

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$2.00 a copy; \$80 a year

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Massachusetts governor seeks to kill universal health care law

BOSTON—The Massachusetts Legislature this week will vote whether to override Gov. William Weld's veto of a bill that would delay by two years the state's landmark universal health care statute.

The delay would preserve the universal health care statute that Gov. Weld says he favors repealing.

The bill passed by the Legislature, part of a broader budget bill, would delay to 1994 from 1992 a provision in a 1988 law that imposes on employers with at least six em-

Continued on next page

AMA calls on private UR vendors to divulge criteria

By CHRISTINE WOOLSEY

Health insurers and private utilization review firms should release their review standards so they can be scrutinized by the medical community and the public, two American Medical Assn. researchers say.

The researchers found that standards used by Medicare Peer Review Organizations to review the appropriateness of specific medical or surgical procedures vary greatly and are not consistent with practice guidelines developed by national medical groups.

As a result, standards used by both the Medicare PRO program and by private insurers and UR firms should receive increased attention, the researchers say.

However, executives of utilization review vendors say that publishing medical review criteria will not make review criteria more uniform.

And, they say, publication of internally developed review criteria could hurt some firms' competitive edge in the market.

Unlike Medicare PRO criteria, private UR firms' medical review standards are considered proprietary and are generally not available for examination by providers, employers or patients.

"Bottom line, the AMA report
Continued on page 58

Sometime next year?

P/C profits continue to fall, but rate hikes still not near

By JUDY GREENWALD

Commercial property/casualty insurers are glumly facing at least another year of poor operating results.

Insurers and industry analysts do not anticipate a significant turn in the overall marketplace until at least 1992—if then—despite the declining earnings reported by many insurers in 1990.

"Who's to say it's going to be any different a year from now?" asked Bernard C. Hlavac, vp and treasurer at Sentry Insurance Cos. in Stevens Point, Wis. "This malaise may continue for quite a while. We're just puzzled and perplexed by the situation we find."

"This has all the earmarks right now of going on ad nauseum," says Michael A. Lewis, first vp at Dean Witter Reynolds in New York.

Fourteen of the 26 publicly held commercial property/casualty in-

Group health insurers expect a profitable 1991. Page 66

surers tracked by *Business Insurance* reported lower profits in 1990, although catastrophe losses last year totaled only \$2.8 billion, down from a record \$7.3 billion the previous year (*BI*, Feb. 4).

Overall, the net income of the 26 insurers plunged 27.4% to \$5.4 billion in 1990 from \$7.4 billion in 1989.

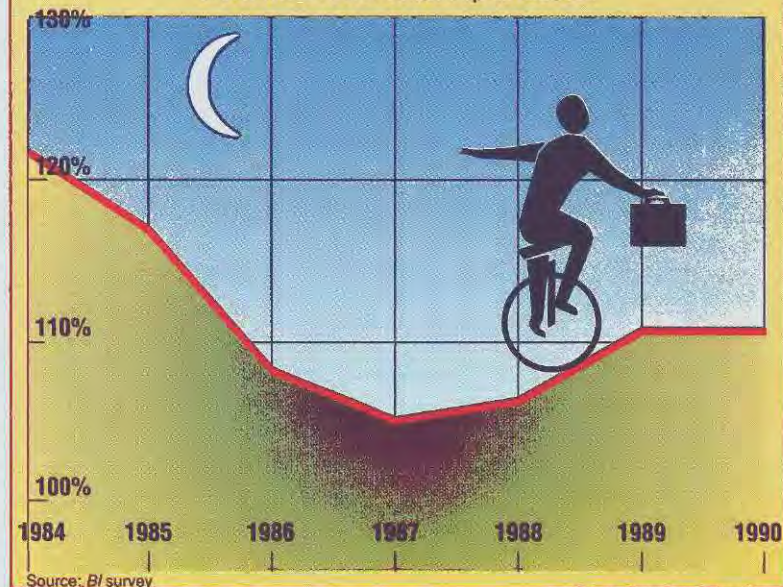
However, many observers say the losses should have been worse. They contend that insurers failed to bolster reserves as needed last year.

Three insurers—USF&G Corp., Home Insurance Co., and Royal Insurance Group—reported net losses for the year.

USF&G Corp. attributes much of its \$569 million loss to losses on
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Has the cycle run its course?

Major commercial property/casualty insurers reported an aggregate combined ratio of 110.7% last year, unchanged from 1989. However, overall underwriting performance still deteriorated last year because there were fewer catastrophe losses.



GRAPHIC BY JOHN SMITHER

Pan Am punitive awards blocked

By STACY SHAPIRO

NEW YORK—Plaintiffs may ask the U.S. Supreme Court to review a recent appellate ruling that punitive damages cannot be recovered from airlines in aviation disasters involving international flights.

A three-judge panel of the 2nd U.S. Circuit Court of Appeals ruled March 22 that, under the Warsaw Convention, plaintiffs can't sue Pan American World Airways Inc. for punitive damages stemming

from the December 1988 explosion of a Pan Am Boeing 747 over Lockerbie, Scotland. The disaster killed 270 people.

The victims' families were seeking at least \$350 million in punitive damages from Pan Am, says Lee S. Kreindler, chairman of the Pan Am plaintiffs' committee and a partner at Kreindler & Kreindler in New York.

In the same ruling, the appellate court also held that plaintiffs could not recover punitive dam-

ages from Pan Am for the September 1986 hijacking of an aircraft at Karachi International Airport in Pakistan. An undetermined amount of punitive damages had been sought in this case, said Mr. Kreindler, who also represented these plaintiffs.

Both of the flights were governed by the Warsaw Convention as amended by the Montreal Agreement, which limits airlines' compensatory liability for accidents on international flights to \$75,000 per

passenger, unless willful misconduct can be proven. Damages are not capped in cases of willful misconduct.

The appellate court ruled, however, that the Warsaw Convention never envisioned the payment of punitive damages, regardless of whether willful misconduct is proven.

"We are persuaded that the purposes for which the convention was created are not consistent with an
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Loss of members spurs III to refocus efforts

By MARK A. HOFMANN

NEW YORK—The recent resignations of three major insurers from the Insurance Information Institute will spur the property/casualty insurance industry's public relations arm to concentrate more on traditional media relations and less on high-profile advocacy advertising.

However, Gordon C. Stewart, who succeeds Mechlin D. Moore as III president in June, said that the withdrawals of Kemper National



Insurance Cos., CIGNA Corp. and Travelers Corp. will result in no "big financial hit."

The III's 1991 budget of \$13.3 million—a 10.8% increase from \$12 million last year—will be adequate to support the III's continued efforts to represent property/casualty insurers nationwide, officials say.

The III is the broadest-based property/casualty insurance indus-

try organization, providing the media and the public with the industry's viewpoints on current issues and industry statistics. For example, the III recently commissioned a report which showed that the property/casualty insurance industry is not another savings and loan disaster waiting to happen (*BI*, Jan. 14).

Insurer expense controls, rather than dissatisfaction with the III, are blamed for members' recent resignations.

Both Mr. Moore and Mr. Stewart,

currently the III's executive vp and chief operating officer, pointed out that the group has undergone similar exoduses in previous soft insurance markets.

"We went through this same situation in 1984," said Mr. Moore, when companies like Nationwide Mutual Insurance Co. and Fireman's Fund Insurance Co. dropped their membership.

Columbus, Ohio-based Nationwide rejoined the III last year, but Novato, Calif.-based Fireman's Fund has not.

Mr. Moore said an exodus also occurred in the 1970s, though many resigning members returned after market conditions improved.

"It tends to track pretty much what goes on in the industry," said Mr. Stewart.

While the III's 1991 budget has been increased this year, the group will scale back its activities if new budgetary constraints so dictate.

"Losing one or two or three members and picking up another one is not going to put the III out of
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Directory of employee benefit information systems vendors . . . Page 30

NEWSPAPER

Update

Massachusetts' universal plan

Continued from previous page

employees a new "medical security tax" that could total as much as \$1,680 per employee (*BI*, Sept. 4, 1989; May 2, 1988). An employer with a health plan could offset the tax by each dollar spent on its plan. Employers whose annual health care expenditures exceed \$1,680 per worker would be exempt from the tax.

But, Gov. Weld, a Republican, said the tax places too great a burden on small employers. He backs legislation to repeal the entire statute.

The universal health care statute, backed by former Democratic Gov. Michael Dukakis, had been hailed as a model for other states.

IBM to take retiree care charge

ARMONK, N.Y.—International Business Machines Corp. will take a one-time charge—\$2.3 billion in the first quarter—to recognize its accumulated retiree health care obligations under new accounting rules.

Under the rules, employers can amortize, generally over 20 years, accumulated retiree health care obligations at the time they adopt the FASB rules (see related story, page 53). Employers also have the option of recognizing this so-called transition obligation by a one-time charge.

The Financial Accounting Standards Board does not require large employers to adopt those rules until 1993 under FASB 106, which was adopted last December (*BI*, Dec. 17, 1990). But, IBM "wanted to remove any cloud or drag from future earnings," a spokesman explained. "We had a strong enough balance sheet to do this."

By recognizing the obligations, the company is sending a signal to employees that it is committed to retiree health care, he added.

"This is big news. The fact that a company of this stature is doing this will cause other firms to" consider the same strategy, said Jerry Carnegie, a Hewitt Associates consultant in Rowayton, Conn.

1985 JAL crash claims settled

LONDON—Boeing Co. and Japan Air Lines last week agreed to pay \$55 million to settle claims filed by 55 Japanese families that lost relatives in the 1985 Japan Air Lines Boeing 747 disaster.

The crash, one of the worst ever, killed 520 people. There were only four survivors (*BI*, Aug. 19, 1985).

Aviation underwriters notified of the settlement were also told that only 12 claims totaling less than 3.4 billion yen (\$24.1 million at current exchange rates) now remain to be settled.

To date, 492 settlements have been made, "the vast majority" without trial, said V. Woolston, a partner with Perkins Coie, the Seattle law firm representing Boeing.

In 1987, Seattle-based Boeing and its aviation product liability underwriters agreed to pay 82.5% of liability losses from the crash. Liability underwriters for the Tokyo-based airline agreed to pay the other 17.5% (*BI*, June 8, 1987). As a result, Boeing's aviation product liability underwriters will pay \$45.7 million and underwriters for JAL will pay \$9.7 million of the total \$55.4 million, said a London aviation underwriter involved in the loss.

Of the 12 cases remaining, Boeing's underwriters will pay just under 2.6 billion yen (\$18.5 million) and JAL's underwriters will pay 828.4 million yen (\$5.9 million), the underwriter estimated.

Domestic partner health cover

NEW YORK—A large New York City hospital is extending its employee health benefit program to cover the domestic partners of gay and lesbian staff members.

However, benefits are not being extended to heterosexual domestic partners since they are able to marry.

The Montefiore Medical Center in the Bronx, which has 9,000 employees, is the largest private employer in the United States to adopt a domestic partner policy, according to the American Civil Liberties Union, which negotiated the policy on behalf of employees.

The policy will take effect today, the hospital announced last week.

Employees must enroll by April 30 for domestic partner coverage—identical to that for spouses and dependents—retroactive to April 1. Participating employees must prove that they and their domestic partners live together, are financially interdependent and are responsible "for each other's common welfare," according to hospital documents. Montefiore self-insures its medical benefits program.

Of the handful of employers that provide domestic partner medical benefits, most are public entities. Many employers have shied away from such programs for cost reasons (*BI*, March 11).

"While Montefiore, like all institutions, is constrained by the spiraling costs of employee health care, we have a long-standing commitment to fair and equitable treatment of all Montefiore employees," a spokeswoman said in a statement.

Meanwhile, a state court in East Lansing, Mich., has upheld a restraining order preventing the city from instituting health, dental and family leave benefits for all domestic partners. The court criticized the city for approving the changes in its benefit package without formal public hearings, said a spokeswoman for the city manager.

Four local married couples sought the restraining order, which was granted on March 1, the effective date for the benefit changes. The couples, none of whom are city employees, filed for the order "suggesting that this was not a proper use of tax funds," the spokeswoman said.

Alliance seeks McCarran option

SCHAUMBURG, Ill.—The Alliance of American Insurers says it will continue to oppose legislation introduced in the House to overhaul the McCarran-Ferguson Act, but will consider other reform alternatives.

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Errors & omissions

• Claims related to excessive use of force by San Diego police officers represent about 41% of the city's total 1990 police liability claims, including third-party property damage. This was incorrectly reported in the March 25 issue as representing 41% of the city's total liability claims.

Final defendants settle Texas antitrust litigation

By MICHAEL BRADFORD

AUSTIN, Texas—Three-year-old antitrust litigation filed by a former Texas attorney general is finally over—at a cost of \$6.6 million in settlements by defendants.

The remaining insurance industry defendants in the suit filed by former Texas Attorney General Jim Mattox have agreed to pay \$4.1 million and initiate certain reforms to end the litigation.

The payment will bring to \$6.6 million the amount paid by defendants in three separate settlements since the suit was originally filed by Mr. Mattox in March 1988.

Mr. Mattox alleged that nine U.S. insurers and two insurance industry organizations boycotted

certain lines of insurance and attempted to artificially inflate rates (*BI*, March 28, 1988).

While current Texas Attorney General Dan Morales said the settlement will lead to broad reforms in the way insurers operate in Texas, insurers said last week they do not expect big changes in light of the settlement.

The settlement, signed Wednesday by District Court Judge Peter M. Lowry, calls for changes in the way the Insurance Services Offices Inc. operates in Texas.

Under the agreement, insurers will no longer have any decision-making authority regarding ISO's development of commercial general liability policies in Texas. Those functions now will be left

solely to ISO staff members, though ISO can still consult with insurers on matters relating to CGL forms.

The change is a "further expansion of what we have implemented over several years" in other states, said an ISO spokesman.

Another portion of the settlement calls for ISO to provide data on non-ISO CGL policies if current law is amended to allow more than one general liability form to be used in the state, the ISO spokesman said. Currently, all insurers operating in Texas must use ISO's CGL form as approved by the State Board of Insurance.

In addition, the settlement calls for ISO to shift from providing ad-

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Changes give commercial insurers more flexibility

Prop. 103 rules revised

By LOUISE KERTESZ

LOS ANGELES—Newly amended proposals to implement Proposition 103, designed to provide commercial insurers in California greater ratemaking flexibility, particularly in specialty lines, still pose significant problems, insurers say.

The revised proposed regulations, unveiled last week by California Insurance Commissioner John Garamendi, also take a "less severe" approach to efficiency standards—which would be used in determining insurers' allowable rate of return for ratemaking purposes—than earlier proposals, according to insurer attorney Steven H. Weinstein, a partner with

Barger & Wolen in Los Angeles.

Although the revisions are a step in the right direction, the proposed rules are still essentially flawed, insurance industry groups argue.

Harvey Rosenfield, author of Proposition 103 and director of consumer advocacy group Voter Revolt, cautiously approved of the greater ratemaking flexibility the amended proposal would provide commercial insurers.

However, the revised efficiency standards and other revisions in the proposal are "a serious retreat" from Mr. Garamendi's original regulations, Mr. Rosenfield said at a hearing last week on the proposal.

He had applauded Mr. Garamendi's original regulations, calling them "some of the toughest

regulations that we've ever seen in the United States" (*BI*, Jan. 14).

Mr. Garamendi explained at last week's hearing that the changes in the regulations were in response to "some 37 feet of comments" from insurers and consumer groups on his original proposal.

Immediately after Mr. Garamendi took office in January, he proposed regulations to implement Proposition 103. That law's most notable provisions call for:

- "Charges" for most property/casualty insurance lines to be rolled back 20% from November 1987 levels.

- Rates to be subjected to prior approval for the first time.

Mr. Garamendi's proposals set

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Firms did not make product but still must face lawsuit

By ADRIENNE C. LOCKE

WASHINGTON—Two truck tire rim manufacturers must face a \$25 million product liability lawsuit even though neither company manufactured the rim that exploded and killed a truck driver.

The 3rd Judicial Department of New York's Appellate Court Division last week refused to dismiss Goodyear Tire & Rubber Co. and The Budd Co. from a product liability lawsuit against them and the manufacturers of the multipiece tire rim that exploded.

While Goodyear and Budd were not involved in manufacturing the

rim that exploded, the court said they could be held liable under the "concerted action theory of recovery" if evidence shows they conspired with other manufacturers to hide the product's dangers.

The lawsuit was filed by the fiancée of John A. Wunderlich, a truck driver who was killed while inflating a tire on a dump truck. While inflating the tire, the "RH5-degree multipiece tire rim" upon which the tire was mounted exploded, striking him in the head.

The rim was manufactured by Firestone Tire & Rubber Co. of Akron and Kelsey-Hayes Co. of Romulus, Mich., both of which are

named defendants.

But, the plaintiff, Francene Rastelli, alleges that all multipiece rim manufacturers knew about the dangers of the product and conspired to keep it secret from consumers and the government.

Further, Ms. Rastelli alleges, Goodyear was aware of the inherent dangers of multipiece rims because it made a tire exclusively for installation on multipiece rims. Indeed, the tire on the rim that exploded was made by Goodyear, according to court papers.

The plaintiff is seeking a total of \$25 million for wrongful death and

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Inside

✓ The Illinois Self-Insurers Advisory Board should bar brokers and other vendors from membership, this week's editorial says. **PAGE 8**

✓ Benefit consultants advise clients to begin planning now to minimize the 1993 impact of FASB retiree health care accounting rules. **PAGE 53**

✓ The American Council of Life Insurance says life insurers would be willing to be regulated under two longstanding federal antitrust acts as long as they are exempt from Federal Trade Commission oversight. **PAGE 57**

✓ The NAIC will not require states to adopt its model law on producer-controlled insurers while it works to clarify portions of the law. **PAGE 59**

✓ Georgia's Supreme Court throws out a tort reform law requiring disclosure of plaintiff's insurance. **PAGE 59**

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Vol. 25, No. 13—Business Insurance (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to Business Insurance, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611. Copyright 1991 by Crain Communications Inc.

Benefit administration

Employers try to eliminate the guesswork when picking a consultant

By JERRY GEISEL

When Pacific Telesis Group decided to establish a managed health care network, the San Francisco-based telecommunications giant knew it needed a

benefit consultant to handle the project.

"We just didn't have the size staff to review and evaluate providers and get a network up and running in a few months," said Neil Austin, manager of health plans for Pacific Bell, a Pacific Telesis unit.

"Our consultant was able to put several consultants on the project. They had resources and expertise we didn't have. We're a telecommunications firm, not a benefit consultant," he explained.

Employers like Pacific Telesis are increasingly seeking out consultants to obtain help in controlling their health care costs as well as a cornucopia of other assignments.

For example, benefit managers increasingly are asking for help in administering 401(k) plans, evaluating different health maintenance organizations, developing new benefits communications strategies, auditing third-party claims administrators and interpreting the latest Internal Revenue Service pension regulations.

In fact, the employee benefit consulting profession has been one of the hottest growth industries of the 1980s, with revenues increasing at a 20% annual clip.

However, the demand for consulting services may finally be ebbing. TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. and the nation's second-largest benefit consultant, recently said it would lay off about

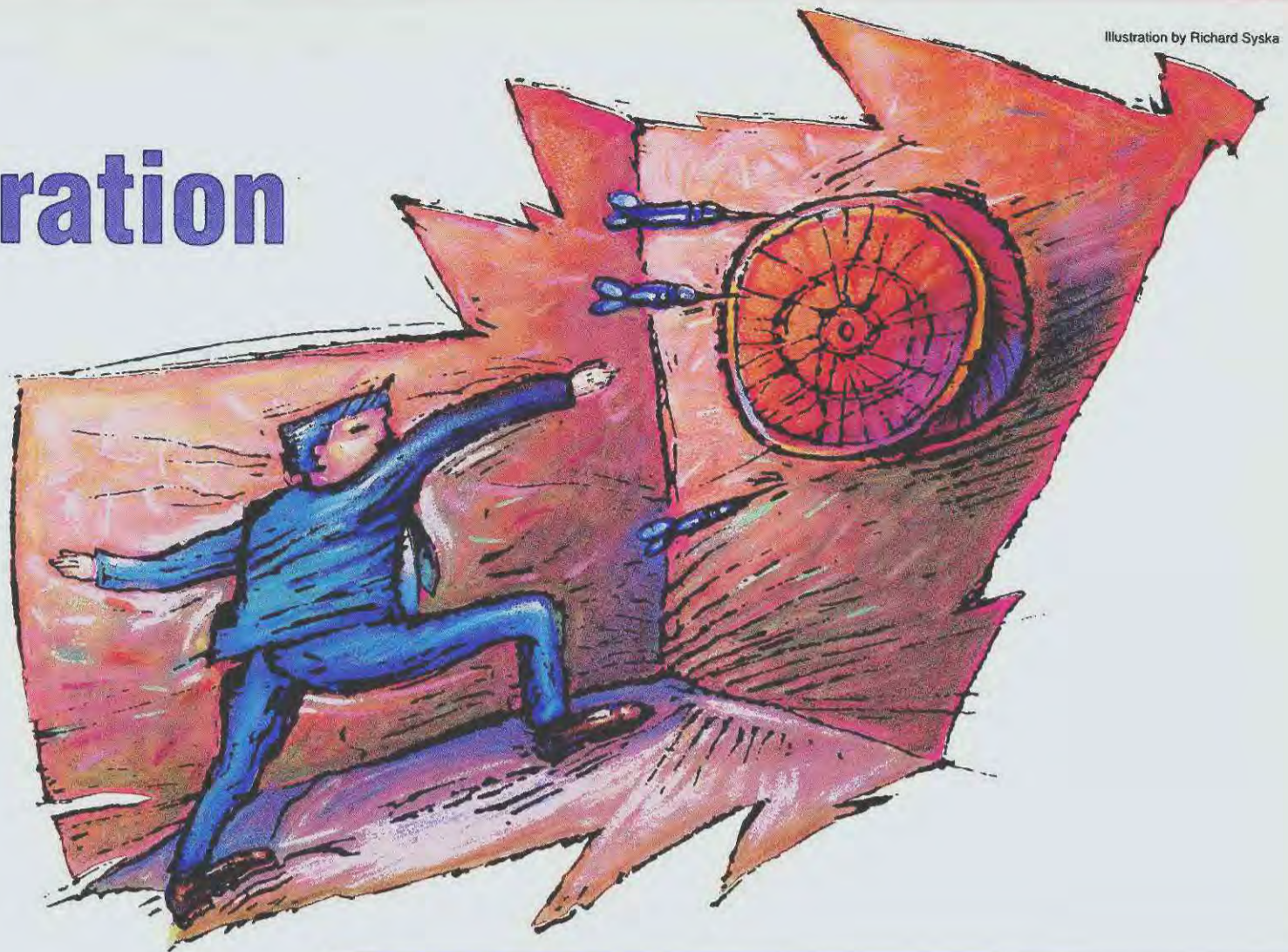


Illustration by Richard Syska

10% of its U.S. workforce—or 180 to 200 employees—at all levels of the company (*BI*, March 4).

