ga.

Called Inte*Link, the system is being developed for a consortium of 16 health insurers and will be marketed to self-insurers and other commercial insurers starting next month, said Michael A. Penney, manager of personal computer products for Dyer Wells.

Inte*Link enables insurers and self-insured employers to have claims data uniformly edited and stored so that the data can be interfaced with the employer's or the insurer's data base.

The system electronically processes hospital, medical, dental, Medicaid and Medicare claims directly from health care providers, therefore eliminating paperwork, Mr. Penney said.

To enter claims data or to adjudicate a claim, claims analysts need only answer a set of interactive questions on the computer screen. The analyst describes the particular format of the claim being entered, and Inte*Link automatically interfaces the information with the employer's or insurer's claims data base.

Dyer Wells has not yet released the system's price.

Benefit managers concerned about managing their health maintenance organization premium costs also learned of a new software product available from MEDSTAT Systems Inc. of Ann Arbor, Mich.

RateCheck currently is being used by General Motors Corp. and the United Auto Workers in a project to determine adequate rates to be paid by the company and union members to HMOs, said Bruce W. Boldurian, a product manager with MEDSTAT (*BI*, July 25, 1988).

With the RateCheck software, employers can:

- Determine HMO rates that reflect the demographics of the employer's HMO enrollees, such as age, gender and geographic location.
- Evaluate premiums charged by various HMOs and justify premium changes.
- Perform modeling to determine the financial effects of enrollment shifts from indemnity plans to HMOs or vice versa.

The system uses claims data from an employer's indemnity plan, plus any available data from the HMOs with which the employer contracts. RateCheck enables employers to perform actuarial studies of their HMO costs, as well as help them determine adequate HMO premiums, Mr. Boldurian said.

MEDSTAT also offers a variety of other health plan data analysis products. These products can be used by employers to identify efficient health care providers, determine the effects of utilization review programs and negotiate with health insurers, among other things.

After data collection and analysis, the next step on the shopping spree at RIMS included an array of health care cost management programs and services.

Intracorp of Berwyn, Pa., passed out flashlights to help conference attendees see the potential savings in health care case management.

"We hope that the people attending the RIMS conference get a better understanding of how to save costs with case management," an Intracorp spokeswoman said.

Intracorp, a subsidiary of Philadelphia-based CIGNA Corp., specializes in designing comprehensive case management and UR programs that range from standard precertification for inpatient and outpatient hospital care to catastrophic and long-term care case management.

Also, PCC of Burbank, Calif., offers hospital bill audits and analyses to help employers avoid overpaying hospitals for services.

The company also provides review and analysis of pharmacy bills. This review checks for appropriateness of the prescription drug for the employee's illness plus reasonableness of the charges for the drug therapy.

Increased prescription drug costs are the target of a utilization review product offered by MedView of Farmington Hills, Mich.

DURIS provides employers with a comprehensive review of their prescription drug utilization and costs. The program then identifies problems and makes recommendations for strategic intervention.

The program includes a software system that helps employers collect and analyze their prescription drug claims data, said Dr. David S. Segel, an officer with MedView. The program also provides employers with an easy-to-read report of problems and recommended solutions.

DURIS can be used to analyze the drugs prescribed in the employer's population; the amount of generic drug substitution; costs of prescriptions; patient and pharmacist behaviors; and prescribing physician behavior.

MedView then assists employers in implementing such measures as generic substitution programs or preferred pharmacy networks.

Fair Lawn, N.J.-based Medco Con-

Continued on next page



Continued from previous page
tainment Services Inc., a mail-order prescription drug service, quelled the cravings of exhibition hall attendees by dispensing M&M chocolate candy in pill bottles.

While conferees were able to take an M&M prescription with them, they could also place an order for a mail-order supply of the sweets from Medco—in exchange for their business card.

Medco can tailor a mail-order prescription drug program to meet individual companies' needs, substituting generic medication if possible and ordering drugs in volume quantities to reduce costs, a company spokeswoman said.

Because quality care is of the highest priority, Medco runs every prescription through a computerized Patient Profile System that evaluates each prescription in relation to the patient's medical history and red flags potentially dangerous drug interactions resulting from inaccurate prescriptions, the spokeswoman explained.

If all of these products sent benefit managers heads spinning, they could pop an aspirin from office first-aid kits distributed by America's Pharmacy, a mail-order prescription drug firm.

America's Pharmacy can cut the amount that employers pay on the cost of maintenance prescription drugs used by their employees, said a company spokeswoman.

Under the program, employees receive 60-day supplies of drugs, such as anti-hypertensives or heart medications, through the mail. These drugs are sold at a discounted wholesale prices instead of the retail prices that would be charged by a pharmacy, she explained.

In addition, Preferred Health Care Ltd. provided conferees with information on managing increasing costs of mental health care and substance abuse treatment.

Based in Georgetown, Texas, PHC offers employers its PPO-styled PsychCare program, which enables employees to seek appropriate treatment from a preferred provider network of mental health care professionals.

After helping employers design the type of program best suited for their needs, PHC also will assist in developing educational programs for communicating PsychCare to employees, a PHC spokesman said. PHC also offers UR services to help employers manage mental health care costs, he said.

Information about each patient is entered into an interactive computer information system that tracks utilization and cost information on the basis of medical necessity and appropriate care.

A 24-hour hot line is included in the PsychCare program to further ensure that employees receive the help they need without being overtreated at the expense of their employer. ■

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Several areas viewed ripe for cost control

By DONNA DiBLASE

ATLANTA—Employers are fighting the battle of bulging health care bills by identifying new areas ripe for cost control efforts, according to benefits experts.

For example, employers can take steps to identify and manage prescription drug-induced illnesses and physician overbilling. Employers also can control health care costs related to their short-term disability plans.

And, they can reduce their psychiatric and substance abuse costs by improving the quality of care employees and dependents receive.

Specific methods for accomplishing these goals were discussed during "New Ways to Trim the Fat in Health Care Delivery," a session at last week's 27th annual Risk & Insurance Management Society conference in Atlanta.

An area targeted by many experts was prescription drug costs.

Prescription drug costs account for an average of 7% to 10% of total benefit costs today. And, the rate of increase in the prescription drug component of the Consumer Price Index has exceeded the rate of increase in both the medical care CPI and the overall CPI (*BI*, Feb. 20).

"Prescription drug costs are the fastest rising part of Ryder's health care costs," noted Joseph G. Charles, group director of employee benefits for Miami-based Ryder System Inc., which has 30,000 employees.

"These costs increased 31% or more per employee in 1988," he said.

But, M. Lee Morse, president of Health Information Designs Inc. in Arlington, Va. explained that "a very significant risk that often is overlooked in the development and administration of benefit plans is that of prescription drug-induced illnesses." HID provides a prescription drug utilization review program known as "ValueRx."

Drug-induced illnesses most commonly occur when a patient takes a prescription drug that aggravates the patient's ailments.

Or, some drugs used to treat one ailment can create another side effect or condition, Mr. Morse said.

For example, 53% of diabetic patients take prescription drugs for other ailments that actually elevate their blood sugar levels.

And, 37% of patients with stomach ulcers developed them as a result of taking a prescription drug that caused gastrointestinal problems, he said.

"The cost of treating these illnesses often overshadows the cost of the medicine that caused the disease. About 20% of prescription drug costs are related to treating the adverse effects of other drugs," Mr. Morse said.

"One in five of your beneficiaries receives medicines that are contra-indicated for other illnesses or diseases. These can result in nursing home care or hospital care, including surgery," he said.

For example, some 15% to 20% of patients who develop ulcers from medicines used to treat other illnesses need surgical treatment to correct the ulcer.

With the ValueRx program, employers can control their prescription drug costs by "focusing on the appropriateness of care and identifying and correcting unintended, conflicting drug therapies," he noted.

ValueRx merges prescription drug claims data with medical claims data and then uses a software program including more than 200 clinical criteria to analyze patterns of drug use in the employer's population.

The claims data is obtained either from the employer's insurer or prescription drug claims administrator.

Profiles of the patients then are reviewed by specially trained physicians and pharmacists. If these professionals believe that a risk of a drug-induced illness exists, letters are sent to alert the patient's physician. ValueRx issues about 20,000 of these letters monthly, Mr. Morse said.

ValueRx has found that as a result of risk alert letters sent to physicians, 34% of the physicians discontinued the drug in question; 10% reduced the frequency of the drug; 8% had made changes in the drug therapy prior to receiving a letter; and 6% changed to a safer drug as a result of the letters. Forty-two percent, though, made no change in drug therapy at all.

On average, employers can save from $3 to $5 for every dollar spent on the ValueRx program, Mr. Morse contends.

Employers also can trim their health plan costs by guarding against physician overpayment, according to Marcia Radosevich, president of Health Payment Review Inc.

The Boston-based firm's "CodeReview" program detects physician overpayment resulting from physicians' use of improper medical coding under guidelines in the Current Procedural Terminology-IV, or CPT-IV, system.

For example, sometimes codes for more expensive procedures are substituted when a less costly procedure actually was performed.

In addition, physicians sometimes bill for services on an unbundled basis when a particular procedure should be billed for as a package of services, which can be less costly, she said.

For example, some surgeons break down and bill separately for the procedures that are necessary steps in performing a hysterectomy, she explained.

Continued on next page



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Continued from previous page

CodeReview analyzes physician and surgeon bills for correct usage of payment coding. The program has found that "about 35% of all paid surgical claims contain coding errors," Ms. Radosevich noted.

On the average, CodeReview saves its employer clients between 10% and 12% on physician and surgeon bills, which translates to an average savings of 1% of an employer's total health care costs, she said. "One percent might sound insignificant, but consider how much 1% of $1 million translates to."

Another health benefits area employers can better manage is short-term disability, said Ronald Smentek, president of Medeval Corp. of Lombard, Ill., which provides disability cost-containment consulting and services.

According to the National Center for Health Statistics, an average of 4.2 days were lost per employee in 1983—the latest year for which figures are available—because of short-term disability and sick time in the United States, he said.

And, about 61% of the 96 million people employed at that time were covered by some form of disability plan, Mr. Smentek said.

Today, between 30% and 40% of disability claims are overstated, or overextended, by an average of three to four weeks, according to Mr. Smentek. And, "25% of the total costs of disability plans are overstated, totaling $4 billion in overpayments," Mr. Smentek said.

Mr. Smentek noted that because physicians often feel a loyalty to the patient, employees can sometimes persuade their physicians to extend their medical excuses for disability leave, he said.

"Income continuation plans do require outside medical oversight to assure that proper time for recovery is allowed but also to assure that no more than the proper amount of time is allowed," he noted.

Employers must identify how their disability claims are being paid and how the plan is being abused, he asserted.

MedEval reviews disability claims to ensure that these guidelines are followed.

Upon receiving a disability claim from the patient's physician, MedEval advises the employer of the proper time needed for recovery.

"The employer then tells the employee how long of a disability term has been approved. The doctor also is contacted by the employer or employee as to this information," Mr. Smentek explained.

"The result is the employee now knows the rules of the income continuation plan and the employer gains control of the plan," he said.

Four out of 10 claims reviewed by MedEval result in at least a 25% reduction in disability costs, Mr. Smentek contends.

Employers also can control the rapidly increasing costs of psychiatric and substance abuse treatment, experts said.

From 1985 to 1987, these costs increased 44.8% nationwide, pointed out Steven L. White, an executive vp with Preferred Health Care Ltd., a managed mental health care firm.

About 30 million Americans suffer from some psychological disorder at any one time, and 15% of them seek some form of mental health treatment each year, he said. About 1% are hospitalized.

"Managing the quality of mental health care employees receive is the way to manage the costs of this care," Mr. White pointed out.

Preferred Health Care offers a managed care program that includes case management and preferred provider negotiations.

The program, known as PsychCare, was launched in 1987 with GTE of California in Los Angeles as its first client, he said.

PsychCare includes four components:

- Patient assessment and referral. Patients call a toll-free number to discuss their problem and obtain direction to a PsychCare provider.
- Contracted providers of psychiatric and substance abuse counseling and treatment. There currently are 6,000 providers nationwide in the network, and they represent a wide range of specialities, Mr. White said.
- Case management. PsychCare concurrently reviews the treatment plan proposed by the provider and acts as a patient advocate.
- Processing and payment of claims. PsychCare prospectively reviews the patient's case and concurrently reviews the claim.

As a result of PsychCare's services, GTE reduced its mental health expenditures 33% to $10 million in 1987 from $15 million in 1986.

GTE's mental health expenditures fell 20% more to $8 million in 1988.

Employers pay for PsychCare's services either on a per-case basis or a shared savings basis.

Under the latter form, Preferred Health Care and the employer usually share 50% each in the savings generated by PsychCare, he said.

Mr. Charles of Ryder moderated the session. ■

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Implement drug testing carefully: Expert

By MICHAEL BRADFORD

ATLANTA—Employers structuring substance abuse testing programs must consider not only their own concerns for job site safety, but also the worries that workers will express, an expert says.

Employers start drug testing programs partly because they are concerned with avoiding on-the-job accidents caused by drug use, said Gregory R. Post, director of special chemistry/nuclear medicine at Pathology Medical Services P.C. in Lincoln, Neb.

Employers also hope to boost productivity by instituting detection programs aimed at reducing drug use among employees, added Mr. Post, whose company functions partly as a laboratory for the Nichols Institute in San Juan Capistrano, Calif.

On-the-job injury rates are two to three times higher among employees who use drugs, he noted.

"Productivity is really the bottom line," he told a group at the Risk & Insurance Management Society conference last week.

Panel moderator William D. Dodge, vp at Fuqua Industries in Atlanta, pointed to statistics compiled by the National Council on Compensation Insurance that indicate work time lost as a result of substance abuse has quadrupled since 1970.

Various surveys on alcohol and drug abuse show "the workplace problem has worsened," he said.

But while employers are shooting for higher productivity and a reduction in workplace injuries, they have to be careful to consider workers' concerns when structuring a drug testing program, said Mr. Post.

The employee "wants that policy to be fair," Mr. Post stressed. "He wants to get a fair shake. If he's not using drugs, he doesn't want to come up positive."

Employees also demand confidentiality. "That one is real important, underline that one," Mr. Post said.

A worker whose confidentiality is violated may have grounds to sue the company, he explained. To illustrate, he referred to a case in which an assembly line worker filed charges against his employer after being "pulled off the line" in front of coworkers because of a positive drug test.

And if a positive result comes back from the lab, employees are concerned that they be allowed due process to explain any drug or alcohol use, he added. "Due process must be there," Mr. Post stressed.

Workers also want access to rehabilitation services when tests come up positive, said Mr. Post.

Some union contracts require companies to provide rehabilitation services and even if there is no mandate, such services should be considered when a drug testing program is being developed, said Albert L. Giles, vp of Independent Forensics Inc. in Voorhees, N.J.

"Rehabilitation is very costly," said Mr. Giles. Most rehabilitation begins with a 30-day program on an inpatient basis "and have a follow-up program after that," he noted.

Mr. Giles said rehabilitation programs generally are not offered with a package price but contain different costs depending on the services required. "The commitment in dollars and cents for rehabilitation is something that is very, very important."

Mr. Giles also said that because of the differences in drug availability and use in different parts of the country, detection programs have to be geared differently according to geographic location.

To learn about such nuances and determine "what you should test for," Mr. Giles suggested that, "the best friend you can have is the Drug Enforcement Agency."

The DEA can provide information on what types of drugs are being used in specific areas, Mr. Giles said. "Believe me, every community. . .is different."

For example, he pointed out that there are drugs in New York "that you virtually cannot find in Philadelphia and vice versa."

He also mentioned that drug testing programs have to be reviewed and changed if necessary, because of changing drug habits.

For example, the use of phencyclidine—also known as PCP—in most parts of the country fell about four years ago. But, he added, "as cocaine enforcement has been more effective in the last year and a half, we see more and more PCP factories going back into operation in a number of metropolitan areas."

Mr. Giles also stressed that a company thinking of instituting a drug testing program needs legal advice early in the process. "Your best guide to your program must be your corporate counsel."

Several factors must be considered when structuring a program, such as jurisdiction and the type of industry the business works within, he said. And the corporate attorney will be available to provide valuable direction for complying with applicable laws and regulations related to drug testing, he added.

Mr. Post mentioned that legal challenges and requirements will be around for the duration of any testing program. He pointed out that lawyers representing a worker who files suit related to drug testing procedures will look closely at how test results are determined.

Plaintiffs' attorneys will be particularly interested in the standards of labs used to test blood and urine samples, Mr. Post said. "Accuracy and liability are issues that are not going to go away."

Labs certified by the National Institute on Drug Abuse meet stringent guidelines established by the organization, and those facilities set the "gold standard" for testing procedures, he said. However, Mr. Post added: "I'm not saying that if you're not using a lab that is NIDA approved, it is sub-standard."

Mr. Giles said that in addition to enlisting the corporate attorney for legal guidance, the designer of the program must form a committee made up of representatives of other departments and involve them in structuring the program.

A top management executive has to be involved in structuring a program, said Mr. Giles, and so do members of the medical, personnel, security, operations and financial departments.

Once a committee is formed, one of its responsibilities will be to come up with a plan for training and supervising personnel responsible for testing, said Mr. Giles.

"This is a program that must be managed like any other good personnel program," he said.

"There are no magic policies or set of rules that can be followed" to ensure that a testing program does not encounter problems, Mr. Giles pointed out.

But those in charge of operating it need to be smart and have sound judgment skills, he noted. ■

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RIMS strives to harvest opportunities

By MARK A. HOFMANN

ATLANTA—The Risk & Insurance Management Society's greatest challenge is to make the most of opportunities that so far "have gone unharvested," said RIMS President Richard C. Heydinger.

For example, the potential of risk management as an "exciting career path has hardly been tapped," said Mr. Heydinger, who is risk management director of Hallmark Cards Inc. in Kansas City, Mo.

To demonstrate where RIMS has been and where it is going, Mr. Heydinger and RIMS President-elect Robert Stasch narrated a visual presentation of the society's activities and challenges for the past year and into the future at the society's annual membership breakfast meeting last week during the 27th annual RIMS conference in Atlanta.

RIMS has continued and will continue to push for enhanced risk management education.

Mr. Heydinger cited the development of nine case studies in risk management for use in collegiate business curricula as an example of this effort.

Mr. Stasch, director of risk management at Detroit-based Federal-Mogul Corp., said this was only one step in RIMS' goal to get risk management included in the course work required by accredited business schools (*BI*, Aug. 29, 1988).

Mr. Stasch noted that one of RIMS' goals is to build the Robert S. Spencer Memorial Foundation Inc.'s scholarship account to $1 million by 1993. The account currently has about $500,000, he said.

Turning to the international risk management community, another speaker cited his group's attempts to further professional education as a means of ensuring that risk management can function in an increasingly global economy.

Brendan Ryan, president of the Australian Assn. of Risk Managers, said education was his group's "primary goal." Education boosts risk managers' professional self-esteem and allows them to meet the increasing demands of their employers, he said.

Advances in technology make the risk manager's job more difficult because new technology often creates new exposures, Mr. Ryan said. The importance of education "cannot be overemphasized."

The International Federation of Risk & Insurance Assns. hopes to "reach agreement on an international standard of risk management education" in the near future, he added.

Promoting risk management education is only one of the major areas in which RIMS and its members will be taking an active role during the next year, stressed Messrs. Heydinger and Stasch.

Other areas include events that have had a significant impact on RIMS during 1988-89: the filing of the massive federal antitrust suit against numerous insurers, reinsurers and Lloyd's of London syndicates last March by state attorneys general; and the passage of California's Proposition 103 in November, Mr. Heydinger said.

Mr. Stasch, who becomes RIMS president on May 1, said RIMS members want to have an "open, competitive marketplace," but that is threatened by both the antitrust suit and Proposition 103. "We—all as members of RIMS—will have to fight for it," Mr. Stasch said.

To aid that fight, RIMS has begun establishing a cadre of members who can act as media spokesmen, Mr. Stasch said.

Mr. Stasch cited two other matters of major importance to the society during the coming year: the work of a recently formed governance task force to enhance the relationship between RIMS and its members and the beginning of a succession planning process to fill the shoes of RIMS Executive Director Ron Judd when he retires in the next few years.

RIMS also will continue to support the National Assn. of Insurance Commissioners' model law on collision damage waivers (*BI*, April 3).

James T. McIntyre, a partner in The McNair Law Firm of Washington, D.C., who serves as RIMS' Washington counsel, offered a few predictions of what Congress might and might not do during its session.

For example, he said that although federal product liability legislation may be introduced this year, action is unlikely because of the continued opposition of Sen. Ernest F. Hollings, D-S.C., he said.

In addition, RIMS will continue to oppose the Reinsurance Assn. of America on the issue of increased excise taxes on reinsurance ceded overseas, Mr. Stasch said.

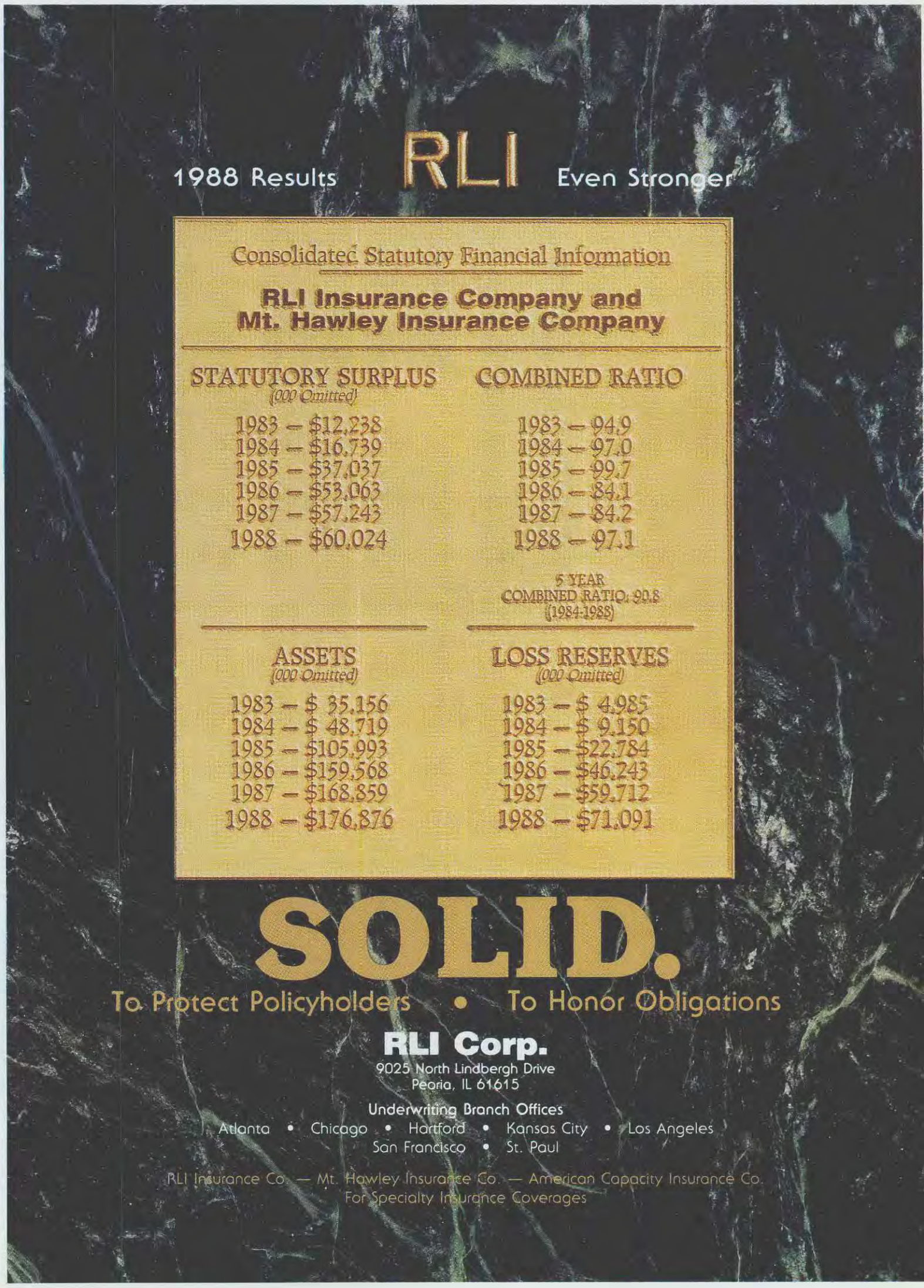
RIMS also is seeking new members. Appropriately, RIMS' newest chapter won the honors as the chapter that increased its membership by the largest percentage during 1988.

The Nevada Chapter, which was formed in 1987, grew by 33%—to 20 from 15 corporate members—in RIMS' membership competition.

The chapter received a complimentary trip for two to London.

In all, RIMS' 79 chapters registered an additional 481 corporate members in 1988. As of April 1, RIMS reported 4,319 corporate members.

Also during the breakfast, Mr. Heydinger bestowed the 1989 Dorothy and Harry Goodell Award on *Business Insurance* Editor and Associate Publisher Kathryn J. McIntyre. ■



Accurate claims data prevents 'death spiral'

By JAMES M. BURCKE

ATLANTA—Employers must take decisive steps to ensure that health maintenance organization premiums reflect the claims experience of the younger, healthier employees who most commonly opt for HMO coverage, experts say.

If not, employers will be locked in a health care cost "death spiral," from which there is no escape, they add.

The "death spiral" starts to churn when employees who are less likely to require medical care leave an employer's indemnity health care plan and opts for HMO coverage, which poisons the loss experience for the employer's indemnity plan, explained Steven J. Richter, vp-product division at Equicor Inc. in Nashville, Tenn.

This adverse selection causes indemnity plan costs to rise as indemnity plan loss experience deteriorates.

And, as indemnity plan costs rise, more low-risk employees will join HMOs to decrease their premium contributions, which can transform the death spiral into a whirling dervish.

"With no treatment, the death spiral will be the end of indemnity plans," Mr. Richter said last week at the 27th annual Risk & Insurance Management Society conference in Atlanta.

Indemnity costs per employee can skyrocket as more employees at a company join HMOs, Mr. Richter noted.

For instance, if 10% of a company's workers join HMOs, indemnity plan costs per employee will rise 3% because of adverse selection, Mr. Richter explained. And, at companies where 40% of the workforce enroll in HMOs, indemnity plan costs likely will jump by 15%, he said.

Another panelist, Brian E. Sweeney, vp and regional financial officer for Equicor in Brea, Calif., noted that 20% of an employer's workers account of 80% of all health care costs.

"And those 20% are likely to be in your indemnity plan," Mr. Sweeney said.