However, even if revenue growth tails off this year, the nation's 10 largest benefit consultants alone will easily garner \$2.5 billion in revenues from employers, up from just \$1 billion in 1985.

Many factors have fueled the increasing demand from employers for employee benefit advice.

First, benefit plans themselves have become more complex. Instead of a simple profit-sharing plan, for example, many employers have added 401(k) features, which entail a massive amount of record keeping that companies often cannot do themselves.

The soaring cost of health care has forced employers to adopt innovative procedures and plans, like utilization review and point-of-service health plans. While the object is to control costs, some companies—like Pacific Telesis—turn to expensive outside help to

establish a plan that they hope will really work.

And, the flood of new benefit laws and rules that have come gushing out of the halls of Congress and regulatory agencies in recent years also have made the use of a consultant mandatory for many benefit managers.

"It's not possible for a benefit manager to keep abreast of all the regulatory and legislative changes," said Mr. Austin of Pacific Bell, which hired William M. Mercer Inc. to help form its managed care network.

All this outside expertise has its price.

Large employers often pay annual benefit consulting fees of anywhere between \$250,000 and \$2 million, said Ann Hailey, senior vp at Greenwich, Conn.-based Duggan Consulting Associates, a business strategy and marketing research firm.

This often is money well-spent, both benefit managers and consultants say.

"Our consultant has saved us a ton of money in developing funding strategies for

our cash balance pension plan," explained Paul Nordine, vp and benefits consultant at BankAmerica Corp. in San Francisco (*BI*, Nov. 19, 1990). Kwasha Lipton of Fort Lee, N.J., helped BankAmerica set up its pioneering pension program (*BI*, Nov. 19, 1990; Aug. 26, 1985).

"If you spend \$40,000 for a consultant to audit your TPA and that saves you \$250,000 in claims payments that should not be made, a consulting fee is highly cost-effective," said Bob Cliff, a principal in the Los Angeles office of A. Foster Higgins & Co. Inc.

But deciding when to use a benefit consultant and which consultant to use is not always so clear. And the selection process sometimes is akin to blindly throwing a dart at the wall as distinctions between consulting firms become harder to measure.

"Benefit consulting firms are struggling to differentiate themselves. The distinctions are blurring," said Jeffrey Horn, a Mercer man-

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Group long-term care insurance

Programs gaining flexibility as employers and workers show more interest in benefit

By DEBORAH SHALOWITZ

Four years after the first plan was established, employer-sponsored group long-term care programs are rapidly increasing in popularity.

In fact, the number of people covered under employer-sponsored plans grew by almost 300% over an 18-month period, according to an insurer trade group.

As group LTC insurance products mature, they are becoming increasingly flexible, with insurers offering employees more coverage choices.

However, despite the impressive growth, only a small minority of employers offer group LTC plans. And, except at a handful of companies, employees must foot the entire bill for the coverage (see story, page 26).

The Health Insurance Assn. of America reports that 153 employers either already had or were committed to offering a LTC plan to their employees as of June 1990.

About 79,500 people were enrolled in employer-sponsored LTC plans as of last June, the Washington, D.C.-based HIAA noted. That does not include 32,000 employees at International Business Machines Corp. that have signed up for a plan introduced by the computer giant last fall.

The HIAA estimated that about 60% of those enrolled were active employees and their spouses and the other 40% were either retirees, their spouses or parents, or par-

ents-in-law of employees.

In comparison, just 18 months earlier, only 20,000 people were covered under employer-sponsored group LTC programs, the group pointed out.

Group LTC insurance is "growing substantially in popularity," agreed Dennis DeWitt, a managing consultant with A. Foster Higgins & Co. Inc. in Los Angeles.

There is a "pretty steady growth of interest by employers" in offering the programs, agreed Kathleen Glynn, a consultant with The Wyatt Co. in Washington, D.C. "Employees seem to be enthusiastic to having access to group (long-term care) benefits."

"We're seeing ever-increasing numbers of requests for information and requests for proposals," noted Pam Germain Skagias, division vp of managed care and employee benefits operations for The Travelers Insurance Co. in Hartford, Conn.

There is "absolutely an increase in the level of interest among employers" in long-term care insurance, agreed Laida Kearney, a managing consultant with Aetna Life & Casualty Co. in Hartford.

However, partly because almost all employer-sponsored programs are employee-financed, participation in these plans is well behind that for other benefit options.

According to the HIAA, an average of about 5% of eligible workers enroll in employer-sponsored LTC plans.

New programs commonly aim for 10% participation, several consultants noted.

"Given the infancy of the product, I think 10% is fairly good," commented Ann Lemmon, a consultant with Hewitt Associates in Lincolnshire, Ill.

It is "not unrealistic to expect 10%" participation, noted

Ms. Glynn, adding that that is a "pretty good number for a new benefit" that people are just learning about.

Furthermore, "it's a building effect year by year," she said.

For example, when John Hancock Mutual Life Insurance Co. in Boston began offering its own active employees a LTC plan in January 1988, 7.8% enrolled, noted Nancy Bern, vp of group marketing and product development. That has since grown to 10.5%.

"The word gets out and the enrollment builds over the years," she explained.

While there are wide differences among employer-sponsored LTC programs, most contain these features:

- Coverage for skilled, intermediate and custodial nursing home care; home health care; and adult day care. Maximum daily benefit options vary significantly.

Benefits for home health care and adult day care generally are capped at half of the benefit for nursing home care.

Benefits generally begin after a certain period of time—90 days, for example—after an accident or illness, like a stroke, that causes the need for long-term care.

- Eligibility for benefits usually is based on an objective set of criteria, like the inability to perform a certain number of daily functions. Such functions can include eating, dressing, using the toilet, transferring from a bed to a chair or from sitting to standing, bathing, walking, maintaining continence and taking medication.

According to the HIAA, among employer-sponsored plans in 1989, the most common triggers for benefits included limitations in eating, using the toilet, dressing,

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Spotlight report

Consultants

Continued from previous page
aging director in New York.

But benefit managers say there are many ways to find out which benefit consultant will work best for them.

For example, BankAmerica's Mr. Nordine makes a point of attending benefit seminars to meet consultants.

"To stay in your office is a big mistake. Seminars are an excellent way to get a feel for a firm and the expertise they provide," he said.

Other benefit managers say mentions in business newspapers and magazines as well as awards given for projects are a good way to begin the consultant selection process.

Chicago-based Hartmarx Corp., for example, called in consultants who designed winning entries in *Business Insurance's* annual Employee Benefits Communications

conference to discuss redesigning the company's benefits statements.

While a good reputation and proven success are important in the selection of a consultant, benefit managers say the chemistry between them and a consultant has to be right in order for the relationship to work.

"The consultant is, in effect, a business partner. You have to trust each other. You have to feel comfortable with the person from the start," said Rick Dreyfuss, director of executive compensation and employee benefits at Hershey Foods Corp. in Hershey, Pa.

"If the chemistry isn't there, it is time to change players," said Allan Grosh, a vp and manager of The Wyatt Co.'s Minneapolis office.

"We are looking for experience, references, the clients they have worked with and the chemistry," said Mr. Nordine.

"On a project, I am looking for someone who I can work well with,

'We like to spread the business around,' says Mr. Nordine of BankAmerica, which uses about a half-dozen consultants on a regular basis. 'There is a lot of talent out there and no one has a monopoly of talent in all consulting areas.'

who respects my opinions. Some consultants say: 'I know more than anyone.' I don't need someone to put me down. There has to be mutual respect," Mr. Austin said.

Because personal relationships are so important, benefit managers must make certain that the consultant they meet during an interview really will handle the account.

"You have to watch out that the guy who wowed you during the sales presentation turns out not to be the person who will handle your account," said Gerry Bell, a partner at Kwasha Lipton.

"You are going to have a problem when you find out that a consultant who waved the flag at a presentation doesn't show up at the first strategy meeting," said Mercer's Mr. Horn.

Consultants say a face-to-face meeting is essential in the selection process. And, they add there are some signs—only possible by a face-to-face meeting—that may reveal why a consultant should not be selected.

"Be suspicious of the consultant who shows up at the first meeting with 10 people from his office. The

implication is that the consultant does not know his job. You don't need to launch an invasion to convince a client that you can do the job," said Wyatt's Mr. Grosh.

Benefit managers, though, should come armed with plenty of questions when interviewing a prospective consultant.

Some of those questions, according to Chris Palmer, a consultant in the Boston office of Hewitt Associates, include:

- Which individual consultant will handle the project.

- How much experience does that consultant have in a particular area.

"The employer wants to ask about similar projects that did and did not work out," Mr. Palmer said.

- How much backup does the consultant have.

This is important because the primary consultant could, for example, leave the firm, endangering the project if other consultants are not available or capable of completing the work.

Face-to-face meetings can help an employer gain other insights about a prospective consultant.

"It is important for an employer to get to know us and how we operate. One employer, for example, wanted more insight in how we viewed client relationships. They asked tough questions, such as how we deal with errors and how we train consultants," Mr. Palmer said.

At the same time, an employer should ask how the consultant might provide—based on the information provided at the meeting—at least a preliminary sketch of how it would approach a company's project.

"The No. 1 question an employer has to ask is: 'I explained the issues to you. Have you dealt with these issues in the past? If so, can you tell how you might approach the problem?' The employer gets a sense of the consultant's thinking process," explained Richard Raskin, a Wyatt consultant in New York.

Some employers say it makes more sense to divide work on a single project among different consulting firms rather than hire only one firm.

Hershey, for example, retained benefit consulting firm Treacy & Rhodes of Solana, Calif., to help the company develop a team of consultants from different firms to develop and implement a managed health care program.

"We found no one consultant had the expertise in the various aspects of the project," said Mr. Dreyfuss.

Other benefit managers also say it makes sense to spread work among a number of consultants.

"We like to spread the business around," said Mr. Nordine of BankAmerica, which uses about a half-dozen consultants on a regular basis. "There is a lot of talent out there and no one has a monopoly of talent in all consulting areas."

Some benefit managers say the number of consultants they use depends on the nature of the work.

For example, Chicago-based Quaker Oats Co. uses one consultant—The Wyatt Co.—for the bulk of its benefit consulting work.

"You can't run your business if you are talking to eight or 10 different consultants all the time," said Dennis Corry, Quaker Oats' manager of benefit plans.

On the other hand, when Quaker Oats makes an acquisition, it tends to retain the pension actuary used by the acquired company. "We try to maintain the relationship. The pension consultant will have a lot of experience with the firm as well as many records," Mr. Corry said.

No matter which consultant an employer selects, the consulting fee will be based on the number of

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**EMPLOYEE BENEFITS BULLETIN:
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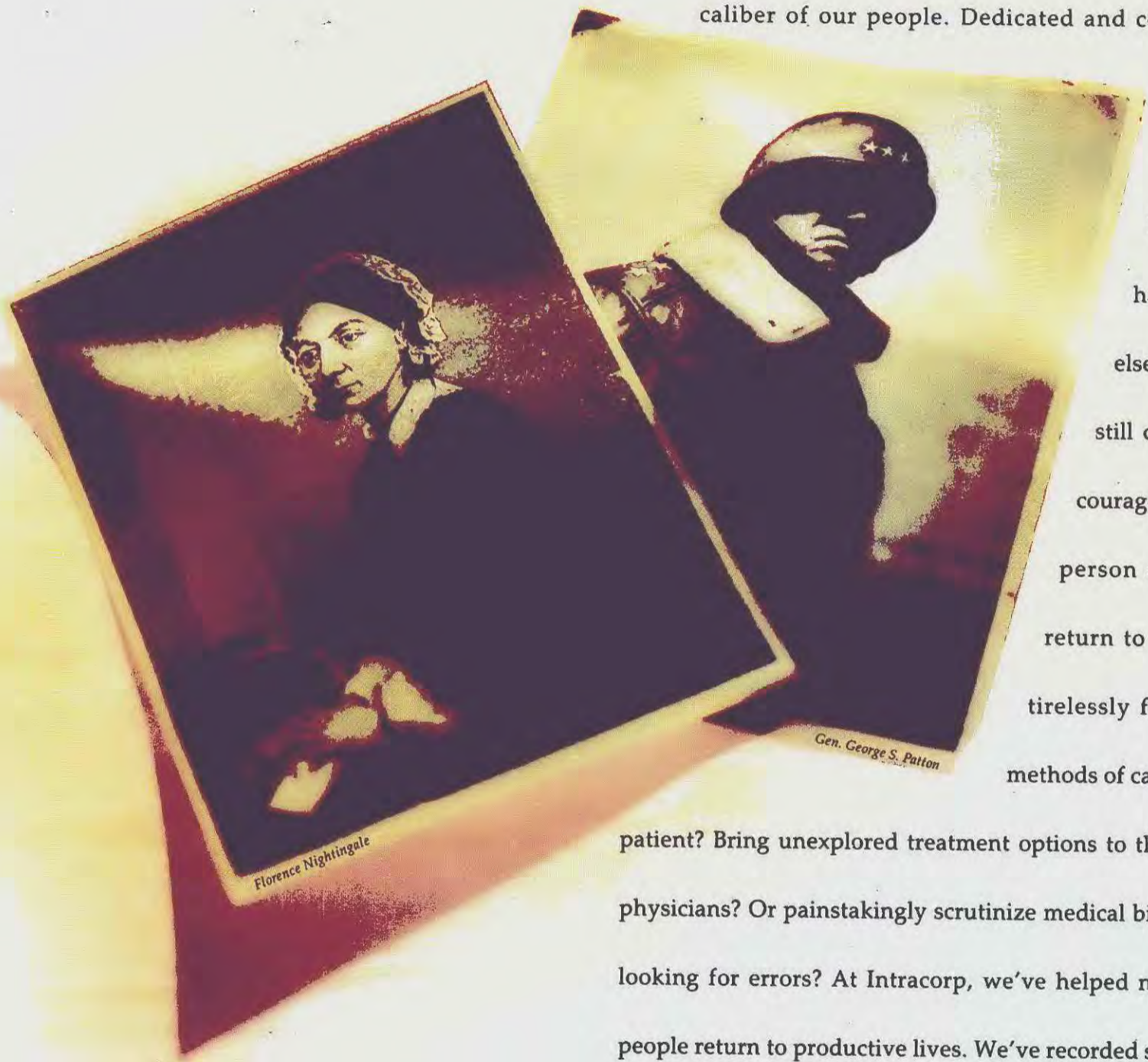
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Consultants

Continued from page 4

hours and expenses the consultant believes it will take to complete the project. Consulting fees usually are billed monthly.

But time-and-expense fees can be expressed in different ways, depending on the nature of the project.

For example, charges for certain administrative work, like 401(k) plan record keeping, usually are quoted on a per-participant basis. How much is charged per participant, though, will vary based on the complexity of the work.

For example, record-keeping fees will be substantially higher for a 401(k) plan that allows employees to change investment options than for a straight profit-sharing plan where there are no investment options.

For one-time projects, like examining whether a company

should overhaul its retiree health care program, a flat fee typically will be charged.

However, despite receiving an initial estimate of the cost of a project, the fee that the employer ultimately pays the consultant could end up much higher than expected.

When a consultant and employer agree on a fee, it is based on a certain set of assumptions, like the availability of data to be provided by the company.

"As long as the nature of the project does not change, an employer and consultant will agree that the fee will not exceed a certain amount," said Jack Mahurin, a principal in Mercer's St. Louis office.

Often, though, assumptions can change. The data may be harder to obtain than previously thought, or the employer may want to broaden the scope of the project.

"Some consulting work is like

'It is time to change when you lose confidence in your consultant, when you are not getting new ideas and when projects always come in over budget,' says Richard Spitznass of Georgia-Pacific Corp.

remodeling a house. You don't always know in what condition everything will be," said David Glueck, manager of the Chicago office of TPF&C.

When the scope of a project changes, employers should be told by the consultant as soon as possible that its costs could be going up.

"Clients don't like surprises. They want to know what something is going to cost," said David Walker, a principal in Mercer's Chicago office.

Increasingly, employers are ask-

ing for formal requests for proposals on benefit consulting projects.

But before asking a consultant to complete an RFP, many employers will invite consultants for a preliminary interview.

"How can a consultant have an understanding of what we want them to solve without a meeting?" asked Charles Mazza, vp-human resources at Mead Corp. in Dayton, Ohio.

But not all consulting projects require RFPs. For example, Bank-America's Mr. Nordine says on a small project he would want the

consultant to give an indication of how much the fee would be.

Similarly, if an employer is satisfied with its current consultant, there is no need to send a project out to bid, consultants say.

Instead of a formal bidding process, an employer might call a few competitors to reaffirm that what the company is paying its consultant is not out of line with current market rates.

But, even when an employer is satisfied with a consultant it has used for many years, it should still test the market to make sure it isn't paying too much.

"You don't need to take formal bids. But a buyer should be aware of costs. An employer might call up three or four consultants to try to get a sense of what a fee for a service should be," said David Rahill, a principal with Foster Higgins in New York.

If competing firms' fees are much lower, the employer could go back to its consultant and say, "Your fee is out of line," Mr. Rahill.

No matter how much care is taken to select the right consultant, relationships can sour, leading companies to look for new help.

Indeed, benefit managers and consultants agree there are tell-tale signs indicating when a new consultant is in order.

"It is time to change when you lose confidence in your consultant, when you are not getting new ideas and when projects always come in over budget," said Richard Spitznass, vp of compensation and benefits at Georgia-Pacific Corp. in Atlanta.

"You want to change when a consultant loses credibility with your staff, where they have given bad advice in an area where the firm was supposed to have expertise," added Kevin Flatley, vp-employee benefits at American Express Co. in New York.

It also is time to change consultants when employers sense that the consultant becomes more of a salesman rather than a provider of objective advice.

"You should be suspicious when a consultant always tries to sell you something," said Wyatt's Mr. Grosh.

However, it isn't always necessary to find a new consulting firm if a benefit manager becomes dissatisfied with the relationship, benefit managers say.

"You might ask for a different individual at a consulting firm to do the work. This would be particularly true if I had a long-standing relationship with a firm," Mr. Spitznass said.

And, despite rigorous evaluations, requests for proposals and face-to-face interviews, it is possible to sign on with a benefit consultant that doesn't meet the employer's expectations.

Several years ago, Minneapolis-based Dayton-Hudson Corp. sent out requests for proposals to 18 consultants to provide savings plan record-keeping services.

The consultant selected had a great administrative system, recalled Fred Hamacher, Dayton-Hudson's vp-compensation and benefits. But it soon was clear the consultant was not service-oriented.

"They were not very responsive to our requests. It didn't take us long to determine that customer service was not adequate," Mr. Hamacher said.

Dayton-Hudson dropped that firm and selected a new consultant—Hewitt Associates—that had a similar administrative system but dramatically better service, Mr. Hamacher said.

"In short, we measured all the right things. But you can't always measure customer service ahead of time. It is something you only can find out when the job is being performed," he said.

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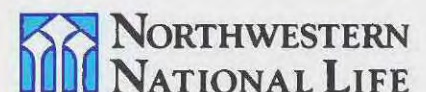
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Opinions

Conflict of interest

THE ILLINOIS Self-Insurers Advisory Board should seriously consider adopting new membership rules.

The ISIAB, which advises the chairman of the Illinois Industrial Commission on workers compensation self-insurance matters including broad security requirements and approval of individual firms to self-insure, faces a conflict-of-interest issue.

Resolution of the issue is important to Illinois employers and to employers elsewhere whose states often look to Illinois as a leader in insurance and self-insurance regulation.

One of the ISIAB's members, as we reported last week (BI, March 25), owns a brokerage firm that sells surety bonds to workers comp self-insurers.

Furthermore, last year when Illinois self-insurers were being informed of widespread higher security requirements, that brokerage sent letters to self-insurers informing them of its ability to place \$2 million of surety bonds.

The letter raised more than a few eyebrows at companies that self-insure workers compensation exposures in Illinois.

A member of the board voting for higher security requirements is in a position to sell more surety bonds if security requirements are raised. Furthermore, he votes to recommend or not recommend that employers be allowed to self-insure. And, he votes on applications to renew approval to self-insure from employers' whose financial situation has deteriorated. Those so-called troublesome renewal applications include the name of the surety bond broker and the amount of surety previously posted.

The brokerage firm member of the board, James L. Sandner, president of Brokers' Risk Placement Service Inc., says his firm earns less than 1% of its revenues from selling surety bonds.

Nonetheless, we see the potential for conflicts of interest and a very real issue of a perceived conflict of interest. His name and his firm's name appear on the ISIAB's stationery on which self-insurers are told how much security they must post.

We fear that employers may look at that stationery and at the very least wonder whether they would have a better chance of being approved to self-insure workers compensation risks if they purchased bonds from Brokers' Risk.



We do not think that is a question that should be raised.

For that reason, we recommend that the ISIAB ask the Illinois Board of Ethics for an opinion on the appropriateness of Mr. Sandner's service.

And, we have some advice for the ethics board:

No vendors of surety bonds or other products and services for self-insurers should be appointed to the ISIAB. No board member should be in a position to gain financially from decisions the board makes—whether it be to increase security requirements in general for self-insurers or to recommend that an individual employer be approved as a self-insurer.

We appreciate that Mr. Sandner's advice and counsel are valued by the ISIAB. If the Illinois Industrial Commission believes that quality of advice is not available elsewhere, Mr. Sandner—and any other vendor—could be appointed as a non-voting member of the board.

At the very least, we believe that Mr. Sandner should decline any comment on any matter in which he has a personal involvement, which we believe includes security requirements for self-insurers in general and recommendations on individual applicants that are clients.

Letters

Access to health care not equal to socialism

To the editor: Can you imagine my consternation when, upon reading Richard C. Mattingley II's diatribe about health care (BI, Feb. 18), I suddenly realized I am living in a socialist country!

Until then, secure in the knowledge that any personal health care crisis would not be exacerbated by an additional financial crisis, I thought Canada was just a country caring about its people.

Mr. Mattingley should be reminded that not all our predecessors sailed to these shores to obtain freedom. For many, the journey meant just the opposite. Times, of course, have changed, but with every right comes a duty and every freedom a responsibility. One of these is to take care of the less fortunate ones.

It is just about everyone's aspiration to reach not necessarily new financial heights but to at least attain financial security. Unfortunately, we are not living in a society of 100% full employment, and not everybody has the means or talent to become a chief financial officer like Mr. Mattingley. Is that then a crime that deserves banishment to a "socialist" country, or should the less fortunate ones just be ordered to stay healthy until they can afford to be sick?

Our friend should ponder the fact that

How far does right to privacy extend?