However, employers can slow down the death spiral if they adopt a coordinated strategy to ensure that their HMO premiums reflect the fact that the HMO is primarily covering low-risk employees, Mr. Richter pointed out.

"The death spiral can be reversed, but first decisive action must be taken," he said.

However, he added, "each employer must draft strategy based on his own specifics."

The "most effective" way to combat adverse selection is to negotiate a multiple-option health care plan in which indemnity plan, HMO and preferred provider organization experience is pooled, according to Mr. Richter.

Under such a program, indemnity plan costs will not skyrocket because of adverse selection since the claims filed by indemnity plan members are balanced by the favorable claims experience of the younger, healthier employees enrolled in HMOs, he said.

However, he warned benefit managers to watch for so-called multiple option plans in which HMO and indemnity plan experience are not pooled.

"That won't do the job," Mr. Richter said.

If an employer is unable to establish a multiple-option plan, the next best way to combat the death spiral is to contract only with HMOs that will base premiums on the employer's own claims experience, Mr. Richter said.

Traditionally, HMOs have set premiums using "community rating," in which the claims experience of all HMO members—not just a single employer's workers—is used to calculate premiums.

Noting the fact that indemnity plans are commonly experience-rated, Mr. Richter said employers must develop the philosophy that "we're not going to pay more to the HMO than we would pay to the indemnity plan" for a low-risk employee.

"You're probably paying too much for HMOs because healthier people are in there" if an employer contracts with HMOs that use community rates, asserted Dennis E. Martin, a principal with benefit consultant William M. Mercer Meidinger Hansen Inc. in Atlanta.

"There's no question about it. Avoid community rating whenever possible," Mr. Martin said. "Experience-rated contracts eliminate windfall HMO profits."

Equicor's Mr. Richter said another way to reverse the death spiral is to base employee contributions to HMOs and indemnity plans on experience factors.

He explained that most employers contribute the same dollar amount toward HMO and indemnity plan coverage, which he described as "the worst method to use."

He said the best method is to actuarially determine how much the employer should contribute to a particular HMO based on the plan's costs and experience.

Chicago-based FMC Corp. recently adopted that strategy, according to Denese M. Wojcik, administrator of health care management of FMC.

She explained that FMC actuarially determined how much it will contribute toward HMO coverage in each city in which FMC has employees. These maximum contributions are based on what FMC has determined it would cost its self-insured indemnity plan to cover employees now enrolled in the HMOs.

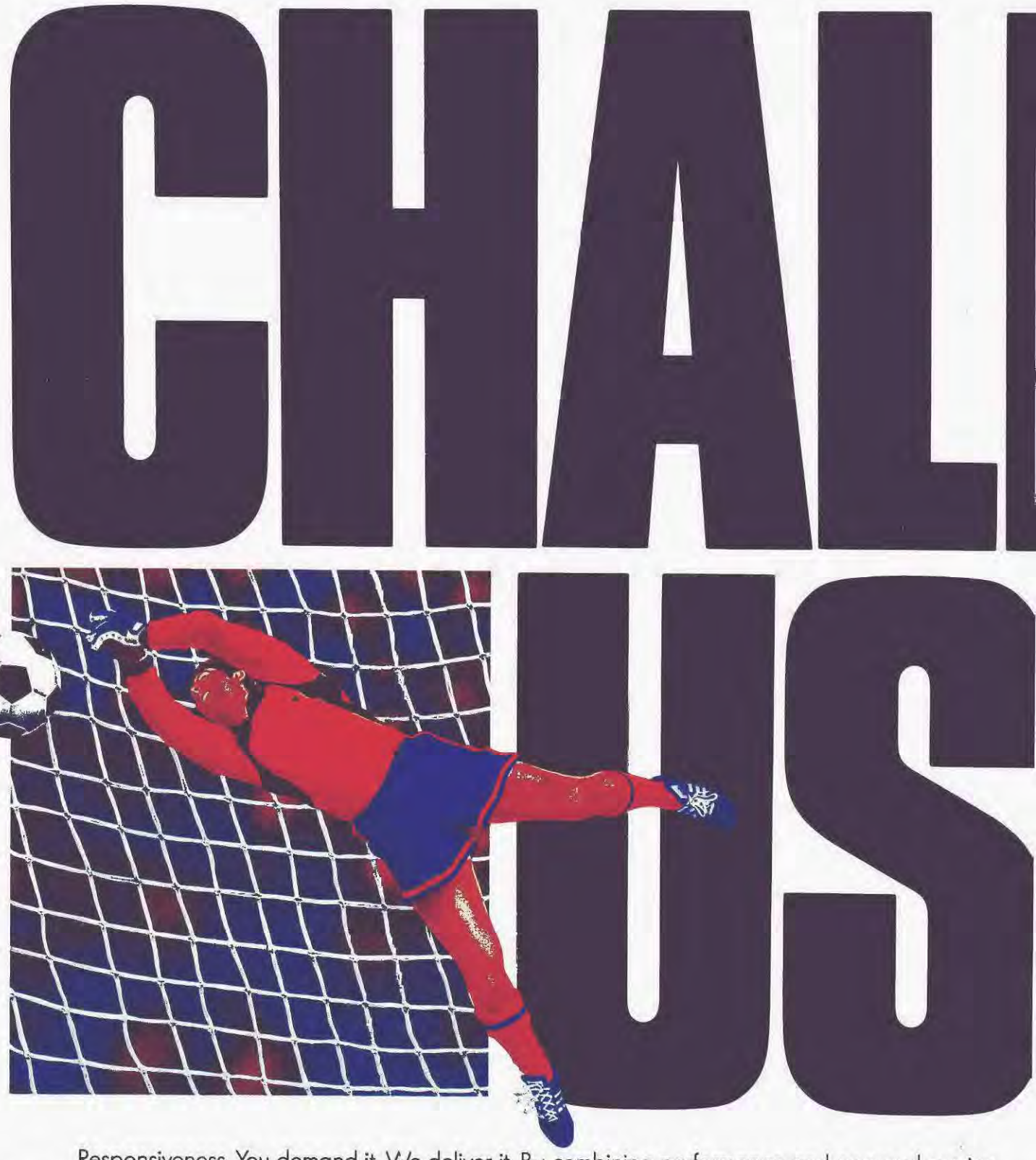
Then, local FMC human resources managers, who are responsible for contracting with individual HMOs, negotiate rates with each HMO that FMC offers its employees. If the rate charged by the HMO exceeds the actuarially determined amount that FMC will contribute, the local human resources manager can choose either not to contract with the HMO or offer the plan with the employee picking up the additional cost.

Ms. Wojcik said FMC expected that employees would be angered by this system. But, "we were surprised. Employees were not disgruntled."

In addition to capping the amount that FMC will contribute toward HMO coverage, the company also drafts its own contract with each HMO instead of using a standard contract, she pointed out.

"We do not sign an HMO's contract; they sign ours," Ms. Wojcik said.

The session was moderated by Martin S. Brown, corporate manager of employee benefits at The Clorox Co. in Oakland, Calif. ■



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'Red flags' signal need for claims audit

By MICHAEL BRADFORD

ATLANTA—Employers should look for several "red flags" that could indicate it is time to audit their benefit claims administration process, a benefits consultant advises.

And, when an audit is necessary, the employer should be able to develop "an action plan" from the audit report that allows it to make any necessary changes in the way the plan is being administered.

While "the first hot button is an increase in claims costs," that is not reason enough to audit a claims administrator, according to Richard P. Miller, regional managing director of benefit consultant Godwins Inc. in Chicago.

"Everybody has increases in claims costs," he observed.

"I think what you need to focus on is not just an increase in the cost of claims but rather, claims that have increased unexpectedly," Mr. Miller said during a panel discussion held during the 27th annual Risk & Insurance Management Society conference last week in Atlanta.

"Have you suddenly had a blip in claims? Have they gone up more than you expected them to, and can you explain why they've gone up?" Mr. Miller asked.

A sharp rise in claims costs is even more significant if it happens over a short period, "as opposed to over six months or a year," he pointed out.

But, not every blip in claims activity means an administrator—whether it is an insurer, third-party administrator or in-house employee—is doing something wrong, Mr. Miller cautioned. There may be a good reason for the increase, like one large claim that pushes up the total, he pointed out.

Complaints can be another good indication that the claims administration process should be scrutinized, Mr. Miller suggested.

"Everybody is going to get some complaints," he acknowledged. "That goes with the territory."

But just as with claims activity, an increase in the number of complaints from employees or providers about the quality of service from the administrator can be a tipoff that something is not right in the way claims are handled, Mr. Miller said.

For example, complaints may focus on slow claim payments.

"Is something happening out there that's causing lots of people to be upset?" he asked. If so, a close look at claims administration might be in order, he said.

However, the "complaint issue is a two-way issue," he pointed out.

"If you get too many complaints, that's a trigger that you ought to be thinking about whether or not an audit would be required.

But, "it's just as appropriate, or maybe more so if you have no complaints," he said. "The worst thing you can have, with a properly run health care program, is no complaints."

Mr. Miller explained that a lack of complaints can indicate that the administrator may be writing checks for every claim. "If they are properly adjusting the claims," some claims will be reduced and others will be turned down, he explained.

And, when that happens, complaints from employees will follow, he said. "So if you get in a situation where there are no complaints, it's just as dangerous as a situation where you have too many complaints."

Staff changes within an administrator's ranks also could signal the time for a claims administration audit, Mr. Miller observed.

If an administrator goes through a management change, it could mean lower level staffers are taking new directions, and they may no longer process claims the way an employer expects, he pointed out.

And, "if you see a pattern of continual turnover, particularly in the adjuster level—people who are day-to-day working on the claims for your employees—that's an indication that something might be wrong," Mr. Miller pointed out.

"Anyone who's worked in plan administration knows how much time it requires to get your administrator to understand what you want to do and pay your claims properly. Probably it's fair to say it takes a year or two before you really have things running smoothly," he said.

Changes to a claims administration system, like switching computer hardware or software, also can interrupt the process, necessitating a reassessment, according to Mr. Miller.

"How many times have you heard your insurance company say, 'We're going to put in this great new system, and it's going to solve all the problems of the world'? And lo and behold, it takes you a year and a half to get back to where you were before they put in the great new system."

When a system change is implemented by a claims administrator, that's the time to make sure "they're paying claims right," Mr. Miller advised benefit managers.

To assess an administrator's performance, benefit managers should conduct an occasional "spot check," Mr. Miller advises.

"You want to ensure that the administrator is on his toes," Mr. Miller noted. An unannounced audit is a way to do that, he added.

"If you do spot checks, even though they may not be comprehensive audits, the people at the claims office are going to know they are subject to audits at any time," he said.

And, once a full-scale audit is determined to be necessary, the employer should expect the auditor to include several types of information in its report, said Barbara Renaud, principal benefits consultant with Thomas L. Jacobs & Associates Inc. in Chicago.

The executive summary in the report "will tell you what's going on, will give you a flavor for what's happening" regarding claims administration, Ms. Renaud said.

The summary, which gives a broad view of the claims administrator's operation, should be followed with information on the administrator's "performance standards," she said. That section of the report should include statistics detailing the number of errors the administrator makes in handling claims.

"The report also gives feedback to the administrator," Ms. Renaud observed. "They know the source of errors, the types of errors that were found, if indeed errors were found."

The objective data helps the administrator avoid repeating mistakes in the future. "So you don't just want a report card. You want information that is going to allow corrections to be made," she said.

Also participating on the panel was Winnie Brock Hinton, assistant manager of Aetna Life & Casualty Co.'s Macon, Ga., claims office.

Perry S. Zukowski, director of corporate risk management at Lane Industries Inc. in Northbrook, Ill., moderated the discussion. ■

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Three options for creating RMIS

A RISK MANAGER FACES three options once he has decided to invest in a risk management information system. Either the RMIS will be developed by in-house data processing technicians, or it will be purchased outright or leased from an outside vendor, or the risk manager will combine elements of both.

Of course, each organization developing an RMIS has its own unique application and selection process. However, the intent of this column is to outline the basic advantages and disadvantages of the available options. This framework would be the same regardless of the hardware environment chosen: mainframe, minicomputer or microcomputer, or a combination of any of the three.

Several immediate advantages to in-house system development are apparent:

- Greater corporate understanding. If the data processing department is selected to build the RMIS, they will have the advantage of knowing the particular organization in terms of its structure, goals, peculiarities. And, they will have access to essential financial data useful to an RMIS exposure data base.

The data processing manager would have—or should have—instant credibility with other line and staff management people and would be in a good position to construct a reflective data base on which the risk manager could develop his analytical software needs.

Obviously, there is little learning curve involved in terms of start-up costs for the data processing department as opposed to an outside vendor, which would need to spend considerable time in getting to know the organization.

- Greater security. Another great advantage would be that the developed internal system would be on a par with the security, quality control and editing features of the existing internal systems. If those in-place systems are excellent already, the RMIS extension also should have those quality features.

There are also some disadvantages associated with an internally developed RMIS, including:

- Low priority. Unless the risk manager and risk management department enjoy a high visibility within an organization, the needs of the risk manager may not receive the priority required to quickly develop a sound and efficient RMIS. Other corporate and management priorities and projects would be in keen competition with the needs of the risk management department. Unless there is a senior executive backing the development of the RMIS, it might not get done for some time.

This also becomes true if a house-developed RMIS is in place already and maintenance work, or system upgrading or debugging routines need to be performed. The priority assigned to the risk management department may not be as high as desired and, therefore, results may be slow.

- Learning curve problem. Although the internal data processing department may have no problem with understanding the organization, it might not have a thorough understanding of risk management and the types of data bases, analytical procedures, report requirements, etc., that are required by the risk manager and senior management.
- Subjective problems. Lastly, should delays, misunderstandings, or other problems surface between the data processing and risk management departments, it may cause some interdepartmental strife that could further exacerbate the problem. Keen political and diplomatic insight by those involved are essential.

The option of purchasing an outside system or leasing a system is becoming a more popular one, especially with the greater availability of low-cost microcomputer-based RMIS. Yet, there are offsetting advantages and disadvantages in going with an outside vendor and system.

The advantages include:

- Experience. The outside vendor—assuming the risk manager has selected the right one—possesses the experience and understanding of RMIS development, implementation and monitoring. There is no learning curve involved concerning the systems themselves and potential applications in a number of different situations.

Usually, these vendors have well-qualified and experienced staff able to design system solutions to the recognized needs of the risk manager. And, they have qualified support staff able to keep the system running properly.

- Availability. Also, these vendors are quickly available. There is no priority scheduling as with a data processing department. These vendors are willing and able to sell the interested buyer a system now. They are also generally available for routine maintenance, system enhancement, etc., after the contract is signed.

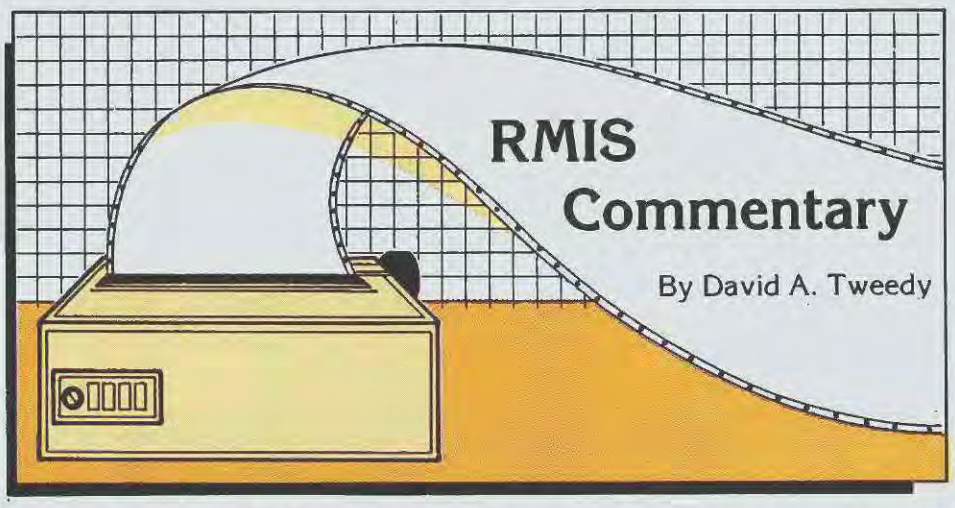
The disadvantages of using an outside leased or purchased system include:

- Learning curve. Although this is not quite as much of a problem for the internally developed system, there is some start-up cost involved here because the vendor must familiarize itself with your particular operation. Not all companies are the same, and although these vendors have probably had similar experience with other companies, a thorough understanding of the information flow and needs of your organization are essential before an RMIS can be designed and installed.

This, of course, leads to increased technical assistance costs during this initial "get acquainted" period. Again, the problem should not be too severe because the RMIS vendor is in the business of installing its systems in a number of different environments.

- Expense. Whereas, many times, costs for an internally developed RMIS system can be spread among various departments using the system, the bill for a vendor-supported system will be directed at the risk management department. If it is an extensive, mainframe-based, time-sharing system, costs can run quite high.

That is not to say that the system is not worth the expense. It is assumed that the risk manager has already convinced senior management of the benefits derived from having an RMIS in place. Nevertheless, the costs will be deducted from the risk management department, and the expectations of staff and line management and other departments, to justify the purchase, will be high.



- Hardware/software incompatibility. Another potential problem is that the hardware and software environment of an organization may not be compatible with that provided by the desired vendor and system. For example, the organization may have an IBM environment for hardware, but the vendor and system that is most attractive to the risk manager may use, say, Digital equipment.

Although, today, this gap has been effectively bridged between many hardware environments, it is an additional barrier to be considered. Even among IBM systems, some bridging is necessary for true compatibility to exist between an RMIS and other data processing elements of an organization. Therefore, more technical assistance is required to ensure proper integration among systems.

- Data control. Although many vendors provide up-front contracts in a relationship guaranteeing the organization ownership of the data, this is a very important point to consider. The risk manager must be certain that he or she has control over that data if a relationship is terminated with an outside vendor.

And, that data must be made available immediately upon the end of that relationship.

- Increasing variety. Though the ever-expanding RMIS industry, in terms of number of vendors and systems, poses unique opportunities for the risk manager, it also presents a dilemma. How does one choose among the variety of systems all essentially claiming the same capabilities and claiming that system is the best for a particular organization?

The risk manager is probably not a computer engineer to be able to tell the difference among these growing numbers of alternatives.

Therefore, he or she must rely on an objective outside consultant or an internal specialist, such as the data processing manager, for guidance. Correct selection is essential considering the expense and the high expectations from senior management and the risk management department itself.

- Political sensitivities. Deciding to use an outside vendor, and, essentially bypassing the data processing department, may cause some sensitivities. The experienced risk manager should be able to carefully chart a course through these potentially difficult waters.

Oftentimes, the best solution to choosing an RMIS system is a combination of the in-house and outside systems. The blending can take many forms. A risk manger may choose to have access to the time-sharing system of an outside vendor, yet use his own personal computer to extract information from that database when needed and perform necessary analysis and reports. Or, he may purchase a stand-alone microcomputer system from an outside vendor with analytical software and communications ability and tie in with the central computer in his organization.

The personal computer can act as a dedicated terminal in hooking up not only with his own organization's mainframe and database, but also an external vendor, if necessary. Many outside vendors are providing stand-alone microcomputer-based products and hoping the risk manager will buy continuous service help from them or occasionally tie in with the mainframe system.

This option seems to be the best in terms of compromise since the benefits of an internally developed system and an externally developed system are both present. More and more, this option is being selected and used by risk managers desiring to have better control over their own programs and becoming more involved in the overall decision-making process of their organizations.

David A. Tweedy is a senior consultant for D.A. 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.



ASK A RISK MANAGER

Several criteria used in broker selection

Q **What criteria do you think are important when selecting an insurance broker?**

A Most discussions on the dilemmas facing the insurance industry today mention the importance of "trust" as the bonding force in the insurer-policyholder relationship.

Trust is also the key element that distinguishes a strong broker-client relationship from one that lacks the essence of a true professional partnership. Communication is a vital link in the relationship since both parties must have a clear understanding of what service objectives are required. It is the risk manager's responsibility to initiate the communication process and to make certain the channels remain open.

One could debate endlessly the question of whether a large, international broker is able to provide a service advantage over a smaller, independently owned brokerage house. I am of the opinion, from personal experience, that "big is not always better" and suggest certain guidelines when evaluating the ability of a broker to service an organization's risk management program.

Gone are the days when purchasing an insurance policy was the most expeditious means of protecting an organization from exposure to accidental loss. In today's climate, a broker must be prepared to provide the client with programs offering an array of risk financing and service alternatives.

Risk financing options are endless, ranging from self-insured programs to sophisticated captive arrangements. A broker should emphasize the importance of employing risk control techniques to reduce the potential of loss and have the capability of providing loss prevention services on a direct basis or assisting in the design of a program through the use of an independent loss control firm.

The same criteria applies for providing a computerized risk management information system. When evaluating the broker's ability to provide services compatible with the needs of the organization, the risk manager must be satisfied that the broker can successfully fulfill the risk management department's goals and objectives.

Most organizations have unique exposures that can develop into significant financial losses if not managed properly. Often there are select markets for these exposures. A broker's ready access to such markets can result in a definite economic advantage to the client. Familiarity with an organization's exposures through the servicing of similar accounts broadens the broker's perspective, thus providing insight into potential liabilities perhaps overlooked by the risk manager. In this regard the broker becomes a second set of eyes and ears, alerting the risk manager to market trends and social issues that could adversely impact the organization.

The business of underwriting an account is sometimes shrouded in mystery! Who are these people called underwriters and what is it that they do? A broker who insists on keeping the underwriter and risk manager at arm's length is providing a disservice to his client. The risk manager is, after all, the best salesperson for his or her organization. By personally explaining reasons for changes in exposures and advising of potential future activities that will further alter the exposure base, the risk manager brings a greater degree of confidence to the underwriter's assessment of the organization's risk profile.

The broker should insist on regular loss reviews with the claims administrator. A risk manager's personal involvement in directing settlement of large losses is a key element in a successful claims management program. All of the service providers, together with the risk manager, should subscribe to the team approach to accomplish the desired objectives. To this end the broker performs a major role by bringing the various parties together and encouraging a close working relationship on an ongoing basis.

Ideally the broker should be imaginative and innovative. By subscribing to "state of the art" technology in operating an agency, the broker is better prepared to provide a vast menu of services. Internally the agency operates more efficiently by computerizing the large volumes of financial, market and client information. Specific examples are maintaining policy information on each client, utilizing a claims tracking system and keeping a current profile on major markets.

Rethinking the question of whether "big is better" when evaluating the size of a brokerage firm I would caution the risk manager to also consider:

- Efficient servicing of a client becomes inundated with bureaucratic red tape if too many hands are involved on an account. Does your account manager have the authority to immediately respond to your needs?
- Continuity of the relationship between broker and risk manager is important. Have key brokerage staff members been employed with the firm for a period of years? Will your account receive personalized attention?
- Customer satisfaction tells the real story! Ask for a list of client references and utilize your risk management network. What is the firm's general reputation with its clients?

I have found the use of a broker qualification checklist, such as the one below, to be useful in the broker selection process. When tallying up the score you may realize the size of a firm is not always the true measure of its service capability.

Broker scorecard

- ✔ Experience with similar risks (same size and complexity): **20 points.**
- ✔ Market expertise (availability to varied markets): **20 points**.
- ✔ Understanding new techniques and developments within the risk management industry (risk finance, risk control): **20 points**.
- ✔ Understanding policy provisions (restrictive clauses and exclusions): **15 points**.
- ✔ Firm's general reputation (client references): **10 points**.
- ✔ Service facilities (supervisory capacity):
  - Claims services: **5 points**.
  - Loss prevention services: **5 points**.
  - Financial services (loss reviews and assessment of rating procedures computer system capabilities): **5 points**.

Total points:
(100 possible points)

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

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


Ms. Werner

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

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

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

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

Youth's death not compensable: Court

The drowning of a 16-year-old employee during an unpaid lunch break at a lake about one-half mile from his worksite was not compensable, according to the Supreme Court of Tennessee.

Tracy Jordan, 16, drowned in a small lake while he and several other young people were on their lunch break.

The young people had been employed for a two-week period to receive training and then supervise other young people in the renovation of low income housing.

Tracy drowned on the third day of the first week of his employment. The program he was employed by arranged to go to the farm to train the youths in the hanging of wall board and the use of other building materials. The supervisors and young workers knew of the lake, which was about one-half mile from the work site.

The young people asked for permission to go to the lake for lunch, which was given, although no supervisor went with them. While there, the youths found a boat and put it into the water.

Tracy drowned while trying to swim from the boat to shore. His mother filed for compensation benefits, but they were denied.

The appellate court was satisfied that Tracy and his companions were engaged in an independent recreational activity at the time of his death.

"They could not in any way be deemed to be furthering any interest of their employer," the court said.

The court noted that the employer neither sponsored nor consented to the boating activity.

The boating and swimming activity constituted a complete departure from the scope and course of their employment, the court concluded.

Jordan vs. United Methodist Urban Ministries, Supreme Court of Tennessee, Nov. 16, 1987 (*BI*/04/Sept.-$10).

Legal briefs

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.*

Canada nets 10 goals to retain the coveted Golden Skate award

By MICHAEL SCHACHNER

ATLANTA—You can argue that the best defense is a good offense, especially when you fill the opposition's net 10 times.

Team Canada proved this theorem in defeating a scrappy Team USA club 10-7 in the closest thing to the Stanley Cup finals in the world of commercial insurance: the 1989 Risk & Insurance Management Society's "All Star" hockey game.

It's a good thing Team Canada won, because the Golden Skate trophy wasn't brought south from its Canadian trophy case anyway.

Unknown to members of Team USA, Steve Patenaude, a senior account representative with Arkwright Mutual Insurance Co. in Montreal and Team Canada's veteran goaltender, left the Golden Skate back in his office in Quebec.

"We were going to keep it. That's why I left it at home," Mr. Patenaude quipped after the game.

The mood on both sides of the red line was upbeat as the "old-timers" played 60 minutes of wide-open hockey for the benefit of the Robert S. Spencer Memorial Foundation Inc. at Stone Mountain Memorial State Park Ice Chalet April 9 to kick off the first day of the 27th annual RIMS conference.

Since the first time these two teams met—at the 1986 RIMS conference in Toronto—Team USA and Team Canada have battled earnestly for the coveted Golden Skate, a trophy only a participant could be proud to win.

The Golden Skate was donated by Georges Balcer, risk and insurance manager for Consolidated Bathurst in Montreal, who captained Team Canada's first team three years ago.

Mr. Balcer said he donated the skate as a symbol of the condition of many of the players.

But, Team USA came to play hard, aiming to capture the trophy for the first time.

"We were embarrassed last year," said Team USA defenseman John Chaney of Rollins Burdick Hunter of Michigan in Detroit, referring to last year's 5-3 defensive match, which Team Canada also won.

"We left a hell of a brunch for this," offered Team USA forward

Continued on next page

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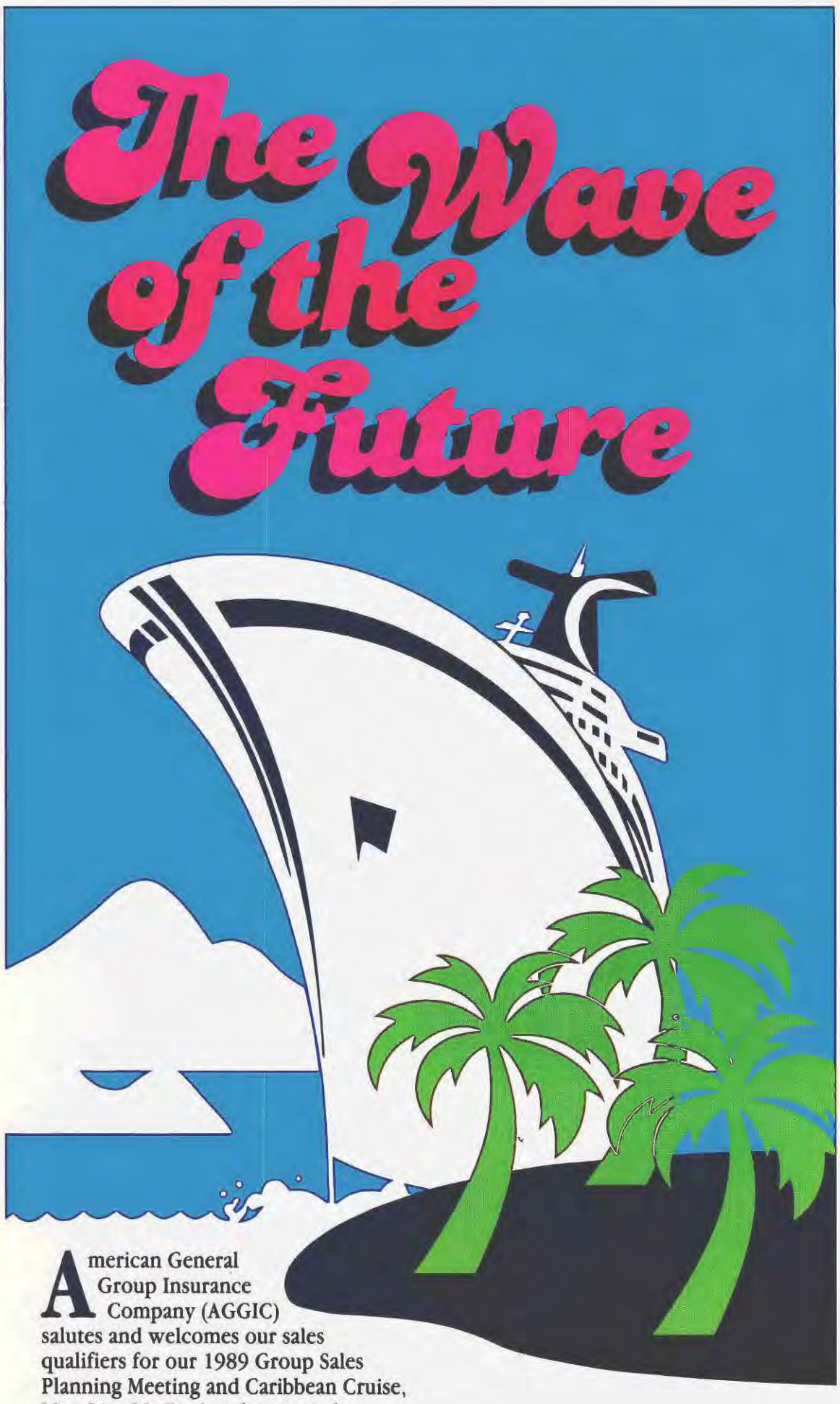
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Spotlight report

RIMS 'All Stars'

Continued from previous page

Sandy McMillan, also of RBH of Michigan.

Team USA's game strategy actually began the night before the contest, according to Peter J. King, who played a little hockey at the University of Dayton in Dayton, Ohio, and who now is an assistant vp with Marsh & McLennan Inc. in Philadelphia.

Mr. King explained prior to the game that Team USA took Canada's best players out the night before until the early morning hours of game day in an effort to tire them out.

But on the bus ride to the rink, the only thing the Canadian players—some of whom were decked out in sunglasses to shield off the morning sun—wanted to know was where were the Team USA players they were with the night before.

In the game, Team Canada got on the scoreboard first as Bob Pusiak of CIGNA Corp. in Toronto jammed home a goal at 4:27 of the first period off a pass from behind the net from Ron Williams of CSP Foods Ltd. in Saskatoon, Saskatchewan.

Two minutes later, Mike White of the Holborn Agency in New York evened the score for Team USA when he picked up a loose puck in Team Canada's slot and skated to his right, snapping off a low wrist shot that handcuffed Mr. Patenaude, Team Canada's goalie, for the tying goal.

The two teams skated out the rest of the first period, with Mr. Patenaude playing sparkling defense to come up with a couple of big saves to thwart Team USA.

First, Mr. Patenaude stopped Bob Nusslein of Arkwright Mutual in Baltimore. Then he stonewalled Dick Pierpont of Johnson & Higgins of Connecticut Inc. in Stamford, who broke in alone despite the fact that Team USA was playing shorthanded while Mr. White served a minor penalty for hooking.

Much to the dismay of Team USA, the second period was all Team Canada.

At 1:16 of the period, Team Canada's Mr. Williams tallied the first of his three goals when he took a feed from Daniel Desjardins of Domtar Inc. in Montreal and slammed the puck by Team USA goaltender Hank Harvey, an Atlanta CPA with Post & Associates.

Shortly thereafter, Greg Hales of American International Group Inc. in Toronto, a solid forward for Team Canada and a member of the sunglasses crew, picked up a loose puck at his own blue line and broke down ice untouched. After a beautiful fake that brought Team USA goaltender Mr. Harvey to the ice, Mr. Hales flipped a shot high into the net over the fallen Mr. Harvey.

A Team Canada goal at 5:24 of the second period by the speedy Mr. Desjardins made the score 4-1 in favor of the Canadians.

Then Rick Morris of RBH of Michigan in Grand Rapids, Mich., finished off the play-of-the-day by beating Mr. Patenaude on a textbook three-way passing play from Stewart Steffey of CIGNA in Philadelphia, and Mr. Pierpont.

But only 20 seconds after Mr. Morris' goal, at 11:59 of the second period, Team Canada delivered the backbreaker.

On the face-off after Mr. Morris' goal, Mr. Pierpont broke in on Mr. Patenaude but was denied by the steady goaltender. Team Canada's Mr. Hales picked up the rebound and drove up the right boards and fed Mr. Pusiak for the winger's second goal of the game.

"That was the turning point of the game," said Team USA Coach Stan Tait of Cadbury Schweppes Inc. in Stamford, Conn. "We had a breakaway, they stopped it and scored at the other end. Instead of the score being 4-3 it was 5-2 and that was it."

After Mr. Pusiak's goal, the two teams played bump and grind for a while as fatigue began to set in. As the players got tired scoring chances became more plentiful.

At 16:55 of the second period Team Canada's Mr. Williams scored his second goal to improve Team Canada's advantage to 6-2.

But, Team USA got that goal back immediately as Mr. Pierpont cashed in a pass off the face-off from Mr. Steffey six seconds later to bring Team USA within 6-3.

However, Mr. Desjardins took a pass from Team Canada's senior member, 59-year-old Lionel Lalonge of Reed-Stenhouse Cos. Ltd. in Montreal, and beat Mr. Harvey with only 21 seconds remaining on the clock in the second period to make the score 7-3.

Mr. Lalonge, who also assisted on Mr. Pusiak's first goal, is certainly no stranger to the game. In his youth, Mr. Lalonge played junior hockey with National Hockey League greats Bernie "Boom Boom" Geoffrion and Jean Beliveau.

"I remember in 1949 my father said to me, 'It's either hockey or insurance,' " Mr. Lalonge said in his French-Canadian accent. "I ended up going to work for the Royal Exchange Assurance of London."

Too bad for the National Hockey League.

In the third period, after a goal by Team Canada's Mr. Hales, teammate Mr. Williams scored his third goal of the afternoon at 7:02 to put his team ahead 9-3.

At 13:32, Mr. Desjardins completed Team Canada's scoring by driving home his third goal of the afternoon off passes from Mr. Pusiak and Dan Vujacic of Scor Reinsurance Co. in Toronto.

But, the never-say-die Team USA gained some respectability by pouring four goals into Team Canada's net in the final six minutes of the game.

Mr. White scored his second goal of the day off assists from RBH's Mr. McMillan and Joseph Tarbell of Corroon & Black Corp. in Boston.

Mr. Tarbell then scored off a feed from RBH's Mr. Chaney.

That goal was followed by an unassisted goal from Peter Bostwick of Johnson & Higgins of New York.

Mr. McMillan closed out the scoring in the game with the game's only power play goal as he smashed the puck past Mr. Patenaude with an assist from Mr. Tarbell.

"I think they had a little better ability," Team USA forward John Gray of General Reinsurance Corp. of Stamford, Conn., said after the match.

"Hey, they scored when they had their chances and we didn't," Mr. Chaney added.

But the true spirit of the afternoon was captured by Team Canada's Mr. Williams, who had a piece of four of his team's goals.

"It was a good game, and we enjoyed ourselves," Mr. Williams said. "Our goalie played well, and he kept us in there."

"I think it was a good game all around," said rookie Team Canada Coach Brian Hammond of the Federal Business Development Bank in Montreal.

And, as for senior Team Canada player Mr. Lalonge, he plans to skate in a few more contests. "As long as I can keep playing this way I will. I'll be back next year. Hopefully, in the Boston Garden."

Next year's 28th annual RIMS conference is scheduled for Boston. When an "old timer" like Mr. Lalonge is already talking about next year and fantasizing about playing in the Boston Garden, you know these guys are loving every minute of it. ■

Risk managers debate changing role

By STACY SHAPIRO

CAMBRIDGE, England—Risk management today is not fulfilling its potential and must change if it is to survive, risk managers, brokers and insurers agree.

Risk managers must take the opportunity to change their roles to maximize their performance in controlling risk for their corporations, according to participants of the recent Assn. of Insurance & Risk Managers in Industry & Commerce conference.

The conference, held April 5-6 at Robinson College, University of Cambridge, was titled "The Rise or Fall of Risk Management—the Present Dilemma." About half of the 300 conference participants were risk managers.

At the opening of the conference, speakers questioned whether risk management could survive under its old insurance-oriented definitions.

But by the end of the conference, risk managers debated whether risk management is too important of a corporate function to be the responsibility of risk managers with limited skills.

Roderick Strutt, managing director-risk finance services division of Sedgwick Risk Management Services Ltd., set the tone of the conference as its first speaker by suggesting that the old definition of risk management is not being fulfilled and in some respects is out of date.

Since a 1956 article in the Harvard Business Review set out the principles of risk management as "the potential guarantor of corporate survival. . .nothing fundamental has changed," he asserted.

Risk management today as it was 33 years ago is defined as a process that comprises four distinct stages, namely:

- Identifying risk.
- Quantifying risk.
- Eliminating, or more usually, reducing risk through risk control techniques.
- Transferring any risks remaining that cannot be eliminated, via self-insurance or commercial insurance.

However, Mr. Strutt argues that there are inherent flaws in the common risk management definition.

"It is a static model envisaging four distinct stages followed in a predetermined and logical sequence," he said. But it does not take into account the interrelationship between the four stages.

Also, the placing of risk transfer at the bottom of the stages "is both theoretically and behaviorally wrong," said Mr. Strutt.

Once a catastrophic risk is identified, the next step must be to transfer it since "in the event, albeit a low probability, of the loss occurring, the corporation could be ruined," he said.

The common risk management definition also has been used as a marketing tool by insurance brokers and others "as a new approach to risk," said Mr. Strutt.

But the message is "naive" when applied for marketing purposes because then corporate executives think it is just another "gimmick to sell more insurance," he said.

Education is totally lacking on the risk management discipline, too, said Mr. Strutt.

While Glasgow College and Nottingham University, which sent students to the AIRMIC conference, both offer university degrees in risk management, and the Institute of Risk Management offers certificate courses, the University of Pennsylvania dropped its course in risk management in 1974 because of "what was viewed as a lack of anything concrete to teach," he said. However, the university currently offers risk management courses as part of its insurance curriculum.

Many books also are written on the subject, but they lack analysis of risk identification and quantification and are more geared toward insurance buying, according to Mr. Strutt.

"This heavy emphasis upon insurance has been reinforced by both the brokers and the underwriters since a broad view of risk management would appear to be beyond the competence of both," he said.

"Indeed, it can be argued that their response to pure risks is wholly inadequate since major areas of pure risk are effectively uninsurable and some insurable areas of risk contain unacceptable exclusions or inadequate limits of indemnity," said Mr. Strutt.

Mr. Strutt warns that professionals may take over the risk management function if risk managers do not change their perspective of their roles.

Otherwise, "the result is that we may be left as insurance managers rather than risk managers. . . .As an industry we have not fulfilled (our) requirement(s) and we have been too complacent.

"Consequently, risk management today has not fulfilled its potential and, unless we remedy this, the territory which we claim as our own will be taken over by other professional groups who will apply the rigor, courage and intellectual honesty which modern organizations will increasingly demand," Mr. Strutt said.

"AIRMIC has recently celebrated its 25th anniversary. Unless we renew our efforts, it will not celebrate its 50th anniversary—the "R" will be missing," said Mr. Strutt.

Mr. Strutt agreed with Felix Kloman, principal and vp of the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. in

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U.K. waste disposal laws

Continued from previous page

Kingdom continues to be dumped in landfills, with 7% disposed of at sea and the rest being chemically treated, solidified or incinerated.

Landfills already have polluted groundwater and contaminated land in the United Kingdom, Mr. Griffiths said.

In Kent, for example, landfills of "co-disposed waste"—waste made up of both household and industrial rubbish—produced methane gas that caused a nearby home to explode when an occupant lit a match in the house, he said.

"In my opinion, there is more ground water contamination than we are being told about," Ms. Lewis said.

In addition, although solid toxic wastes can be incinerated "problems arise when it is not managed correctly," Mr. Griffiths said. For example, if polychlorinated biphenyls are burned at low temperatures instead of high ones, they could produce more toxic fumes rather than neutralize the PCBs.

When managed properly, however, incineration "is an effective way to reduce hazardous waste," he said.

However, many U.K. incinerators are "inadequate" because the smokestacks are not built high enough, causing excessive land pollution, he warned. The smokestacks should be taller to disperse the exhaust further up into the atmosphere and avoid land pollution, he said.

"America is clean compared to us," commented Brian Street, City Production Manager with London-based American International Underwriters (U.K.) Ltd., a unit of American International Group Inc. Mr. Street was a member of the AIRMIC workshop audience.

'As a layman, I am worried about the health of my children and grandchildren. I want someone's head. I don't think the U.K. industry gives a damn about waste disposal,' says Mr. Street of AIU.

Mr. Street pointed out that the House of Commons' Environment Committee on Feb. 22 issued a "damning" report on toxic waste disposal in Britain. "The report is an indictment on the gross negligence of the Department of the Environment, and waste disposal authorities," he said. "As a layman, I am worried about the health of my children and grandchildren. I want someone's head. I don't think the U.K. industry gives a damn about waste disposal."

"We have got a Love Canal in the waiting," Mr. Street warned, referring to pollution resulting from the leakage of toxic chemicals in the Love Canal section of Niagara Falls, N.Y. That pollution resulted in more than $10 billion in claims against Occidental Chemical Corp., which owned and operated the site as a landfill from 1947 to 1952. Occidental, which is appealing a January 1988 decision that it is liable for cleanup costs, settled 1,334 claims against it in 1985 for about $20 million (*BI*, Feb. 29, 1988; Jan. 7, 1985).

"Do we have to wait for a Love Canal to do something?" he asked.

Mr. Street then asked Mr. Griffiths and Ms. Lewis if Britain had the "adequate expertise" to manage hazardous waste in the country.

Generally, the laws are there and the money is there for corporations to properly manage hazardous waste, said Mr. Griffiths. The problem, however, "is enforcement," he said. For example, to date, no one has been prosecuted in the United Kingdom for dumping hazardous waste unsafely, he noted.

"Panic will set in" when an agency like the Environmental Protection Agency is set up in the United Kingdom, Mr. Street says, adding that he thinks such an agency eventually will be created.

Ms. Lewis noted that there are many environmental consultants available in the United Kingdom, although only a few have the scientific equipment necessary to provide full services to clients.

Environmental Strategies Corp., based in Leesburg, Va., has recently opened an office in London, she noted.

And Clayton Bostock, the U.K. branch of Clayton Environmental Consultants Inc., a Novi, Mich.-based unit of Marsh & McLennan Cos. Inc., offers a full range of services, she added. ■

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Units shun sharing risk with parent

By STACY SHAPIRO

CAMBRIDGE, England—Some risk managers for British multinational corporations are having difficulty persuading subsidiaries to share risk financing responsibilities.

For example, some risk managers say their attempts to have subsidiaries assume deductibles rather than purchase first-dollar coverage is being met with hostility from the units' management.

British-based risk managers raised questions about the deductibles at two separate workshops on "Multinationals" and "Problems of Implementing Risk Management in Large Organizations" at the recent Assn. of Insurance & Risk Managers in Industry & Commerce conference at Robinson College, University of Cambridge.

A problem risk managers of large firms face is 'diverse operating divisions,' says Mr. Sparkes.

One of the problems risk managers of large corporations face is "diverse operating divisions," said Terry Sparkes, insurance manager for MB Group P.L.C. in Reading, who headed the "Problems of Implementing Risk Management" workshop.

"We have deductibles. But how do you select the level of deductibles? How do you implement an expensive (insurance) program when small companies who can least afford a loss can't afford the deductible?" he asked.

Mr. Sparkes said his company imposes a 10,000 pound ($16,960) deductible on each operating division for property damage and 50,000 pounds ($84,800) deductible for liability losses.

The group's captive retains 90,000 pounds ($152,640) of both the property and liability risks, he noted.

The corporation then retains a 200,000 pound ($339,200) property/casualty deductible above the captive's retention before risks are insured in the conventional markets, he said.

"We had our overseas operations make their own insurance arrangements until recently when we ar-

Continued on next page

were against the motion. ■

Continued from previous page
ranged a worldwide global liability insurance program," he said. "Some (of the overseas operations) were up in arms with the 50,000 pound deductible, when before they were happy that there was no deductible at all.

"But the philosophy is changing. . .that insurance isn't the answer. They know that they must look to quality control. They want to tackle problems via insurance, and we tell them the way to tackle the problems is via risk management and quality control," Mr. Sparkes asserted.

In the audience, Felix Kloman, principal and vp with the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn., agreed.

After a medical pharmaceutical manufacturer recently imposed a $25 million retention on each operating division, "Their units' attention to loss prevention as a result is much higher," said Mr. Kloman.

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"Insurance gave them an illusion (of security) when the problem was still there. The quality control measure (of imposing the deductible) has improved the performance of the company radically. Insurance may not only be not cost effective, but a long-term disaster," he said.

During the workshop on "Multinationals," leader Ken Hocking, risk control coordinator for Unilever P.L.C., told participants that his company also imposes "substantial" retentions on its subsidiaries.

Unilever owns 500 companies around the world and sells more than 1,000 brands of consumer goods ranging from Pepsodent toothpaste to Lipton tea, detergents and household cleaning products.

The company, with 16.5 billion pounds ($28 billion) in revenues last year, also owns plantations, fish farms and factories that produce medical products.

Part of the retention is assumed by each subsidiary as a deductible, which is partly funded by Unilever's London-based captive, Blackfriars Insurance Ltd., one of only three captives set up in England before World War II.

The operating company's retention is in the "tens of thousands" of pounds, he said. The corporation then funds or insures property/casualty risks above the captive's retention.

Asked whether the deductible posed a problem, Mr. Hocking said: "We had a lot of friction when we introduced it to the chairmen of the companies." But, "generally, they were receptive."

Mr. Hocking said he "sensed" from the audience, however, that there was some resistance by operating companies to deductibles.

"It depends," said one risk manager. "Some say it is OK. Others don't want the deductibles. They would prefer insuring" from the ground up.

Another risk manager said that his company doesn't ask a subsidiary if a deductible is "OK."

"We impose the deductible," he said. "We tell the companies that if they have a problem they should consult with the regional offices, and if they have a problem then they can call us. We haven't had a call yet."

Meanwhile there are other risk management techniques that risk managers of large corporations can use to cut the losses of their multinational subsidiaries, noted Mr. Sparkes in his workshop. These include:

- Writing a corporate risk management policy statement to which the board of directors has agreed. Only a handful of the workshop participants had such policy statements.
- If the company is decentralized, forming a risk management committee that meets at least twice each year.

The MB Group's 16-member committee formerly included primarily the operating divisions' finance directors.

But "it was too finance-oriented," so now there are other production people on the committee, said Mr. Sparkes.

- Produce effective communications to spread the risk management word.

Some MB Group operations now realize 'insurance isn't the answer. They want to tackle problems via insurance, and we tell them the way to tackle the problems is via risk management and quality control,' says Insurance Manager Terry Sparkes.

Mr. Sparkes and other risk managers at the workshop travel regularly to overseas operations to get loss control points across, but the exercise is time-consuming and expensive.

"A video presentation may be one approach which is more effective," said Mr. Sparkes. One risk manager in the audience said he spent 25,000 pounds ($42,400) to put together a video, and the response was so good that he is considering doing another.

"But anything in the video which is too broad-based will not work. You must involve the local company" in the video, said the risk manager.

When another risk manager asked whether large corporations should strive to maintain the parent domicile's safety and security standards in overseas operations or to follow the standards of the local company's domicile, Mr. Kloman responded from the audience: "Union Carbide tried that and failed miserably."

A 1984 explosion at Union Carbide Corp.'s chemical plant in Bhopal, India, killed at least 2,500 people and cost the company more than $400 million in compensation and four years of litigation.

And, Mr. Sparkes said that after he discovered that his company's factories in Malaysia had no fire sprinklers, he persuaded the company to install sprinklers into a new factory at the corporation's expense.

But the manufacturers of the sprinklers had a problem complying with U.K. standards. "We ended up with a costly undertaking," said Mr. Sparkes.

In addition, in the Malaysian factory, the company was persuaded to install a halon gas system to protect the computer room from fire, but the computer room burned during a fire anyway because although the system was installed, someone had turned it off.

"This human error is a local risk management function," said Mr. Sparkes. "Unfortunately they learned from their mistake."

Mr. Kloman asked if the MB Group factored into the purchase of the Malaysian company the expense of bringing the plant up to stricter safety standards. "It wasn't calculated," said Mr. Sparkes.

Asked Mr. Kloman: "Would your company have made the investment in Malaysia" had it known these things in advance? "It shows the importance of the risk manager to be involved in decisions. . .before investments are made." ■



Issues need eyeing after 1992: Experts

By STACY SHAPIRO

LONDON—European risk managers, underwriters and brokers believe there will be a lot of issues to consider after 1992, the target date for the removal of trade barriers in the European Community.

After 1992, they say risk managers with operations in EC member countries will, theoretically:

- Have a greater choice of insurers and brokers.

By 1990, EC nations should have adopted the freedom of insurance services directive to allow large risks to be insured by underwriters across national borders for the first time.

- Work for bigger employers as European companies merge to form huge conglomerates.
- Handle increasing concentrations of risk as corporations consolidate their operations into specific sites across the European Community.
- Be forced to consider learning other languages to conduct risk control and insurance negotiations.

'There aren't many in this room who won't be able to freely buy insurance in the (European) Community' under the directive, says David Ovendon, group insurance manager for industrial conglomerate The Wellcome Foundation.

These were some of the conclusions drawn by the 36 participants of a workshop on 1992 changes at the Assn. of Insurance and Risk Managers in Industry and Commerce conference at Robinson College, University of Cambridge, this month.

The workshop's leader, David Ovendon, is group insurance manager for the U.K.-based industrial conglomerate The Wellcome Foundation.

Mr. Ovendon, who also spoke last week at the Risk & Insurance Management Society conference in Atlanta on the impact of 1992, told AIRMIC participants that he was using the workshop to help generate ideas for his American audience.

"I'm here to get information to give in my paper in Atlanta next week," he said.

Outlining the development of the European Community, Mr. Ovendon pointed out that the original EC members signed the Treaty of Rome to create a common European market in 1957.

Article 52 of that treaty said that one of the objectives of the EC was the "freedom of establishment" allowing European companies in one country to set up controlled subsidiaries in other countries, he explained.

In addition, Article 59 said that one of the other objectives of the EC is to allow the freedom of services across borders.

The EC wrote its first draft of the freedom of insurance services directive for non-life risks in 1973, and the first draft of the life insurance directive followed in 1976.

"But then the EC went to sleep," said Mr. Ovendon.

It wasn't until 1985 that the Single European Act was signed by all EC nations providing enabling legislation to set new objectives for the completion of the internal market by 1992 and the strengthening of economic and social cohesion.

In accordance with the act, the European Commission's White Paper of June 1985, written by Lord Cockfield—vp of the commission until Prime Minister Margaret Thatcher removed him from the post last year—gave a detailed timetable to achieve a European market without internal barriers by Dec. 31, 1992.

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Last year, the EC passed its directive on freedom of service in non-life insurance, which will allow insurers in one EC nation to cover large corporate risks based in another EC country.

Up until now, only the United Kingdom and the Netherlands have allowed such cross-border insurance placements (*BI*, May 16, 1988).

The directive, which should be enacted by almost all EC members next year, provides minimum requirements concerning the size of the risk that can be insured across borders and the size of the company that can purchase insurance across borders, according to Mr. Ovendon.

"There aren't many in this room who won't be able to freely buy insurance in the (European) Community" under the directive, he commented.

The directive's limits are in "ECUs," or European Currency Units, which will eventually become the universal currency throughout the European Community, Mr. Ovendon predicted.

"Some insurance policies are already being written in ECUs to avoid currency problems," said Mr. Ovendon.

However, the directive can be superseded by some national laws that govern insurance purchases, one workshop member pointed out. For example, companies will have to buy compulsory third-party auto insurance within borders of their own countries.

Also, the construction and pharmaceutical industries may have difficulty buying insurance across borders to comply with national laws.

"So, what will all this mean to you?" Mr. Ovendon asked his audience.

"It sounds like there will be a lot of change, in structure, management and so on," he said.