To the editor: The decision by the Appellate Court in San Francisco that a physician had violated a claimant's "right to privacy" under California law when he reported that a workers comp claimant was HIV positive and that this virus could be contributing to the claimant's complaint of headaches, shoulder and back pain raises several questions (BI, Feb. 25).

What if, in the course of his examination, the physician had found that the claimant had a tumor on his spine that was causing and would continue to cause

of all the Western countries, the United States is the only one without some form of universal health care, putting it on par with what we classify as Third World countries in this area. Access to health care is something that more than 30 million Americans, which is more than all the people in Canada, can only dream about.

John Buyschaert
Manager-Corporate Insurance
Trizec Corp. Ltd.
Calgary, Alberta

headaches, shoulder and back pains unless surgical intervention was performed? Would disclosure of that situation be a violation of the claimant's right to privacy under California law?

In short, is the state of California interested in reality, or is it intent on creating unequal justice under the law, i.e., rights for HIV-positive persons that HIV-negative persons don't have?

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Western General Management Inc.
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Some jobs can be done in-house, some can't

By JERRY GEISEL

Benefit managers constantly have to decide whether to have in-house employee benefits staff members tackle a project or turn the project over to an outside consultant.

"It is an ongoing dilemma determining whether benefits work should be done internally or externally," said Neil Austin, manager of health plans at Pacific Bell, a unit of Pacific Telesis Group in San Francisco.

It's not yet clear whether employers—pinched by the recession—are handling more projects on their own.

"There are often conflicting trends. Some companies are trying to reduce the size of their benefits departments and they use consultants more" while other companies are handling more jobs internally, said David Glueck, the manager of the Chicago

office of TPF&C, the benefits and actuarial consulting division of Towers, Perrin, Forster & Crosby Inc.

For companies that can use staffers to handle consulting projects, savings can be significant.

Bethesda, Md.-based Marriott Corp.'s internal benefits development and communications staff, which is now being expanded, is expected to save various corporate divisions several hundred thousand dollars annually in consulting fees.

"We can be much more efficient than an outside provider," said Bob Dankmyer, vp-employee benefits.

On the other hand not using a consultant can cost even more.

"You have to compare consulting fees compared to payments companies make for their benefit programs. If a consultant can come up with an idea that will save 5% in

medical plan costs, that will pay for consulting fees for many years," said Al Kleinberg, a group executive with Buck Consultants Inc. in New York.

"With a consultant you can get a whole range of experience that an individual employer cannot duplicate," said David Rahill, a principal with A. Foster Higgins & Co. Inc. in New York.

Mr. Rahill recalls how a group of teaching hospitals wanted to establish a preferred provider organization made up of their own institutions. The project, though, backfired and actually increased costs.

"The teaching hospitals didn't recognize that their own costs were much higher than community hospitals'. By attracting employees to their own higher-cost facilities, costs increased geometrically," he said.

When another group of teaching

hospitals also considered forming a PPO, Mr. Rahill pointed out the mistake made by the first group.

There are no universal answers to guide employers or when to use a consultant. The need for help varies with the project.

Some companies say they prefer to hire a consultant when starting a new project.

For example, when Hartmarx Corp., a Chicago-based apparel manufacturer, decided to redesign its benefit communications program, it brought in Buck Consultants.

"Why re-invent the wheel when a consultant has so much experience in designing programs?" asked Michael Pikely, Hartmarx's employee benefits manager.

When starting a new project, many benefit managers say they want someone looking over their shoulder,

playing devil's advocate.

"We use consultants differently than we used to. There is less consulting on the administrative side and more over-the-shoulder consulting," said Cathy Corse Wooster, benefits planning manager at Barnett Banks Inc. in Jacksonville, Fla.

"We may say to the consultant: 'This is what we want to do.' Does it make sense? Give us a second opinion. Tell us if we have overlooked anything," Ms. Wooster said.

At the same time, Barnett's benefits staff gradually has taken over more of the administrative work spawned by the company's flexible benefits program, like enrolling new participants and handling those who choose different benefit options because of lifestyle changes.

And, by next year, Barnett expects all flex plan enrollment to be handled in-house through a new interactive telephone system.

Other benefit managers ask consultants to educate in-house staffs so they can eventually handle the work.

When Hartmarx retained TPF&C to audit the firm's third-party claims administrator, it had the consultant train Hartmarx benefits department staffers on auditing techniques so Hartmarx staffers can take over more of the work in succeeding years.

Consultants caution, though, that employers have to think of more than just money when deciding what work can be done in-house.

For instance, an in-house staff may not be able to handle unexpected problems.

"A company may have the culture to invest in staff and computer equipment, but what if a crisis hits?" asks Buck's Mr. Kleinberg.

Not surprisingly, many benefit managers say a project's degree of difficulty will be the deciding factor in whether to use a consultant.

For example, Barnett's Ms. Wooster said 401(k) plan record keeping is too complex—at least for now—to be handled internally. "Developing a system from the ground up is more than we are currently ready to take on, though eventually it is something we'd like to."

"Record keeping has become extremely difficult as time and regulations have passed. Our systems have become old and antiquated," agreed Dennis Corry, manager of benefit plans at The Quaker Oats Co. in Chicago.

It may make better economic sense to turn over 401(k) record keeping to a consultant than make an investment in new equipment—which could become obsolete—and staff training, Mr. Corry said.

Employers, even those with large benefits departments, say developing a managed care network requires a time commitment they do not have.

"Marriott could have developed a managed health care network, but not in the time we had allotted," Mr. Dankmyer said.

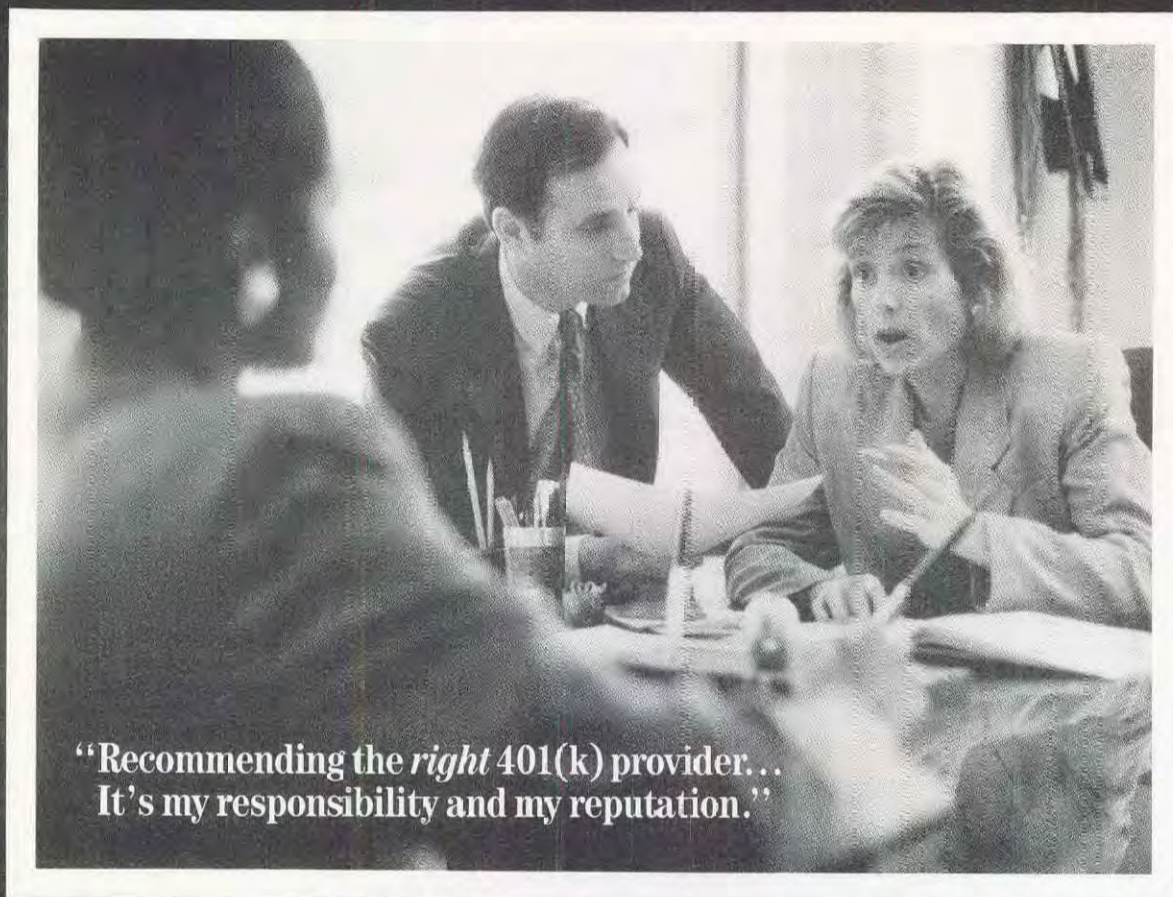
Other benefit managers say the decision on whether to use a consultant simply comes down to quality.

"Our philosophy is to have the highest quality in the operation of our benefits program. If we can assure ourselves of that quality by doing the work internally, then we do it internally," said Charles Mazza, vp-human resources at Mead Corp. in Dayton, Ohio.

Indeed, some benefit managers say because they know their companies better than an external consultant they can communicate new benefit programs more effectively.

For example, Ms. Wooster designed the communications package used to introduce Barnett's flexible benefits plan rather than turn it over to a consultant.

"We knew our employees. We knew how to talk to them. It is difficult for an outsider to know how to do that. The message had to be Barnett-specific," she said.



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The Good News

In some states, Workers Compensation works without a hitch. Workers are compensated quickly, and fairly.

But to bring that same quickness and fairness to the troubled states today, and to strengthen all systems for tomorrow, we have to promote change. A few examples:

Simpler procedures, better communication of rights and benefits, plus teamwork between doctors, employers and state regulatory agencies would do wonders for the individual systems.

So would agency-sponsored toll-free numbers for injured workers to inquire about their income benefits. And consumer brochures outlining specific workers' rights.

Ideally, alternative methods for resolving legitimate disputes should be adopted — short of going to court. This would allow for quicker resolution of those disputes and faster income benefits.

It's Up To All Of Us

To charge ahead and implement ideas like these, you can do one of two things to help.

One: Be aware. Find out what's happening in your state, how you're affected, and what you can do. Talk to your insurance company or business trade association.

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OFF	CASE	CLAIMANT NAME	STATE	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	S	E PBA	R HBR	V	T PPO	C	E OTHERS	S	GROSS SAVINGS	
001	123451	S. MURCHALLA	PA	2	1,230.00	984.93		0.00	245.07			0.00	0.00		245.07	
001	123452	G. KOSTURK	OH	1	225.00	183.49		0.00	0.00			31.01	10.50		41.51	
001	123453	M. DOMM	FL	6	2,231.58	1,751.74		258.59	0.00			221.25	0.00		479.04	
001	123454	J. GREENE	TX	1	190.00	152.19		26.04	0.00			11.77	0.00		57.91	
001	123455	K. MURRAY	CA	5	15,203.48	11,719.38		369.63	0.00			3,114.47	0.00		3,404.10	
001	123456	J. HARRINGTON	MI	2	6,081.38	4,687.74		0.00	0.00			1,245.78	147.86		1,393.64	
001	123457	A. HAYES	PA	1	3,040.69	2,343.87		0.00	73.93			422.89	0.00		496.82	
001	123458	D. PSZONEK	FL	3	9,122.07	7,031.61		221.79	0.00			1,408.60	60.07		2,000.46	
001	123459	C. FINN	GA	1	1,520.33	1,171.98		0.00	36.96			319.83	0.00		338.40	
TOTALS FOR LOCATION 011 ALL LOCATIONS					22	38,844.53	30,026.88		876.05	355.96			7,367.21	218.43		8,817.65
TOTALS FOR DIVISION 100 ALL DIVISIONS					22	38,844.53	30,026.88		876.05	355.96			7,367.21	218.43		8,817.65

TYPES OF SAVINGS
 PBA: PROVIDER BILL AUDIT PPO: PREFERRED PROVIDER ORGANIZATION HBR: HOSPITAL BILL REVIEW OTHERS: OTHER TYPES OF SAVINGS

American International Companies

MEDICAL COST CONTAINMENT SUMMARY

ACCOUNT NO	POLICY NO	ACCOUNT NAME	POLICY NAME	NUMBER BILLS	ORIGINAL AMOUNT	AMOUNT PAID	S	E PBA	R HBR	V	T PPO	C	E OTHERS	S	GROSS SAVINGS
9999999	99999999	ABC CORPORATION	XYZ CORPORATION	22	38,844.53	30,026.88		876.05	355.96				7,367.21	218.43	8,817.65
9999999	99999999	ABC CORPORATION	XYZ CORPORATION	22	38,844.53	30,026.88		876.05	355.96				7,367.21	218.43	8,817.65
9999999	99999999	ABC CORPORATION	XYZ CORPORATION	22	38,844.53	30,026.88		876.05	355.96				7,367.21	218.43	8,817.65
9999999	99999999	ABC CORPORATION	XYZ CORPORATION	22	38,844.53	30,026.88		876.05	355.96				7,367.21	218.43	8,817.65
9999999	99999999	ABC CORPORATION	XYZ CORPORATION	22	38,844.53	30,026.88		876.05	355.96				7,367.21	218.43	8,817.65

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Consulting fees can be controlled

By JERRY GEISEL

It is possible to hold down consulting fees without reducing the quality of consulting services.

Employers waste a great deal of money by providing sloppy data, like incorrect employee Social Security numbers, to consultants. That can slow down—and increase the expense—of services like 401(k) plan record keeping.

"In a substantial number of cases, a company may pay a higher consulting fee than another firm because its data is not clean," said Al Kleinberg, a group executive with Buck Consultants Inc. in New York.

In other cases, fees may be wasted because a consultant's time isn't being used efficiently.

For example, David Rahill, a principal with A. Foster Higgins & Co. Inc. in New York, recalls how one employer wanted weekly meetings with senior consultants to monitor the

progress of a health care consulting project.

"We told the client that a lot of information could be exchanged—at much lower cost—simply by faxes and through teleconferences," Mr. Rahill said.

At the same consulting dollars may be wasted if a corporate benefits department doesn't do its homework and find out whether top management will support a project before a lot of work is done.

"We may find out—after a project is completed—that senior management has no interest in the recommendations," Mr. Rahill pointed out.

Survey costs can also be held down by doing more of the work in-house.

For example, rather than pay thousands of dollars to a benefit consultant to research benefit trends in the banking industry, Cathy Corse Wooster, benefits planning manager at Barnett Banks Inc. in Jacksonville, Fla., in-

quired about a half-dozen benefit managers from six Southeastern banks to a one-day conference to discuss a variety of employee benefit issues.

"Do you really need a third party to find out what is going on in your own industry? Not necessarily. There is a great willingness to exchange information and share experiences," Ms. Wooster said.

Other benefit managers say they can obtain some of the advice that a consultant would give—for a big fee—by attending conferences.

Shirley Perkins, senior vp and director of human resources at First Interstate Bancorp in Los Angeles, said that conferences are cost-effective ways of finding out what is going in the field.

But attending conferences never can completely replace the use of consultants because of individual company needs, consultants said.

If you can't beat 'em

AT&T actuaries provide advice to other firms

PISCATAWAY, N.J.—A former American Telephone & Telegraph Co. internal pension actuarial division now is one of the nation's fastest-growing benefit consultants.

AT&T's actuarial sciences section provided pension services to members of the Bell System for about five decades—until a federal judge ordered AT&T operations broken up into many independent regional phone companies.

As the unit was completing its last major task before the divestiture—the allocation and distribution of \$54 billion in assets from two giant Bell System pension plans to new pension plans formed by the so-called Baby Bells—executives of the actuarial sciences section considered forming a new company.

"We felt there was a natural market. We had a foundation with the companies that were to be spun off (following the court-ordered breakup of the Bell System). And we understood the regulatory environment and had experience with how decisions are made at the corporate level," recalled Michael J. Gullota, then AT&T's chief actuary.

Launched on July 1, 1985, with just \$25,000 in seed money from AT&T, Actuarial Sciences Associates Inc. has enjoyed phenomenal growth.

Last year, the Piscataway, N.J.-based firm generated consulting revenues of \$11 million to \$12 million, up from just \$3 million in 1985.

As the firm has grown, its dependence on AT&T for consulting business has declined, though AT&T remains its biggest client. Initially, 85% to 90% of Actuarial Sciences Associates' revenues were derived from AT&T-related work, but more than half its revenues today come from other clients.

Indeed, said Mr. Gullota, some of the nation's best known companies, including W.R. Grace & Co., Squibb Co., Xerox Corp., Merck & Co. Inc., as well as the regional phone companies, have used Actuarial Sciences Associates on consulting projects. It now has about four dozen clients.

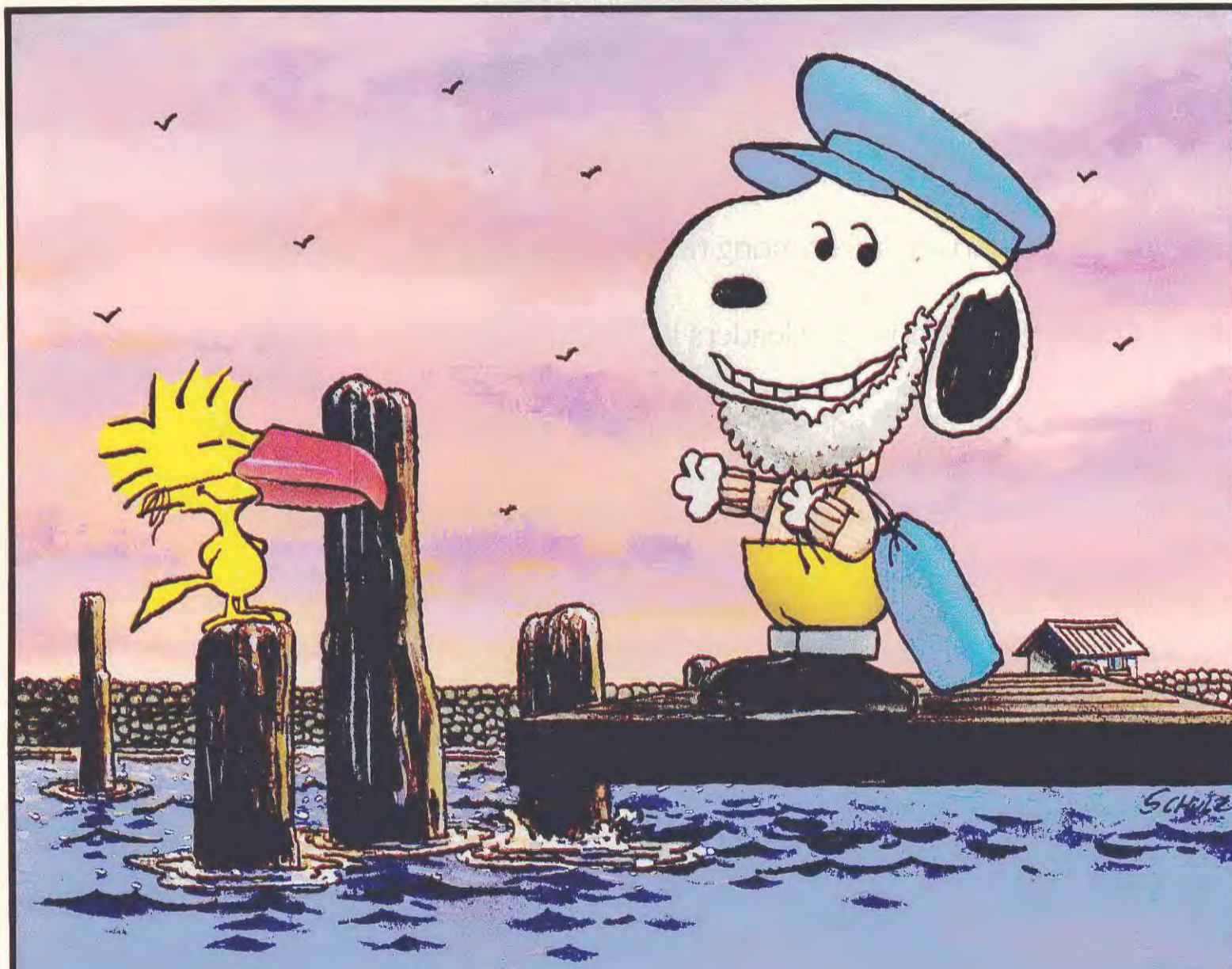
The company also has expanded its expertise.

Most of its early revenues came from pension actuarial work, but about half of its current business is non-pension related.

That business includes retiree health care plan design, consulting on the new Financial Accounting Standards Board rules on recognizing retiree health care costs and liabilities (see story, page 53), pricing of flexible benefit plan options, analysis of demographic data to help negotiate health maintenance organization premiums and analyzing benefit obligations in mergers and acquisitions, said Mr. Gullota, who now is the firm's president.

Actuarial Sciences Associates now has about 90 employees, up from about 15 in 1985. And further expansion into areas like compensation consulting is possible, Mr. Gullota said.