One broker said he had a client in Greece that is trying to become more international. However, the client is inhibited by Greece's special treatment by the European Community, which gives the country more time to pass the directives.

"The client is thinking of setting up outside Greece and going back to Greece when barriers are down," he said.

This is an example of the advantage larger European corporations will have over smaller ones, said other participants.

"So we will get fewer, bigger industries, and the strongest will win," said Mr. Ovendon.

Continued on next page

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Continued from previous page

Another delegate said that risk managers and other executives will have difficulty if "we can't speak any (foreign) languages. We can't go to France and compete if we can't speak French."

Another mentioned that companies will start unifying their companies' brand names across Europe.

"Companies are trying to introduce brand names all across Europe," said Mr. Ovendon.

"We have resisted that in my company, but we are thinking of changing that."

Felix Kloman, principal and vp with the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn., said that U.S. risk managers believe that there will be an increasing concentration of risk as corporations grow and businesses are consolidated.

"So, there will be a need for greater sophisticated control facilities," said Mr. Kloman.

"We are seeing that already," said Mr. Ovendon, whose company has one major facility in Germany. "We (risk managers) could have all our eggs in one basket—one factory in the U.K. for all of Europe."

"You could have risks of 400 million ECU, which pushes the (limits) of the insurance market," said Mr. Kloman.

"Shouldn't we as risk managers warn our executives of the dangers

'So we will get fewer, bigger industries, and the strongest will win,' says David Ovendon.

of concentrating our companies?" asked one risk manager.

"It will create a dangerous imbalance," he said.

The executives and risk managers "are becoming more aware of it (the problems) all the time," added another participant.

Meanwhile, brokers and risk managers debated the significance of the 1992 changes for risk managers.

One French broker said that his company in Paris placed more than 400 insurance programs throughout Europe and worldwide.

"We do not find it difficult to place property/casualty insurance policies" across borders or outside the EC, the broker said.

For example, in France, which is one of the strictest EC countries for placing insurance, brokers have had no problem placing coverage outside France, he said.

And Mr. Ovendon agreed that it is not difficult to place coverages across borders for subsidiaries in other nations.

However, what is difficult to find "is one insurance policy that will cover all subsidiaries on similar conditions," observed Mr. Ovendon.

"You still need DIC (difference-in-conditions) covers to solve the problem" of ensuring uniform coverage among all subsidiaries, Mr. Ovendon.

Mr. Kloman said that American corporations are considering establishing captives in domiciles like Ireland to write one uniform insurance program for all European units.

However, a European risk manager wants something much simpler.

"I would like to see one European insurance policy in all the languages required," he explained.

Mr. Ovendon also said he would like to see one broker handling the Europewide insurance program rather than having brokers representing the subsidiaries in each country.

Come the end of 1992, said Mr. Ovendon, "there won't be more demand on insurance. But there will be more competition for the same amount of insurance. There will be bigger risks. How is the insurance industry going to respond?"

"I can get the best cover in the world in the U.K., and I want it to apply to our world operations, whether it's in Luxembourg or Thailand," Mr. Ovendon added.

Nine brokers, eight risk managers, 11 insurers and eight others in periphery fields such as consultancy attended the workshop. Some of the companies represented included EuroTunnel, the Anglo-French mega-construction conglomerate building the underground tunnel under the English Channel to link the shores of France and England; British confectionary company Roundtree P.L.C., which last year was bought by Swiss giant Nestle S.A.; and a British company that was about to set up an office in Paris. ■

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Needless papers may haunt manufacturers

By STACY SHAPIRO

CAMBRIDGE, England—Documents that are not required by law to be filed and kept for years should be thrown out, a U.S. attorney advises British risk managers.

Otherwise, some documents, such as customer complaints and memos about certain products, will come back and haunt defendants in U.S. product liability litigation, warned George W. Flynn, an attorney with the Minneapolis law firm of Feagre & Benson.

"If you've got to keep documents, keep them," said Mr. Flynn, who has represented such companies as Honeywell Corp. "But don't keep them just for potential product liability cases."

For example, "you don't have to keep highly inflammatory letters like customer complaints," Mr. Flynn explained.

However, "complaints sometimes are kept on file for over 10 years without anyone ever looking at them again" until the plaintiffs' attorney finds them in discovery, Mr. Flynn warned risk managers, underwriters and brokers attending a workshop held during the Assn. of Insurance & Risk Managers in Industry & Commerce conference April 5-6 at Robinson College, University of Cambridge.

During the session, titled "Defense of Product Liability Lawsuits in the U.S.A.," Mr. Flynn explained to the British audience what to expect when defending a lawsuit in U.S. courts.

"If you are going to end up in U.S. court—the court has permitted U.S. jurisdiction—then you will need every document you have on the product. If you don't have them, the judge will say that you are defaulting on the case," said Mr. Flynn.

In addition, if a European product liability case is heard in the United States, "you must submit all the documents and you must submit to U.S.-style depositions," Mr. Flynn said.

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"Those documents turn out to be the worst source of evidence in product liability cases."

"If you get involved in discovery, the plaintiffs' attorneys will get into your files and read those documents and they will find all the documents that they can to show the jury that the company knew about the problem and failed to warn. Then they will ask the jury for punitive damages," Mr. Flynn continued.

Under U.K. law, there is no discovery procedure. As a result, the documents do not have to be produced for plaintiffs' inspection.

In addition, European companies cannot depend on the definition of strict liability as permitted under the EC product liability directive because it is interpreted differently in most U.S. courts, Mr. Flynn said (*BI,* July 31, 1988).

It's an "unwinnable" argument in many states, to say that a defending company knew nothing about the defect of a product until it was sold on the market, he said.

For example, under the EC definition of strict liability, manufacturers do not have a wholesale duty to warn consumers of the potential dangers of their products, Mr. Flynn claims.

But, in the United States, many product liability cases are based on a "failure to warn" argument in which companies are expected to have foreseen possible misuse of a product and to have warned customers of the effects of any foreseeable misuse, according to Mr. Flynn.

For example, one company that Mr. Flynn defended had documented the extensive research it conducted on a valve, showing that the part was studied and found safe before it was sold. Unfortunately, after it was sold the valve was found to have a hidden failure that stopped it from closing after six or seven years of usage. Gas explosions occurred as a result of the defect and, after 10 or 15 deaths, the product was taken off the market, he said.

In addition, U.S. courts also have ruled that companies should have anticipated the dangers of not equipping all industrial machinery with safety devices, he noted.

"In the U.S., you can't make safety design optional. . . .In the United States, the courts are plaintiff-recover oriented," he said.

U.S. juries, most of which have "pretty good judgment," award punitive damages, which are not awarded so far in British courts, Mr. Flynn reminded AIRMIC participants.

As an example of the size of punitive damages in U.S. product liability cases, Mr. Flynn told of a recent $42 million award in Michigan for a single death resulting from a house fire alleged to have been started by the hot plate on a coffeemaker.

However, the U.S. Supreme Court has agreed to address the constitutionality of punitive damages, which is a "good omen," said Mr. Flynn, referring to the justices' decision to hear an appeal by Browning-Ferris Industries Inc. The Houston-based waste disposal firm is challenging a $6 million punitive damage award in 1987 by a federal court jury in Vermont (*BI,* Dec. 12, 1988).

Mr. Flynn urged the European risk managers attending the session to seek the best lawyers they possibly can when their companies are involved in U.S. litigation.

"I can't emphasize the importance of the lawyer you hire," he said.

And, since 98% of all U.S. product liability cases are settled out of court, the defendants need a lawyer who is skilled at negotiation, because "he can make the difference between an award of $50,000 or $3 million," said Mr. Flynn.

How the lawyer deals with discovery, works with co-defendants and handles depositions "has enormous value on the outcome of the case," he said. "You should spend time and money to get your lawyer. Get recommendations from your industry and travel to interview them. . .because once you hire them, you're in bed with them."

Today several major U.S. corporations are hiring one law firm as national counsel to coordinate all the cases related to one product, and that firm hires and manages local law firms to defend the individual cases.

That assures that testimony and documents used in a case in one state will be available and ready for use in a similar case in another state, said Mr. Flynn.

Mr. Flynn also recommends that every company sit down with its attorney and "work out a litigation plan" and a litigation budget so that the client knows roughly how much the case will cost to defend. "Sit down and enforce the ground rules," he said.

For example, one of Mr. Flynn's clients states in writing that there will only be one lawyer working on the case unless the client approves more than one to be present. The client also states that no computer analysis can be used "without prior approval." ■



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Update U.S. retirement policy: Official

By DONNA DiBLASE

SAN DIEGO—The United States must develop a national retirement policy that better responds to changing economic and demographic conditions, according to a federal official.

And, this policy must not be developed in a vacuum: It must include input from employers, labor unions, the federal government and others, said David Walker, assistant U.S. secretary of labor for pension and welfare benefits.

"We have to recognize that the world has changed since Social Security was passed in 1933 and ERISA was passed in 1974. Government, employers and unions have to step back and assess where we've been, where we are going and how to prepare a national retirement policy," Mr. Walker said.

"We should be shooting for a national retirement policy that is both fiscally responsible and economically rational," he asserted.

Mr. Walker discussed the steps policymakers should take in forging a retirement policy that will meet the income and health care needs of America's future retirees during "Forging a New Partnership for Employee Benefits with the 101st Congress and Bush Administration," a conference sponsored by the National Employee Benefits Institute in San Diego March 30-31.

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"Our current retirement income policy is too general and vague," he said.

Mr. Walker observed that most Americans think of retirement income in terms of a three-legged stool: One leg is Social Security benefits, one is pension benefits from a private employer-sponsored pension plan and the third leg is income from personal retirement savings.

"Social Security was never intended to be the only source of retirement income. And, private pension benefits were intended to be a supplement and not a substitute for personal savings," he explained.

Because of the enactment of several pieces of federal regulation governing private pension plans over the last several years, "you might ask whether the government itself has a retirement income policy. However, these regulations have been fairly revenue-driven," he noted.

"But, some have also included some major retirement policy changes. For example, there has been a quest for equity" in pension benefits among both higher and lower paid employees. In addition, some federal regulations have made portable pension benefits more attractive for employers, he said.

However, the current three-legged stool retirement policy does not ensure adequate retirement income for retirees today, he said.

This is partly because the stool's legs often are uneven. For example, a retiree's personal savings and private pension plan may be inadequate, which makes the retiree more dependent on Social Security.

In addition, there are changes in the demographics of today's retiree population that must be factored into retirement policy, he said.

For example, "there are more older Americans working (in a part-time capacity) after they retire from their careers," Mr. Walker noted.

"So, should a fourth leg be added to the stool to reflect earnings from part-time employment? And, what role do these earnings play in retirement earnings?" he asked.

'We have to recognize that the world has changed since Social Security was passed in 1933 and ERISA was passed in 1974. Government, employers and unions have to step back and assess where we've been,' says Mr. Walker.

In addition, Mr. Walker said he believes "that health access and financing and affordability ought to be included in a retirement income policy."

However, he noted that "the president does not believe in mandated benefits," such as the minimum federal standards of employer-provided health benefits proposed by Sen. Edward Kennedy, D-Mass.

"I think there is some merit to what Sen. Kennedy is doing; he is playing a constructive role. However, I don't think we ought to address the problem of uninsured Americans in a piecemeal approach, such as mandating employers to pay for it," Mr. Walker asserted.

"We ought to step back, look at the big picture and develop a comprehensive approach to solving this problem. And, all of the players should be involved in this: employers, health care providers, government policymakers and legislators," he noted.

Mr. Walker suggested several steps toward developing an appropriate retirement income policy:

- "We need to raise the priority of retirement income policy issues both in government and in corporations," he said.

Employers must involve their chief executives in working on a retirement income policy with government leaders and legislators.

- "We ought to try to develop a set of principles by which retirement policy initiatives can be evaluated," Mr. Walker suggested.

These principles should not be binding, but instead should be used as guidelines in developing a policy that is economically responsive to retirees and fiscally responsible for employers and the government.

- "We need to nurture congressmen to become more versed in the pension and benefit area and understand retirement policy implications," Mr. Walker said.

Employers and policymakers must inform congressmen of the nation's pension and benefit needs. "Retirement policy cannot take a back seat," he said.

Today, "the answer to the question of 'Do we have a national retirement income policy?' is a qualified yes. However, we are in a tremendously changing economic, labor, accounting and compliance environment," he said. ■

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Health care plan links public, private sector

By DONNA DiBLASE

'One out of four people are uninsured or underinsured,' says Dr. Henry E. Simmons.

SAN DIEGO—A partnership between the public and private sectors would provide access to health care for the nation's uninsured under a proposal by a health policy group.

The inequity in access to health care of 37 million uninsured or underinsured Americans is "a ticking social time bomb" that must be addressed, said Dr. Henry E. Simmons, president of the National Leadership Commission on Health Care.

Under a restructured U.S. health care system the group proposes, there would be universal access to a basic level of health care services, and escalating health care costs would be controlled through greater use of innovative health care purchasing and through expanded research on the quality and appropriateness of care.

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Dr. Simmons presented the NLCHC's preliminary findings and proposals at "Forging a New Partnership for Employee Benefits with the 101st Congress and the Bush Administration," a conference sponsored by the National Employee Benefits Institute last month in San Diego.

The Washington-based commission is composed of leaders from health care, business, law, economics, politics, ethics and labor. It was formed in 1986 to address the three major problems of health care: cost, quality and access to care.

"We have found that the health care system has done a wonderful job in providing health care to Americans. But, we found three major problems with the current system," Dr. Simmons noted.

First, there is a rapid and massive escalation of costs, despite "15 years of vigorous cost controls by employers and the government," he said. And, there are three major payers of health care costs: employers, Medicare and Medicaid.

The second problem with the U.S. health care system is that there is diminishing access to the health care system for many Americans, according to Dr. Simmons.

"We have the least equity of access of any of the developed nations. One out of four people are uninsured or underinsured, and the problem shows every sign of getting worse," he said.

The third problem is that there is insufficient information on the quality and outcomes of medical services. "This is unknown to the medical profession, and we have to agree on a definition of quality," he said.

"We find a system in great distress. And who's to blame? All of us. Providers, employers, consumers and government," Dr. Simmons charged.

Therefore, the NLCHC is proposing that each party take responsibility in improving the health care system.

The commission's proposal is designed to continue relying on employer-provided health care insurance without mandating that employers provide such coverage, Dr. Simmons explained.

Under the proposal:

- All Americans would have access to a basic level of health care services, regardless of income.

Most people would continue to receive coverage through their current employer-sponsored health plans, and the elderly would receive Medicare coverage.

But, everyone else would be covered though a Universal Access Fund—or UNAC.

To finance this program, the commission proposes that all employers and all individuals with incomes above 150% of the poverty level pay a fee to finance health insurance for those not covered by employer plans.

The proposal calls on state health agencies to help develop and administer the fund and assess the fee.

- Existing state agencies also would negotiate fair compensation for providers who serve the population using the funds.
- All individuals would be responsible for obtaining a basic level of health care insurance through a UNAC or a health care insurer.
- The basic level of health care insurance individuals must obtain would be established at the federal level, but states would be able to require greater minimum coverage.
- The existing health care insurance system would be expanded by encouraging all employers to provide health insurance for employees.
- There would be increased research on the appropriateness, effectiveness and quality of health care, and the results would be publicized to help patients and providers assess the appropriateness of treatment.
- This research and the dissemination of research results would be coordinated through health professional organizations, such as the American Medical Assn.
- Health care costs would be controlled by reducing the amount of inappropriate care.
- Greater efficiency in the health care marketplace would be further encouraged by allowing employers to use this information to negotiate more effective preferred provider arrangements or other cost-effective health care delivery systems.
- Promoting medical malpractice reforms. ■

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THE VOICE OF CHANGE

DENTAL BENEFIT PROVIDERS, INC.

Catastrophic risks alarm insurers: Broker

By DONNA DiBLASE

SAN FRANCISCO—Exposure to catastrophic risks is the greatest force affecting today's property/casualty insurance industry, according to an industry executive.

"The rate and the growth of exposure to catastrophes and to major losses is, I believe, the single biggest pressure on the insurance industry today," said David V. Palmer, chairman of the British Insurance & Investment Brokers Assn.

"Very few of the hazards that relate to these exposures are new in themselves. But, the scale of the losses they generate have rocketed," added Mr. Palmer, who also is the retired chairman of broker Willis Faber P.L.C. of London.

To ensure adequate and stable coverages for catastrophic risks, commercial insurance buyers and the insurance industry must cooperate and establish long-term relationships, he suggested during the Russell Miller Inc. Insurance Symposium in San Francisco April 3-4. Russell Miller is an investment banking firm specializing in the insurance industry.

According to Mr. Palmer, who spoke at a session titled "Setting the Direction for Change," some of the catastrophic exposures that the insurance industry faces include:

- Product liability for aircraft, automobiles and pharmaceuticals.
- Professional liability for accountants, and directors and officers.
- Pollution liability for nuclear and chemical accidents.
- Property/casualty coverage for natural disasters, such as earthquakes, floods and windstorms.
- Political risk coverages for terrorism or confiscation of property.
- Long-latent liability exposures for asbestos.

"If you add to those hazards the increases in the values of vessels, etc., the whole subject of major loss takes on a completely new dimension of frequency and severity," Mr. Palmer noted.

"Now, catastrophic exposures are going up far faster than the world gross domestic product and world premium income" in monetary value, he said.

But, risk is involved in every aspect of the business world. And, "today, in the corporate world, more chief executives and more boards of directors take a close interest in insurance and risk management than they ever did 10 years ago," he observed.

In addition, "there is a realization that insurance is often a license to trade. The availability of insurance can often be the stimulus to enterprise: The initiative would not be undertaken if it were not possible to get insurance," he said.

However, "conventional insurance can only respond to a very small area of total risk. Today, there are numerous risks, both individual and cumulative, for which the insurance industry can provide only part of what is needed. There are and always have been risks which are just too big for the insurance industry to cope with," Mr. Palmer said.

Catastrophic losses of $1 billion are a common occurrence today and losses of $5 billion have and will continue to occur, he said.

The size of these exposures presents the insurance industry with a number of uncertainties, he said. For example, "what is the capital and surplus base needed to insure a $5 billion loss? And, how much of an insurer's capital, net of reinsurance, should be exposed on a single loss?"

To help fill the gap in coverages left by the traditional insurance market, captive insurance companies and other policyholder-owned facilities have been created, he noted.

"But, do conventional, commercial insurance markets have a responsibility to respond at all" to catastrophic coverage needs, he questioned. "I believe and I submit that the insurance industry does have a duty to respond and not retreat from catastrophic risks," Mr. Palmer asserted.

However, the industry and commercial insurance buyers must ensure that coverage is available and arranged for catastrophic risks, he said.

And, buyers must understand that underwriting is "the most sophisticated of all financial skills," Mr. Palmer said. "I suggest that underwriting is a combination of art and science," he added.

Insurers must 'respond and not retreat from catastrophic risks,' Mr. Palmer says.

But, "in recent years, there has been a quagmire over the semantics in insurance policies," and courts have interpreted any doubts over intended coverage in favor of policyholders, he pointed out.

Mr. Palmer stressed that insurance buyers and insurers must agree from the onset what the policy will and will not cover.

He also warned insurers that they hurt their capacity to cover catastrophic risks by engaging in dramatic pricing competition. "As an industry, we make ourselves look ridiculous with these swings in rates."

Ensuring adequate, stable coverage for catastrophic risks can best be achieved through the establishment of long-term relationships between buyers and insurers, he said.

Also, "governments must recognize the need for synchronicity" and cooperation among competing insurers, Mr. Palmer said. "They must recognize that slavish consumerism is counterproductive" to solving insurance coverage problems, Mr. Palmer noted.

Insurance brokers are the catalysts for this cooperation and understanding between insurers and buyers, he said.

To this end, brokers should possess several key attributes, he said. Brokers must have:

- Market strength. Brokers must be large and have access to a variety of insurance markets.
- The ability to provide a full range of risk management services on an unbundled basis, including claims services, loss prevention and captive management.
- International capabilities.
- Wholesale and retail brokerage capabilities.
- Balance. For example, brokers should be able to handle both small and large clients or have equally strong skills in reinsurance and wholesale brokering. ■

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Industry's past reveals its future: Gallagher

By DONNA DiBLASE

SAN FRANCISCO—The property/casualty insurance industry can better control its future by studying the past, says a brokerage executive.

"Anticipating the future by knowing what has happened in the past is the way for the industry to move forward," said Robert E. Gallagher, president and chief executive officer of Arthur J. Gallagher & Co. of Rolling Meadows, Ill.

In addition, the insurance industry must take specific actions now so it can better react to regulatory, economic and societal changes affecting the industry, he said.

"It's time for our industry to get back to basics. Once we do this, our industry will stop being shifted" by outside forces, he predicted.

Mr. Gallagher discussed the current state of the U.S. insurance industry during "Setting the Direction for Change," a Russell Miller Inc. Insurance Symposium in San Francisco earlier this month.

Using highlights from his career as an insurance broker as illustrations, Mr. Gallagher advised insurance industry executives to reflect on history to better understand today's industry events and prepare for the future.

He offered the following lessons:

• "All business is in constant motion. So, as business moves, you either shift or, inevitably, you will be shifted," he said.

The insurance industry has been shifted over the last 20 years by the formation of captive insurance companies, purchasing groups and risk retention groups. "The alternative market is growing and it's here to stay. Why? Because society wants more control," Mr. Gallagher explained.

Mr. Gallagher pointed out that some experts contend that these alternative markets represent about 35% of the insurance marketplace today and may increase to 40% in the next hard market. "This is the greatest outside force on our industry today," he said.

• "Give the client what the client wants, or someone else will," Mr. Gallagher warned.

This became very clear to Mr. Gallagher when the brokerage's largest client in 1961 decided it wanted to self-insure its property/casualty exposures.

After one attempt at trying to talk Chicago-based conglomerate Beatrice Co. out of this notion, Mr. Gallagher found that the client would "become a self-insured with or without Gallagher & Co. So help me, Gallagher Basset was born right then and there," he said, referring to the broker's risk management consulting firm, Gallagher Bassett Services Inc.

Beatrice helped Gallagher to develop Gallagher Basset, which officially was launched in 1962, he said.

"This would never have occurred if we didn't have a client that had faith in us—that believed in us because we served him well," Mr. Gallagher noted.

• "You grow or you die and nothing counts but pretax profits," he said.

In 1963, his first year as president of the brokerage, Gallagher & Co. reported $562,000 in revenues and had 19 employees. But, the firm also reported a net loss of $12,500, he said.

Between 1963 and 1988, when Mr. Gallagher celebrated his 25th anniversary as president, the brokerage reported over the past 25 years a 49% average annual growth in earnings and a 46% average annual growth in earnings per share over the same period. "The lesson learned was that you continue to grow and you grow pretax profits," he said.

Gallagher & Co. was ranked as the eighth largest insurance broker in the United States last year, based on 1987 gross revenues of $134.7 million (*BI*, June 20, 1988).

• Brokers and insurers must be innovative in serving clients because "in my humble opinion, many of the large, traditional, first-dollar insurance companies can't or won't change because of their cultures," he observed.

"It's the buyer who matters. We represent the client," he added.

• "It's very important in the insurance business to know where you're at at all times," he said.

To illustrate his point, Mr. Gallagher recalled his first job at age 17 as a messenger in Chicago's Insurance Exchange building, which was then home to more insurers in the United States than any other building and currently is the home of the Illinois Insurance Exchange.

One day, as he hurried to deliver a package, he ran to an elevator, yelling "hold it," to the elevator operator.

Once inside the elevator, he said, "17th floor please," to which the operator remarked, "you're already there, dum-dum."

• "Management gets what management wants," he quipped.

Mr. Gallagher learned this lesson in his second job as a receptionist at Gallagher & Co. At that time, the switchboard had four telephone lines, he said.

One morning, when all four lines were busy, Arthur J. Gallagher yelled for an open line from the only private office in the firm. A few minutes later, Mr. Gallagher's secretary ran to the switchboard and pulled the plug on all four lines in an effort to clear a line for her boss.

Mr. Gallagher predicted that the industry will continue to be shifted by many other forces.

For example, the public's perception of the insurance industry is very negative.

"They don't understand how insurance works. The charge begun by California's Proposition 103 and Ralph Nader is going to spread, regardless of whether the California Supreme Court upholds the law," he predicted.

While some forces are outside of the insurance industry's control, there are many things the industry can do to take greater control of its destiny, he said.

"First, we must educate society in what we do and how the insurance process works. And, we must also have a massive program of public relations," Mr. Gallagher suggested.

The industry also must lead change and not just react to change.

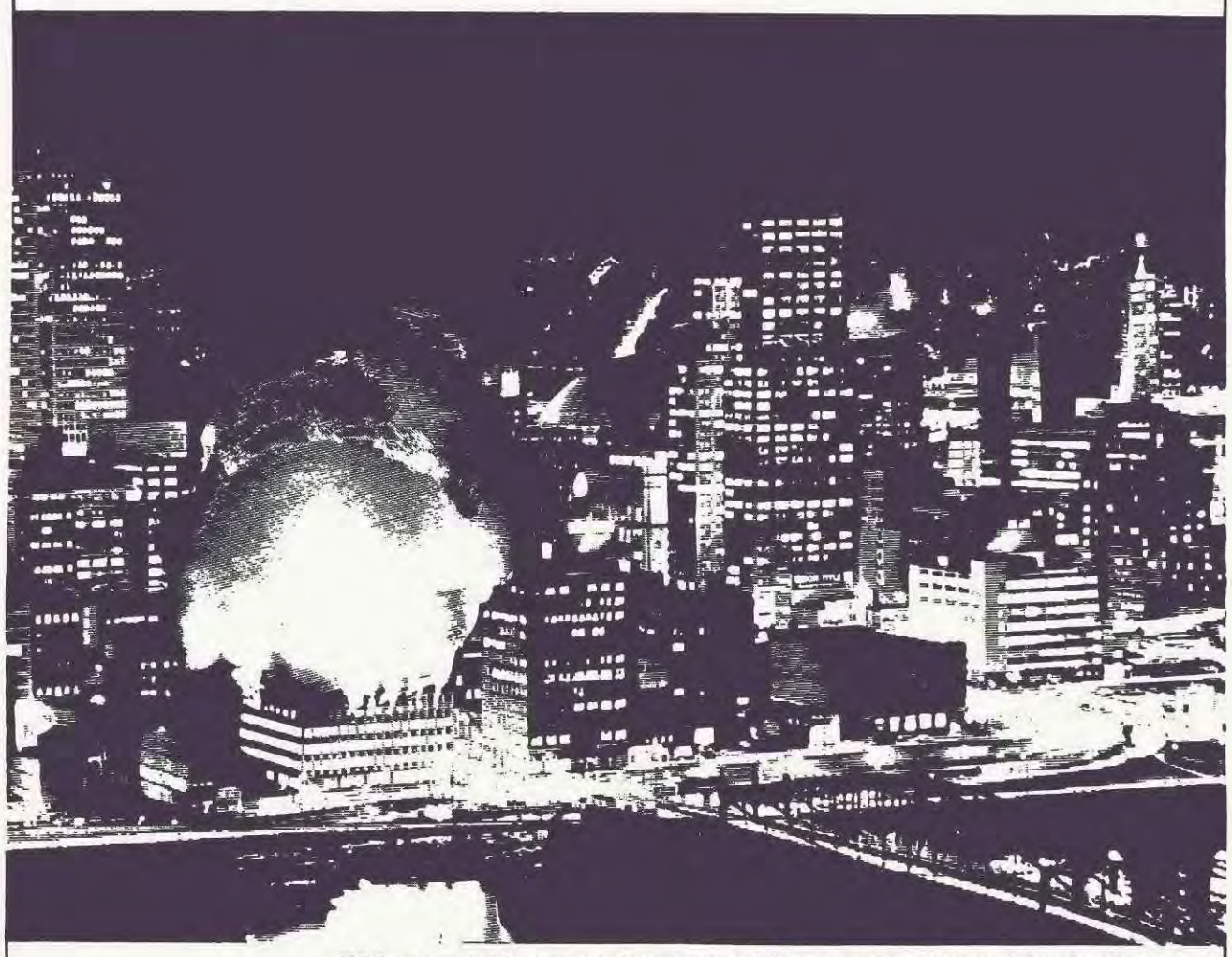
In addition, "we must develop leaders in all of our disciplines."

Mr. Gallagher also said the industry "must listen to the buyer. And, let's listen to society, since they are the buyers."

Also, the industry must "lobby more effectively at the federal and the state level," he said. ■

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Reinsurance in throes of change

By CAROLYN ALDRED

The industry is 'facing an enormous change. Getting a positive outcome from this is going to require a deep understanding of the underlying nature of that change,' says Kenneth Irons of London-based KIA Management Consultants.

BOURNEMOUTH, England—Reinsurance executives must learn how to adapt in a radically changing reinsurance environment, executives agreed at a reinsurance seminar earlier this month.

"The challenge of adapting to changing economic criteria looms as a significant survival issue for many companies," said James F. Dowd, chairman of the Reinsurance Assn. of America and president and chief executive officer of Skandia America Corp.

Mr. Dowd presented a U.S. perspective on reinsurance to delegates at the ninth International Reinsurance Seminar organized by the British-based Reinsurance Offices Assn.

Reinsurance Offices Association

The conference, which was held in Bournemouth, South England April 4-6, attracted 260 participants from around the world.

"The U.S. reinsurance industry is well into a period of consolidation, which has been under way since the early '80s," Mr. Dowd said.

"The consolidation of which I speak relates to both reinsurance companies and to the broker community, which produces business for us. In all likelihood, this consolidation will continue into the mid-90s with the ultimate shape of the industry rather profoundly affected," he said.

Among the factors contributing to this phenomenon, Mr. Dowd pinpointed:

- Higher retentions among ceding insurers, "removing, perhaps permanently, many working layer covers from the market."
- Increased expense burdens on reinsurance companies with the introduction of technology and increased financial, actuarial and engineering skills.
- The expense burden on reinsurance intermediaries administering the "tails" of canceled casualty business.
- Increased and continuing concern about financial security.
- Increased tax burdens imposed by the Tax Reform Act of 1986.

Meanwhile, regulatory authorities "continue to tighten the noose," said Mr. Dowd, referring to the fact that the National Assn. of Insurance Commissioners has approved an accounting change that imposes a penalty to surplus of at least 20% of undisputed reinsurance from authorized reinsurers if the reinsurance is more than 90 day overdue (*BI*, Dec. 26, 1988; Dec. 19, 1988).

However, changes sweeping the reinsurance market are not confined to U.S. reinsurers, executives at the conference noted.

The industry is "facing an enormous change. Getting a positive outcome from this is going to require a deep understanding of the underlying nature of that change," said Kenneth Irons, managing director of London-based KIA Management Consultants.

Many of the major changes facing reinsurers are a result of socio-economic changes occurring throughout the world, he told delegates.

Among the major socio-economic changes that will influence the world's reinsurance industry Mr. Irons identified:

- Increased economic growth and wealth.
- An aging population.
- The increasing economic role of women in society.
- An increasing expectation of individuals' rights.
- Increasing environmental concerns.
- A changing perception of security. The traditional view of what protection and security entail "has moved on, and the old answers of financial indemnity are simply not enough in a large number of cases," said Mr. Irons.
- The erosion of the welfare state in many European nations, particularly state-provided health care.

"The outcome will be a dramatic

Continued on next page

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Reinsurance changes

Continued from previous page

shift—over time not overnight—of power in the many industries in which insurance plays a part," warned Mr. Irons.

"For reinsurers, the challenge is to understand this better than anyone and, at the same time, recognize that they, too, must change not only externally, but internally," he added.

Meanwhile, major corporate insurance buyers "are becoming increasingly expert and are fulfilling roles internally," such as risk financing, reducing their reliance on outside advisers, he noted.

The effect of the political, social and economic environment on reinsurance also was noted by Hans Kaufmann, a director of the Swiss Reinsurance Co.

"Political and macro-economic events can have a very profound effect on our business, more so than changes in insurance/reinsurance products or changes in the technique of transacting our business," he said.

But, radical changes in the methods of transacting reinsurance business, particularly in the London market, also loom on the horizon, several speakers and attendees pointed out.

'For reinsurers, the challenge is to understand this better than anyone and, at the same time, recognize that they, too, must change not only externally, but internally,' says Mr. Irons.

"I genuinely believe that in 10 years time we will look back with amazement and wonder at the way we did our business in 1989," said Hady Wakefield, chairman of C.T. Bowring Reinsurance Ltd.

Much of the change in London will come through the adoption of new technology, Mr. Wakefield said. The result will be that computer networks will replace the "old boy network" in the London market, he said.

Already, a computer network dubbed LIMNET that links organizations operating in the London market and a network named RINET that links leading European reinsurance companies are beginning to be implemented, Mr. Wakefield pointed out.

The introduction of these networks will lead to "a decline in the face-to-face handling of much future routine business and a decline in the number of brokers needed in the market," he predicted.

"The computer can change our hours of business and the sort of employees that we have. We are entering into a fascinating period, and I am convinced that the greatest care must be given to this evolutionary progress," Mr. Wakefield said.

C.T. Bowring's North American reinsurance department is about to launch a pilot program of computer risk placement for the Jan. 1, 1990, reinsurance renewal season together with other brokers and underwriters in the London market, Mr. Wakefield pointed out.

The prototype offer and acceptance program was developed with Lloyd's of London underwriting agency D.P. Mann Underwriting Agency Ltd. A trial run will begin soon with several other Lloyd's underwriters and several other major London brokers, including Sedgwick Group P.L.C., Willis Faber P.L.C. and Alexander Howden Reinsurance Brokers Ltd., Mr. Wakefield said.

Meanwhile, more than 50 reinsurance companies in the London market are planning to move their underwriting offices into one centralized building to create a reinsurance bourse, or exchange.

A group of 13 companies led by CNA Reinsurance of London Ltd. has formed a company called Market Building Ltd. that plans to lease an office complex to house the reinsurers.

The company currently is looking at a 295,000-square-foot office block in London's financial district that is due to be completed next year.

An additional 44 companies already have expressed interest in subletting space in the building, according to Victor Blake, chairman and chief executive of CNA Re in London.

However, Bowring's Mr. Wakefield warned that "the accelerating pace of computer technological capability is such that without the greatest care, evolution can grow into revolution."

Many in the London market fear the introduction of computer technology will eradicate London's face-to-face method of trading, Mr. Blake noted.

But, with many reinsurance companies relocating to one building and the increased use of technology for processing routine work will reduce expenses and allow the London reinsurance market to compete more effectively while maintaining face-to-face negotiation where it continues to provide added value, explained Mr. Blake. ■

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Recent losses identify London market faults

By CAROLYN ALDRED

BOURNEMOUTH, England—Two major catastrophes since 1987 highlight technical inadequacies in London's reinsurance market, reinsurance executives say.

Hurricane-force winds that wreaked havoc in parts of western Europe in October 1987 and the destruction of the Piper Alpha North Sea oil platform last July still are producing billions of dollars of claims in London's reinsurance market, noted speakers at the ninth International Reinsurance Seminar organized by the British Reinsurance Offices Assn. earlier this month in Bournemouth, England.

Although the direct policyholders that suffered losses in both catastrophes were promptly paid, "there is a currently held notion that it will take nine years for a catastrophe loss to be completely settled in the retrocessional market," noted Lloyd's of London underwriter David Gilchrist of R.J. Kiln & Others.

Large losses in London spiral through the London excess-of-loss reinsurance market because Lloyd's syndicates and London companies reinsure each other. Any one syndicate or insurer can end up paying the same loss several times on different layers of reinsurance protection for other syndicates and companies.

Reinsurance Offices Association

As the losses entered the retrocessional market, "so, understandably, is the number of advices and collections received by brokers multiplied," noted Jim Payne, chairman of reinsurance broker E.W. Payne Ltd., a subsidiary of London-based broker Sedgwick Group P.L.C.

For example, E.W. Payne alone so far has handled more than 1,000 separate reinsurance claims stemming from the European windstorm—known in the market as 87J—with a total recovery value of more than 300 million pounds ($508.8 million), Mr. Payne said.

A special claims settlement procedure was set up by London's marine market to pay the direct insurance claims stemming from Piper Alpha, but reinsurance claims settlement procedures within the London market currently are inadequate, several speakers and conference delegates agreed.

"Whilst some claims only require agreement by leading underwriters, the vast majority of treaty reinsurance claims require agreement by all markets. This process can often take six to eight weeks," Mr. Payne pointed out.

In the case of a catastrophic loss, the settlement process is further slowed by the fact that most reinsurance programs have a "simultaneous reinstatement requirement" built into them, he added.

Reinstatement premiums are paid by a ceding underwriter to reinstate its existing policy after the ceding company has filed a specified number of claims to its reinsurer or retrocessionaire.

Reinstatement premiums that must be paid by a ceding company after a major claim "adds another complex layer of activity, overloading further technical processing and accounting systems precisely at the moment that they are under maximum pressure," Mr. Payne said.

"Have you considered how many credit notes and accounts entries may be generated by a single collection when managing an occurrence of this scale?" he asked, referring to the October 1987 European windstorm.

"Many thousands of reinstatement-related accounting transactions and entries that a major catastrophe creates are themselves a massive burden to back office systems," he explained.

Eric Alexander, the marine and aviation underwriting manager for Victory Reinsurance Co. Ltd., agreed that the reinsurance industry must examine "the question of reinstatement premiums."

As well as causing administrative problems, reinstatement premiums have become "too much of a factor in rate setting for excess-of-loss business," he asserted.

"I believe we should have higher general levels of rating with lower reinstatement provisions so that we get a more level equation between claims-free years and those that suffer losses," Mr. Alexander said.

The lack of co-reinsurance, whereby a ceding company retains a percentage of the loss, results in business being retroceded many more times, further extending the so-called LMX spiral, some of the speakers noted.

"In the reinsurance arena, and more particularly the retrocessional market, co-reinsurance has been and no doubt will continue to be a heavily debated topic," Mr. Payne said.

"The spiral causes nervousness. The upward unfinished spiral is feared by us all, including, may I say, the processors of the endless recoveries, your intermediaries," Mr. Payne told the reinsurance company delegates.

"A sophisticated, consistently applied co-reinsurance system does act as a brake on the spiral; it also serves as a reminder that we are reinsurers not arbitrageurs," he noted.

However, the speakers also noted the difficulty in introducing co-reinsurance in a soft reinsurance market.

"As an alternative, I would suggest a mandatory gap in coverage so that at certain levels an extra retention was required from the reinsured," Mr. Alexander suggested.

Some speakers and delegates wondered how large a loss the reinsurance market could sustain after Lloyd's underwriter Mr. Gilchrist told the conference that a windstorm hitting Western Europe could conceivably produce a loss of 6 billion pounds ($10.2 billion).

Some delegates and speakers surmised that the LMX market provided an illusion of capacity the reinsurance market did not possess.

"If capacity is the sum total of every underwriter's retention, then something surely has to be done to increase retentions," Mr. Alexander said.

"If we recognize that XL on XL (excess of loss on excess-of-loss reinsurance) does practically nothing toward providing capacity, and in consequence of the Piper Alpha loss the system is changed—as for example by incorporating a co-reinsurance idea—it seems that capacity may well be diminished," he explained.

Swiss Reinsurance Co. Director Hans Kaufmann also expressed concern about the LMX market.

"Is the LMX system not somehow geared to the expectation that large losses are not very frequent and that payments can be spread over a good many years, some of which may be light on claims?" he asked.

"Would the system still work if large catastrophic losses occurred in several successive years and an accelerated payment pattern emerged?" he asked. ■



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Indiana considers work comp, insurer reform

INDIANAPOLIS—Separate bills that would establish vocational rehabilitation benefits for injured workers in Indiana and increase some liability insurers' reporting requirements await Gov. Evan Bayh's signature.

The Legislature passed both bills April 5.

S.B. 543 would, effective July 1, amend Indiana's workers compensation code to provide vocational rehabilitation benefits to recipients of workers comp and occupational disease benefits.

The bill also would establish a division of vocational rehabilitation within the workers comp board to administer the program. Recipients would be eligible for vocational rehabilitation if their compensable injury resulted in temporary total disability of longer than 21 days or if it appeared that their compensable injury might permanently prevent them from returning to their previous employment.

Immediately upon receipt of a report of injury, the office of vocational rehabilitation would be required to provide an injured employee with a written explanation of the rehabilitation services available and how to apply for those services. The office also would be responsible for implementing the plan and providing job placement services to the rehabilitated employee.

The insurer reporting bill, S.B. 311, would require insurers to report their premiums and losses, including allocated and unallocated loss adjustment expenses, for the following lines of liability insurance: recreational facilities; lawyers professional; products; uninsured and underinsured motorist; owners, landlords and tenants; and day-care centers. Insurers previously reported this information for public entity and liquor liability risks only.

The bill would be effective Jan. 1, 1990.

—By Linda J. Collins

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InsurerTopics

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Price vs. service

Demand for loss control withstands soft market

By MARK A. HOFMANN

The softening property/casualty insurance market is not dampening the demand among large policyholders for insurer-provided loss control, according to insurers.

In fact, some insurer loss control officials report that the demand for their services from large accounts appears to be on the upswing.

However, small policyholders are more interested in lower premiums than loss control during the soft market, insurers, agents and brokers agree.

Some agents say that when given a choice between enhanced loss control service and a lower premium, small policyholders will opt for the lower premium just about every time.

Some insurers say they are concerned about this trend. However, they are not surprised and are promoting to small accounts the need for loss control in all markets.

Larger clients dealing with larger loss control projects, such as the installation of fire walls, take a more long-term view of their needs than smaller policyholders and accept loss control recommendations, said Michael Burke, vp and chief engineer for Johnston, R.I.-based Allendale Mutual Insurance Co., a Factory Mutual company.

Mr. Burke said that resistance to loss control measures during the soft market is confined to small divisions of larger clients.

Agents agreed that the larger an account's premium, the more likely the account will emphasize loss control services.

Insurers point to risk managers' insurance availability problems because of inadequate loss control measures during the hard market of the mid-1980s as one reason the demand among large accounts and some medium-sized accounts for loss control services is not diminishing.

"It's not that far back that insurance was hard to get," pointed out Kenneth E. Ryan, vp and director of loss control for Transamerica Insurance Co. in Los Angeles.

Mr. Ryan reported no decline in demand for loss prevention services as rates have fallen.

'In this soft market, I don't see the slackening we saw in the last soft market because (then) they could buy coverage cheaper than they could loss control,' says USF&G's Burdette Short.

"In this soft market, I don't see the slackening we saw in the last soft market because they could buy coverage cheaper than they could loss control measures," said Burdette L. Short, assistant vp-insurance engineering and audit department for Baltimore-based United States Fidelity & Guaranty Co., a unit of USF&G Corp.

"We have not had any downturn in terms of staff or amount of loss control service business," agreed William T. Nebraska, assistant vp-engineering at Hartford, Conn.-based Aetna Life & Casualty Co.

In fact, the demand for loss control services from agents "has increased significantly" during the past two years, pointed out James Davis, senior vp-loss control for Basking Ridge, N.J.-based Crum & Forster Inc.

Dennis Warnock, president of Brecksville, Ohio-based North Coast Insurance Systems Agency Inc., pointed out that the demand from large accounts for loss control services remains strong and is even increasing.

Mr. Warnock, who specializes in commercial accounts, said he does not think customer demand for loss control services changes significantly with market conditions.

"I'm still seeing demand there—maybe even more" than a few years ago, he said.

The agency president attributed the possible increase in demand to greater sophistication on the part of corporate risk managers as well as deeply embedded memories of the availability and affordability problems of the hard market.

But, smaller accounts, particularly those without a formal risk manager, "tend to be driven more by price" than larger accounts, according to Mr. Davis of Crum & Forster.

There has been some, although "not much," resistance to instituting new loss control measures on the part of "very small accounts," Mr. Davis said.

While interest in loss control services remains in accounts with premiums of $100,000 or more, the insurance market is "price driven" in general, said James H. Davies, president of Davies & Associates in Murray Hill, N.J.

Most smaller risks are much more concerned about

Continued on next page

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Insurer topics

Loss control professionals are in demand by insurers

By MARK A. HOFMANN

A good loss control professional is hard to find and even more difficult to keep, insurance company loss control experts say.

A successful loss control professional requires a rare combination of both technical expertise and human relations skills, experts say.

As a result, competition among insurers scouting for qualified candidates is stiff, and a good loss control professional who works for an insurer with a reputation for quality service is constantly the target of corporate headhunters, they point out.

"You have to have someone who knows organizations and who knows how to deal with people. If you send in robots who don't have people skills, they're lost,' said Kenneth E. Ryan, vp-loss control for Los Angeles-based Transamerica Insurance Co., a unit of Transamerica Corp.

"The better we can talk the underwriters' language, the better we can serve them," he said.

The best recruit is a technically trained person with salesmanship abilities, according to Burdette L. Short, assistant vp-loss control and premium audit department for Baltimore-based United States Fidelity & Guaranty Co., a subsidiary of USF&G Corp. "We really don't want a highly technical person who just wants to crunch numbers."

Paul M. Fitzgerald, senior vp and chief operating officer of the Factory Mutual Engineering Assn. in Norwood, Mass., said that his group seeks three attributes when hiring loss control professionals: a strong academic record in engineering, good communications skills and a pleasant personality.

Of the three, communications skills, both oral and written, rank "very high on the hit list," Mr. Fitzgerald said.

However, demand for these professionals is growing at a time when the supply of loss control specialists with undergraduate engineering degrees may be contracting, he pointed out.

While competition for qualified engineers of all types is intense and "seems to be getting worse," the United States faces a shortage of engineers within five years, Mr. Fitzgerald contends.

However, the effects of such a shortage would not be felt evenly by all insurers, because many companies tend to hire some or most of their loss control personnel from disciplines other than engineering, according to Transamerica's Mr. Ryan.

"If you look around most companies, you'll find that most loss control people aren't engineers," he said.

Most insurers, including Transamerica, staff their loss control departments with individuals with technical training who complete continuing education courses in safety, technical specialities, insurance or other disciplines, he said.

Transamerica generally looks for recruits with industrial technology and scientific backgrounds in addition to engineers, according to Mr. Ryan.

At Liberty Mutual Co., most entry-level loss control people come in as generalists, said Clarence Moon, assistant vp and manager of personnel for the Boston-based insurer.

While 26% of Liberty Mutual's loss control personnel at year-end 1988 were engineers by training, 29% held degrees in physical sciences, Mr. Moon said. In addition, 13% were trained in industrial management or technology, 3% as nurses and another 29% came from all other disciplines.

"Hiring consistently follows this type of pattern," Mr. Moon said.

Only about 21% of the Hartford-based Hartford Group Inc.'s loss prevention professionals are engineers, said Mike Tetto, assistant vp-loss control.

And, Philadelphia-based CIGNA Corp. tries "to draw more on business graduates than anything else," said Mac D. Livingston, vp-loss control services for CIGNA's property/casualty companies.

"They need to have an understanding of business." But, he added, recruitment depends on what is needed—engineers, business graduates, liberal arts or industrial hygienists. "You name it, we've got it," Mr. Livingston said.

About 55% of the loss control staff at Warren, N.J.-based Chubb Corp. hold engineering degrees, and the remainder holds degrees in mathematics; hard sciences, such as physics and chemistry; industrial technology; safety and fire protection, according to Jimmy R. Deaderick, national manager-loss control department.

At the other end of the spectrum, though, the Factory Mutual Engineering Organization recruits an average of roughly 150 engineers annually, most of whom hold degrees in chemical, mechanical, electrical or industrial engineering (see story, page 56E).

Continued on next page

Maatman's background

Continued from previous page

majoring in mechanical engineering at the Illinois Institute of Technology in Chicago in 1947 when his father died. He said his father's death would have forced him to drop out of school if the head of the college's fire protection engineering program had not told him about full scholarships that were available to students who would major in fire protection engineering.

Mr. Maatman switched majors and stayed in school. The fact that the fire protection engineering curriculum was largely a mix of chemical and mechanical engineering made the program attractive to him, he said.

And, the chance to complete his college education outweighed a string attached to the scholarship: that recipients work for one of the members of the Midwestern Fire Insurance Rating Organization for three years.

Mr. Maatman ended up working for the Illinois Inspection & Rating Bureau for eight years.

In 1959, Mr. Maatman returned to his alma mater as an associate professor and chairman of the school's fire protection engineering program. Although he held no graduate degree, he was not at a disadvantage —no graduate programs in fire protection engineering existed at the time.

And, only a handful of schools now offer advanced degrees in the discipline.

Mr. Maatman explained that the opportunity to do outside consulting during his academic tenure led to his career at Kemper.

The insurer offered Mr. Maatman a position as director of loss control engineering services after a 1965 assignment to evaluate the quality of Kemper's loss control engineering services.

In 1968, he helped found Kemper Corp.'s National Loss Control Service Corp., also known as NATLSCO.

He was elected vp of the insurer's national property/casualty insurance companies in the same year.

Six years later, he became director of Kemper's corporate planning and research, a position he held until 1978. As planning director, he was responsible for creating operating plans for both Kemper Corp. and its mutual companies.

Mr. Maatman next served as vp in charge of Kemper's regional property/casualty insurance companies and the insurance group's information services group, where computer systems are developed and maintained.

He was named to his present post as president of the property/casualty insurance companies two years ago. ■

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Insurer Topics

Recruiting

Continued from previous page

The only consistent requirement for each new loss control staffer is that he or she hold a bachelor's degree, which is a standard prerequisite for a loss control job throughout the property/casualty insurance industry.

"If you profiled by staff, less than 1% are non-degreed," said Chubb's Mr. Deaderick.

Loss control professionals lacking degrees tend to be specialists that were hired before insurers set a four-year college education as a minimum requirement, Mr. Deaderick said.

But, for certain loss control specialties, a degree is not required, according to Robert McSherry, assistant vp-engineering for Charlotte, N.C.-based Royal Insurance Co., a unit of Royal Group.

For example, Royal often recruits U.S. Navy veterans as boiler and machinery loss control specialists, Mr. McSherry explained.

"It could be anybody who worked on a ship who worked with boilers," including officers and enlisted personnel, regardless of whether they have a college education, he said.

Specialists lacking a degree are encouraged to take continuing education offered by Royal or by outside sources but do not have to complete a degree to keep their jobs, he said.

But even when insurers are able to find qualified applicants, keeping them on the payroll is not easy, most loss control experts concur.

"We don't seem to have any trouble getting top-notch people," noted James Davis, senior vp-loss control department for the property/casualty insurance companies of Basking Ridge, N.J.-based Crum & Forster Inc.

Crum & Forster generally is able to recruit college graduates who ranked academically within the top 10% to 15% of their graduating class to fill positions in its loss control department, he said.

However, engineers are sometimes hard to retain in loss control, he pointed out. He explained that as loss control professionals, these recruits may not get to exercise much of what they learned in college, such as advanced calculus. And, if they do not find loss control challenging enough, they leave.

Richard S. Betterley, president of Betterley Risk Consultants Inc. in Worcester, Mass., a risk management consulting firm, agreed that engineers often get restless in loss control positions.

Some newly minted engineers gain their experience working for insurers, he said. But once they gain expertise, they discover that they can command higher pay elsewhere, Mr. Betterley said. As a result, many talented loss control engineers leave their employers to join brokerages or to set up shop as consultants, he said.

In addition, qualified loss control personnel often are the target of corporate headhunters.

"On average, my engineers get three calls per year," said Victor J. Sordillo, loss control manager for Chubb's Boston office. But, "I never lost one," he added with more than a touch of pride, saying that his company was willing to pay for the expertise demanded in its personnel.

William T. Nebraska, assistant vp-engineering department for Hartford, Conn.-based Aetna Life & Casualty Co., said that his staff is "perpetually a target of raiders."

"We're known as one of the training grounds," he said. He also had to contend with attempts by customers to lure loss control professionals out of the insurance industry. ■

Factory Mutual: Loss control training ground

By MARK A. HOFMANN

NORWOOD, Mass.—Officials of the Factory Mutual Engineering Organization not only accept the fact they will lose some of their best and brightest loss control professionals to other companies, but they expect to as well.

"We have a mission statement to develop people for the Factory Mutual companies," said Benedict A. Kleiber, vp and manager of the Factory Mutual Engineering Corp.'s human resource development division.

The Factory Mutual companies, which own and set the direction for the engineering organization and draw their engineering personnel from it, are: Johnston, R.I.-based Allendale Mutual Insurance Co. and its affiliates; Waltham, Mass.-based Arkwright Mutual Insurance Co. and its affiliates; and Park Ridge, Ill.-based Protection Mutual Insurance Co.

The engineering organization consists of three segments: Factory Mutual Engineering Corp.; Factory Mutual Research Corp.; and Factory Mutual Engineering Assn.

The engineering corporation operates the engineering organization's Training Resource Center for Loss Control Management; the research corporation conducts tests of fire protection products and sets loss-control standards; and the engineering association provides inspection and adjustment services to Factory Mutual companies.

Mr. Kleiber said that when the engineering organization recruits on campuses it usually has no problem competing with other organizations for talented engineers.