—By Jerry Geisel



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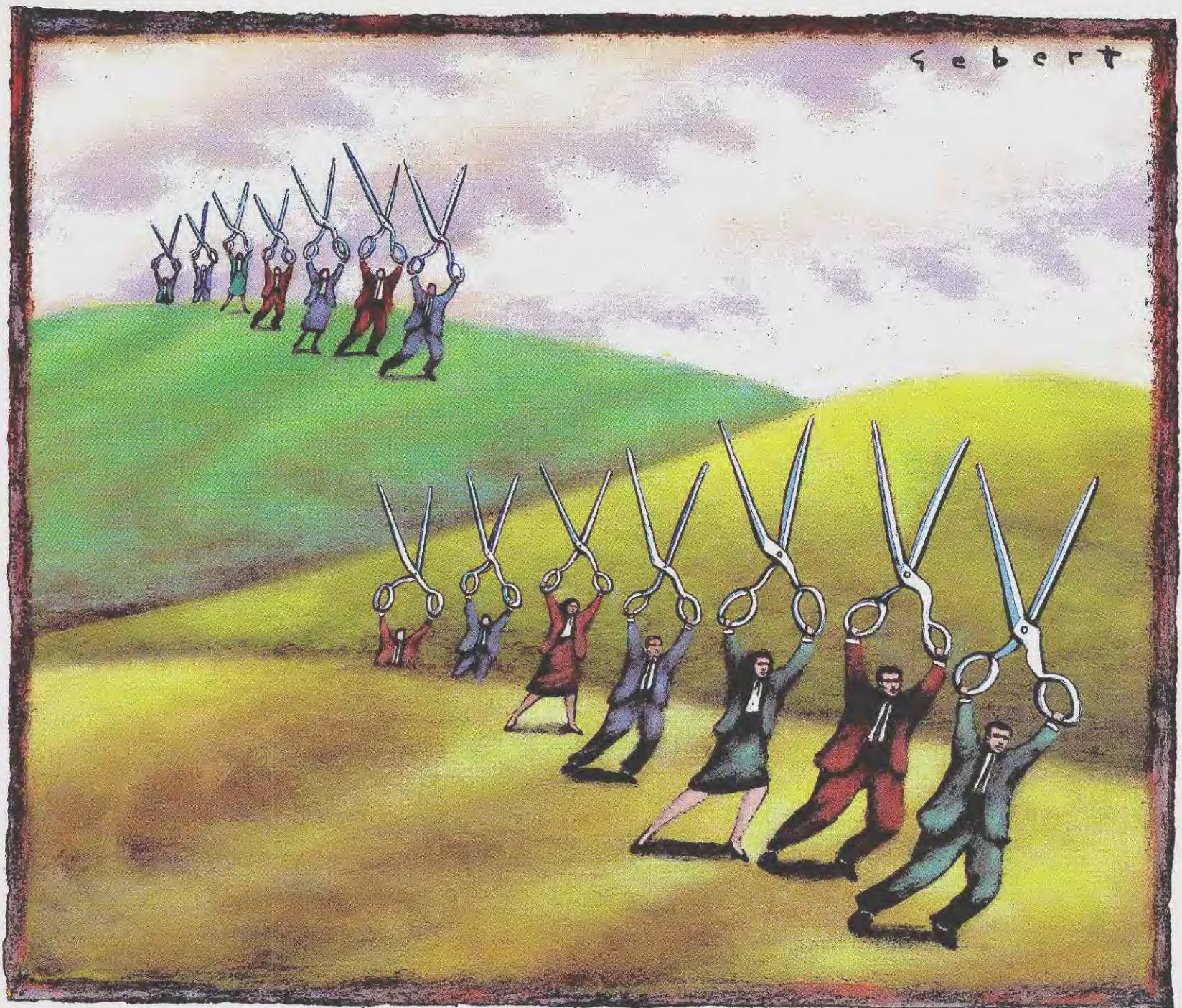
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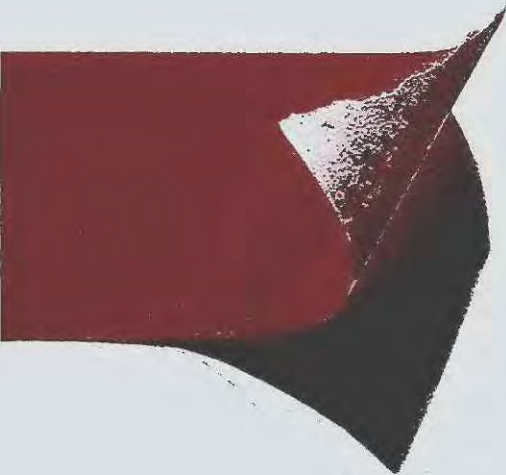
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Employees actually do read them

Interest high in benefits statements

By ADRIENNE C. LOCKE

Employee benefit statements are alive and flourishing.

Employers and employees still highly value the information provided in the annual benefits statement, consultants say.

Employers use these statements to provide their workforce a complete compensation picture and to educate employees on the amount of money employers spend to provide these benefits.

"Employees lose sight of the value because it's not in the dollar-and-cents paycheck they get every week," said Donald C. Martin, a consultant in the Philadelphia office of TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc.

Once just a listing of the cost of offered benefits—like health care, pensions and disability insurance—benefits statements also have become a useful financial planning tool for employees, consultants say.

A growing number of annual benefit statements are organizing benefits by life events, like retirement, disability or death.

And, new and improved technology has made efforts to provide more personalized information on benefits statements easier and less costly.

But, employers must strike a balance on the amount of information they provide in statements, consultants warn. Excessive information will complicate the statement, which will reduce employee interest in it, they say.

"I think there is still strong interest in benefit statements," said Max Caldwell, manager of the communications practice in the Boston office of Hewitt Associates.

"We've seen continued interest in the employee benefits statement, and we continue to see not only repeat customers but new clients as well," said Nancy Collins, a consultant in The Wyatt Co.'s Washington, D.C., communications office.

And, employees' interest in the statement is high, consultants say.

"Of all the reams and reams of paper that employers send out, the benefit statement is the one that employees are reading," Mr. Caldwell said.

"If the April statement, for some reason, is delayed until June, there tends to be a barrage during April and May at human resources about where the statements are," said Frank G. Pirrone, an administrative consultant at Buck Consultants Inc. in Secaucus, N.J.

One of the most important goals of the annual benefit statement is to make employees recognize and understand the value of the benefits they receive, said Mr. Caldwell of Hewitt.

"The cost of benefits are going up. The employee benefit statement is a very useful way to get across to employees what the employer is paying for these benefits," he said.

It may not sink in immediately, but employees gradually begin to see the value of their benefits, he said.

Many employers in their benefits statements provide a personalized comparison of the amount the employee and the company pays for benefits, Wyatt's Ms. Collins said.

Wilmington Trust Co. of Wilmington, Del., provides its employ-

ees such a statement.

"The biggest value is that it paints a picture on how comprehensive the benefit package you have is, said Betty Blair, health benefits and systems manager.

Coral Gables Federal Savings & Loan in Coral Gables, Fla., sends a similar statement to its employees.

"The first year we distributed these statements we got many calls from employees who said that they had no idea they received all of these benefits," said Susan Rey, assistant vp and personnel manager.

Mobile Infirmity Health Systems in Mobile, Ala., provides employees a similar statement. "We received a lot of favorable feedback on the statement, said Tom Betancourt, vp of human re-

sources.

More employers also are using annual statements as a tool to help employees better use the benefits available to them, according to benefit consultants.

Benefit statements increasingly are moving toward explaining benefits by "life events" and away from listing benefits only on a plan-by-plan basis, observed Mark Shuman, a consultant in the Dallas office of William M. Mercer Inc.

The outcome of employee benefits choices are provided as well as how they will work together when employees reach a certain point in life, like retirement, he said. Employees will know what their retiree health care coverage and pension benefits will be, he said.

In addition, employers can show

employees projections of future outcomes if they should decide to change their benefits in some way, Mr. Shuman said.

For example, an employee participating in a 401(k) plan would see how much money would accumulate in 10 years by contributing, say, 2% of pay. The statement also could show how much money would accumulate if the contribution was increased to 4% or 6% during the same period.

"Employees will see the value of the choices made last year and the opportunity to make new choices this year," Mr. Shuman said.

Advances in computer technology, like laser printing, have made it easier for employers to provide personalized information in benefits statements, consultants say.

"Laser printing has been a big plus because you can personalize the statement line by line if you want to," said TPF&C's Mr. Martin.

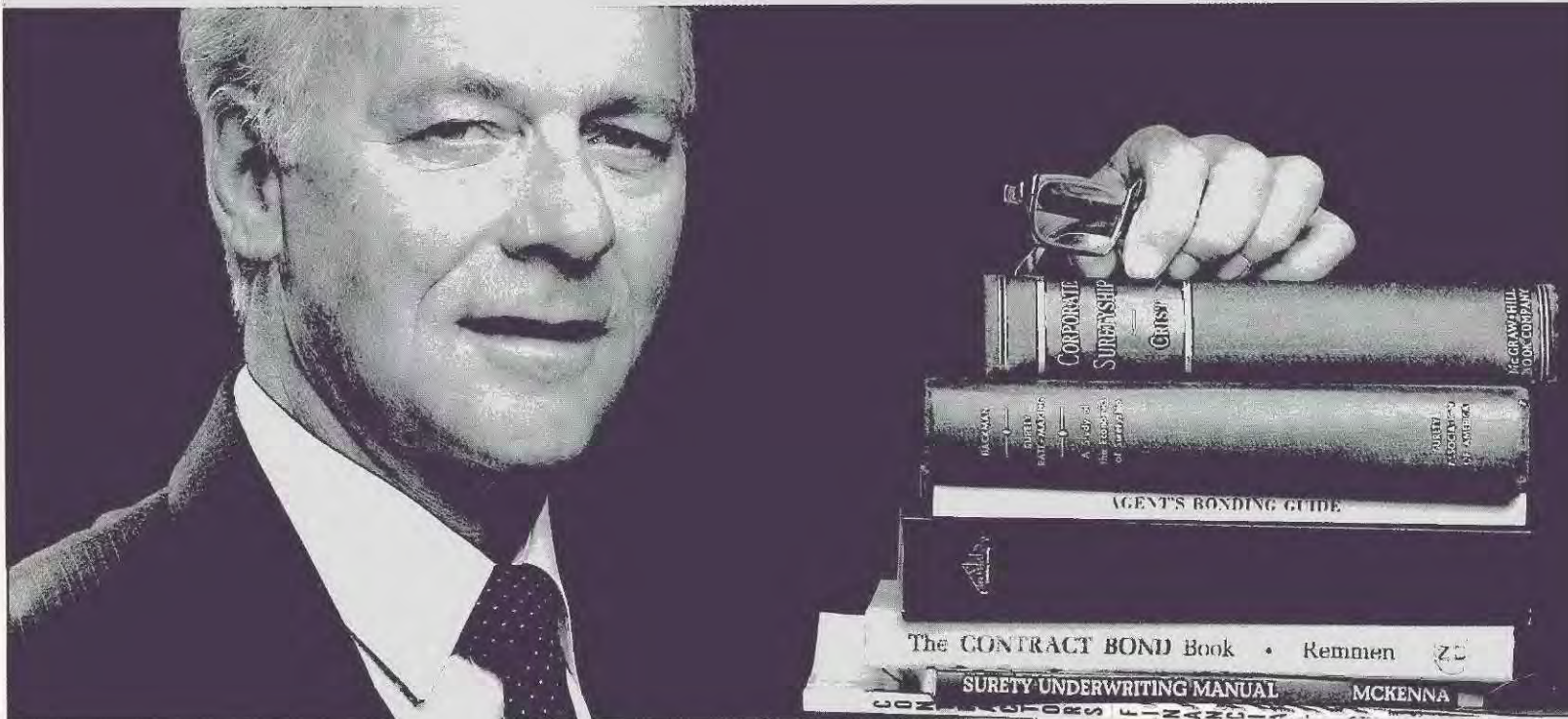
With laser printing, the costlier pre-printing process can be eliminated if an employer wants to provide personalized graphics—like pie charts or bar graphs—in benefits statements, he said.

Another new trend in annual benefit statements is the interactive computer system, from which employees obtain part or all of their benefits information from a computer.

This process can be as simple as using a toll-free telephone number and a touch-tone phone. Or, it can involve sitting down in front of a

Continued on next page

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Continued from previous page
personal computer and using a prepared program that takes an employee through the benefits statement program step-by-step.

One of the advantages of the interactive system is that it can provide the most up-to-date employee benefit information available, according to Mr. Caldwell of Hewitt Associates.

The system also can be used to make any changes in benefit choices the employee wants to make, he said.

However, consultants caution that an interactive employee benefit statement is not for all employers.

"There was a time when we thought that the interactive medium was going to be the save-all, but we underestimated the fact that people like human contact," Mercer's Mr. Shuman said.

One consultant pointed out that many employers simply cannot af-

'Employees don't want anyone looking over their shoulders,' says Donald C. Martin.

ford an interactive system.

An interactive system also would be impractical for the employer with a workforce spread out in many locations, said Ms. Collins of Wyatt.

And, some employees—like those who work on assembly lines—may not be able to spare the time during the course of the workday to use an interactive system, she cautioned.

In addition, employers also must motivate workers to use the computer system, noted Mr. Pirrone of Buck.

"You are relying on that individual's savvy to pull all of those things together. It is up to the individual to go beyond those initial screens," he said.

Employee privacy is another issue when considering a PC computer-based interactive employee benefit statement, said Mr. Martin of TPF&C.

"Employees don't want anyone looking over their shoulders when they are printing out their statement," he said.

But, if used the right way, an interactive computer system can be quite helpful, according to Mr. Shuman.

"Where it works the best is where the computer technology enhances the human aspects in benefit communication. Where we get into trouble is when we use technology to replace it," said Mr. Shuman.

Obtaining employee feedback on annual benefit statements is important for an employer so that it can determine what information is useful to its employees, said Barbara Miller, vp and communications consultant at Booke & Co. in Winston-Salem, N.C.

But, an employer should formally ask employees their opinions of the benefit statement instead of waiting for them to offer it, she said.

Ms. Miller also said employers should not assume that a lack of response from employees about the benefit statement means that workers are not interested in receiving them.

"Employers may not think that employees are getting a lot out of the statements because they don't get any feedback from them. But when they skip a year, they find out that employees will ask about them," she said.

Mr. Martin of TPF&C agreed. "Survey employees to see what the reaction was, what they would have liked to have seen, what was the least useful information on the statement," he said.

Employers also should prepare employees for the arrival of the annual statement so they aren't inadvertently overlooked, said Mr. Shuman of Mercer. "Don't send it by itself—let employees know it is coming," he said.

Ms. Rey of Coral Gables uses the company newsletter after the statements have been mailed to alert employees to watch for the statements.

But, after determining what employees would like to see on the benefits statement, employers should not provide too much information, warned Buck's Mr. Pirrone.

For example, some employers might think that including individual health care claims data on the annual benefits statement is a good idea.

Employees would be able see the amount of claims the health insur-

ance plan paid on their behalf in the past year compared with how much they paid in premium contributions, deductibles and copayments, he said.

But the trend in employer-provided health care within the last few years has been to cover catastrophic care rather than more routine medical needs, said Mr. Pirrone.

And, "for those who don't have a medical episode, they may think that the plan doesn't work for them. They don't see that if their child has to go into the hospital and it costs \$100,000, they might only have to pay \$2,500," Mr. Pirrone said.

Trying to give the employee too much information is a mistake that is often made in annual employee benefit statements, agreed Richard J. Knapp, principal and national practice leader for communications at A. Foster Higgins & Co. Inc. in Princeton, N.J.

Employees become so overloaded with data that they end up no better informed than they were before they received the statement, he said.

Mr. Knapp also said the annual benefit statement should not be a replacement for a summary plan description.

"It is not a good opportunity to provide every detail of a benefit plan. Employees can become overwhelmed and won't read it," he said.

Other consultants agreed. "If it looks too difficult to read, employees will just gloss over it and not internalize the information," pointed out Mr. Caldwell of Hewitt.

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There when it counts.

User-friendly EBIS boost efficiency

By SARA J. HARTY

Employee benefit information systems are becoming more user friendly while providing more analytical capabilities to employers, vendors say.

To help speed health care claims administration and make processing easier for self-insurers that administer their own claims, most vendors report that their systems now allow claims data to be input on a single screen. Most used to require five or six screens of information.

Function keys enable the claims processor to bring up other screens in a window without losing data on the screen, or even to automatically move data from other screens to the initial input screen.

"Ninety percent of administrative time is spent in entry," said Monique Knox, account executive for Insurance Software Packages of Tampa, Fla. Limiting the number of data entry screens to one can save a lot of time, she explained.

However, employers are not "looking for flashy or cute systems," said William Whitmore, president of Santa Barbara, Calif.-based SW Systems Inc.

Employers tend to be looking for very functional and flexible software that will adapt to change, Mr. Whitmore said.

"Our system is really user friendly. Files can be maintained and modified by users rather than technical support staff," said Tom Szukala, customer service manager in New York for Policy Manage-

ment Systems Corp., formerly Advanced Systems Applications.

Systems that are easy enough to use without constant support from technical staff "free program administrators to pay attention to the things they should be concerned with, which is how is the benefit program working, not 'is our system paying claims,'" said Ellen J. Lockwald, manager of market development at Resource Information Management Systems in Naperville, Ill.

To make health care claims handling easier for self-insured employers, vendors report that they are moving closer to the goal of paperless processing.

An on-line diary and logging system from SW Systems, for instance, eliminates paper on the

claims desk. Everything from nurses' notes to notes from a phone call received by a claim handler is stored and can be retrieved immediately, Mr. Whitmore said.

Eventually, vendors hope to establish electronic links between providers and employers to speed billing and payment.

Resource Information Management Systems currently offers a module that uses tapes to transfer billing information from the provider to the processor. Eventually this will be done on-line, Ms. Lockwald said.

The difficulty is in achieving a common interface that employers, doctors, hospitals, health maintenance organizations, preferred provider organization and third-party administrators would all use,

explained John Bonk, director of research and development at California Interactive Computing Inc. in Northridge, Calif.

Although some vendors are providing very limited electronic links, there is still no common data format, Mr. Bonk said.

In addition to ease of use, vendors report that employers are looking for much more extensive medical editing. That feature lets the system identify charges that are not usual and customary or procedures that are out of line with normal medical practice.

"You're relying on the system vs. the adjuster to control medical costs," said Tom Mosca, senior sales executive at Marietta, Ga.-based Magnus Software Corp., formerly Computations Inc.

One offering from SW Systems—an enhanced dental plan module—features more extensive dental editing, Mr. Whitmore said.

Flagrant abuses, like a claim for a new filling in an already extracted tooth, would have been caught by the old module. But the new product can pick out much more subtle problems.

For instance, it may call attention to the fact that a bridge couldn't have been designed the way it is presented in a claim unless a certain tooth had also been extracted, or that it is not physically possible for a dentist to perform a particular procedure three times within 72 hours.

A new feature on an Erisco medical claims system identifies inappropriate or fraudulent claims by providers. The system also includes new modules that check laboratory, radiology and prescription drug codes, said James Donnelly, a senior director at the New York firm.

This is an expansion of the original objective in developing the original product, which was to flag services that are being billed separately when they should actually be included as a part of a bundled service, said Craig P. Luftig, product specialist at Erisco.

And, the system is now able to deal with some quality of care issues. For instance, it will flag claims for outdated diagnostic and medical procedures, Mr. Luftig said.

Some systems are now capable of carrying more than one set of usual, reasonable and customary charge data.

The data provide a basis for paying claims based on procedure and ZIP code, explained Allan Machesney, president of Insurance Software Packages. "Systems can now use a variety of tables."

Besides helping to spot problem claims, some systems contain new features that are activated after a problem is found.

On PMSC's system, for instance, options include a warning message that does not prevent payment, a message that prohibits payment but allows an adjuster to override it, and a command to automatically deny the claim, said Mr. Szukala.

A system from SW Systems gives the administrator a number of options, said Mr. Whitmore. The system can be programmed to automatically prepare a statement explaining to the provider and employee why benefits are being denied, or to stop all action on a claim until the administrator decides what to do next.

Beyond processing and payment, employers want to use claims data generated by their EBIS systems to gain information on the utilization of different benefits and to determine how effective their plans are. In response, most systems have

Continued on page 22

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Spotlight report

EBIS functions

Continued from page 20

been updated to include enhanced reporting features.

Employers "are not buying systems to save the 5% (claims) servicing fee but are saying, 'Let's get at the other 95% of our costs,'" said Thomas C. Colgan, executive vp and principal at Resource Information Management Systems.

Enhanced standard and ad hoc cost containment reporting capabilities "help self-administered firms identify what areas are giving the most return," said Jerry C. Buckley, president of California Interactive Computing in Northridge.

FACTS Services plans to offer a new report generator in the next three to four months that enhances the user's ability to extract virtually any type of claims data without extensive programming knowledge, said Robert S. Graham Jr., president of the Coral Gables, Fla.-based vendor.

Resource Information Management Systems offers a link with Health Economics & Market Analysis, a Springfield, Ill.-based research firm, through which the employer can strip data from its personal computer-based system in a format HEMA's programs will accept. HEMA can then provide the detailed reporting and analysis that a mainframe system can offer as well as compare the employer's specific data against national norms, said Ms. Lockwald.

However, employers that want to use their claims data base to provide detailed ad hoc reports must make sure they have adequate claims history stored in their system, said John Gilbert, outsourcing manager at PMSC.

Employers and vendors face a Catch-22 in that while more data is necessary to do in-depth analysis of claims records, it takes more time for claims personnel to input that data, said Michael Green, vp of the consulting division at Tesseract Corp. in San Francisco.

Vendors point out that integrating a health care claims system with systems handling payroll, workers compensation and other benefits and human resources data can help benefit managers structure more meaningful reports.

And, if the health claims system is integrated with the employer's workers comp claims systems, it is easier to control "double-dipping" employees who submit claims to both the group health plan and the workers comp plan, explained CIC's Mr. Buckley.

Some EBIS vendors report that their market is expanding as more employers are finding it feasible to administer their health care benefit claims themselves.

"Certainly since the first of the year we're seeing more interest from our marketplace in becoming self-insured," said Mr. Green.

"One of the trends we see is that smaller and smaller employers are candidates to use this type of software," said ISP's Mr. Machesney.

Health claims systems popular with benefit managers

System Vendor	Number sold directly to employers	Year first installed at employer	Types of claims administered
Benefit Plan Administration System Tesseract Corp.	122	1982	Health, dental, vision, drug
ClaimFacts Erisco Inc.	61	1980	Health, dental, vision, drug LTD, STD
QicClaim Health Claims Processing System Resource Information Management Systems Corp.	46	1981	Health, dental, vision, drug LTD, STD
Claims Work SW Systems Inc.	40	1979	Health, dental, vision, drug
CAS II Claims Administration System Policy Management Systems Corp.	27	1982	Health, dental, vision, drug LTD, STD
FACTS FACTS Services Inc.	26	1982	Health, dental, vision, drug LTD, STD
FASTRAK Magnus Software Corp.	22	1981	Health, dental, vision, drug LTD, STD, life
GenMed California Interactive Computing Inc.	16	1979	Health, dental, vision, drug
HealthStar Insurance Software Packages	15	1986	Health, dental, vision, drug LTD, STD
Medical Claims Adjudication Professional Computer Services	15	1975	Health, dental, vision, drug LTD, STD
Claims Processing System Tesseract Corp.	15	1983	Health, dental, vision, drug

*Number given is from 1990 BI survey. Source: BI survey of vendors.

GRAPHIC BY CYNTHIA WATSON

"Smaller employers may not save money on administrative fees by self administering, but they do it anyway to get control of their actual medical costs," said Magnus' Mr. Mosca.

As new—and sometimes smaller—companies begin administering their health care claims, many are seeking more support from vendors than have past clients, vendors report. Some employers are asking

the vendor to serve as a claims administration backup.

For example, Insurance Software Packages has medical specialists on staff who can provide some administration services for smaller firms that have just begun to administer their own claims and who are not comfortable handling more complex claims.

Some vendors, however, say that some smaller firms are finding the

complexities of self-administration more than they bargained for and are instead contracting for third-party administration services.

The expense and the quickly changing nature of health care claims administration is forcing some smaller companies to reconsider self-administering, according to Ed Brown, PMSC's marketing manager of group health care products.



Long-term care

Continued from page 3
transferring and mobility.

Most LTC insurance plans also cover cognitive impairment stemming from causes like Alzheimer's disease or senile dementia.

- Premiums are directly based on the age of the participant at the time of enrollment in the plan and the coverage options he or she chooses.