"Within recent years, we've been excellent. I think we're getting a wonderful selection of people out of the universities," he said.

Engineering officials of the Factory Mutual companies themselves agree with Mr. Kleiber's assessment, because they regularly fill their loss control staffs with professionals who have passed through the engineering organization.

"We work closely with Factory Mutual in developing engineering graduates into loss control specialists and commonly recruit our account engineers from the ranks of FM field engineers with five or more years of technical experience, strong communication skills and account management abilities," said Leo Turgeon, vp-loss control for Protection Mutual.

"The majority of our hiring has been within Factory Mutual Engineering," said Frank Suppe, vp-engineering for Arkwright.

Mr. Suppe said that Arkwright generally looks for engineers with five to 10 years of experience.

Michael Burke, Allendale's vp and chief en-

Continued on page 56G

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Factory Mutual

Continued from page 56E

gineer, said that one of the pluses of hiring engineers from the Factory Mutual Engineering Organization is that Allendale can hire someone who already has worked on Allendale accounts. That makes the transition from organization field engineer to insurer loss-control employee much easier, he said.

But, the Factory Mutual companies are not the only beneficiaries of the engineering organization's training, according to Paul M. Fitzgerald, senior vp and chief operating officer of the engineering association.

Other firms, both in and outside of the insurance industry, also seek Factory Mutual Engineering Organization-trained engineers for their staffs, he said.

One reason the organization is raided for personnel is that competitors do not "have the culture that develops people" for loss-control careers as well as his group does, Mr. Fitzgerald surmised.

He pointed out that the Factory Mutual companies historically have put a great emphasis on loss control and promoting more efficient methods of protecting property. Indeed, the Factory Mutual concept came into being in 1835 when Zachariah Allen, a Rhode Island mill owner, persuaded other mill owners to pool their resources and seek more effective ways to prevent fire.

The 19th century mill owners' philosophy was that mills and other factories should be inspected before they could be insured. They held that facilities with effective loss control devices represented better risks.

Mr. Kleiber said he looks at the attempts of other organizations to recruit loss control professionals from the engineering organization two ways: He hates to lose well-trained, qualified professionals to other employers, but the fact that his people are being actively sought by other concerns indicates that the engineering organization is doing a very good job, he said.

"It puts us in a challenging position," he said. ■

Automation to aid loss control efforts

By MARK A. HOFMANN

The biggest challenge for loss control in the next decade is managerial rather than technical, loss control experts say.

But technological advances will be key weapons for loss control professionals in their fight to improve the management of worksite hazards, the experts note.

Maintaining safe worksite conditions requires a management commitment above all else, stressed Bill Duncan, vp-loss control for Des Moines, Iowa-based Employers Mutual Insurance Cos.

"The problem area is that safety isn't managed," said Mr. Duncan, who heads Employers Mutual's risk improvement department.

"We work with top management. We bring them into our office and sit them down and talk to them," he said.

"It's up to the insured to design the safety program," Mr. Duncan said. "We don't have a magic wand."

However, new technology and automation can make assessing safety programs easier, Mr. Duncan said.

"We've designed computer programs to show our insureds where noise is at a higher frequency than is acceptable," he said.

Employers Mutual also has developed tests and programs for detecting carpal tunnel syndrome and other work-related maladies to reduce employers' workers compensation exposures, he said.

Boston-based Liberty Mutual Insurance Co. also stresses the importance of automated safety programs in loss control, according to Gary Lia, vp and general manager of loss control.

A company's safety programs can now be subjected to computerized analysis to determine its strengths and weaknesses, he said.

Mr. Lia also pointed to the possibility of artificial intelligence playing an increasing role in loss prevention during the next few years. "We are just beginning to explore the possibilities" of artificial intelligence, he said.

"I think we're on the verge of large change" in the use of automation as it relates to loss control, he added.

Other loss control experts see the impact of automation more in terms of improving the efficiency of existing loss control systems.

For example, Burdette Short, assistant vp-insurance engineering and loss control for Baltimore-based United States Fidelity & Guaranty Co., a USF&G Corp. subsidiary, predicts that loss control report processing will become more efficient through automation.

Kenneth Ryan, vp and director of loss control for the property/casualty operations of Transamerica Corp. in Los Angeles, foresees more sophisticated loss runs and ergonomic evaluations.

Under an Aetna Life & Casualty Co. pilot program that could lead to a paperless environment between engineers and underwriters, field engineers are using laptop computers to file reports, pointed out William T. Nebraska, assistant vp-engineering department for the Hartford, Conn.-based insurer.

Within two years, Aetna hopes to turn the project into a companywide system in which all field engineers will use laptops to file reports with underwriters, he said. And, within four to five years, Aetna hopes to come as close as possible to creating a paperless environment between engineers and underwriters, Mr. Nebraska said.

In addition to making loss control engineering processes more efficient, automation will help reduce the possibility of human error and thus reduce the possibility of man-made losses, experts said.

For example, loss control engineers in the near future should be able to gain access to an increased number of data bases by using laptop computers in the field, Mr. Nebraska said.

Using the laptops, field engineers who find that they are unfamiliar with a substance used in a client's manufacturing process would be able to access a data bank with their laptops that almost instantly could match the chemical's name with all the other names by which it is known. They then would be able to determine whether the substance is dangerous, Mr. Nebraska envisions.

Experts also predict a greater role for loss control within society as a whole in the immediate future.

"Everybody's looking more and more at loss control," in part because of changes in legal and legislative definitions of liability and the increasing monetary size of potential losses, said Mac D. Livingston, vp-loss control services for the property/casualty companies of CIGNA Corp. in Philadelphia.

The challenge facing insurers is to put together a "cadre" of people who possess the business and technical knowledge to handle such an environment, Mr. Livingston said (see story, page 56D).

Mr. Lia listed some serious exposures that will demand loss control experts' attention in the next decade. For example, the emerging issue of stress in the workplace, the continued problems presented by workplace-related maladies such as carpal tunnel syndrome and the problems presented by aging "smokestack" industries should all concern loss control professionals, he said.

But of all exposures, the risk of any kind of pollution may present the most serious demand for loss control, he said.

And the question for which loss control professionals have no answer yet is: "Is there something out there that is the asbestos of the '90s?" Mr. Lia said.

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Insurer topics

Insurers shift wellness program focus

By ALISON KITTRELL

Some insurers are dropping their wellness program products because employers cannot quantify whether the programs control health care costs.

But, the programs will survive by expanding beyond the emphasis on fitness that characterized many of the pioneer programs, experts say.

"Wellness programs are not a fad—they are in a process of transition," said Steve MacGill, a consultant with A. Foster Higgins & Co. Inc. in Chicago.

But, continuing high health care costs are slowing down that transition, he pointed out.

"Health care costs are increasing so fast that employers are looking for many immediate answers," Mr. MacGill explained. However, there is a lack of hard data on whether the programs actually save money, Mr. MacGill said.

"Wellness is still in its infancy, and its measurability is somewhat limited," he noted. "It seems to be falling through the cracks in the scramble to cut costs," he said.

"Benefit costs have taken benefits into the board rooms, so quantifying the cost savings becomes the issue," he said. And, many executives may be reluctant to commit money to wellness programs until they see the savings quantified, he observed.

In fact, some insurers are dropping their wellness products for lack of employer interest.

For example, John Hancock Mutual Life Insurance Co. in Boston has stopped offering wellness programs, "because demand did not meet expectations," a spokesmen said.

And, Aetna Life & Casualty Insurance Co. had been trying to interest policyholders in buying "booklets in various wellness areas," said Howard Bailit, vp for health care management, "but we found there was very little interest. In fact, we couldn't give them away."

While Aetna has dropped that effort, the insurer has not given up on the idea of wellness promotion, Mr. Bailit pointed out.

"It was clear to us that the route we were going of just trying to provide information was the wrong route," he explained.

So, the company is planning to offer two new services to policyholders: ongoing individual health risk assessments and videotapes geared to individual health questions or risks.

"We decided that we need individual-specific information," Mr. Bailit said. "For example, only about 28% of the people in the country smoke. So 70% of the people don't want or need to hear about smoking."

Individualized information is the cornerstone of two of the largest health promotion, or wellness, programs in the country.

The Center for Corporate Health Promotion in Reston, Va., a unit of Travelers Corp., offers a program called "Taking Care" (*IT*, Oct. 24, 1988) that emphasizes communication and education.

The program especially keys in on teaching people how to take care of themselves better and how to be wiser consumers of medical services.

Communication is critical to the success of a wellness program, according to Dr. Donald Vickery, president of the Center for Corporate Health Promotion and co-author of "Take Care of Yourself," a medical self-care book from which the Taking Care program draws.

For employees to benefit from a wellness program, they must get involved, but they first must be shown that the program can help them, according to Dr. Vickery.

"The science of health promotion has always indicated that communication was the most cost-effective way to get utilization out of your wellness program," he said.

The basic Taking Care program involves communicating with employees about their specific health situations.

Then, "the communications program forms the basis for anything else employers want to do," including, for example, opening fitness centers, Dr. Vickery asserted.

Dr. Vickery said that some companies have dropped the Taking Care program.

But, he said he does not think the companies based their decisions "on the notion that they don't need it anymore." Rather, some companies facing extremely high health care cost increases simply found it impossible to cut anywhere else, he explained.

And, "overall, we're not losing customers; we're gaining," Dr. Vickery said, declining to elaborate.

San Francisco-based Healthtrac, the wellness provider for Blue Cross & Blue Shield Assn. plans, offers a wellness program that also is based partly on Dr. Vickery's book.

Healthtrac is "a comprehensive health promotion program," said John Riedel, a vp for Healthtrac in Chicago.

Employees are given individual health screenings and health risk appraisals and then are provided with information and counseling on their health risks.

They also are encouraged to practice the kind of medical self-care described in Dr. Vickery's book.

Mr. Riedel explained that the book shows how to be a wiser health care consumer, including how to decide when to see a doctor, what questions to ask and how to make sure to get the best and most cost-effective care.

"We hit hard on that, because there are some pretty immediate returns on investment" for employers, Mr. Riedel pointed out.

Mr. Riedel said that the spiraling cost of health care is not hurting interest in Healthtrac. "I'm not experiencing any lessening of interest. In fact, I see it continuing fairly strongly," he said.

In addition, many employers are expressing interest in such touted program benefits as increased employee productivity and morale, as well as dollar savings.

Programs like Healthtrac and Taking Care—both of which cost an average of $20 to $25 per employee per year and are set up to reach all employees—are much more popular with employees than are more costly and less universal approaches such as fitness centers, according to Mr. Riedel.

"Most companies aren't going in for the real expensive products," he said. "The bang for the buck is not as great as if you create a program that is targeted for everyone.

"I see the programs that are successful are the ones that are broader, focusing on the issues that are important today," such as nutrition, he said. "The important thing is to have a broad range, incorporating more than just fitness."

That broad range also fits well with the increasing emphasis by insurers and health care plans on managed care.

"What's really happening is that all the insurers are evolving toward managed care programs, which means they are involved in health in a way they never were before," Dr. Vickery said. Health promotion is a natural outgrowth of that new, expanded involvement, he observed.

"If you look at the history of managed care, we started at the end (when people are seriously ill), and we are working our way up to the front," he said.

Mr. Riedel agrees. "We are starting to see insurers getting more interested in incorporating health promotion into their programs."

And, that increasing interest bodes well for the future of wellness programs, proponents say.

"Health promotion in five years may look very different than it does today, but it will still be here," Mr. Riedel said. ■

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Business Insurance

Jack of all trades

Risk managers have more hands-on responsibility at small firms: Survey

By JERRY GEISEL

Risk managers at the nation's smallest companies have more diverse responsibilities than their counterparts at larger firms, a new survey illustrates.

For example, risk managers at small companies often are directly responsible for employee benefit plan administration, while risk managers at the largest companies rarely have that responsibility.

Similarly, a majority of risk managers at the smallest companies have direct responsibility for corporate data security, while their counterparts at the largest companies almost never have that responsibility.

The varying responsibilities of risk managers at companies of all sizes are detailed in a new survey by Logic Associates Inc., a New York-based recruiting firm that specializes in risk management. The survey is based on the responses of 1,329 risk managers nationwide.

The survey respondents were divided into categories according to company size, with the smallest companies reporting annual sales of less than $201 million and the largest reporting more than $7 billion in sales.

The most striking difference in responsibility between risk managers—based on the size of the companies for which they work—is their level of involvement with employee benefit plan and pension/profit sharing plan administration.

Logic Associates President Bill Perry suggests that the growing complexity of employee benefits administration at larger firms is the reason behind this trend.

"There's just too much to handle. Benefits have become so complex, especially at large firms, that you need a separate individual—if not an entirely separate staff—to handle benefits," he said.

According to the survey, among risk managers at the smallest companies—those with annual sales of less than $201 million—57% had direct, hands-on responsibility for employee benefits administration in 1988, down from 64% in 1987 (*BI*, Aug. 22, 1988).

And, 29% had supervisory or advisory responsibility for benefits administration, up from 24% the year before.

In addition, 29% of risk managers at the smallest companies had direct responsibility for pension/profit-sharing administration last year, down from 31% in 1987. The survey also shows that some 32% had supervisory responsibility for pension administration, up from 27% in 1987.

Risk managers' areas of responsibility

(By company sales in millions of dollars)

	0-$200	$201-$500	$501-$1,000	$1,001-$2,000	$2,001-$4,000	$4,001-$7,000	More than $7,000
Risk financing	55% / 23%	72% / 18%	59% / 18%	65% / 13%	60% / 14%	81% / 9%	44% / 20%
Negotiation of coverage placement	68% / 25%	62% / 25%	72% / 18%	73% / 13%	63% / 15%	67% / 15%	44% / 11%
Claims handling	65% / 24%	59% / 27%	62% / 29%	44% / 35%	38% / 51%	38% / 48%	22% / 33%
Safety/fire loss engineering	59% / 34%	62% / 22%	45% / 26%	37% / 39%	24% / 53%	25% / 57%	16% / 40%
Data security	57% / 23%	20% / 47%	16% / 28%	10% / 37%	7% / 40%	10% / 51%	2% / 20%
Benefits administration	57% / 29%	39% / 24%	13% / 26%	17% / 21%	7% / 29%	1% / 20%	7% / 33%
Pension/profit sharing administration	29% / 32%	30% / 33%	16% / 11%	15% / 14%	6% / 24%	4% / 5%	0% / 22%

Direct, hands-on responsibility / Supervisory/advisory responsibility

Source: Logic Associates

Chart: Amy Palmer

At companies with between $201 million and $500 million in annual sales, 39% of risk managers had direct responsibility for benefit administration last year, up from 37% in 1987.

And, 24% had supervisory responsibility for benefit administration last year, down from 27% the year before, according to the survey.

At companies in that same category, the percentage of risk managers directly responsible for pension and profit-sharing plan administration fell to 30% in 1988 from 32% the previous year. Slightly more risk managers—33%—had supervisory responsibility for pension administration last year than in 1987, when 32% had supervisory responsibility.

At companies with between $501 million and $1 billion in annual sales, 13% of risk managers were directly responsible for benefits administration in 1988, unchanged from 1987. Twice as many risk managers—26%—had supervisory responsibility for benefits administration in 1988, up from 24% in 1987.

Within the same category, the percentage of risk managers directly responsible for pension/profit sharing plan administration increased slightly to 16% in 1988, from 15% the previous year. And, 11% had supervisory responsibility for pension administration in 1988, up from 7% in 1987.

Seventeen percent of risk managers at companies with $1 billion to $2 billion in annual sales had direct responsibility for benefit administration in 1988, down slightly from 18% in 1987.

But, more risk managers—21%—had supervisory responsibility for benefits administration last year, unchanged from 1987.

Fifteen percent of risk managers in this category were directly responsible for pension/profit sharing plan administration in both 1988 and 1987. And 14% had supervisory responsibility for pension administration, up from 13% the year before.

At companies with $2 billion to $4 billion in annual sales, just 7% of risk managers had direct responsibility for benefit administration last year, unchanged from 1987. But, more than four times as many risk managers—29%—had supervisory responsibility for benefits administration last year, up from 27% in 1987.

Among risk managers in this same category, 6% had direct responsibility for pension/profit sharing administration in 1988, up from 5% in 1987. But, four times as many risk managers—24%—had supervisory responsibility for pension administration in 1988, up from 22% the year before.

Only 1% of risk managers at companies with $4 billion to $7 billion in annual sales were directly involved in benefit administration last year, compared with 2% in 1987. But, 20% had supervisory responsibility for benefits administration in 1988, down from 25% the year before.

At companies of the same size, 4% of risk managers were directly involved with pension/profit-sharing administration, down from 5% in 1987. Five percent had supervisory responsibility for pension administration in 1988, down from 6% in 1987.

Among the largest companies—those with more than $7 billion in

Continued on next page

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* Source Business/Occupational breakdown of qualified circulation, November 28, 1988 issue, as submitted to BPA for December 1988 BPA Publisher's Statement.

Transit Casualty

Continued from page 61

the charges leveled against him at the April 5 hearing (see related story).

Transit's receiver is currently suing Mr. Mitchell, Mr. Bowie and others involved in Transit's operations in U.S. District Court in Los Angeles. The suit, charging breach of fiduciary duty, negligence and unjust enrichment, seeks more than $178 million in compensatory damages.

The defendants, meanwhile, have filed third-party complaints against Mr. Miro and others involved in Transit's MGA programs, according to Charles Patterson, a lawyer with the Los Angeles firm of Lillick & McHose, representing the receiver.

A trial of the case is scheduled for January 1990, though the parties are discussing the possibility of a settlement, he said.

Last week's hearing was the latest in the House subcommittee's ongoing inquiry into insurer insolvencies and the adequacy of state regulation of insurance.

The subcommittee last September held hearings on the failures of Mission Insurance Co. and Integrity Insurance Co. of Paramus, N.J., and later recommended investigations of possible criminal fraud and securities law violations by persons connected with the two companies (*BI*, Jan. 16; Dec. 19, 1988).

In the April 5 hearing on Transit's collapse, Mr. Arnold testified that the insurer's problems began in 1980 when it decided to expand beyond its traditional transportation insurance business into fronted property/casualty insurance programs produced by MGAs.

Over the next five years, Transit assumed business through 17 MGAs and about 1,000 subproducers, with much of the business reinsured by unauthorized companies lined up by the MGAs.

Transit's gross written premium volume exploded to a peak of $277.9 million in 1984, from $89.2 million in 1980, while net premiums actually fell during the same period to $60.5 million from $64.7 million.

During this period, Transit's operations went "out of control," Mr. Arnold testified. The insurer did not have the personnel or systems in place to keep track of the huge number of policies issued by the MGAs, the premiums due on those policies or the reinsurance applicable to the policies, he said.

Among other things, Mr. Arnold noted that Transit did nothing to review the financial condition of its unauthorized reinsurers and did not even set up a security committee to monitor the adequacy of collateral posted by the reinsurers until the beginning of 1984. In testimony last week, Mr. Arnold added that Transit's management was repeatedly warned about the problems it faced with the MGA business.

Among other documents, Mr. Arnold cited:

- An April 1981 memo to Transit's management from Senior Vp Eleanor Leary—later to become the insurer's chief financial officer—noting that Transit was organized to handle low-volume business.

"Transit's structure, staff, procedures and controls all were developed to provide insurance for 500-600 policies," the memo said. "The risk management division budget for 1981 calls for a sales volume of 37,000 policies! Gearing up to support this kind of volume is not an insignificant task. Turning on the spigot for this kind of business, before the administrative and processing systems are in place, is an invitation for trouble."

- A May 1982 memo from Ms. Leary to William L. Gregory, president of Transit's risk management division, advising that "the company's lack of written procedures, lack of managerial controls and lack of expertise in setting up new operations jeopardize any smooth transition into high-volume processing operations. Fronting may have no risks associated with it from an underwriting view, but as you know, it does have a financial risk. Agents and reinsuring entities must be financially sound. Where they are not, practices start appearing which expose the primary carrier to significant risk."

- A March 1982 memo in which Transit Executive Vp Gerald S. DeGennaro told Mr. Gregory: "We are entering areas where we don't belong. We have picked up programs which have historically been unprofitable industrywide and provided coverage where most companies wouldn't participate. We really don't have the background or experience in some of these areas and, frankly, it scares me."

"The warning flags were up, the red lights were flashing and, yet, Transit plunged onward," Mr. Arnold told the House panel.

Subcommittee Chairman John D. Dingell, D-Mich., questioned Mr. Bowie, Transit's chairman, about repeated warnings between 1979 and 1983 from Touche Ross & Co., Beneficial Standard's auditor, that Transit's systems of accounting for agents' balances and policy issuance were inadequate.

Mr. Bowie insisted that Transit responded to these criticisms—despite the fact that Touche Ross reiterated them for several years in reports to management—and resisted Rep. Dingell's suggestion that they constituted "warnings," describing them instead as "suggestions."

"Look at the reports of Touche Ross to management and you will see the litany of things that they decided would be the perfect accounting system," Mr. Bowie said. "We don't agree with all of those recommendations."

Rep. Dingell also asked about several changes in Transit Casualty personnel, including the resignation of Ms. Leary as chief financial officer.

Asked why Ms. Leary resigned, Mr. Bowie explained that she had been offered a job with Kramer Capital Corp.

"She didn't tell you that one of the major reasons she decided to resign was that she was not being listened to?" Rep. Dingell asked.

"Absolutely not," Mr. Bowie responded.

"Would it surprise you that she told the (subcommittee) staff that?"

"Yes."

"I can report to you that that is the case," Rep. Dingell said.

Transit began to report the adverse effects of its MGA business in its 1982 financial statements, causing Mr. Mitchell and Beneficial Standard increasing concern, since dividends from Transit were one of the major sources of cash to the parent, according to Timothy N. Weissenberger, director of financial operations for the Transit receivership.

In 1983, Transit executed a loss portfolio reinsurance contract with a unit of Bermuda-based Clarendon Group Ltd. The contract—under which Transit reinsured $25.3 million of liabilities by ceding reserves of $16.8 million—allowed Transit to "artificially inflate" its surplus by $4.6 million by year-end 1983, Mr. Weissenberger told the subcommittee.

This in turn facilitated Transit's payment of a $4 million dividend to Beneficial Standard in early 1984, he said.

Transit's board of directors voided the contract with Clarendon in October 1985—two months before Transit was ordered liquidated—and Clarendon returned the $16.8 million in loss reserves with $2.7 million in interest in November 1985, he said.

In 1984, Transit also entered into a surety bond deal with a Clarendon unit, according to Thomas F. Crone, controller of the Transit receivership. Under this deal, Transit paid an $8 million premium in return for Clarendon guaranteeing payment of $23.8 million in reinsurance recoverables from several of Transit's unauthorized reinsurers.

This transaction allowed Transit to avoid taking a $15.8 million charge to surplus in 1984, when it reported total surplus of $21.9 million, Mr. Crone told the subcommittee.

The surety bond deal was "suspect" for several reasons, Mr. Crone said, observing:

- There was no real coverage, since a side agreement provided that Transit would ultimately pay premiums equal to losses.
- Mr. Bowie told Clarendon before the agreement was executed that Transit would not file a claim for $14.4 million in worthless recoverables that the insurer might otherwise have collected from Clarendon. Instead, Transit wrote off these recoverables.
- The agreement "appears to have been back-dated" to comply with a New York Insurance Department regulation prohibiting this type of transaction.

The surety bond deal also was voided by Transit's board just before the company went into liquidation, Mr. Crone said.

"It would appear that the voiding of these two deals with Clarendon was done by Transit management so as to place any of the supposed financial 'benefits' to Transit beyond the reach of Transit's liquidator," Mr. Crone charged.

While Transit's financial condition deteriorated between 1982 and 1984, the insurer was paying a total of $15.7 million in cash and stock dividends to Beneficial Standard, Mr. Crone noted.

Missouri law forbids the payment of dividends except from the "surplus profits" arising from an insurer's business, and the Missouri Insurance Division challenged the payment of most of the dividends in May 1985.

The receiver's claim that the dividends were illegally declared is now a part of its lawsuit against the Transit directors and officers, Mr. Crone said.

In early 1984, Beneficial Standard's compensation committee also voted to accelerate the company's stock option plan "for reasons which are difficult for us to understand," Mr. Weissenberger told the subcommittee.

The action allowed Messrs. Bowie and Mitchell to quickly exercise their stock options and convert them to cash, resulting in payments to the two men of $647,250 and $1.2 million, respectively.

In its December 1984 10-K filing with the Securities and Exchange Commission, Beneficial Standard reported that it was writing its $47 million investment in Transit Casualty down to zero because, among other things, it could not quantify Transit's liabilities, Mr. Weissenberger reported.

"So, Mr. Bowie's bonus of $647,250 is certainly unique—if not shocking—in that he was rewarded in May 1984 for running a company that was declared a few months later to be out of control and financially worthless," Mr. Weissenberger told the subcommittee.

Transit's liquidator has also questioned the disparity between Beneficial Standard's 1984 10-K filing—which wrote down the value of Transit to zero—and Transit's own 1984 statutory financial statement, which reported policyholder surplus of $21.9 million, Mr. Crone testified.

The disparity raises the question of whether Beneficial Standard knew something about Transit that Transit's own management did not, Mr. Crone said.

More important, however, is the issue of whether Beneficial Standard should have provided for liabilities greater than its initial $47 million investment in Transit, he added.

By simply writing off the value of its insurance unit, Beneficial Standard walked away with several benefits, including the $15.8 million in Transit dividends and the tax benefits of the $47 million write-down, Mr. Crone told the subcommittee.

"Looking back at the actions taken by (Beneficial Standard), it appears that extreme measures were taken. . .to ensure they would not have to provide any additional moneys for the financial fiasco which Transit was in," Mr. Crone said.

"The insurance industry is a public industry," Mr. Arnold testified. "And the public should be protected from the corporate holding company, who through stock control can manipulate the insurance subsidiary and 'milk it,' if you will, until it does go into insolvency and then just walk away from the wreckage, leaving the policyholders and creditors to sink or swim in what little assets may be left," he said.

Mr. Mitchell defended the write-down in his testimony.

"I thought it was a very conservative position to take," he said.

"I probably could have negotiated with the auditors to give some value to it," he added, explaining that he instead decided to "bite the bullet" and write off Transit Casualty entirely. ■

Liquidator outlines steps to prevent Transit repeat

WASHINGTON—Transit Casualty Co.'s liquidator recommends that federal and state regulators take several steps to ensure the Transit debacle is not repeated.

In testimony last week before the House Oversight and Investigations Subcommittee, Special Deputy Receiver J. Burleigh Arnold suggested that:

- Managing general agent contracts that completely delegate authority for underwriting and reinsurance placements be outlawed.
- A federal regulatory authority be established to accredit alien reinsurers.

Accreditation requirements might include minimum capital and surplus of at least $10 million; the filing of annual financial statements similar to U.S. statutory statements; periodic on-site examinations by federal authorities; and minimum standards for collateral that alien reinsurers must post for the benefit of domestic ceding companies.

- Greater responsibility be imputed to the directors and officers of insurance companies and on the insurers' holding companies for the failure of a company.

For example, the burden of proof should be shifted so that mismanagement is presumed unless directors and officers can prove otherwise.

Mr. Arnold also suggested that holding companies be held responsible for the liabilities of insolvent insurance subsidiaries.

- Controls be placed on fronting operations. Insurers should be prohibited from reinsuring more than two-thirds of individual risks, Mr. Arnold said.
- Officers and directors of insolvent companies be prevented from later mismanaging other insurers.

"The public must be protected from insurance gypsies," Mr. Arnold said.

He recommended that officials of failed insurers be barred from becoming owners, officers or directors of other insurance companies or insurance holding companies for a specified period of time.

They also should be barred from becoming agents or brokers, and should be allowed back into the insurance industry only after proving that their re-entry would not be detrimental to the public interest, Mr. Arnold suggested.

- Current triennial examinations of insurers be replaced by annual examinations conducted by outside auditors.

The outside auditors should be required to certify the insurers' financial statements, Mr. Arnold recommended.

—By Douglas McLeod

Miro denies charges of mishandling insurer

LONDON—Former Transit Casualty Co. managing general agent Carlos I. Miro denies charges that he hastened Transit's collapse and later drove a Louisiana insurer he controlled into insolvency.

In an April 5 House Oversight and Investigations Subcommittee hearing, Transit's receiver accused Mr. Miro of abusing his underwriting authority and of funneling millions of dollars of premiums into offshore reinsurers he controlled that later failed to pay Transit's claims (*BI*, April 10).

The receiver for Anglo-American Insurance Co. of Louisiana also charged Mr. Miro with intentionally bleeding millions of dollars out of that insurer. Anglo-American was declared insolvent by $19 million and ordered into liquidation last month.

"I am truly shocked at the blatant errors contained in and omissions from (the receivers') testimony as it relates to my activities," Mr. Miro said in a statement issued by his lawyer last week. He denied abusing his authority as a Transit MGA and insisted that two offshore reinsurers he controlled met their obligations.

Of the $102 million in premiums Mr. Miro's operation generated, the largest part was used by the two reinsurers to pay claims on the Transit-fronted programs, he said. Millions more went to Transit's own fronting fees and to retail brokerage commissions, while about $20 million went to London market excess reinsurers, he added.

Mr. Miro also charged that Transit's receiver has failed to make a single claim on $23 million in collectible aggregate excess reinsurance, and denied that London market reinsurers have refused to pay claims because Mr. Miro's accounting records were inadequate.

Mr. Miro also charged that testimony by Anglo-American's receiver was "so misleading as to be bordering on perjurious."

Mr. Miro was the founder and majority shareholder of Anglo-American's parent company.

Specifically, Mr. Miro denied allegations that he siphoned $12 million out of Anglo-American through unsecured loans to the parent company, which were then concealed in the insurer's financial statements. "Every penny of the more than $12 million borrowed by the parent was put into the insurance company. Neither I nor anyone else at Anglo-American profited from this transaction at all," he said.

He also denied other charges of self-dealing, including having the insurer make mortgage loans to associates and affiliates of Mr. Miro.

"Every mortgage bore an arms-length market rate of interest," he said, adding that one of the loans for $1 million was repaid with interest before the Louisiana Insurance Department's audit of Anglo-American began last year.

—By Douglas McLeod

AIGlobal to service multinational firms

American International Group Inc. of New York has consolidated several units into a new organization, called American International Global, to service the insurance needs of both domestic and foreign multinational firms.

The New York-based unit, dubbed AIGlobal, consolidates the North American and Global Accounts divisions of American International Underwriters with the multinational units of AIU's overseas operations and the foreign-based business of AIG's North American Managers subsidiary.

Multinational clients that formerly were handled by any of the named units will now work with AIGlobal, the company said.

AIGlobal, which already is in operation, provides multinational companies with property/casualty

Markets

insurance, life insurance and group benefits, as well as financial services capabilities, said President Vincent J. Masucci.

AIGlobal's 500 employees are based throughout North America as well as in London, Paris and Hong Kong, said Mr. Masucci, who formerly was president of AIU's North American Division.

Mr. Masucci would not speculate on AIGlobal's expected revenues, except that they will be in the "hundreds of millions of dollars."

"Everywhere you look the world is getting smaller," said Mr. Masucci, in explaining AIG's decision to integrate all its multinational activities into one unit.

AIGlobal represents a "holistic cross section of AIG's strengths" that will be well-positioned to service multinationals' needs, he added.

The unit will offer property/casualty, marine, directors & officers liability, professional liability coverages and bonds.

In addition, the unit also will offer specialty services and political risk coverage, plus life, accident and health insurance and risk management services.

Financial services offered include facilitating access to interest rate and currency swaps, among other services.

Claude Gallello, formerly president of the AIU Global Accounts Division, will join AIGlobal to direct business development for foreign-based clients.

For further information, contact Peter Haller, Senior Vp, at 1-800-343-7963.

Travelers PPO grows

Travelers Corp. of Hartford, Conn., has added two new preferred provider organizations, one in Indianapolis and one in Fort Wayne, Ind.

Four hospitals and more than 500 physicians are in the Indianapolis Travelers Preferred-Indianapolis network.

Two hospitals and more than 100 physicians are in the Travelers Preferred-Fort Wayne provider network.

Participating physicians and hospitals in the Indianapolis PPO are located throughout Hamilton, Marion and Tippecanoe counties. The PPO services those counties as well as Madison, Boone, Hendricks, Morgan, Johnson, Shelby and Hancock counties.

The Fort Wayne PPO includes providers in Allen and Wells counties.

Both Travelers PPOs include the Patient Advocate utilization review program and the Taking Care wellness program. The Taking Care program is optional for employee groups of 150 or more.

For more information about Travelers Preferred-Indianapolis and Fort Wayne, contact Marilyne Nixon, Health Plan Manager, Travelers Preferred, 1 Mellon Bank Center, 500 Grant St., Pittsburgh, Pa. 15219-2502; 412-338-5545.

New name

San Francisco-based **Northern California Health Center** has changed the name of its Children's Hospital of San Francisco and IPM Health Plans' health maintenance organization to **BRIDGEWAY Plan For Health.**

Mergers/acquisitions

Aetna Life Insurance Co. of Hartford, Conn., has agreed in principle to acquire **HealthWays Systems Inc.** of Tarrytown, N.Y., for $7 per share. The sale is expected to be completed by July 1.

After the merger, HealthWays will be integrated into PARTNERS National Health Plans' network of health maintenance and preferred provider organizations.

New York-based Corroon & Black Corp.'s Baltimore subsidiary, **Corroon & Black/Stump, Harvey & Cook Inc.**, has merged with **Herget Risk Management Inc.** in Baltimore.

New offices

New York-based **Fred S. James & Co. Inc.** has opened a new office in the Chicago area at 3030 Warrenville Road, Suite 560, Lisle, Ill. 60632; 312-505-1515.

San Francisco-based excess and surplus broker **Sherwood Insurance Services Inc.** has opened two new California offices. The Northern division office is at 201 California St., Suite 900, San Francisco, Calif. 94111; 415-956-3236.

The southern division office is at 3435 Wilshire Blvd., Los Angeles, Calif. 90010; 213-487-3260.

Buck Consultants Inc. of New York has opened a new office in Sydney, Australia, at Level 2, 20 Clarke St., P.O. Box 412, Crows Nest-Sydney, Australia 2065; 61-2-439-1491.

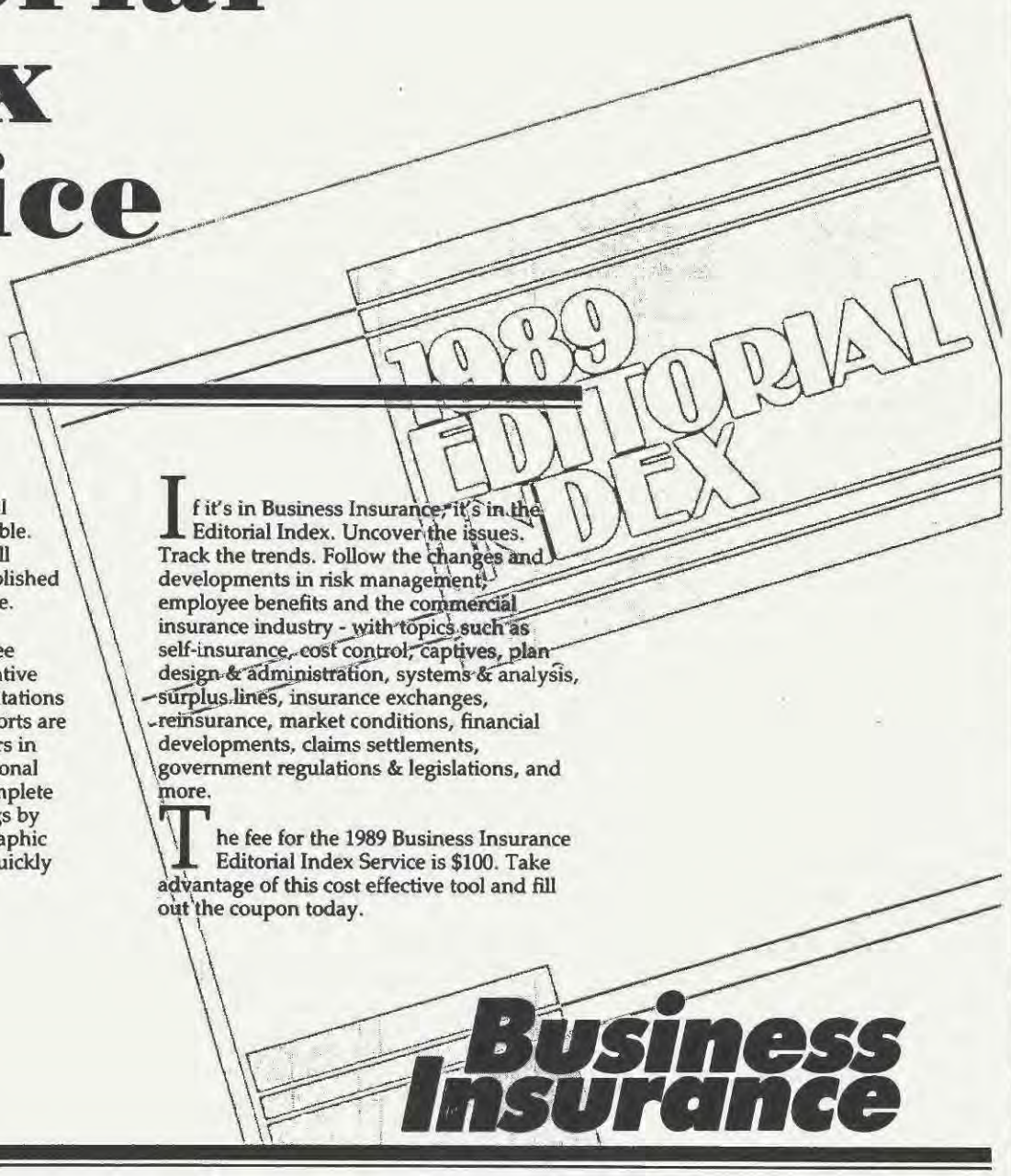
The Prudential Insurance Co. of America of Newark, N.J., has opened a new marketing and administration office for group insurance products at 3151 Airway Ave., Suite G3, Costa Mesa, Calif. 92626; 714-545-1026.

Crum & Forster Corp. of Morristown, N.J., is moving its senior management and headquarters to 211 Mount Airy Road, Basking Ridge, N.J. 07920; 201-204-3500.

William M. Mercer Meidinger Hansen Inc. is moving its Chicago offices to 10 S. Wacker Drive, Chicago, Ill. 60606; 312-902-7500.

Albany, New York-based **A.W. Lawrence & Co. Inc.** has opened two new offices. The Los Angeles office, A.W. Lawrence Insurance Agency Inc., is located at 8489 W. Third St., Los Angeles, Calif. 90048; 213-651-0672. The newly opened New York office is located at 770 Broadway, New York, N.Y. 10003; 212-674-8753. ■

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Business Insurance
a publication of Crain Communications Inc

Kennedy bill

Continued from page 1

sponsored program to eventually provide health care coverage for Americans who do not work.

This program would be funded by general revenues.

A bill, H.R. 1845, that is virtually identical to Sen. Kennedy's was introduced in the House last week by Rep. Henry Waxman, D-Calif.

Sen. Kennedy said last week that his new proposal mandating that employers offer health care coverage addresses "the legitimate concerns of the small business community."

"Our message to small business today is that government is on your side and that there is no inherent conflict between small business and basic health insurance," Sen. Kennedy said.

But, business groups generally are not rallying around the bill.

Although the changes "certainly are in the right direction. . . .We are still firmly against" the bill, said James Klein, deputy executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

"The idea of an employer mandate is no more palatable to the business community this year than it was last year, and we plan to oppose all attempts to mandate employee benefits," said Karen Berg, manager of human resources policy for the U.S. Chamber of Commerce in Washington, D.C.

"It is unfortunate that Sen. Edward Kennedy is once again introducing his thinly-disguised plan to mandate national health insurance," said John Sloan, president of the National Federation of Independent Business in Washington, D.C.

Sen. Kennedy's plan "would impose unrealistic requirements on entrepreneurs, which will force them to reduce or drop the coverage they now provide," he said.

The bill "still has major flaws that are opposed by a majority of the business community," asserted Sharon Canner, assistant vp for industrial relations for the National Assn. of Manufacturers in Washington, D.C.

Under both the new Kennedy bill and his previous proposal, employers would be required to offer as part of their health care plans benefits including hospital and physician services, diagnostic tests, pregnancy and well-baby care and limited mental health care.

Under the bill, annual deductibles for hospital and physician services generally could not exceed $250 per person or $500 for family coverage. These deductibles would be indexed to match annual increases in the Consumer Price Index.

Copayments for covered services, except outpatient psychotherapy, generally could not exceed 20%, with a maximum annual out-of-pocket expense of $3,000. This catastrophic expense cap also would be indexed to CPI increases.

Prenatal and well-baby care, though, would have to be offered without deductibles or coinsurance requirements.

Employers would be allowed to alter benefit provisions as long as the overall value of the plan is not reduced. For example, if an employer offered a prescription drug benefit, it could require employees to make a higher premium contribution.

The bill would not allow exclusions for pre-existing conditions.

While employers would have to pay 80% of the health care plan premium for most workers, employers would have to pay the full premium in the case of low-wage earners—those who earn less than 125% of the federal minimum wage.

However, in an attempt to garner small-business support for the measure, Sen. Kennedy has included several new provisions in the proposal.

Under one provision, the federal government would subsidize 75% of a small employer's health care plan costs that exceed 5% of the company's gross revenues. Small businesses are defined as those with 25 or fewer workers.

Another new provision would allow businesses to pay less than 80% of the health care plan premium for part-time workers who work between 17.5 and 25 hours a week. However, the bill does not contain a schedule detailing how much of these employees' health care premiums employers would have to pay.

Under the previous version of the legislation, employers had to pay the same amount—80%—toward the premium of all employees who worked at least 17.5 hours per week.

In addition, the new legislation would:

- Pre-empt the hundreds of state laws requiring companies with plans to offer certain benefits, which would cut costs for nearly all employers.
- Give employers with fewer than six employees five years to comply.
- Require employers with fewer than 10 employees that have been in business for fewer than two years to offer only a low-cost plan to their workers, but the bill does not specify what a low-cost plan means.

Under the previous bill, these employers would have had to provide a plan that only covered health care expenses exceeding $3,000 annually.

- Establish a system of regional insurers through which small employers could buy a standard minimum health care plan.

Acknowledging that business support for the legislation is weak, Sen. Kennedy said the debate on mandated health insurance is "a continuing process of exchange with the business" community.

"We have made some progress," though, he noted. "Business is understanding the competitive situation between" those employers that incur the costs of providing health insurance to employees and those that do not.

Furthermore, "the issue is back on the public agenda," Sen. Kennedy said. "The country is prepared to come to grips with this issue. The real question is whether the financial and economic interests are going to be powerful enough to block" the bill.

Backers of the bill say the legislation requires employers to provide only a slightly richer package of benefits than is standard.

For example, according to David Nexon, Sen. Kennedy's top health care aide, the bill's mandate of full coverage for pregnancy and well-baby care are the only types of coverage mandated by the Kennedy bill that are not included in most current group health care plans.

However, TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc., found that not one of the health plans of 74 employers it surveyed in 1987 complied with all the benefit requirements laid down by the Kennedy bill (*BI*, Aug. 31, 1987).

Sen. Kennedy said he hopes the Senate Labor and Human Resources Committee will approve the bill by early summer.

"This is going to be a priority item," he asserted.

Addressing whether Congress would enact the proposal, Sen. Kennedy said: "The American people have made up their minds—whether the politicians are going to catch up with them is the question."

"I give the bill a 50/50 chance" of passage, "which is higher than I would have given it last year," said Howard Weitzmann, executive director of the APPWP.

However, NAM's Ms. Canner speculated that the Kennedy legislation's chances of passage are "no better than last year."

'The real question is whether the financial and economic interests are going to be powerful enough to block' the bill, Sen. Kennedy says.

While critical of the health care mandate, several business lobbyists did approve of a new section of the legislation that would make the public sector responsible for providing health insurance to the unemployed and those not covered by Medicaid or Medicare.

The cost of this coverage would be financed by federal and state general revenue funds, but the bill does not specify what portion the federal government will pay and what amount states will pay.

Of the approximately 37 million uninsured Americans, an estimated 13 million are not members of families in which the head of the household works at least 17.5 hours per week, according to the U.S. Census Bureau.

But, the Employee Benefit Research Institute, a Washington-based employee benefits think tank, places that figure at closer to 5 million. EBRI says that nearly 80%, or 32.7 million, of the 37 million uninsured Americans are employed or are dependents of workers (*BI*, Nov. 7, 1988).

The provision would mandate that the public sector provide the unemployed the same benefits that employers would be required to provide their workers. Deductibles, copayments and premiums would range from none for those below the poverty level to the same levels as those set forth for employer-based plans for people with incomes above 185% of the poverty level.

The public program would be phased in gradually, covering first those unemployed and uninsured people below the poverty level. This would cost about $5 billion annually, according to Sen. Kennedy.

The next phase, which would be implemented in 1996, would cover those unemployed and uninsured people with incomes between 100% and 185% of the poverty level.

The third phase, which would be implemented in 1999, would cover the remainder of the uninsured population.

Sen. Kennedy did not have cost estimates for the second and third phases of the program.

Sen. Kennedy also said he plans to introduce complementary legislation that would address employers' concerns over the complicated Section 89 non-discrimination rules for welfare plans.

Sen. Kennedy declined to discuss the nature of that legislation in detail.

However, he noted that "if we pass the minimum benefits bill, it's not exactly clear that we need the Section 89 rules."

Rep. Dan Rostenkowski, D-Ill., meanwhile, has introduced a bill that would provide employers some relief from the Section 89 rules (see story, page 1).

Sen. Kennedy said he also intends to introduce complementary legislation that would allow self-employed individuals a 100% tax deduction for health insurance. A provision allowing this deduction was contained in the mandated health care bill Sen. Kennedy introduced nearly two years ago.

Currently, self-employed individuals can deduct as an expense only 25% of the cost of health insurance. ■

Update

Oil spill suit coordination eyed

Continued from page 2

ports coordinated litigation. Mr. Belli represents fishermen and others who seek more than $2 billion in compensatory damages and punitive damages from Exxon and other defendants in a suit that seeks class-action status filed in Alaska Superior Court.

Mr. Belli also has asked the 3rd District Superior Court in Anchorage for expedited arbitration to distribute proceeds from the Trans Alaska Pipeline liability fund as interim relief for fisherman and others who face immediate financial problems from the spill. The fund, financed by oil companies that use the Alaska pipeline, would provide Exxon with $86 million in coverage for pollution liability claims excess of a $14 million deductible.

St. Paul asks med mal rate cuts

ST. PAUL, Minn.—St. Paul Fire & Marine Insurance Co. plans to cut physicians and surgeons medical malpractice rates an average of 14% in 34 of the states in which it writes that business.

The insurer will file for rate decreases ranging from 5% to 30%, a spokeswoman said. The filings include a proposed 25% decrease in medical malpractice rates for doctors in Minnesota.

The spokeswoman said St. Paul is filing medical malpractice rate increases in three other states, but it will not disclose those states or the proposed increases until the rates are filed later this week. Rates in the five other states in which St. Paul insures physicians will not change.

After a study of Minnesota medical malpractice rates earlier this year, Commerce Commissioner Michael A. Hatch accused St. Paul and another insurer of charging unnecessarily high rates (*BI*, Feb. 27).

But the St. Paul spokeswoman said the adjustments are the result of the insurer's annual claim and rate review process.

Outhwaite members' liability

LONDON—A new report on the operations of Lloyd's of London syndicates underwritten by Richard Outhwaite may provide a legal loophole that could free members from liability for as much as $444.5 million in 1982 losses on runoff reinsurance policies.

The syndicate's managing agency, R.H.M. Outhwaite (Underwriting Agencies) Ltd., closed the 1982 account in May 1985, at which time cash profits were distributed to the members for the 1982 year.

However, three months later Mr. Outhwaite told members that he was reopening the 1982 account because of uncertainties about runoff reinsurance policies, says London law firm Freshfields in its second report to the Lloyd's Outhwaite Members' Agents' Steering Committee.

In a letter attached to the report, Steering Committee Chairman John Heynes told underwriting agents there is no legal precedent or procedures on reinsurance to close. As a result, the committee is seeking further legal advice. Reinsurance to close is the method Lloyd's syndicates use to close their accounts.

The second report gives no legal opinion on the events in 1985, although its first report last May concluded its members would not likely win a judgment against the syndicates' managers for breach of duty (*BI*, May 23, 1988).

Outhwaite Chief Executive Officer Edward Bloxham said that second Freshfields report is accurate but that he is "very concerned" the matter will drag on and pose an even greater burden of legal costs—and uncertainty for members' agents.

$48 million S&L settlement

SANTA ANA, Calif.—International Insurance Co., the Federal Savings & Loan Insurance Corp. and a Big Eight accounting firm have agreed to pay $48 million to settle several class-action lawsuits brought by shareholders of bankrupt Financial Corp. of America.

International Insurance, a Crum & Forster Inc. unit, wrote directors and officers liability coverage for FCA directors and officers. Arthur Andersen & Co. was the auditor for the Tustin-based S&L holding company when it ran into financial problems in the early 1980s. FCA filed for bankruptcy in September 1988 after the FSLIC took over its failing American Savings & Loan unit.

Details about the dollar amount each defendant will pay have been sealed by the bankruptcy court.

The proposed settlement was filed in U.S. Bankruptcy Court in Santa Ana last week and requires approval by that court, U.S. District Court in Los Angeles and the federal Home Loan Bank Board.

Pollution exclusion clear: Court

HARRISBURG, Pa.—A Pennsylvania state appellate court ruled April 3 that the pollution exclusion clause is not ambiguous and bars coverage for pollution that is not sudden and accidental.

The decision stems from a coverage dispute between USF&G Corp. of Baltimore and the Lower Paxon Township of Pennsylvania over a $212,000 cleanup.

The appellate court ruling is expected to affect Philadelphia-based Westinghouse Electric Corp., which is suing more than 140 of its property and liability insurers for the cleanup of 80 hazardous waste sites nationwide, 17 of which are in Pennsylvania (*BI*, April 4, 1988).

The decision marks the second Pennsylvania appellate court to interpret the pollution exclusion clause against policyholders.

Briefly noted

The U.S. Supreme Court earlier this month declined to hear the California Supreme Court decision in *Nally vs. Grace Community Church of Sun Valley, Calif.*, in which the state court ruled that church pastors who counseled a man before he committed suicide were not negligent. . . .The California Assembly rejected a bill that would have penalized insurers for arbitrarily canceling or refusing to renew **private passenger auto insurance policies**. . . .The Louisiana Insurance Department last Friday obtained a conservation order for **New England International Surety of America Inc.**, which earlier this month was ordered to halt all underwriting.

Diamond Shamrock ruling

Continued from page 1

In 1984, Diamond Shamrock sued Aetna Casualty & Surety Co.—its primary liability insurer for more than three decades—and 125 excess liability insurers for coverage of liabilities arising from its production of Agent Orange, including cleanup costs at the Newark plant, coverage of bodily injury and property damage claims filed by workers and nearby residents, and coverage of its contribution to the Vietnam veterans settlement.

Judge Stanton disposed of several coverage issues in rulings on a series of pretrial motions (*BI*, June 27, 1988; Feb. 15, 1988; Jan. 25, 1988).

The judge issued his final ruling last Wednesday.

Diamond Shamrock, or a corporate predecessor, operated the Newark plant from 1951 to 1969, the ruling notes. The company closed the plant in 1969 and sold it in 1971, but later reacquired it as part of a state-mandated cleanup effort.

Diamond Shamrock intentionally and illegally discharged all wastes from the plant into the nearby Passaic River from 1951 to 1956 and continued to dump some effluents into the river after 1956, the judge found. In addition, workers constantly spilled hazardous chemicals onto plant floors and surrounding grounds from 1951 to 1969, he said.

The chemical company knew these discharges were illegal and deliberately concealed them, the judge said. Diamond Shamrock even developed an alarm system to warn employees when inspectors from the Passaic Valley Sewerage Commission were on the premises, the judge wrote.

"The conclusion is inescapable that the consistent policy of Diamond's management (both at the local plant level and at corporate headquarters) was to discharge dangerous chemicals into the Passaic River in known violation of public law," Judge Stanton wrote.

"The policy was consciously adopted by Diamond's management because the pollution of the public waters of the state was not perceived by them as a significant wrong, and because it would have been technically difficult and very costly to have avoided such discharges," the judge wrote.

Although the state cleanup order covered the plant itself and not the Passaic River, the company's history of discharging wastes into the river was relevant as a reflection of its "mindset," Judge Stanton noted.

"Even by the standards of the 1951-1969 period, Diamond's conduct in operating the Newark plant was unacceptably wrong and irresponsible. Diamond always put its narrowly perceived economic interests first. It deliberately and persistently cheated on the limited environmental regulations which were in place," Judge Stanton concluded.