- Benefits are portable. For example, after an employee leaves a company, he or she can continue coverage by paying the premium, though an administrative fee is usually added.

- Coverage is guaranteed to be renewable, as long as the premium is paid.

- Premiums and benefits remain level throughout the coverage term, unless participants choose inflation coverage or upgrade their coverage.

Since the first employer-sponsored LTC plan was offered to workers by the state of Alaska in 1987, the programs have become much more flexible and contain many more options.

Alaska's program, offered only to retirees and spouses, has only one benefit option (*BI*, March 16, 1987).

Retirees can purchase LTC insurance that will pay up to \$125 per day for nursing home care within the state or up to \$75 per day for nursing home care outside Alaska, said Lisa Tourtellot, a benefit specialist with the state in Juneau. There is a lifetime maximum benefit cap for nursing home care of \$200,000.

The daily maximum for home convalescent care is \$75 per day within

the state and \$40 per day outside Alaska. The lifetime maximum benefit cap for home care is \$50,000.

There is a waiting period of 90 days for both coverages.

Aetna underwrites Alaska's plan.

Monthly premiums range from \$16.10 for those under age 50 to \$412.90 for those older than 85, Ms. Tourtellot said. The cost for those age 55—the average retirement age for state employees—is \$26.80 per month. A third of retirees and 14% of their spouses are enrolled.

However, a single-option plan like Alaska's probably would not be established today.

A new LTC program introduced by New York-based Teachers Insurance and Annuity Assn. College Retirement Equities Fund, which finances pensions and other types of benefits for educational employees nationwide, offers a range of benefit levels from a daily minimum of \$40 to a daily maximum of \$200.

TIAA-CREF encourages educational institutions to offer employees three daily benefit options, with the middle option set at the average cost for nursing home care in their area, noted Vp Bruce Boyd.

Participants also can choose plans under which the insured individual must pay a 20% copayment, no matter how high the maximum daily benefit is set, Mr. Boyd explained.

A choice of three lifetime benefit maximums and three waiting periods is also available.

Active and retired employees, their spouses and parents between the ages of 40 and 84 are eligible to partici-

pate in the TIAA-CREF coverage.

The University of Michigan, which began offering the coverage Jan. 1, is the first institution to participate in the program.

Other new employer-sponsored LTC programs also offer participants numerous options.

A new group LTC program introduced by Fort Wayne, Ind.,-based Lincoln National Life Insurance Co. offers a choice of daily maximum benefit levels ranging from \$40 to \$200 in \$10 increments.

Also, instead of mandating that home health care be reimbursed at half the level of institutional care, as is the case under many plans, the Lincoln National program allows beneficiaries to set reimbursement levels for home health care at 50%, 75%, 100% and 125% of the benefit level of institutional care, noted Bill Lubin, second vp and director of Lincoln National Life's LTC and employee benefits division.

Many of the newer group LTC insurance plans offer other features that make the plans more flexible.

"Benefits have changed significantly" since the first group products were introduced, noted Ms. Germain Skagias of Travelers.

For example, the first plans underwritten by Travelers would reimburse beneficiaries for up to the maximum daily benefit level for whatever care was provided: nursing home care, home health care or adult day care. If the true cost of care was lower than the maximum daily benefit, the difference would not be ac-

Continued on next page

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Long-term care

Continued from previous page
counted for and the lifetime benefit maximum would be depleted as if the cost had been equal to the maximum daily benefit.

In Travelers' newer group LTC plans, however, the difference between the actual amount spent on care and the maximum daily benefit would be "stored" in a beneficiary's "account," and that money could be used to extend the beneficiary's benefits, Ms. Germain Skagias explained.

Another feature of some newer group LTC plans is that active employees do not have to provide evidence of insurability or pass a medical examination when enrolling during a plan's initial offering. Most programs still require evidence of insurability for retirees.

And many new LTC programs offer an inflation protection feature that allows participants to increase

their daily maximum benefit levels by a set amount, often 3% or 5%, in return for a premium increase.

An inflation feature has been very popular with employees of the state of Maryland, noted Susan Parks, LTC administrator for the state's Department of Personnel in Baltimore.

Maryland, which first offered workers a LTC plan in January 1988, began offering a "second generation" plan in January 1990 that incorporated many features the first plan lacked, Ms. Parks explained. Noteworthy among the new features was an inflation option that would annually boost maximum benefits up to 5%.

Some 61% of new enrollees chose the inflation option despite the extra cost, she stated. A typical 40-year-old employee opting for a \$100 maximum daily benefit would pay \$25.60 per month for coverage with the inflation option, compared with \$14.10 per month for coverage without the inflation option.

In addition to coverage for nursing home, home health and adult day care, some of the new LTC programs also will reimburse participants for respite care. Respite care allows a family member who normally cares for an disabled relative to hire someone to temporarily replace him or her when he or she cannot fulfill this function.

Other special new plan features have been designed, at least in part, to appeal to younger employees, experts noted.

For example, many of the newer programs offer participants a non-forfeiture option, which provides reduced coverage if the policyholder stops paying the premium. Under older policies, benefits were automatically canceled for non-payment, even if an employee had already paid thousands of dollars into the plan.

Another special feature, called a death benefit or return of premium, pays a portion of the premiums paid by a plan participant to his or her estate if the participant dies before tapping any benefits.

A feature called a paid-up option allows employees to limit their payments to a specific number of years, after which they no longer have to pay premiums to receive a pre-determined benefit.

These kinds of features "all are an attempt to attract younger people" to group long-term plans, noted Wyatt's Ms. Glynn. And, for the most part, they "have indeed been beneficial in increasing levels of participation" in the programs, she added.

In Maryland, for example, participation rates increased when the state offered its "second generation" LTC plan that incorporates many of these features, Ms. Parks noted.

Features that the new plan offers that were not offered originally include an option under which coverage is paid up for life after premiums are paid for 20 years; an opportunity for active employees to enroll in the plan without showing evidence of insurability; and higher daily maximum benefit levels, she explained.

While only about 300 people enrolled in the "first generation" plan in January 1988, close to 900 people enrolled in the "second generation" plan when it was offered two years later, she said.

Many of the newer plans also are bringing managed care techniques to the LTC arena.

For example, a participant in a plan underwritten by Travelers requiring care would be visited by a patient care coordinator employed by Conserco Inc., Travelers' utilization review arm, to assess his or her physical and cognitive capabilities, explained Ms. Germain Skagias. The coordinator, the patient and perhaps members of his or her family then could develop a care plan.

Lincoln National offers a network of preferred long-term care providers, like skilled nursing facilities and home health care agencies, that offer discounts to plan participants.

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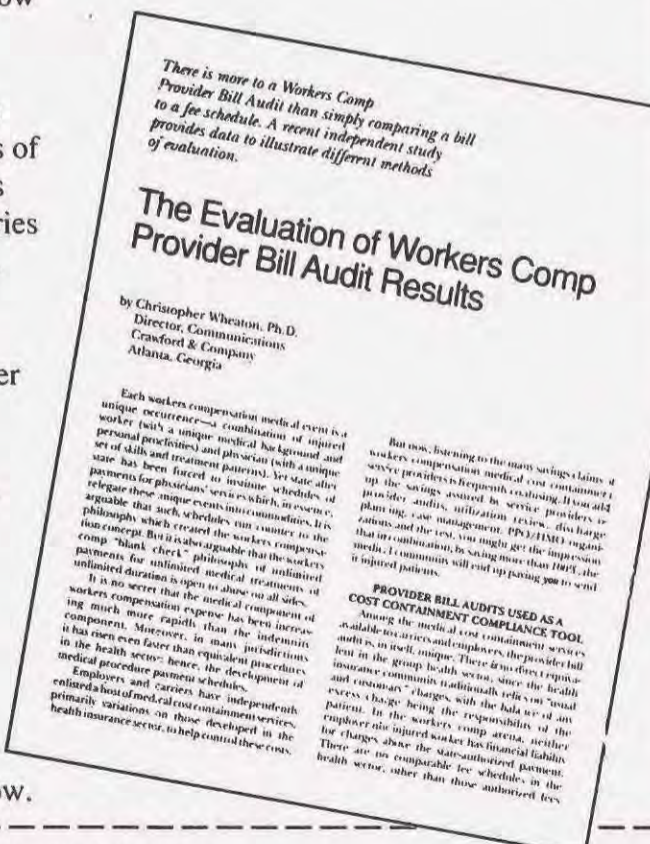
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Some employers starting to pay LTC costs

By DEBORAH SHALOWITZ

Almost all employer-sponsored group long-term care insurance plans require workers to pay the entire premium for the coverage, though several companies subsidize at least a portion of the cost.

And, it is unlikely that employer-paid LTC programs will become widespread.

One reason is that employers, already faced with soaring health care costs, say they cannot afford a new benefit burden.

Also, employers are reluctant to contribute to the plans until their tax status is determined (see story, page 29).

However, employers that do subsidize LTC plan costs are happy with their programs.

For example, Ford Motor Co. is extending a two-year pilot program to fully fund LTC benefits for 6,600 Kentucky employees, retirees and dependents (BI, March 27, 1989).

That program, which was to have ended March 31, has been extended through September 1993, said Jack Dunn, insurance programs supervisor for Ford in Dearborn, Mich. The extension was arranged during negotiations with the United Auto Workers union last year.

However, it is unlikely that Ford will introduce a fully funded LTC program to cover all employees, dependents and retirees at all locations, Mr. Dunn said.

"We do believe that LTC coverage for an older population... would be an extremely costly program," Mr. Dunn said. So, "we don't believe it would be advisable" to assume across-the-board LTC costs in addition to Ford's current annual health care costs of \$1.2 billion, he said.

The self-funded Ford LTC plan covers active employees, their spouses and dependents and any employees who retire after the program began at two plants in Kentucky.

Thus, not many elderly people are covered by the plan, Mr. Dunn pointed out. So far, only 18 people have received formal benefits through the program, at a total cost of less than \$50,000.

The plan provides coverage for up to one year of unlimited custodial care in an institution and a maximum home health care benefit of \$8,200 per person for the first year of care and \$8,400 for the second year.

Ford's group health care plan already covered the cost of skilled nursing care in an institution, skilled nursing home care and hospice care for the terminally ill.

Benefits under the Ford LTC plan are treated as taxable income to plan participants when they draw on the coverage. Ford deducts program costs as a business expense.

General Motors Corp. plans to introduce a pilot LTC program sometime in the near future, said a company spokesman, who declined to provide details.

Another employer, International Business Machines Corp., last fall offered spouses, parents, parents-in-law, retirees and their spouses an LTC program that is partially funded by the employer.

IBM establishes a \$500 account annually for each employee to fund non-covered health care expenditures, such as eye exams, eyeglasses and hearing aids. And employees are allowed to use funds in these accounts to pay for up to 20% of the LTC insurance premium.

IBM decided on a 20% reimbursement cap after determining that was the portion of the LTC premium thought to represent medical expenses, said a spokesman at IBM's Purchase, N.Y., headquarters.

The LTC plan, which is underwritten by John Hancock Mutual Life Insurance Co., offers three daily maximum benefit options for institutional care: \$50, \$100 and \$150. The

daily maximum benefit for home health care is half that of institutional care.

The maximum lifetime benefit is \$95,000 for those selecting the \$50 daily maximum benefit; \$185,000 for those selecting the \$100 daily maximum benefit; and \$275,000 for those selecting the \$150 daily maximum benefit. There is a waiting period of 120 days before benefits begin.

During open enrollment last fall, there were no insurability requirements for active employees and their spouses. Now, however, all applicants must supply evidence of insurability.

Approximately 32,000 people enrolled in the program, the large ma-

jority being active employees or their spouses, the spokesman said. The average age of enrollees is 33 to 40.

IBM in 1990 had 205,000 active employees and 45,000 retirees.

Premiums vary with the participant's age and the options selected. For example, monthly premiums for a 40-year-old would be \$10.60 for the \$50 daily maximum, \$18.26 for the \$100 daily maximum and \$25.43 for the \$150 daily maximum, while monthly premiums for a 50-year-old would be: \$16.54 for the \$50 daily maximum, \$30.09 for the \$100 daily maximum, and \$42.47 for the \$150 daily maximum.

Another employer, Los Angeles-based Security Pacific Corp. is subsidi-

dizing the cost of LTC insurance for employees who retired before Jan. 1, 1991, and elected to leave the company's traditional retiree medical plan for a new, flexible benefits plan that began in 1990 (BI, Feb. 19, 1990).

The company does not subsidize LTC coverage for employees retiring after that date or for active employees or their spouses or parents, although these workers can enroll in the LTC plan, noted Bud Martinez, vp of employee benefits.

Retirees who elect the subsidized LTC coverage, which is underwritten by John Hancock, pay at least \$15 per month for coverage with a maximum daily benefit of \$40 per day for

institutional care, he explained.

Security Pacific pays the difference between the \$15 and the actual cost of the \$40 daily benefit, which varies depending on age.

For higher daily benefit options—\$60, \$80 and \$100—Security Pacific pays the same amount it pays toward the \$40 coverage, with the retiree picking up the remainder.

Of the 6,200 retirees eligible for the LTC plan, 1,184 actually enrolled. The vast majority of those were retirees age 55 to 75. Of the 2,200 spouses of retirees eligible for the LTC plan, 532 enrolled.

Approximately 9% of Security Pacific's active employees also enrolled in the LTC program. ■



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Congress unlikely to clarify tax status of LTC plans this year

Congress is considering how to treat employer-provided long-term care insurance for tax purposes, though action is unlikely soon.

It is not clear whether long-term care coverage is a tax-favored benefit, like health care, for which employees are not taxed.

The point is now mostly moot because only a few employers now pay a portion of group LTC coverage costs (see story, page 26). Others, however, may be more willing to contribute once the tax issues are settled.

Two trade groups—the American Council of Life Insurance and the Health Insurance Assn. of America, both of Washington, D.C.—have asked the Internal Revenue Service to rule that the coverage is tax-favored.

The groups also want the IRS to rule that advance payments of life insurance to ter-

minally ill patients to pay for long-term care would not be treated as income to the beneficiary. And the groups are lobbying Congress to make the coverage tax-favored.

Already more than half a dozen bills have been introduced, said Jim Dorsch, Washington counsel for the HIAA, including:

- S. 314, sponsored by Sen. William S. Cohen, R-Maine, which would allow employers to take tax deductions for LTC premiums; allow employees to receive employer-provided LTC benefits tax-free and to pay premiums with pretax dollars; and allow the insurance to be included in cafeteria plans.

- H.R. 134, sponsored by Rep. Barbara B. Kennelly, D-Conn., and S. 284, sponsored by Sen. Bill Bradley, D-N.J., which would allow life insurers to pay some policy proceeds to a

terminally ill person. For tax purposes, the payments would not be treated as income to the individual, but as part of his estate.

- H.R. 703, sponsored by Rep. D. French Slaughter Jr., R-Va., which would exclude from gross income money received from the surrender or cancellation of a life insurance policy if that money is used to pay LTC insurance premiums.

- H.R. 704, sponsored by Rep. Slaughter, and a companion bill, S. 85, sponsored by Sen. David Durenberger, R-Minn., which would exclude from income money withdrawn from individual retirement plans to pay LTC insurance premiums.

- H.R. 1205, sponsored by Rep. J. Roy Rowland, D-Georgia, which would allow tax-free distributions from individual retirement

accounts for the purchase of LTC insurance by individuals age 59½ and older.

Other proposals are being worked on now, noted Mr. Dorsch. Yet chances seem remote that a bill will pass this year.

"This is probably not the year this is going to happen," said Bryan Lane, a principal with TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc., in Stamford, Conn. "The realities are it's very difficult to (enact new tax advantages) when you've got the budget deficits we've got today," he explained.

"The question is whether there'll be a tax bill at all" to attach LTC tax clarification legislation to, Mr. Dorsch said. "I wouldn't bet a whole lot of money... that there will be a tax bill to attach something to."

—By Deborah Shalowitz

Stability key in selecting LTC insurer

By DEBORAH SHALOWITZ

Employers considering a group long-term care insurance program should become familiar with LTC issues, choose a stable insurer and design a comprehensive communication program.

Employers should research long-term care issues so they have a solid foundation of knowledge when considering a plan, recommended Kathleen Glynn, a consultant with The Wyatt Co. in Washington, D.C.

Local employer health care groups are one source of information on long-term and elder care issues. Information also can be gathered from organizations like the Health Insurance Assn. of America, the American Council on Life Insurance and the National Council on the Aging, all of which are based in Washington, D.C.

Employers should understand the long-term nature of this kind of insurance product, said Bryan Lane, a principal with TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. in Stamford, Conn.

In light of the savings and loan crisis and questions about some life insurers' stability, employers must choose an insurer that will be around in 20 or 30 years, when active employees will file many of their claims, he said. "Know who you're asking your employees to buy from."

"Decide whether you can live with (a given insurer) for a long, long time," agreed Dennis DeWitt, a managing consultant with A. Foster Higgins & Co. Inc. in Los Angeles. "Make sure you're with a strong company that's going to be around for a long, long time."

The popularity of group LTC coverage is often directly related to a company's communication efforts. Because the benefit is relatively new, employees are often unsure just what it covers.

Furthermore, unlike employer-sponsored health insurance, LTC premiums vary considerably depending on the participant's age and the options chosen, so rate tables can be very confusing, consultants say.

"I can't emphasize enough the need for a strong communication plan," said Mr. Lane.

That program should help employees decide how much coverage for long-term care they might need, he said. For example, employees need to consider for whom they need to buy LTC insurance, and they need to project their income and assets at a time when they are more likely to need long-term care.

Some companies phase in an LTC benefit by first offering long-term care referral services, said Ann Lemmon, a consultant with Hewitt Associates in Lincolnshire, Ill.

"You can track the questions that you get and the needs of your employees this way," she noted. ■



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Because if you're like other businesses, the cost of medical care has hurt you enough.

CONSERVCO

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Integrated Medical/Disability Management

Directory of benefit systems vendors

A

Administrative Management Group Inc.

3800 N. Wilke Road, Suite 250,
Arlington Heights, Ill. 60004;
708-577-6000; fax: 708-577-6038

Year founded: 1982.

Software products:

- 401(k) Projection Estimators: Unbundled hardware and software; personal computer; first installation, 1991. Calculates future defined contribution plan balances; can be used to communicate benefit programs to employees.

- Pension Calculators: Unbundled hardware and software; personal computer; first installation, 1987. Calculates defined benefit plan amounts; can be used to communicate benefit programs to employees.

User support: Telephone assistance

available eight hours per day.

Staff: 76 total, 61 professionals.

Principal officers: David Goldenberg, vp.

The Alexander Consulting Group

125 Chubb Ave., Lyndhurst, N.J.
07071; 201-460-6600;
fax: 201-460-6677

Year founded: 1934.

Parent company: Alexander & Alexander Service Inc.

Software products:

- Cobra Compliance Software: \$1,595; unbundled hardware and software; personal computer; first installation, 1986; 168 total installations, 151 in employee benefit departments. Creates database for administering COBRA program, establishes plan parameters, generates payment notices, establishes case histories; can be used to communicate benefit programs to employees; is

designed to administer claims under COBRA.

- Flexible Spending Account Software: Unbundled hardware and software; personal computer; first installation, 1987. Creates database needed to administer an FSA program, establishes plan parameters, generates payments and explanations of benefits, tracks contributions and claims; can be used to communicate benefit programs to employees.

- First Resource: \$15,000; unbundled hardware and software; personal computer; first installation, 1985; 500 total installations, all in employee benefit departments. Functions include general personnel, salary administration, education and skills, EEOC & benefits administration, applicant management, salary planning, survey analysis, stock plan and payroll interfaces; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

- Flex Administration: Unbundled hardware and software; personal computer; first installation, 1989. Functions as a full flex administration system, helps establish plan parameters, enrollment processing with confirmation, builds historical database; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available 12 hours per day, on-site visits.

Staff: 68 total, 43 professionals.

Clients: 1,300 employee benefit information system clients, including 50% with gross revenues less than \$200 million, 30% with \$200 million-\$499 million, 15% with \$500 million-\$999 million, 5% with \$1 billion-\$3.5 billion.

Branch offices: Baltimore; San Jose, Calif.

1990 gross revenues: 15% from software sales, 85% from software services.

Principal officers: A.M. D'Alessandro, chairman; Donald Cleveland, presi-

dent/chief operating officer.

APEX Data Systems Inc.

6464 E. Grant Road, Tucson, Ariz.
85715; 602-298-1991;
fax: 602-296-7948

Year founded: 1977.

Software products:

- Cognac*Plus: \$10,000-\$25,000; unbundled hardware and software; personal computer or local area network; first installation, 1988; 30 total installations, 12 in employee benefit departments. Provides on-line, interactive employee benefits administration and claims processing, detailed management, utilization and ad-hoc reporting; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

User support: User groups/meetings, telephone assistance available nine hours per day, on-site support and training, enhancement releases, personalized modifications, modem hook-up, on-line tutorial, user manuals.

Staff: 14 total, eight professionals.

Clients: 12 employee benefit information system clients. Sold systems to two clients in 1990.

Principal officers: Dwight W. Babcock, president.

Armada Software & Services Co.

13737 Artesia Blvd., Suite 206,
Cerritos, Calif. 90701; 213-404-0549;
fax: 213-926-7241

Year founded: 1983.

Software products:

- Speed Claim Claims Manager Module: \$35,000; unbundled hardware and software; personal computer; first installation, 1983; 51 total installations, five in employee benefit departments. Tracks workers compensation losses and payments.

- Speed Claim Medical Bill Review: \$15,000 and up; unbundled and bundled hardware and software; personal computer and mini computer; first installation, 1984; 51 total installations, 11 in employee benefit departments. Reviews medical bills for cost containment.

- Speed Claim Prescription & Forms Kit: \$15,000 and up; unbundled hardware and software; personal computer and mini computer; first installation, 1989; three total installations, all in employee benefit departments. Reviews prescription drug claims and generates reports.

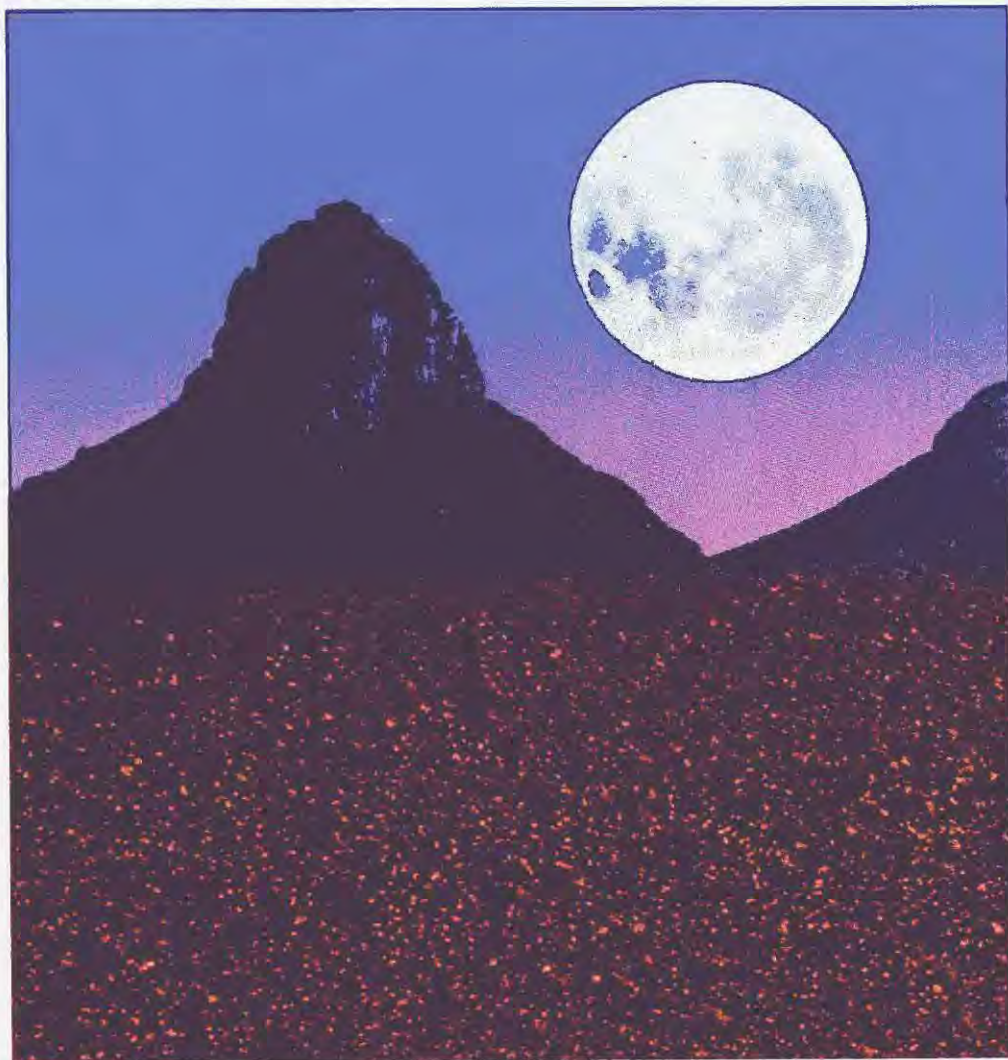
User support: Telephone assistance available nine hours per day, remote access, phone link modem support.

Staff: 13 total, six professionals.

Clients: 43 employee benefit information system clients, including 5% with gross revenues less than \$200 million, 50% with \$200 million-\$499 million, 40% with \$500 million-\$999 million, 5% with \$1 billion-\$3.5 billion. Sold systems to six clients in 1990.

1990 gross revenues: \$500 million total; all from employee benefit information systems, including 15% from hardware sales, 60% from software sales, 25% from software services.

Principal officers: C. Arndt, H.S. Arndt, B. Stein, C. Stein.



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At Delta Dental we keep our promises. Unlike many of our competitors, we focus on true cost management, rather than simply shifting the cost to your employees. Though we never promised the moon, last year alone we delivered savings of over \$100 million to our groups and subscribers. □ How? Through safeguards which include fee reviews, dental office audits, dentist-consultant reviews, and post-treatment reviews, the Delta Dental Cost Management Program offers controls in a way other insurers can't begin to match. □ But Delta's cost management is only one facet of a unique three-point system that also includes plan design flexibility and 106,000 dentists in the nation's largest participating network. □ It's a program only Delta Dental offers. That's why we now cover more than 20 million people in 23,000 groups and pay more than \$2 billion a year for dental care. To learn more about how your group can benefit from Delta Dental, call 1-800-441-3434 today.

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B

Benefit Concepts Systems Inc.

396 Wampanoag Trail, East
Providence, R.I. 02915;
401-438-7100; fax: 401-438-5420

Year founded: 1986.

Software products:

- Benefit Continuation Management System: \$1,595; unbundled hardware and software; personal computer; first installation, 1986; 300 total installations, 250 in employee benefit departments. Functions as a COBRA compliance system; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

- Reimbursement Account Management System: \$2,995; unbundled hardware and software; personal computer; first installation, 1987; 60 total installations, all in employee benefit departments. Functions as a flexible spending account administration system; can be used to communicate benefit programs to employees.

- Flexible Benefit Management Sys-

Continued on next page

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 tem: \$7,495; unbundled hardware and software; personal computer; first installation, 1988; 15 total installations, all in employee benefit departments. Functions as a full cafeteria plan administration system; can be used to communicate benefit programs to employees.

User support: Telephone assistance available 10 hours per day, on-line support, training seminars.

Staff: 16 total, five professionals.

Principal officers: Frank J. Hoder III, president; John W. Hoder, vp.

Benefit Plan Systems Corp.

16 Technology Drive, Suite 161, Irvine, Calif. 92718; 800-523-8047; fax: 714-753-0845

Year founded: 1975.

Software products:

• COBRA EAS: \$1,995; unbundled hardware and software; personal computer; first installation, 1987; more than 1,000 total installations, all in employee benefit departments. Administers claims under COBRA.

• Retiree/Non-COBRA Billing: \$1,295; unbundled hardware and software; personal computer; first installation, 1987; more than 500 total installations, all in employee benefit departments. Functions include complete billing and accounting for retiree/

non-COBRA coverage.

• Benefit Information Management: \$2,495; unbundled hardware and software; personal computer; first installation, 1987; more than 100 total installations, all in employee benefit departments. Functions as a benefit information management system.

User support: Telephone assistance available eight hours per day.

Staff: 17 total, nine professionals.

Principal officers: Leonard B. Wierzba, president; C.R. Jarl, vp.

Benefit Resource Management Inc.

530 Howell Road, Suite 107, Greenville, S.C. 29615; 803-268-4955; fax: 803-268-5018

Year founded: 1990.

Software products:

• DOCS: Unbundled hardware and software; personal computer; first installation, 1991. Functions include duration guides and automated calculations for short-term disability claim management.

• DOCS-Plus: Unbundled hardware and software; personal computer; first installation, 1991. Functions include claim profiling, reserving and report query for long-term disability claim management.

User support: User groups/meetings, telephone assistance, modems, file communication.

Staff: Three total, all professionals.

Principal officers: Theodore W. Mahler, president; Charles Basuino, treasurer.

Benefit Software Inc.

212 Cottage Grove Lane, Santa Barbara, Calif. 93101; 805-966-7323; fax: 805-962-3106

Year founded: 1979.

Software products:

• Fringe Facts: \$1,295; unbundled hardware and software; personal computer; first installation, 1984; 2,300 total installations, 263 in employee benefit departments. Functions include communication of benefits in single or multiple page formats; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available eight hours per day.

Staff: Seven total, five professionals.

Clients: 2,322 employee benefit information system clients. Sold systems

to 972 clients in 1990. 93 corporate employee benefit clients, including 62% with gross revenues less than \$200 million, 36% with \$200 million-\$499 million, 2% with \$500 million-\$999 million. Sold systems to 972 clients in 1990.

1990 gross revenues: Includes 53% from software sales, 11% from software services, 36% from supplies.

Principal officers: Larry DuBois, chief executive officer; Jack Kelly, president.

Benefit Systems & Services

760 Pasquinielli Drive, Suite 320, Westmont, Ill. 60559; 708-990-2082; fax: 708-789-2093

Year founded: 1986.

Software products:

Continued on next page

How to use directory

The directory of employee benefit information systems lists companies that produce and supply proprietary software products to employee benefit personnel in response to their information system needs.

Companies that produce and supply software products used to communicate benefit programs to employees are also included.

Each listing begins with the company's **year founded** and **parent company**, if any.

Information on **software products** follows. Included are the average completely installed price, whether the software and hardware are bundled or unbundled, the type of hardware needed (mainframe, minicomputer, microcomputer, mid-range or personal computer), the year of its first installation, the number of installations to date and the number of installations to date in corporate employee benefit departments. The product's functions, including whether it can be used to communicate benefit programs to employees and whether it is capable of administering claims under the Consolidated Omnibus Budget Reconciliation Act of 1985, are listed here also.

Information on continued **user support** available and **staff** follows. Under **client**, total number of employee benefit information system clients in 1990 (both sales and service), total systems sold in 1990 and total corporate employee benefit clients in 1990 are listed. Locations of **branch offices** and **1990 gross revenues** are next. Names and titles of **principal officers** complete the listings.

The directory is published as an editorial service; there is no charge for companies to be included. However, to be listed companies were required to complete a questionnaire provided by *Business Insurance*.

Although every effort is made to publish complete and accurate information, *Business Insurance* is unable to verify all data supplied by vendors.

If you would like to be listed in the 1992 directory of employee benefit information systems, please write Karen Armanian, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590.

We turned 10 this month...

...for exactly one second.

We were almost ten.
 Then we were older than ten.
 With exactly one second in between.

But that's how it is with time. Relentless. Runs right out from under you while you think about it.

And for the last ten years, every time we thought about the delivery of health care in this country, it changed.

So instead of just thinking about it, we changed with it. Introduced hospital pre-certification when there was none, and made our numbers match HMOs. Developed all the programs that have become the standard in medical utilization review, then moved into specialties like high risk maternity, psych and substance abuse, disability, and workers' comp. And now we're establishing the first Primary Care Networks.

Imagination. Innovation. Extension. Ten years of moving with the constant stream of change to provide the latest and best in managed care.

Cost Care. You. Health Care. Change. Think about it.

But only for a second.

TENTH ANNIVERSARY

COST CARE™

Spotlight report

Continued from previous page

• **DATA-Plus:** \$135,000; unbundled hardware and software; mid-range computer; first installation, 1986; seven total installations, one in employee benefit departments. Functions include claims and premium administration; is designed to administer claims under COBRA.

User support: Telephone assistance available 12 hours per day, on-site training, custom modifications.

Staff: 38 total, 13 professionals.

Clients: Seven employee benefit information system clients, including 71% with gross revenues less than \$200 million, 29% with \$200 million-\$499 million. Sold systems to three clients in 1990.

1990 gross revenues: \$3 million total; \$1.8 million from employee benefit information systems, including 30% from hardware sales, 30% from software sales, 40% from software services.

Principal officers: David H. Lloyd, president; Carmen J. Morreale, executive vp; Roy Wapiennik, vp-operations.

BeneSoft Inc.

P.O. Box 3530, Bethany, Conn. 06525; 203-393-0320

Year founded: 1982.

Software products:

• **BeneSoft's Flexible Software:** \$10,000 per year and up; bundled hardware and software; personal computer; first installation, 1987; 60 total installations, 50 in employee benefit departments. Functions include enrollment, eligibility reporting, premium calculations, payroll interface for flex plan administration; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

User support: User groups/meetings, telephone assistance available 24 hours per day, on-site and classroom training, implementation support and consulting.

Staff: 10 total, eight professionals.

Clients: 50 employee benefit information system clients, including 30% with gross revenues less than \$200 million, 50% with \$200 million-\$499 million, 20% with \$500 million-\$999 million. Sold systems to 15 clients in 1990.

1990 gross revenues: 100% from software sales.

Principal officers: F.A. Saleh, president; Steve Y. Froebel, vp-systems development.

BeneSys

5716 Corsa Ave., Suite 100, Westlake Village, Calif. 91362-4001; 818-879-0044; fax: 818-879-0062

Year founded: 1985.

Software products:

• **HEALTH+** Claims Administration System: \$100,000; unbundled hardware and software; mini-mainframe; first installation, 1988; six total installations, all in employee benefit departments. Functions include eligibility, medical, dental, vision, claims adjudication, billing; is designed to administer claims under COBRA.

• **PENSION+** Pension Administration System: \$125,000; unbundled hardware and software; mini-mainframe; first installation, 1985; nine total installations, all in employee benefit departments. Functions include pension administration, billing, eligibility, retirement payroll, W-2s; is designed to administer claims under COBRA.

User support: Telephone assistance available 12 hours per day, post-installation support, optional maintenance agreement after warranty expiration.

Staff: 12 total, five professionals.

Clients: 15 employee benefit information system clients. Sold systems to four clients in 1990. Corporate employee benefit clients include 75% with gross revenues less than \$200 million, 15% with \$200 million-\$499 million, 10% with \$500 million-\$999 million.

1990 gross revenues: \$1.5 million total; all from employee benefit information systems, including 2% from hardware sales, 90% from software sales, 8% from software services.

Principal officers: Thomas Wedel, chief executive officer; Doug Reid, vp; Bobbie Glassman, vp-research/development.

Contact: William Ayres, vp-sales/marketing; Kathleen Gaviglia, sales coordinator.

Buck Consultants Inc.

2 Pennsylvania Plaza, New York, N.Y. 10121; 212-330-1000; fax: 212-695-4184

Year founded: 1916.

Software products:

• **Buck Social Security:** \$500; unbundled hardware and software; personal computer; first installation, 1988; 19 total installations, 18 in employee benefit

departments. Calculates old age, death and disability, Social Security benefits; can be used to communicate benefit programs to employees.

• **Buck Bencal/PC:** Unbundled hardware and software; personal computer; first installation, 1988; 21 total installations, 16 in employee benefit departments. Calculates retirement benefits for defined benefit plans; can be used to communicate benefit programs to employees.

• **Buck Loans Plus:** Unbundled hardware and software; mainframe; first installation, 1984; 33 total installations, all in employee benefit departments. Functions include loan administration for defined contribution plans; can be used to communicate benefit programs to employees.

• **Buck Recordkeeping Plus:** Unbundled hardware and software; mainframe; first installation, 1987; 14 total installations, all in employee benefit departments. Functions include on-line defined contribution plan and loan administration system; can be used to communicate benefit programs to employees.

• **Buck Actual:** Unbundled hardware

and software; mainframe; first installation, 1970 four total installations, all in employee benefit departments. Functions include actuarial valuation of defined benefit plans.

• **Buck Tax Exclusion:** \$1,200; unbundled hardware and software; personal computer; first installation, 1988; eight total installations, all in employee benefit departments. Determines taxable and non-taxable portions of pension payments; can be used to communicate benefit programs to employees.

• **Buck IDP:** Unbundled hardware and software; mainframe; first installation, 1970; nine total installations, all in employee benefit departments. Manipulates and edits benefits data.

User support: Telephone assistance available, project and implementation support.

Staff: 1,416 total, 1,100 professionals.

Clients: More than 1,000 total.

Branch offices: Atlanta; Boston; Chicago; Columbia, Md.; Dallas; Denver; Detroit, Fort Wayne, Ind.; Honolulu; Houston; Los Angeles; New York; Pittsburgh; San Francisco; Secaucus, N.J.; Stamford, Conn.; Washington D.C.; Antwerp and Brussels, Belgium;

Calgary, Alberta; Dublin, Ireland; Edinburgh, Scotland; Hong Kong; Leeds, London and St. Albans, England; Madrid, Spain; Mexico City; Montreal; Paris; Sydney, Australia; Toronto.

1990 gross revenues: \$155 million total.

Principal officers: William E. Giegerich Jr., president/chief executive officer; Joseph A. LoCicero, secretary.

Business Administration Services Inc.

22 Knight St., Norwalk, Conn. 06851; 203-853-6584; fax: 203-852-574

Year founded: 1984.

Software products:

• **The BASI Administrator:** \$4,500-\$10,000; unbundled hardware and software; personal computer; first installation, 1984; 107 total installations, 90 in employee benefit departments. Functions include participant recordkeeping for defined contribution plans; can be used to communicate benefit programs to employees.

User support: Telephone assistance available eight hours per day, annual up-grades and enhancements.

Staff: 10 total, seven professionals.

Clients: 75 employee benefit information system clients. Sold systems to 10 clients in 1990.

1990 gross revenues: \$300,000 total, all from employee benefit information systems, including 25% from software sales, 75% from software services.

Principal officers: Burton Stevens, president; Gary Oberst, executive vp.

William Byrne & Associates Inc.

1030 Woodcrest Terrace, Suite 135, Creve Coeur, Mo. 63141; 314-275-2600

Year founded: 1985.

Software products:

• **Health Claims System:** Per employee per month, up to \$2,400 per year; unbundled hardware and software; personal computer; first installation, 1988; six total installations, two in employee benefit departments. Functions include claims processing and management of medical, dental, vision and disability benefit programs; can be used to communicate benefit programs to employees.

User support: Telephone assistance

Continued on next page

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Statistical Analysis Claim Reports

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High Density
5.25" HD

LINCOLN NATIONAL
EMPLOYEE BENEFITS

Mr. Stephen C. Johnson
Chief Financial Officer
Nightingale & Associates
2200 Presidential Place
Chicago, IL 60418

Dear Steve:

Upon review of the general cost-effectiveness of Nightingale & Associates' health plan for the past year, I have a few thoughts to consider as you prepare for renewal in the months ahead. Attached please find copies of the reports I used for my analysis.

A detailed review of the plan's overall performance revealed a number of items that, if acted upon, should provide some additional cost savings in the coming year. These items are as follows:

- The trend of more employees enrolling in the Lincoln National Preferred Plan seems to have had a positive effect on overall expenditures for health care services. You may want to encourage other employees to enroll in the Preferred Plan this year. We would be glad to help coordinate a re-presentation of the Plan for the company.
- General utilization of outpatient services for certain kinds of treatment has increased dramatically in recent months. You might want to look at certain areas where the use of these services with the appropriate people.

claims, we have identified certain areas where the use of these services with the appropriate people.

usual. We might want to look at sp

of concern.

**WE BELIEVE BETTER MANAGED CARE
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Lincoln National Life Insurance Company, Lincoln National Administrative Services Corporation, Affiliates of Lincoln National Corporation.

Continued from previous page
available nine hours per day.

Staff: 27 total, 25 professionals.

Clients: Six employee benefit information system clients, 100% with gross revenues less than \$200 million. Sold systems to three clients in 1990.

1990 gross revenues: \$1.5 million total; \$60,000 from employee benefit information systems, including 80% from software sales, 20% from software services.

Principal officers: William Byrne, president; G. Mark Cutler, vp; David P. Young, vp-sales; C. Byrne, secretary.

C

California Interactive Computing Inc.

8550 Balboa Blvd., Suite 180;
Northridge, Calif. 91325;
818-895-5500; fax: 818-891-8913

Year founded: 1977.

Software products:

• GenMed: \$79,500; unbundled hardware and software; mainframe, mini

computer or personal computer; first installation, 1979; 18 total installations, 16 in employee benefit departments. Adjudicates and administers medical, dental, vision and prescription drug claims; is designed to administer claims under COBRA.

User support: User groups/meetings, telephone assistance available eight hours per day, custom programming, training, installation, maintenance, consulting.

Staff: 40 total, 30 professionals.

Clients: 17 employee benefit information system clients. Sold systems to two clients in 1990. 15 corporate employee benefit clients.

1990 gross revenues: \$6 million total.

Principal officers: Jerry C. Buckley, president; Ralph M. Flygare, vp; Eric Hoffberg, vp-system services; Gary L. Smart, vp-sales/marketing.

Cantor & Co.

9348 Civic Center Drive, Beverly Hills, Calif. 90210; 213-859-7277 or 800-553-7267;

fax: 213-859-7415

Year founded: 1982.

Software products:

• PCMS: \$9,875; unbundled hardware and software; first installation, 1985; 250 total installations. Tracks disability benefits and patient care, offers two-dimensional graphics.

• PCMS Plus: \$12,500; single-user version available July 1991. Multi-user network versions also available from \$22,000.

• Riskmap Risk Financing: \$1,950; unbundled hardware and software; personal computer; first installation, 1983; more than 100 total installations. Determines benefit funding mechanisms and budgeting.

• Riskmap Loss Forecasting: \$1,500; unbundled hardware and software; personal computer; first installation, 1984; more than 50 total installations. Forecasts frequency, severity and total cost of benefit programs.

• HMO Membership/Claims Management System: Bundled or unbundled hardware and software. Manages membership and claims of HMOs.

Staff: Six total, five professionals.

Clients: 450 employee benefit information system clients, including 25% with gross revenues less than \$200 mil-

lion, 60% with \$200 million-\$499 million, 10% with \$500 million-\$999 million, 4% with \$1 billion-\$3.5 billion, 1% exceeding \$3.5 billion.

Principal officers: Alan B. Cantor, president.

Cascade Technologies Inc.

1001 Ave. of the Americas, New York, N.Y. 10018; 212-768-7380; fax: 212-768-7806

Year founded: 1985.

Software products:

• Professional Capital Accumulation System: Unbundled hardware and software; personal computer; first installation, 1986; 220 total installations, 12 in employee benefit departments. Functions include defined contribution recordkeeping, administration and communication; can be used to communicate benefit programs to employees.

• CAS Voice: Bundled hardware and software; personal computer; first installation, 1989; 18 total installations, nine in employee benefit departments. Functions as an interactive voice response and communications system; can

be used to communicate benefit programs to employees.

• Compliance Plus: \$1,000; unbundled hardware and software; personal computer; first installation, 1990; 220 total installations. Determines highly compensated employees, performs non-discrimination tests.

User support: User groups/meetings, telephone assistance available nine hours per day, file transfer service, bulletin board, system enhancements, comprehensive training curriculum.

Staff: 12 total, all professionals.

Clients: 28 employee benefit information system clients. Sold systems to 20 clients in 1990.

Principal officers: Vigdis Anstad, president; William E. Colgan, vp-applications; Frank J. Joicy, vp-technology.

CompWatch Corp.

P.O. Box 6471, San Jose, Calif. 95150; 1885 De La Cruz Blvd., Santa Clara, Calif. 95050; 800-522-5265; fax: 408-727-9670

Year founded: 1989.

Software products:

• CompWatch: \$1,500; unbundled hardware and software; personal computer; first installation, 1989; 184 total installations, 116 in employee benefit departments. Manages and maintains workers compensation claims information needed by state and federal agencies.

User support: User groups/meetings, telephone assistance available 10 hours per day, on-site training.

Staff: Six total, three professionals.

Clients: 184 employee benefit information system clients. Sold systems to 141 clients in 1990.

Branch offices: Milwaukee; Nashville, Tenn.; Rochester, N.H.; San Antonio, Texas; Seattle.

Coopers & Lybrand

1251 Ave. of the Americas, New York, N.Y. 10020; 800-232-2717 or 212-259-1000; fax: 212-536-2163

Year founded: 1961.

Software products:

• Benefits Information Line: Unbundled hardware and software; personal computer; first installation, 1988; 50 total installations, 25 in employee benefit departments. Provides generalized and personalized information on benefit plans via touchtone telephone; can be used to communicate benefit programs to employees.