In denying coverage for both the cleanup, and bodily injury and property damage claims arising from the Newark operation, the judge divided Diamond's policies into three groups:

- 1951 to 1960 policies, which provided coverage on an "accident" basis.
- 1960 to 1970 policies, which provided coverage on an "occurrence" basis and did not specifically exclude pollution claims.
- 1971 to 1985 policies, which also were occurrence-based and contained a pollution exclusion.

The accident-based policies provide no coverage because there was never an accident within the meaning of the policies, the judge ruled. "It seems clear to me that any personal injury or property damage for which Diamond seeks coverage in this action was caused by the gradual and continuous dispersal of chemical contaminants into the environment by Diamond at its Newark plant.

Injury or damage incurred in this way is not 'caused by an accident,' " Judge Stanton wrote. He described an "accident" as a "discrete fortuitous event which happens within a short time at a specific time and place."

The 1960-1970 occurrence policies also do not provide coverage, because they insure losses that are "neither expected nor intended from the standpoint of the insured," and the Newark plant contamination was expected—and arguably even intended—by Diamond Shamrock, Judge Stanton said.

Factory floors at the Newark plant were so badly corroded by acid spills that they had to be replaced every year, and trenches and sumps frequently backed up and overflowed onto ground surfaces, he wrote.

"Toleration of substantial and continuous spilling and leaking was the way of life at the Newark plant," Judge Stanton found. "I am satisfied that Diamond's management accepted the spills and leaks as part of the normal routine of operating a chemical manufacturing plant. Accordingly, its acts of pollution should be treated as conduct which was at least knowing. Some of the polluting conduct was fully intentional."

Judge Stanton conceded that Diamond may not have anticipated more stringent environmental regulations back in the 1950s and 1960s.

"Diamond did not know that the (New Jersey) Department of Environmental Protection would come into being and that it would force Diamond to spend tens of millions of dollars to remedy pollution at the Newark plant. Diamond did not know that hundreds of neighbors would file suit against it for damages," he wrote.

"But Diamond did know the nature of the chemicals it was handling, it did know that they were being continuously discharged into the environment, and it did know that they were doing at least some harm."

And, Diamond has no coverage under the 1971-1985 policies because the dioxin contamination "falls unambiguously within the reach of the exclusionary language of the pollution exclusion," Judge Stanton ruled.

The judge took issue with previous New Jersey appellate court rulings that have broadly interpreted the "sudden and accidental" exception to the pollution exclusion in favor of policyholders.

These previous decisions, he wrote, "flatly misread the plain language of the pollution exclusion and have fundamentally misunderstood the way in which the exclusion and its exception are designed to function."

The appellate rulings have generally read the word "sudden" to mean "unexpected" or "unforeseen," he observed. But, because the policies do not define "sudden," courts must interpret the word by giving it its ordinary meaning, the judge said.

"To take the temporal element of instantaneous (or almost instantaneous) swiftness of happening out of 'sudden' is to squeeze the life out of the word," he wrote. "It is an intellectually unacceptable distortion of the fair meaning of the word."

In any case, the judge wrote, the previous appellate decisions do not control his ruling on this point because Diamond Shamrock—unlike the policyholders in the previous cases—was a sophisticated insurance buyer and had made a conscious decision to self-insure gradual pollution risks.

Diamond Shamrock understood that the pollution exclusion barred coverage of these risks and had repeatedly decided against buying separate environmental impairment liability coverage, the judge concluded.

Turning to the Agent Orange class settlement, Judge Stanton found the defoliant to be an inherently defective product and ordered the insurers to indemnify Diamond Shamrock, resolving several coverage issues in the same way a Brooklyn federal judge did in granting coverage last December to Uniroyal Inc., another Agent Orange producer and contributor to the class action settlement (*BI*, Jan. 9).

Judge Stanton rejected the insurers' argument that the veterans' injuries resulted from 133 separate occurrences and that 133 separate deductibles should apply, resulting in little or no recovery for Diamond Shamrock.

"Any interpretation of the concept of occurrence which would result in zero recovery on a $23 million product liability loss simply is not acceptable, because it cheats the purchaser out of his reasonable expectation of coverage," the judge wrote.

Following the lead of U.S. District Judge Jack B. Weinstein, Judge Stanton found that Diamond Shamrock's delivery of Agent Orange to the U.S. military was a single continuous occurrence that resulted in numerous injuries to servicemen. The injuries may be presumed to have occurred four months after Diamond's delivery of a given shipment of Agent Orange to the military, and trigger coverage under policies in force at that time, he ruled.

Judge Stanton directed that the $23.3 million settlement be divided by the total number of gallons of Agent Orange delivered by Diamond to produce a loss-per-gallon figure. The amount of loss to be applied to each policy can then be fixed by examining records that show the size of various Agent Orange shipments made between 1961 and 1969, taking into account the four-month lag between delivery and actual injuries, he wrote.

Lawyers for Diamond Shamrock and the insurers are expected to meet this week to develop figures based on Judge Stanton's formula. The lawyers will then report back to the court.

The insurers that provided most or all of Diamond's coverage between 1961 and 1969 are Aetna, American Re-Insurance Co., Lloyds of London and other London market underwriters and General Reinsurance Corp., lawyers say. ■

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Louisiana tosses its hat into antitrust litigation ring

By GLENN HUNTLEY

SAN FRANCISCO—Louisiana is joining the massive antitrust litigation filed by 18 state attorneys general against the property/casualty insurance industry in federal court in San Francisco.

Louisiana Attorney General William J. Guste filed his state's lawsuit April 5 in U.S. District Court in San Francisco, where it was added to the states' consolidated action (*BI*, June 27, 1988; March 28, 1988).

A spokesman for Mr. Guste said that the allegations in the Louisiana complaint essentially are identical to those contained in the consolidated suit in federal court.

That suit alleges that more than 30 insurance industry defendants conspired to manipulate the U.S. commercial liability insurance market and restrict coverage for businesses and public entities during the mid-1980s.

'Basically, these companies conspired to charge cities the same or more for less insurance coverage. We want to make sure this type of conspiracy doesn't happen again,' Mr. Guste says.

The consolidated suits charge the defendants—including property/casualty insurers, reinsurers, brokers and trade groups—with coercive and manipulative actions, such as restricting the availability of occurrence-based commercial general liability coverage.

The result of the defendants' alleged actions was restricted coverage and dramatically higher premiums for liability and pollution insurance available in Louisiana, the state charges.

U.S. insurers named as defendants are Hartford Fire Insurance Co., Allstate Insurance Co., Aetna Casualty & Surety Co. and Insurance Co. of North America, a CIGNA Corp. unit.

Also named are the Insurance Services Office Inc., the Reinsurance Assn. of America and 25 other defendants, including domestic reinsurers, brokers, and eight Lloyd's of London underwriting syndicates and several London market reinsurers.

"Basically, these companies conspired to charge cities the same or more for less insurance coverage. We want to make sure this type of conspiracy doesn't happen again," Mr. Guste said.

The Louisiana attorney general did not file suit last year, during the first wave of litigation, because he had not been involved in the initial investigation that led to the suit, the spokesman explained. Mr. Guste wanted first to examine how Louisiana entities were affected by the alleged conspiracy, the spokesman explained.

The City of Baton Rouge and four other Louisiana cities joined the state in the lawsuit, which seeks class-action status to represent all non-federal public agencies in the state.

Louisiana seeks to establish a special fund to be financed by the defendants to reimburse public agencies that suffered monetary damages from the liability insurance crisis.

The lawsuit also asks the court to order insurance industry groups to stop meeting in secret and to keep full minutes of their meetings for the next five years.

In addition to the consolidated federal suits, the Texas attorney general has filed a similar lawsuit in Travis County District Court in Austin alleging that ISO and numerous insurers violated state antitrust law (*BI*, March 27; Nov. 7, 1988).

Medicare claims

Continued from page 2

Medicare paid $527 million in hospital claims in 1985 alone that should have been paid by group health care plans.

However, many employee benefit consultants say the problem is not a large one for individual employers.

They point out that while the health care costs of workers aged 65 and older are 2½ to three times higher than for younger workers, the working aged account for less than 4% of the workforce.

Employee benefit managers contacted by *Business Insurance* said they believe their group plans have paid most of the claims of their older workers as the primary insurer as these claims came due. Therefore, the benefit managers do not feel they have a large outstanding liability.

Furthermore, employee benefit managers, insurers and claims administrators believe that if the government did make mistakes and paid claims that should have been paid by group health plans, it is the government's fault and thus it should absorb the costs.

They say problems with administering claims for older workers that resulted in Medicare overpayments stem from the government's failure to issue regulations on how to implement Medicare reimbursement laws.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act, which amended the Medicare Act to make Medicare a secondary payer to employer group health care plans for active employees aged 65 through 69 and their spouses of the same age.

Subsequently, Congress enacted the Deficit Reduction Act of 1984, which extended TEFRA to include working spouses under the age of 65.

And, the Consolidated Omnibus Budget Reconciliation Act of 1985 eliminated TEFRA's upper age limit for both employees and spouses.

Proposed regulations to implement these laws were not published in the Federal Register until June 15, 1988. And, these rules never were finalized.

As a result, "companies have been operating in a complex and confusing administrative environment," explained Geza Kadar Jr., assistant Washington counsel for the Health Insurance Assn. of America.

"Medicare changed the rules without initiating any administrative procedures," agreed Fred Hammacher, vp compensation and benefits at Dayton-Hudson Corp. in Minneapolis.

"Employers and insurers received very unclear signals and often conflicting advice from different government agencies," Mr. Hammacher added.

'The government is liable—they made the mistakes,' says James Kinder of the Self-Insurance Institute of America.

"The government is liable—they made the mistakes," said James Kinder, executive vp of the Self-Insurance Institute of America in Santa Ana, Calif.

"The government has mishandled the program and has failed to tell the industry how to deal with mispayments—it cannot stick the liability on somebody else," said Mr. Havens, the attorney for Provident.

The government "was extraordinarily stupid in not developing a system to identify what individuals are covered by these laws," said Mr. Hunt of the SPBA.

And, he said, the 61 insurers that administer claims on behalf of Medicare "have been phenomenally sloppy" in billing the correct insurer.

Mr. Hunt asserted that group health care plans in some cases attempted to pay the primary coverage for their older workers but that Medicare returned their payments.

Other times, providers received double payments from both the private health care plan and the government, he said.

In addition to suing at least one of the companies it hires to administer Medicare, Blue Cross/Blue Shield of Michigan, the government now is litigating with Provident over the insurer's role as an administrator and insurer of employer-sponsored health care plans. Provident is not an intermediary of Medicare.

Provident's attorney, Mr. Havens, said Provident originally delayed paying claims for older workers whose claims were mistakenly paid by Medicare because the insurer did not want to overpay providers.

But, Provident later changed its policy and began paying older workers' claims, regardless of whether or not Medicare paid, he said.

Mr. Havens said Provident has always been aware that it would owe Medicare money for the claims the federal program paid that should have been paid by the group health care plans that Provident administered. In fact, Provident says it has set up a reserve for these claims, but it would not disclose how much it has reserved.

Provident attempted to settle with the government over an 11-month period. But when negotiations reached an impasse, Provident filed suit March 31 in a U.S. District Court in Chattanooga, Tenn., seeking a declaration of whether the government or Provident must pay these claims.

The government countersued Provident in federal court in Washington, D.C., on April 5. The government lawsuit says Provident is liable for between $7 million and $223 million in Medicare overpayments.

Mr. Havens called these numbers "insane."

The government charges in its suit that Provident was aware of the changes in the federal law and that it knew Medicare was paying claims that should have been paid by the group health care plans that Provident administered.

Provident also has been sued by an a private attorney in U.S. District Court in Miami for allegedly defrauding the government.

This lawsuit stemmed from an unrelated lawsuit filed earlier by an older worker, which was insured under a group health care plan of which Provident was a member. The worker sought to determine the aggregate limits of his group health care coverage. During this litigation, the worker's attorney uncovered Provident's Medicare reimbursement policy.

The attorney then invited the government to join his suit against Provident. The government declined and instead filed its own suit against Provident in federal court in Washington.

The government's suit against Provident is a part of the government's investigation of how some of the nation's largest insurers handle claims for older workers.

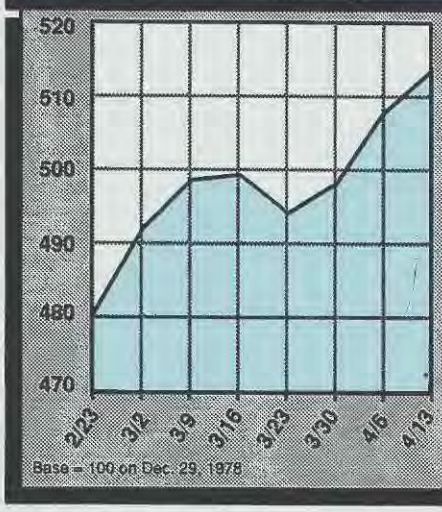
Among the insurers also being investigated is Aetna Life & Casualty Co.

"We are very confident that any review by the government will show we are administering claims in accordance with federal laws," an Aetna spokesman said.

If the government is successful in shifting liability for these claims onto the private sector, there will be a morass of litigation among employers, insurers, administrators and hospitals, observers say, explaining these parties would be sucked into the fracas for failing to determine whether group health care plans should have been the primary payer of Medicare beneficiaries' health care claims.

"There will be a round-robin of litigation" over who should ultimately be held liable for these claims, predicted Mr. Hunt of the SPBA. ■

BI Insurance Index



Insurance industry stocks continued to climb last week as the *Business Insurance Index* rose 6.1 points to 514.2 on April 13, from 508.1 on April 6. Advancing issues were led by Nobel Insurance Ltd., up 30.7%; Western Health Plans Inc., up 23.5%; and Chandler Insurance, up 20.5%. Declining issues followed Phoenix Re Corp., down 10%; Lawrence Insurance Group, down 9.7%; and Home Group Inc, down 5.2%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 44.2 million shares traded. The *BI Index* gained 1.2% for the period; the Standard & Poor's 500 was up 0.4%; the New York Stock Exchange Composite grew by 0.3%; and the Dow Jones 30 Industrials climbed 0.2%.

British Issues

April 13 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	369	12.8	25.3	6.9	374—368
Gent Accident	964	9.0	58.7	6.1	970—961
Gdn Royal Exch	199	10.3	13.3	6.7	203—198
Royal	418	13.0	30.0	7.2	418—412
Sun Alliance	1098	8.6	54.7	5.0	1121-1098
Brokers					
Bradstock	222	12.5	9.0	4.1	240—222
CE Heath	443	14.1	34.5	7.8	443—438
Hogg Robinson	147	13.0	8.7	5.9	150—147
Lloyd Thompson	218	16.8	8.0	3.7	218—214
PWS Holdings	66	17.8	4.6	7.1	68—66
Sedgwick Grp	230	19.0	16.0	7.0	233—229
Steel Brrl Jones	230	19.7	13.3	5.8	230—223
Willis Faber	229	17.0	15.3	6.7	229—224

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

APRIL 13, 1989 — **4/7/89 THRU 4/13/89**

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	25.25	-2.9	7.4	26.50	22.63	165	1.00	4.0	16.1	3.71	6.81
Corroon & Black Corp.	NYSE	34.63	5.3	11.2	34.63	30.75	210	1.24	3.6	5.1	12.40	2.79
Gallagher Arthur J. & Co.	NYSE	18.50	3.5	10.4	18.63	16.13	40	0.52	2.8	13.1	5.46	3.39
Hall Frank B. & Co.	NYSE	4.00	6.7	38.9	4.63	2.50	189	0.00	0.0	-2.3	0.00	N/A
Hilb, Rogal & Hamilton	OTC	14.50	1.8	-4.9	15.75	13.75	24	0.00	0.0	12.6	4.60	3.15
Marsh & McLennan Cos. Inc.	NYSE	63.50	1.6	12.9	64.50	55.13	488	2.50	3.9	15.5	6.48	9.80
Poe & Assoc. Inc.	OTC	8.50	0.0	3.0	8.50	8.25	0	0.40	4.7	9.6	0.27	31.48
BROKERS	AVERAGE		2.3	11.3					2.7	9.9		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	30.88	-0.4	4.7	33.25	29.25	124	0.40	1.3	6.6	20.24	1.53
Berkshire Hathaway Inc. DEL	NYSE	5675.00	11.8	20.7	5625.00	4625.00	198	0.00	0.0	20.8	2492.68	2.28
ITT (Hartford Group)	NYSE	54.75	0.2	9.2	57.00	49.75	1676	1.48	2.7	9.6	52.23	1.05
Sears Roebuck & Co. (Allstate)	NYSE	44.13	-0.3	8.0	45.13	40.13	4417	2.00	4.5	18.4	34.74	1.27
CONGLOMERATES	AVERAGE		2.8	10.7					2.1	13.8		
INSURERS/REINSURERS												
Aetna Life & Cas Co.	NYSE	53.25	4.1	12.7	53.50	46.75	770	2.76	5.2	9.1	54.73	0.97
American General Corp.	NYSE	34.63	-2.1	15.9	35.63	29.50	668	1.50	4.3	10.1	28.04	1.24
Amer Heritage Life Invt	NYSE	27.25	-1.4	5.8	27.88	25.00	1	1.08	4.0	11.3	22.47	1.21
Amer Indty Fin'l Corp.	OTC	10.00	-4.8	-4.8	11.25	9.50	19	0.56	5.6	6.5	17.06	0.59
American Int'l Group	NYSE	79.38	-0.6	17.2	80.88	66.25	1376	0.40	0.5	11.1	33.55	2.37
Aon Corp.	NYSE	32.00	2.8	14.3	32.25	27.00	350	1.40	4.4	10.1	15.13	2.12
Argonaut Group	OTC	53.38	0.7	22.0	56.00	43.50	120	0.00	0.0	7.4	34.94	1.53
AVEMCO Corp.	NYSE	23.88	-0.5	-7.7	26.13	23.63	13	0.40	1.7	11.7	9.20	2.60
Baldwin & Lyons Inc.	OTC	16.00	0.0	7.5	16.25	14.50	7	0.20	1.3	6.4	17.57	0.91
Belvedere Corp.	AMEX	6.00	-2.1	33.3	0.00	0.00	2	0.04	0.7	8.7	8.43	0.71
Chandler Insurance	OTC	11.00	20.5	18.9	11.25	8.75	548	0.00	0.0	5.3	6.65	1.65
Chubb Corp.	NYSE	67.50	-0.6	16.4	69.00	57.63	283	2.32	3.4	7.6	46.13	1.46
CIGNA Corp.	NYSE	54.25	-0.7	15.1	55.13	45.88	649	2.96	5.5	9.7	51.37	1.06
CNA Fin'l Corp.	NYSE	63.25	1.0	4.5	63.38	57.63	159	0.00	0.0	10.0	46.40	1.36
Continental Corp.	NYSE	33.25	0.0	2.7	36.00	31.50	500	2.60	7.8	15.9	42.10	0.79
Durham Corp.	OTC	31.50	-3.1	-4.5	33.75	30.00	18	0.92	2.9	18.6	26.23	1.20
Fireman's Fund Corp.	NYSE	32.63	-3.3	11.6	34.25	29.00	187	0.60	1.8	6.9	30.91	1.06
Forum Re (Bermuda)	OTC	1.38	0.0	-15.3	1.75	1.38	0	0.00	0.0	3.8	2.58	0.53
Fremont Gen Corp.	OTC	16.75	0.0	25.2	18.25	12.13	31	0.60	3.6	10.7	16.06	1.04
Frontier Insurance Group	OTC	16.50	15.8	32.0	16.75	12.25	194	0.00	0.0	8.2	7.53	2.19
General Re Corp.	NYSE	65.50	-3.0	18.0	67.50	54.38	624	1.36	2.1	13.0	27.10	2.42
Home Group Inc.	NYSE	13.63	-5.2	23.9	14.50	11.00	104	0.20	1.5	5.7	18.66	0.73
Hanover Ins Co.	OTC	29.25	4.5	9.3	30.25	26.00	95	0.36	1.2	5.4	31.47	0.93
Harleysville Group Inc.	OTC	20.25	-2.4	12.5	21.38	17.75	23	0.48	2.4	7.3	18.24	1.11
Hartford Steam Boiler	OTC	40.25	-3.0	9.5	42.50	34.75	171	1.40	3.5	11.6	13.04	3.09
Kans City Life Ins	OTC	33.25	0.0	-3.6	35.00	32.75	21	0.00	0.0	10.6	39.22	0.85
Kemper Corp.	OTC	33.13	0.4	38.0	33.75	22.75	1828	0.84	2.5	9.5	28.91	1.15
Lawrence Ins. Group	AMEX	7.00	-9.7	-11.2	8.50	7.00	3	0.24	3.4	15.2	2.90	2.41
Liberty Corp. S.C.	NYSE	36.00	2.5	0.0	38.00	34.63	19	0.80	2.2	14.1	20.76	1.73
Lincoln Nat'l Corp.	NYSE	49.13	-2.0	11.7	50.63	42.75	87	2.48	5.0	11.9	37.11	1.32
NAC Re Corp.	OTC	37.25	0.7	17.3	37.75	31.00	67	0.00	0.0	14.8	22.06	1.69
Navigators Group	OTC	22.50	2.3	12.5	22.75	20.50	8	0.00	0.0	11.2	14.79	1.52
Nobel Ins Ltd.	OTC	2.13	30.7	-55.2	2.50	0.75	345	0.42	9.7	-8.2	7.76	0.27
Northwestern Nat'l Life	OTC	33.50	1.9	7.6	33.75	26.88	409	1.12	3.3	8.4	35.05	0.96
Ohio Cas Corp.	OTC	41.38	0.3	15.7	45.25	35.50	134	2.08	5.0	6.3	33.30	1.24
Old Rep Int'l Corp.	OTC	24.13	1.6	0.5	28.88	23.75	114	0.74	3.1	12.1	26.50	0.91
Orion Cap Corp.	NYSE	20.50	1.2	33.3	20.88	15.38	78	0.76	3.7	6.9	12.93	1.59
Phoenix Re Corp.	OTC	9.00	-10.0	-5.3	11.00	9.00	38	0.00	0.0	4.7	12.49	0.72
Protective Life Corp.	OTC	13.75	0.0	3.8	14.50	12.88	131	0.70	5.1	16.8	17.25	0.80
Re Capital Corp.	AMEX	10.00	-3.7	9.5	10.88	9.13	5	0.00	0.0	22.2	11.93	0.84
RLI Corp.	NYSE	8.63	-2.8	13.1	9.25	7.50	13	0.36	4.2	7.1	10.71	0.81
Provident Life & Acc Ins Co.	OTC	22.88	-2.1	18.9	23.50	19.13	848	0.68	3.0	12.5	21.96	1.04
St. Paul Cos. Inc.	OTC	49.88	0.3	14.7	50.25	43.00	431	2.20	4.4	6.9	43.47	1.15
SAFECO Corp.	OTC	28.13	-0.9	19.0	28.75	23.13	814	1.08	3.8	7.8	24.87	1.13
SCOR U.S. Corp.	NYSE	9.13	-1.3	0.0	9.25	7.50	42	0.20	2.2	6.7	10.35	0.88
Seibels Bruce Group Inc.	OTC	12.00	2.1	5.4	13.00	11.25	18	0.80	6.7	7.6	13.42	0.89
Selective Ins Group Inc.	OTC	23.88	1.6	3.8	24.50	21.75	25	1.24	5.2	5.3	22.33	1.07
Statesman Group Inc.	OTC	3.00	2.0	-4.2	2.00	1.38	123	0.05	1.7	30.0	3.48	0.86
Tokio Marine & Fire Ins	OTC	77.50	0.2	-15.2	95.50	75.75	33	0.22	0.3	47.0	0.00	N/A
Torchmark Corp.	NYSE	32.88	-0.8	7.8	33.75	30.00	110	1.20	3.6	10.3	12.24	2.69
Transamerica Corp.	NYSE	34.25	-0.7	1.1	35.38	32.75	311	1.88	5.5	7.7	27.36	1.25
Travelers Corp.	NYSE	39.38	0.6	13.3	39.75	34.50	974	2.40	6.1	42.8	45.28	0.87
Trenwick Group Inc.	OTC	14.75	1.7	1.7	15.25	13.75	18	0.24	1.6	9.2	16.91	0.87
United Fire & Cas Co.	OTC	29.25	0.4	-4.1	30.75	29.00	1	1.08	3.7	5.2	22.56	1.30
United States Fid & Gty	NYSE	31.75	-1.9	11.4	32.88	28.50	404	2.80	8.8	8.9	22.15	1.43
UNUM Corp.	NYSE	31.63	-1.6	17.1	32.88	26.63	315	0.48	1.5	11.1	30.64	1.03
USLIFE Corp.	NYSE	43.00	0.3	23.3	44.88	34.13	269	1.36	3.2	11.3	46.77	0.92
Washington Nat'l Corp.	NYSE	26.75	0.5	-0.9	27.63	25.25	17	1.08	4.0	-19.1	32.33	0.83
Zenith Nat'l Ins Corp.	NYSE	18.75	0.6	7.1	19.25	16.75	43	0.80	4.3	8.9	13.61	1.38
INSURERS/REINSURERS	AVERAGE		0.5	8.5					3.2	10.4		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp.	OTC	23.38	-1.6	92.7	25.25	11.75	434	0.00	0.0	12.8	3.54	6.60
HMO America Inc.	OTC	2.38	-2.5	153.2	2.88	0.88	23	0.00	0.0	-3.8	1.12	2.13
Maxicare Health Plans	OTC	0.28	0.0	-62.7	0.81	0.13	566	0.00	0.0	0.0	0.00	N/A
Pacificare Health Systems	OTC	23.50	1.1	91.8	24.50	12.25	57	0.00	0.0	18.8	6.35	3.70
Safeguard Health Ent.	OTC	5.38	0.0	-2.2	8.25	4.00	3	0.00	0.0	10.8	2.96	1.82
Sierra Health Services	AMEX	3.00	20.0	84.0	2.75	1.50	84	0.00	0.0	23.1	1.59	1.89
United Health Services	OTC	7.00	1.7	55.6	7.75	4.13	989	0.00	0.0	3.1	2.59	2.70
United Medical Corp.	AMEX	5.75	-2.2	9.5	6.75	5.13	15	0.00	0.0	11.3	4.11	1.40
U.S. Healthcare	OTC	10.00	6.6	72.1	10.38	5.25	3105	0.20	2.0	83.3	2.87	3.48
Western Health Plans Inc.	AMEX	1.00	23.5	44.9	1.13	0.50	28	0.00	0.0	-0.5	0.82	1.22
HMOs	AVERAGE		4.7	53.9					0.2	15.8		
ALL COMPANIES	AVERAGE		1.3	14.6					2.7	11.2		

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