• Benefactor: \$25,000; unbundled hardware and software; personal computer; first installation, 1989; 400 total installations, 14 in employee benefit departments. Functions as a data base to support defined benefit, defined contribution, health and welfare plans; can be used to communicate benefit programs to employees.

• CompSTRATEGIST: \$40,000; unbundled hardware and software; personal computer; first installation, 1990; six total installations, all in employee benefit departments. Functions as a compensation and human resources planning and recordkeeping system.

• DR.CLAIM: \$60,000-\$100,000 for personal computer, \$100,000-\$250,000 for mainframe; unbundled hardware and software; personal computer or mainframe.

• COBRATRACKS: \$1,500; unbundled hardware and software; personal computer; first installation, 1986; 225 total installations, all in employee benefit departments. Administers claims under COBRA; can be used to communicate benefit programs to employees.

• Flexport: Unbundled hardware and software; personal computer; first installation, 1989. Functions as an administrative software system that helps automate and control flexible benefits program administration; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available eight hours per day.

Staff: 1,199 total, 995 professionals.

Branch offices: Atlanta; Boston; Chicago; Cleveland; Columbus, Ohio; Dallas; Denver; Detroit; Houston; Los Angeles; Louisville, Ky.; Minneapolis; Newport Beach, Calif.; New York; Parsippany, N.J.; Philadelphia; Pittsburgh; San Francisco; Seattle; Stamford, Conn.; Syracuse, N.Y.; Tampa, Fla.; Washington D.C.

Principal officers: Jerome Y. Halperin, vice chairman-actuarial, benefits & compensation group; Reed A. Keller, national director-ABC operations; Neil A. Burger, national director-ABC administration; Harold Dankner, national director-ABC technical services unit; James A. Hall III, regional partner-casualty actuarial services; Barry L.

Continued on next page



LINCOLN NATIONAL
EMPLOYEE BENEFITS

SHERLOCK
Customized Information For Managing Health

Managed care is the phrase you hear a lot around insurance circles these days. But without real management, managed care is just a phrase.

There's one health benefits company, however, that has a special capability to help you cost-effectively manage care.

The company is Lincoln National. And what separates us from so many other carriers is not so much the plans we offer, because everybody has plans. The extra element we provide is timely, accurate information. On things like employee utilization. Work related illnesses. Care patterns. The information you need to effectively manage your health care.

As part of the nation's 7th largest insurance holding company, we're committed to leadership in managed health care. A commitment we've demonstrated by developing management information capabilities like StatLinc, specially designed for statistical analysis of claims experience. Sherlock, which provides customized managed care reporting. EZ-Inquiry, a program that lets you access company health care information on your own personal computer.

And we're working on new capabilities that will provide even greater advances in managing and integrating health care information.

If all of this sounds a bit high-tech, there's a simpler way to look at it. It's just a smart way to manage care.

For more information on better managing health care information, contact your broker. Or call your local Lincoln National Employee Benefits office.

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EMPLOYEE BENEFITS

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ADMINISTRATOR**FULL NETWORK COBRA ADMINISTRATION SOFTWARE DESIGNED FROM THE FIRST BYTE FOR TPA'S AND INSURANCE COMPANIES****COBRA EAS™ Administrator is designed to handle the special volume and flexibility requirements you need.**

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- * Handles up to 9999 employer groups with 999 divisions each.
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- * Produces customized reports, billings, & correspondence for each employer.

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Continued from previous page
Blazer, managing partner-New York metro; Jack Forstadt, managing partner-Northeast; John B. Phillips, managing partner-West; Harry D. Spring, managing partner-Southwest; David P. Sunderhaft, managing partner-Midwest.

Corporate Health Strategies

2 Whitney Ave., New Haven, Conn.
06510; 203-789-2989;
fax: 203-624-7935

Year founded: 1981.

Parent company: Metropolitan Life Insurance Co.

Software products:

- Pro-Act: \$30,000; unbundled hardware and software; personal computer; first installation, 1988; 48 total installations, all in employee benefit departments. Functions include timely access to monthly benefit plan cost and utilization experience.

- Chap 2: \$150,000; unbundled hardware and software; personal computer; first installation, 1985; 64 total installations, all in employee benefit departments. Functions include on-line access

to a customized claims data base allowing identification and evaluation of trends in cost and utilization.

User support: User groups/meetings, telephone assistance available 10 hours per day, on-site training and ongoing account management.

Staff: 70 total, 62 professionals.

Clients: 80 employee benefit information system clients. Sold systems to 22 clients in 1990.

Branch offices: Branford, Conn.

Principal officers: Leon I. Hyman, president; Dennis Dang, chairman; Laurent Schor, senior vp-marketing.

Cyborg Systems Inc.

2 N. Riverside Plaza, Chicago, Ill.
60606; 312-454-1865;
fax: 312-930-1033

Year founded: 1974.

Software products:

- The Solution Series-Human Resource Management Solution: \$45,000-\$295,000; unbundled hardware and software; mainframe or mini computer; first installation, 1974; 1,000 total installations, all in employee benefit departments. Provides 10 on-line modules for human resource data management; can be used to communicate benefit programs to employees; can administer claims under COBRA.

- The Solution Series-Payroll Solution: \$45,000-\$295,000; unbundled hardware and software; mini computer or mainframe; first installation, 1974; more than 1,000 total installations, all in employee benefit departments. Functions as a complete payroll administration system with tax and dial-in service; can be used to communicate benefit programs to employees.

- The Solution Series-Time and Attendance Solution: \$7,500; unbundled hardware and software; mainframe, mini computer or personal computer; first installation, 1986; 22 total installations. Functions as an automated employee time card tracking system.

User support: User groups/meetings, telephone assistance available 24 hours per day, training, consulting, tax and dial-in service.

Staff: 175 total, 150 professionals.

Clients: 1,000 employee benefit information system clients. Sold systems to 60 clients in 1990.

Branch offices: Atlanta; Dallas; Memphis; Los Angeles; New York; Toronto and Cornwall, Ontario; London; Sydney, Australia; Hato Rey, Puerto Rico.

1990 gross revenues: \$20 million total, including 45% from software sales, 55% from software services.

Principal officers: Michael D. Blair, president; James O. Pierce, executive vp; John K. Kluska, vp-products & services; Gary M. Tarr, vp-sales & support.

D**Data Management Ventures Inc.**

603 Parkway 575, Woodstock, Ga.
30188; 404-924-7621; fax:
404-924-7708

Year founded: 1985.

Software products:

- FEE FACTS-Prevailing Fees for Rehabilitative Medicine: Unbundled hardware and software; mainframe or personal computer; first installation, 1986; 275 total installations, 15 in employee benefit departments. Functions as a health, personal injury, workers compensation cost containment claim reference source.

User support: Telephone assistance available eight hours per day.

Staff: Five total, three professionals.

Principal officers: Dr. Richard E. Olson, president.

Digital Insurance Systems Corp.

3455 Mill Run Drive, Suite 400,
Hilliard, Ohio 43026; 614-771-5423;
fax: 614-771-6064

Year founded: 1986.

Parent company: Associated Insurance Cos. Inc.

Software products:

- HCPSYSTEM: Unbundled hardware and software; mini computer, mainframe; first installation, 1984; 28 total installations. Functions include enrollment, claims administration, billing for health claims; is designed to administer claims under COBRA.

User support: User groups/meeting, telephone assistance available eight hours per day, updates, documentation, training, consulting.

Continued on page 41

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Europolicy comes of age

E.C. action creates demand for new policy

By Douglas N. Smith

International issues

THE FREEDOM OF SERVICES ACT has not brought the swift elimination of barriers to financial services integration that many had hoped for in envisioning a single Europe, but there has been progress.

Indeed, the implementation last July of the second non-life insurance directive, which expands the concept of freedom of services within the European Community, has prompted several companies to introduce a new product: the Europolicy.

In 1983, the first non-life insurance directive set the conditions under which insurance could be bought and sold within the European Community (*BI*, Nov. 14, 1983). Its intent was to eliminate obstacles to freedom of financial services created by legislation in individual member countries.

Despite this, certain areas were not clearly defined, and disputes arose where laws were in conflict. In 1986, the European Court of Justice heard several cases that examined these gray areas (*BI*, Dec. 15, 1986; Dec. 8, 1986; May 26, 1986). The central issue in these cases was the compatibility between E.C. directives and national laws that required insurers established in one member state to be established or authorized to operate in any other state before providing insurance services to residents of that state.

These cases established that E.C. law superceded national law when the two contradict each other on questions relating to insuring across the borders of member countries. However, these cases did not resolve all outstanding issues. The second non-life insurance directive was therefore implemented to clearly define the rules under which cross-border non-life insurance could be written (*BI*, July 9, 1990; July 2, 1990).

To take full advantage of the second directive, several insurance companies operating in Europe have introduced Europolicies that offer a very flexible approach to insurance. These policies allow policyholders that meet certain minimum size requirements to purchase a policy anywhere in the European Community that includes coverage for their operations in any other E.C. member state, except Spain, Portugal, Greece and Ireland, where the directive will not take effect for several more years.

The Europolicy eliminates the necessity for subsidiaries of the policyholder to purchase a separate local policy in each of the member states where they are located.

To illustrate, let us assume that XYZ Company has its head office (or, in the case of a non-E.C. multinational, its European headquarters) in Belgium, with subsidiaries in Italy, the United Kingdom and France. The office in Belgium acts as the control/coordination center.

The Freedom of Services Act allows XYZ Company to purchase a property insurance contract in Belgium that covers not only Belgium, but also operations in Italy, the United Kingdom and France. (The Freedom of Services Act applies only to property damage/business interruption, inland transit and liability insurance.)

While issued by the Belgian office of an insurance company, the property policy could be issued in any E.C.-approved language and would provide the basic cover applicable to all countries. Endorsements would then be added to reflect the different coverages, extensions and restrictions required in each E.C. member state where a subsidiary is located.

The entire policy could be translated into the native language of any of the counties involved if the subsidiaries want a copy for reference.

The Belgian office of the insurer may handle premium payment for the Europolicy in three ways:

- Bill and collect from XYZ-Belgium the entire premium for all countries.
- Bill each XYZ location separately and collect the premium from each in their respective countries.
- Bill each XYZ location separately and collect the premium for each in Belgium.

In the first situation, XYZ has the option of charging its subsidiaries internally for their portion of the overall premium corresponding to their particular exposure. Whether the premium is collected in its entirety from XYZ-Belgium or from each XYZ subsidiary, premium taxes will be due directly to the respective tax authorities in those countries. As an additional service, the insurance company can make the premium tax payments on their behalf.

While local claims service is provided in each country, it is important to note that such local service is at the behest of the Europolicy issuing office, which retains full control and authority over final settlement.

Several major insurers have introduced Europolicies into the market and others are planning to do so. One major company offers a policy with a per-location property damage/business interruption limit of \$250 million, a general/product liability combined single limit of \$17 million and an inland marine limit of \$25 million.

Another Europolicy has no maximum limit per se, but its basic cover would contemplate a property damage/business interruption limit of \$100 million and a combined single limit of \$40 million for general/product liability.

The Europolicy will be of great interest to policyholders active throughout Europe, but each company should carefully evaluate its insurance needs and internal administration to determine whether it should utilize this innovation or whether it should continue with a more conventional insurance program.

The company most likely to benefit from the Europolicy would be a European company or the European division of a non-E.C. multinational whose operations are largely autonomous rather than tightly integrated into its parent's overall global structure. It should also have a relatively closely controlled and centralized administration as well as effective internal communications.

Conversely, a non-E.C. multinational with centralized control by its home office or European companies with a high degree of decentralization and independence may not be in a position to benefit from a Europolicy.

Clearly, the Europolicy concept, while innovative, is not designed to fit every company. Like any insurance program, it offers certain advantages and disadvantages. Some advantages are:

- The Europolicy provides the policyholder with centralized control.

In our hypothetical case, XYZ in Belgium would oversee and control the Europolicy, thereby relieving its subsidiaries in the other E.C. states of the responsibility of administering this portion of the insurance program.

- By purchasing one property contract for all E.C. member states, the policyholder would achieve economies of scale by pooling values.
- The policyholder has more negotiating leverage and, in certain cases, cost savings.
- The basic Europolicy form provides the policyholder with a "common thread of coverage"

rather than separate and uncoordinated policies and coverages that would result if each individual country purchased a separate property policy.

- The Europolicy allows for a coordinated approach to claims handling and loss settlement. This allows the policyholder's head office in Europe to stay involved in the claims handling procedure while maintaining on-the-spot claims expertise through the insurer's local claims representative.

In essence, the Europolicy gives the policyholder control of its insurance contract at its European head office with the added flexibility of specific wording added as necessary for each E.C. state where the policyholder has a subsidiary.

For some companies, the Europolicy may present certain disadvantages:

- As now structured, the basic coverage of the Europolicy contract contains policy wording that is accepted in the different countries, with endorsements added for each country as required. As such, it tends to be reduced to the least common denominator of acceptability. This is the principal argument against the Europolicy approach for larger multinational manufacturing concerns that usually require tailored insurance programs.

Because the concept of the Europolicy is only applicable to property damage/business interruption, inland marine and liability lines of insurance, the remaining lines—automobile, crime, etc.—still remain the responsibility of each subsidiary. This may lead to an overall splintered insurance program in which the larger lines are handled at the head office, while the ancillary lines are left to the discretion of the subsidiary. Further, the home office may lack the hands-on experience to recognize individual needs of each single subsidiary, which the Europolicy trades off for a "big picture" concept.

Local subsidiaries could lose personalized service because the policyholder's head office administers the Europolicy with a minimum of input from the local operations.

- A single policy will not necessarily result in lower premiums. Technically, lower premiums are justified if services can be provided more efficiently, or if administration is simplified and redundancies eliminated.

Buyers should ask themselves the following questions to evaluate the potential implementation of a Europolicy:

- Is my current insurance program meeting my needs? And my subsidiaries' needs?
- Is our corporate structure one of centralized or decentralized control?
- Will our corporate communications network respond to the communications needs required by the Europolicy?
- Does each subsidiary have the knowledge to negotiate its own insurance program?
- Is the current program competitively priced?

The Europolicy appears to have a promising future. However, it may be some time before Europe finally accepts the concept of "one-ness." The upcoming third non-life directive should help to liberalize services across borders and to realize—for insurance purposes—"one Europe." ■



Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

ASK A BENEFITS ACTUARY

ESOP hybrids can fund retiree medical benefits

Q

How can an employee stock ownership plan be used to fund retiree medical benefits?

A

This question comes from a benefits manager who has heard about some novel approaches to funding retiree medical benefits through an employee stock ownership plan. Two approaches intrigued the benefits manager—those involving a

"KSOP" and an "HSOP." The benefits manager wants to understand these approaches, particularly their advantages and disadvantages.

Some plan sponsors have installed a leveraged ESOP with a 401(k) feature to "fund" a retiree medical benefits program. This type of plan is known as a KSOP. It provides that pretax salary reduction contributions from employees be invested in preferred stock created especially for the KSOP. The employer typically matches the pretax salary reduction contributions made by employees. These matching contributions are also invested in the preferred stock.

The preferred stock is generally purchased by the plan with the proceeds from a loan to the plan. The preferred stock acquired by the plan with the loan serves as the collateral for the loan. Pretax contributions from employees and employer matching contributions are made to the plan and used to repay the loan. As the loan is repaid, shares of preferred stock are no longer encumbered by the loan and are allocated to participant accounts.

The preferred stock has the following characteristics:

- It typically has a minimum guaranteed value equal to approximately 120% to 130% of the share price of employer's common stock at the date of the installation of the KSOP.
- One share of preferred stock can be exchanged for one share of common stock at any time.
- It carries guaranteed dividends of 6% to 8% of the price per share.

Employers that install a KSOP to fund retiree medical benefits accomplish the "funding" by changing the retiree medical benefit promise at the time the KSOP is introduced. The new retiree medical benefit program might require increased contributions for medical coverage after retirement, with the KSOP intended to be the source of some or all of the increased contributions. Or, the employer might simply discontinue offering retiree medical coverage.

Consequently, this approach is not a "true" funding of retiree medical benefits, but is merely an exchange of one benefit (the KSOP plan) for another benefit (free retiree medical).

The principal advantage of this approach is that the employer is able to replace a costly retiree medical benefit promise with a benefit that is very tax efficient from the employer's perspective. The new benefit also does not escalate in cost from year to year as rapidly, because it is not tied to medical trends.

The principal disadvantages of this approach are as follows:

- The KSOP is subject to the qualification requirements of the Internal Revenue Code, including the coverage and non-discrimination rules. These compliance requirements are, in general, burdensome.
- The new asset given to employees (the preferred

shares in the KSOP plan) may not match very well with the new liability that retirees have (increased contributions for coverage or the full cost of retiree medical benefits). The new liability will vary significantly depending upon when an individual retires and if he or she is married at retirement. The accumulated value of the ESOP shares, though, will not vary depending upon when an individual is married and will be less if an individual retires early.

- Whenever a qualified retirement plan is established, most plan sponsors believe it is desirable to seek a determination letter from the IRS. This letter generally signifies that the IRS believes that the plan meets the requirements of the Internal Revenue Code.

In 1986, Congress adopted the Tax Reform Act, requiring significant amendments to all qualified retirement plans. For most plans, the IRS has not yet begun to issue determination letters regarding amendments that plan sponsors have made to comply with TRA 86. However, the IRS has indicated (in Revenue Procedure 91-10, Section 2.09) that when it begins to issue determination letters for amendments to comply with TRA 86, it

Because of the budget deficit and the fact that funds running through an HSOP are never taxed, the IRS may act to discourage employers from operating an HSOP.

will not rule on KSOPs. Consequently, if an employer were to adopt a KSOP, there would be no way to obtain IRS approval that the plan meets the requirements of the Internal Revenue Code. The IRS currently is studying whether KSOPs are consistent with the purposes of an ESOP as reflected in the code.

A second approach to retiree medical funding has been referred to as an HSOP. The HSOP includes a money purchase pension plan; a 401(h) account; and a leveraged ESOP feature. Procter & Gamble Co. is one company that has adopted this approach (*BI*, Nov. 26, 1990).

A money purchase pension plan, also known as a defined contribution pension plan, differs from a defined benefit pension plan. A defined benefit pension plan promises a certain level of monthly income at retirement for life. A money purchase pension plan promises a certain level of contributions—typically a percentage of pay—to an individual's account held under the plan; at retirement, the individual's benefit is the account balance. With a money purchase pension plan, the plan sponsor makes a commitment to contribute on an annual basis based on a formula. The contribution to the plan is not discretionary as with a profit-sharing plan, or with a match under a savings plan.

A 401(h) account is a separate account in a pension plan (either a money purchase or defined benefit plan, but not a profit-sharing, savings or 401(k) plan). The assets in this separate account must be used to pay retiree medical benefits. Except under very limited circumstances, assets cannot be transferred from the pension plan account (the account providing non-medical benefits) to the 401(h) account. Tax-deductible contributions to the 401(h) account are generally limited to 25% of the current service (excluding past service) contributions made to the pension plan as a whole. This effectively limits the 401(h) contribution to 33⅓% of the current service contribution made to the pension plan account.

The HSOP is unusual for two reasons:

- Few companies have established a 401(h) account in conjunction with a money purchase plan. Most 401(h) accounts previously established were

done in conjunction with defined benefit pension plans. The significance of this innovation is that an HSOP's 401(h) account has individual participant accounts. This plan design has an account in each participant's name that holds funds dedicated to retiree medical benefits. All prior 401(h) accounts generally functioned like defined benefit pension plans: The 401(h) account contained a pool of money that could be used to pay the retiree medical benefit of any participant. Assets were not earmarked for any particular participant's benefit.

- This individual account structure within the 401(h) account was made necessary by the second innovation—the combining of a leveraged ESOP feature with the 401(h) account. In P&G's case, for example, the 401(h) account is being funded by preferred stock of P&G acquired through a loan made to the 401(h) account.

There are significant tax advantages to this approach: Contributions to the 401(h) account are tax-deductible to the employer and are not taxable to the employee; investment earnings on the preferred stock are not taxable to the employer or its employees; benefits distributed from the 401(h) account to pay medical expenses are not taxable to the employee; and the use of a leveraged ESOP can be a low-cost way to provide employee benefits.

The principal disadvantages of the P&G approach are:

- The plan is subject to the coverage and non-discrimination requirements of the Internal Revenue Code referenced above for the KSOP approach.
- The contributions to the 401(h) account must be incidental to the contributions of the money purchase account. This limitation effectively means that \$3 must be contributed to the money purchase plan for every \$1 contributed to the 401(h) account. In order to produce large 401(h) account balances, relatively large money purchase account contributions must be made.

- P&G has received a lot of press for its approach, and this has caught the attention of the IRS. The IRS currently is reviewing this approach and is expected to provide guidance within the next few months to its field offices regarding whether this approach meets the requirements of the code. Because of the budget deficit and the fact that funds running through an HSOP are never taxed, the IRS may act to discourage employers from operating an HSOP.

These approaches illustrate that an ESOP can be a part of an employer's approach to dealing with retiree medical benefit issues. Imagination and creativity—and the IRS—seem to be the only limits to their application. ■

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

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

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



Mr. Miner

Continued from page 34

Staff: 86 total, all professionals.**1990 gross revenues:** 25% from hardware sales, 50% from software sales, 25% from software services.**Principal officers:** Merwin D'Souza, president/chief executive officer; Donald F. Demers, senior vp; Paul Balcerzak, vp-marketing/sales.**E****EBG & Associates Inc.**

70 E. Lake St., Suite 1400, Chicago, Ill. 60601; 312-580-2250; fax: 312-580-2252

Year founded: 1978.**Software products:**

- PensionMaker DC-100: Unbundled hardware and software; personal computer; first installation, 1984; 150 total installations, 50 in employee benefit departments. Functions include profit-sharing plan recordkeeping, multiple contribution and investment options, maintaining of loan information, compliance testing.

- PensionMaker DB: Unbundled hardware and software; personal computer; first installation, 1979; 95 total installations. Functions as a proposal and valuation system for defined benefit plans, handles actuarial cost methods, performs best salary routine and compliance tests.

- PensionMaker DC: Unbundled hardware and software; personal computer; first installation, 1979; 60 total installations. Functions include proposal and valuation for money purchase, profit-sharing, thrift and target benefit plans.

- HERBIE: \$1,500; unbundled hardware and software; personal computer; first installation, 1988; five total installations, all in employee benefit departments. Estimates individual retirement benefits based on employee input; can be used to communicate benefit programs to employees.

- Pension Tax: \$695; unbundled hardware and software; personal computer; first installation, 1987; 85 total installations, five in employee benefit departments. Generates 5500 forms, related schedules, and summary annual report.

- PensionMaker Administrator: \$2,500; unbundled hardware and software; personal computer; first installation, 1986; 35 total installations. Assists plan administrator with valuation process, increases productivity and punctuality.

- PensionMaker DB-Xtra: Unbundled hardware and software; personal computer; first installation, 1986; 20 total installations. Serves as a multi-decrement valuation system for larger defined benefit plans, calculates ancillary benefits, performs compliance testing.

- Trust Accountant II: Unbundled hardware and software; personal computer; first installation, 1991. Functions as a pension plan asset recordkeeping system with global securities, pricing features and default accounts, calculates Form 5500 financials.

- DocuMaker: Unbundled hardware and software; personal computer; first installation, 1989; 60 total installations. Functions as a mass submitter regional prototype system, offers software and documents for defined benefit, contribution and 401(k) plan document generation.

- 1099-R/W2-P Utility: \$395; unbundled hardware and software; personal computer; first installation, 1984; 175 total installations, 50 in employee benefit departments. Performs 1099-R and W2-P calculations and prints on HP laser jet dot-matrix printers, capable of electronic media-filing.

- Coach: \$195; unbundled hardware and software; personal computer; first installation, 1988; 60 total installations, five in employee benefit departments. Simplifies rules for pension plan and social security integration, includes tutorial, reference library and consultant modules.

- Benefits Calculator: Unbundled hardware and software; personal computer; first installation, 1991; One total installation in an employee benefit department. Functions include benefit calculating for in-house administration and plan projects, maintaining employee plan data, calculating pension benefit amounts, generating customized statements; can be used to communicate benefit programs to employees.

- **User support:** User groups/meetings, telephone assistance available 10 hours per day, remote assistance, PensionMaker Edge Newsletter, PensionMaker

BBS, complete documentation.

Staff: 40 total.**Clients:** 300 employee benefit information system clients. 50 corporate employee benefit clients.**Branch offices:** Bethesda, Md.**Principal officers:** Emmanuel Garcia Jr., president; Dee Holt, vp-sales/customer support; Mary Jo Arthur, vp/actuary.**EDS-Health & Benefits Division**

5400 Legacy Drive, Plano, Texas 75024; 214-604-6028; fax: 214-604-3119

Year founded: 1962.**Parent company:** General Motors Corp.**Software products:**

- EDS*INFORM: Unbundled hardware and software; personal computer; first installation, 1989; four total installations, one in employee benefit departments. Monitors cost effectiveness of health benefit programs by several variables, including provider, demographic group or procedure type.

- **User support:** Telephone assistance, on-site customer support, training and documentation.

Staff: 2,000 total.**1990 gross revenues:** \$6.1 billion total.

- **Principal officers:** Alice Lusk, president; Terry Conner, vp-managed care; Joe Cushing, vp-northern region; Rusty Gaston, vp-marketing; Rich LeFebvre, vp-system services; Don McArdle, vp-national accounts; Michael Thompson, vp-sales; Mark Travis, vp-finance/accounting; Floyd Trim, vp-western region.

Eldorado Computing Inc.

880 E. Northern Ave., Suite 4, Phoenix, Ariz. 85029; 602-493-0288; fax: 602-867-7920

Year founded: 1981.**Software products:**

- Health Care Claims Management System: \$25,000-\$300,000; unbundled hardware and software; mini computer or mainframe; first installation, 1984; 40 total installations, 10 in employee benefit departments. Functions include on-line, automated health claims adjudication with cost-containment features.

- **User support:** Telephone assistance available, on-line modem support and service, regular enhancements.

Staff: 21 total.**Principal officers:** Zane Bell, president; Win Brayer, vp-marketing.**Erisco**

1700 Broadway, New York, N.Y. 10019; 212-765-8500; fax: 212-765-8500 ext. 421

Year founded: 1968.**Parent company:** The Dun & Bradstreet Corp.**Software products:**

- ClaimFacts: Unbundled hardware and software; mainframe or mid-range; first installation, 1980; 153 total installations, 61 in employee benefit departments. Functions as a health management system for administering medical, dental, short- and long-term disability and triple option claims, includes new ClinicalLogic medical edit sub-system and Batch Adjudication sub-system; can be used to communicate benefit programs to employees.

- CertiFacts: Unbundled hardware and software; mainframe or mid-range; first installation, 1986; 23 total installations, three in employee benefit departments. Functions as a utilization management system supporting administration of pre-admission certification, concurrent stay review and discharge planning; can be used to communicate benefit programs to employees.

- Implefacts: Unbundled hardware and software; mainframe; first installation, 1972; 203 total installations, 193 in employee benefit departments. Functions as a recordkeeping system, manages defined contribution plans including 401(k), profit sharing, ESOP and saving plans; can be used to communicate benefit programs to employees.

- **User support:** User groups/meetings, telephone assistance available 10 hours per day, consulting, training, documentation, systems and customer support/computer-based training.

Staff: 481 total, 408 professionals.**Clients:** Sold systems to 48 clients in 1990.**Branch offices:** Union, N.J.; Tampa, Fla.; Staten Island, N.Y.; Charleston, W. Va.**Principal officers:** Thomas Barrea, chairman; Cliff Bateman, president; Anthony Fiumefreddo, senior vp-opera-

tions; Anthony Bellomo, senior vp-products; Jeffrey Sauerhoff, senior vp-finance/human resources/administration; John Manginelli, senior vp-benefits administration services.

F**FLX Corp.**

220 Willowbrook Lane, West Chester, Pa. 19382; 215-696-6600; fax: 215-692-2205

Year founded: 1985.**Software products:**

- FLX Recordkeeper Series II: \$25,000; unbundled hardware and software; personal computer; first installation, 1985; 75 total installations, all in employee benefit departments. Functions as a flexible benefit administration system, including enrollment, insurer reporting, management reports, ad hoc capabilities, employee history and flexible spending account administration; can be used to communicate benefit programs to employees.

- FLX Enroller: \$2,500-\$5,000; unbundled hardware and software; personal computer; first installation, 1990; 20 total installations, all in employee benefit departments. Enrolls employee elections and utilizes scanning; can be used to communicate benefit programs to employees.

- **User support:** User groups/meetings, telephone assistance available 8.5 hours per day.

Staff: 12 total.**Clients:** 75 employee benefit information system clients. Sold systems to 20 clients in 1990.**1990 gross revenues:** 80% from software sales, 20% from software services.**Principal officers:** Richard F. Gordon, director-marketing; Edward J. Hughes, president.**FACTS Services Inc.**

1575 San Ignacio, Coral Gables, Fla. 33146; 305-284-7400; fax: 305-665-0598

Year founded: 1981.**Software products:**

- FACTS: \$75,000-\$150,000; unbundled hardware and software; mini computer or mainframe; first installation, 1981; 100 total installations, 10 in employee benefit departments. Functions include full automated claims adjudication for medical claims; is designed to administer claims under COBRA.

- FACTS 125: \$10,000; unbundled hardware and software; mini computer or mainframe. Functions include full flex benefits, automatic adjudication.

- FACTS Comp: \$25,000; unbundled hardware and software; mini computer, mainframe. Functions include full workers compensation automatic claims adjudication.

- **User support:** User groups/meetings, telephone assistance available nine hours per day, new software releases and updates.

Staff: 32 total, all professionals.**Clients:** 80 employee benefit information system clients. Sold systems to eight clients in 1990. 10 corporate employee benefit clients.**1990 gross revenues:** \$1.6 million total; all from employee benefit information systems, including 20% from hardware sales, 20% from software sales, 60% from software services.**Principal officers:** Robert S. Graham Jr., president; David L. Graham, vp.**G****Genelco Inc.**

1600 S. Brentwood Blvd., Suite 500, St. Louis, Mo. 63144-1330; 314-962-2040; fax: 314-968-9589

Year founded: 1973.**Parent company:** General American Life Insurance Co.**Software products:**

- Health Benefit Management System: Unbundled and bundled hardware and software; mini computer; first installation, 1985; 29 total installations, five in employee benefit departments. Functions include health claim processing and administration, information collection and reporting capabilities for cost analysis; can be used to communicate benefit programs to employees.

- Benefit Administration and Reporting System: Unbundled and bundled hardware and software; mini com-

puter; first installation, 1987; 17 total installations. Administers billing and collecting functions, provides eligibility information for health claim administration, manages new cases from application to policy issue and processes commissions.

- **User support:** User groups/meetings, telephone assistance available 8.5 hours per day, on-site training, modem hook-up, documentation, maintenance agreement available.

Staff: 156 total, 58 professionals.**Clients:** 75 employee benefit information system clients. Sold systems to 22 clients in 1990. 51 corporate employee benefit clients.**Branch offices:** Atlanta, Dallas.**1990 gross revenues:** \$16.9 million total; \$14.1 million from employee benefit information systems, including 11% from hardware sales, 19% from software sales, 70% from software services.

- **Principal officers:** David B. Johnson, president; Russell E. Korte, executive vp; Ben C. Allen Jr., senior vp; Larry M. Amundsen, vp-S&P sales/marketing; David Garver, vp-ASO sales/marketing; Robert Helbig, David Litschgi and Mike Molinar, product vps; Mary Layton, claims vp (St. Louis); Carol Heikkinen, vp-operations (Dallas).

GENESYS Software Systems Inc.

5 Branch St., Methuen, Mass. 01844; 508-685-5400; fax: 508-683-7665

Year founded: 1981.**Software products:**

- Defined Contribution: \$50,000; unbundled hardware and software; mainframe; first installation, 1987; 125 total installations, all in employee benefit departments. Functions support record-keeping, calculations and reporting for 401(k), 403(b), profit sharing, money purchase, savings and other investment plans; can be used to communicate benefit programs to employees.

- Defined Benefits: \$50,000; unbundled hardware and software; mainframe; first installation, 1987; 60 total installations, all in employee benefit departments. Functions support record-keeping, calculations, participant reports, spousal, dependent and beneficiary data, historical data, pre-retirement counseling, benefit statements, benefit payments and taxation; can be used to communicate benefit programs to employees.

- Flexible Benefits: \$50,000; unbundled hardware and software; mainframe; first installation, 1988; 60 total installations, all in employee benefit departments. Functions offer eligibility and enrollment processing, confirmation statements, medical plans, dental plans, vision plans, default benefits, employee contributions, employer contributions and more; can be used to communicate benefit programs to employees.

- **User support:** User groups/meetings, telephone assistance available 24 hours per day.

Staff: 128 total, 94 professionals.**Branch offices:** Atlanta, Chicago, Dallas, Los Angeles, New York.**Principal officers:** Larry Munini, president; Ruth Ladner, vp-sales/support; Bob Pomerleau, vp-finance; Linda Koski, vp-consulting services.**H****John Hancock Financial Services**

P.O. Box 111, Boston, Mass. 02117; 617-572-6000

Year founded: 1862 (parent company).**Parent company:** John Hancock Mutual Life Insurance Co.**Software products:**

- ICAS: Unbundled hardware and software; personal computer; first installation, 1987. Functions include analysis of medical claims experience.

- Star-View: Unbundled hardware and software; personal computer; first installation, 1986. Functions include providing benefit information to employees.

- **User support:** Telephone assistance, electronic mail communication.

Staff: 16 total, 10 professionals.

- **Branch offices:** Atlanta; Chicago; Cleveland and Columbus, Ohio; Dallas; Detroit and Kalamazoo, Mich.; Fort Lauderdale, Fla.; Greensboro, N.C.; Houston; Indianapolis; Los Angeles; Manchester, N.H.; Milwaukee; Minneapolis; Nashville, Tenn.; New York and Rochester, N.Y.; Philadelphia and

Wayne, Pa.; San Francisco; Washington D.C.

Contact: Susan Dayno, director-client counseling; Alex Malcolm, director-strategic systems.**Hay/Huggins Co. Inc.**

229 S. 18th St., Philadelphia, Pa. 19103; 215-875-2472; fax: 215-875-2833

Year founded: 1911.**Parent company:** Hay Group.**Software products:**

- Pension Valuation Language: \$25,000; unbundled hardware and software; time sharing; first installation, 1985; 24 total installations, all in employee benefit departments. Functions include defined benefit plan actuarial valuations, gain and loss analysis.

- Capital Accumulation Language: \$10,000; unbundled hardware and software; time sharing; first installation, 1986; 30 total installations, all in employee benefit departments. Functions include administration of defined contribution plans; can be used to communicate benefit programs to employees.

- MediCalc: \$5,000; unbundled hardware and software; personal computer; first installation, 1987; 10 total installations, all in employee benefit departments. Functions include valuation and projection of post-retirement medical benefits.

- **User support:** User groups/meetings, telephone assistance available eight hours per day.

Staff: 130 total, 70 professionals.**Clients:** 50 employee benefit information system clients. Sold systems to 10 clients in 1990. 900 corporate employee benefit clients.**Branch offices:** Atlanta; Boston; Chicago; Los Angeles; New York; Walnut Creek, Calif.; Washington D.C.**1990 gross revenues:** \$25 million total; \$5 million from employee benefit information systems, including 5% from software sales, 95% from software services.**Principal officers:** Kenneth Shipiro, president; Kurt H. Fichtorn and Donald Samples, executive vps.**Hazlehurst & Associates Inc.**

400 Perimeter Center Terrace, Suite 850, Atlanta, Ga. 30346; 404-395-9880; fax: 404-512-6230

Year founded: 1971.**Software products:**

- H&A IRC Section 415 Limit Testing System: \$7,500; unbundled hardware and software; personal computer; first installation, 1985; 15 total installations. Functions include checking IRC 415 individual or combined limits.

- H&A COBRA and Other Beneficiary Data Maintenance System: \$3,000; unbundled hardware and software; personal computer; first installation, 1985; five total installations. Provides election notices, premium invoices/coupons for qualified beneficiaries, standard COBRA reports, maintains beneficiary data on tax-qualified and health/welfare plans; is designed to administer claims under COBRA.

- H&A H&A Benefit Information Transfer: \$9,500; unbundled hardware and software; personal computer; first installation, 1987; seven total installations. Functions include on-line data entry and inquiry into participant information with the H&A Defined Contribution Plan Recordkeeping system.

- H&A Tailored Pension Calculation System: \$21,800 and up; unbundled hardware and software; personal computer; first installation, 1985; 12 total installations. Enables a plan sponsor to calculate pension benefits for an individual or group of employees.

- H&A Social Security Calculation System: \$395; unbundled hardware and software; personal computer; first installation, 1985; 11 total installations. Calculates individual Social Security benefits, covered earnings projections and estimates of PIA, actual benefits payable and maximum family benefits from retirement, disability or death.

- **User support:** Telephone assistance available 10 hours per day, brochures, demo diskettes, on-site demos, sample reports, complete user documentation, hands-on training.

Staff: 147 total, 120 professionals.

- **Clients:** 30 employee benefit information system clients. Sold systems to 16 clients in 1990. 175 corporate employee benefit clients, including 10% with gross revenues less than \$200 million, 20% with \$200 million-\$499 million, 20% with \$500 million-\$999 million, 20% with \$1 billion-\$3.5 billion, 10% exceeding \$3.5 billion.

Branch offices: Bellevue, Wash.

Continued on next page

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Continued from previous page

Principal officers: James G. Pope, president; R. David Parsons, principal actuary/chairman; T. Ray McKinney and David M. Gladstone, executive vps.

Health Management Technologies Inc.

1042 Country Club Drive, Suite 2C, Moraga, Calif. 94556; 415-376-0980; fax: 415-376-7178

Year founded: 1986.

Software products:

- Return, Disability Case Manager: \$10,000; unbundled and bundled hardware and software; personal computer; first installation, 1989; 75 total installations. Functions include case management for disability insurance, workers compensation, medical liability.
- Medwatch, Benefits Acute & Ambulatory Case Management: \$15,000; unbundled and bundled hardware and software; personal computer; first installation, 1990; two total installations.
- PPO Control-Peer Review Case & Contract Management: \$15,000; unbundled and bundled hardware and software; personal computer.

User support: Telephone assistance available 10 hours per day, customization.

Staff: Six total, five professionals.

Principal officers: Karen J. Wolfe, president; Jim W. Wolfe, senior vp-marketing.

Health Risk Management Inc.

8000 W. 78th St., Minneapolis, Minn. 55439; 612-829-3500; fax: 612-829-3578

Year founded: 1977.

Software products:

- HRM BeneCALC: Unbundled hardware and software; personal computer; first installation, 1989. Reporting and analysis system; identifies medical cost and pricing problem areas, monitors health care cost management programs and tracks results.
- HRM Benefit Plan Modeling: Unbundled hardware and software; personal computer; first installation, 1989. Models the financial impact of medical plan design changes using client health care claims data.

User support: Telephone assistance available eight hours per day, on-site training, analytical and benefits consulting.

Staff: 355 total, 140 professionals.

Clients: 162 corporate employee benefit clients.

Branch offices: Chicago; Glendale, Calif.; Shrewsbury, N.J.

1990 gross revenues: \$17.1 million total.

Principal officers: Dr. Gary McIlroy, chief executive officer; Marlene Travis, president/chief operating officer; Tom Clark, chief financial officer; Steven Osterkamp, senior vp-sales/marketing.

Hewitt Associates

100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000; fax: 708-295-7634

Year founded: 1940.

Software products:

- FlexSystem: Unbundled hardware and software; personal computer or mainframe; first installation, 1983; 215 total installations, all in employee benefit departments. Administers flexible benefit programs including enrollment, reimbursement accounts, reporting and maintaining an employee database; can be used to communicate benefit programs to employees.
- Pension Administrator: Unbundled hardware and software; mainframe or personal computer; first installation, 1985; 107 total installations, all in employee benefit departments. Calculates pension benefits, produces management reports, maintains an employee data base; can be used to communicate benefit programs to employees.
- Defined Contribution Plan Administration: Unbundled hardware and software; mainframe; first installation, 1974; 260 total installations, all in employee benefit departments. Functions include recordkeeping for defined contribution plans including savings, 401(k), profit sharing and ESOPs; can be used to communicate benefit programs to employees.
- 415 Calc: Unbundled hardware and software; personal computer or mainframe; first installation, 1988; 90 total installations, all in employee benefit departments. Calculates Section 415 benefit limits, maintains an employee database, produces reports.
- Social Security Calculator: Unbundled hardware and software; personal computer or mainframe; first installation, 1979; 200 total installations, all in employee benefit departments. Calculates employee Social Security benefits.
- FutureSaver: Unbundled hardware and software; personal computer; first installation, 1989; 15 total installations, all in employee benefit departments. Projects future retirement incomes; can be used to communicate benefit programs to employees.

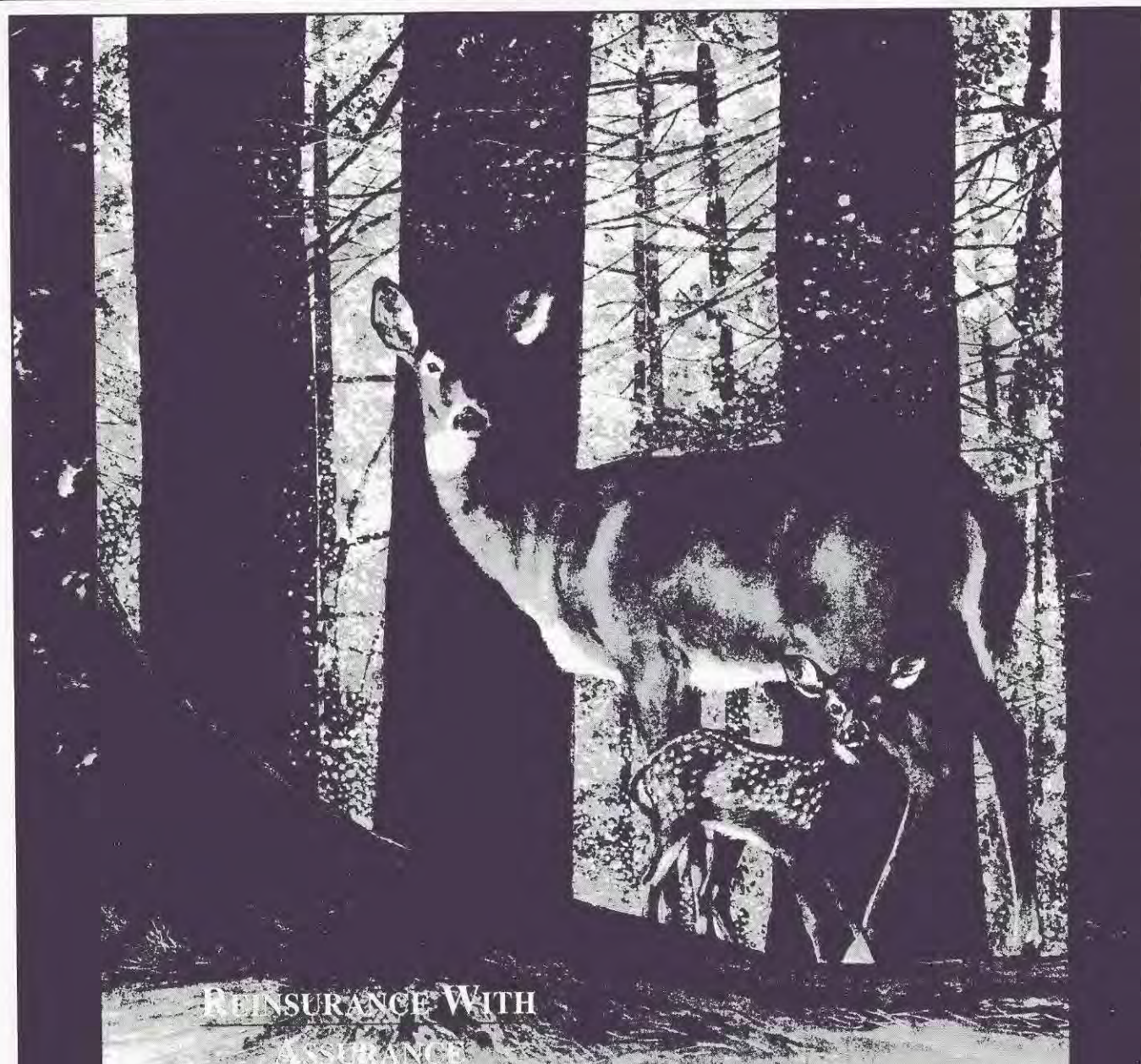
User support: User groups/meeting, telephone assistance available eight hours per day.

Staff: 2,800 total, 1,900 professionals.

Clients: 887 employee benefit information system clients. Sold systems to 85 clients in 1990.

Branch offices: Atlanta; Bedminster, N.J.; Boston; Charlotte, N.C.; Chicago; Cleveland and Dayton, Ohio; Dallas, Houston, Las Colinas and The Woodlands, Texas; Denver; Detroit; Los Angeles, San Francisco, Santa Ana and Walnut Creek, Calif.; Milwaukee; Minneapolis; New York; Philadelphia; Phoenix; Pittsburgh; Richmond, Va.; Rowayton, Conn.; St. Louis; Seattle; Tampa, Fla.; Washington D.C.

Continued on page 44



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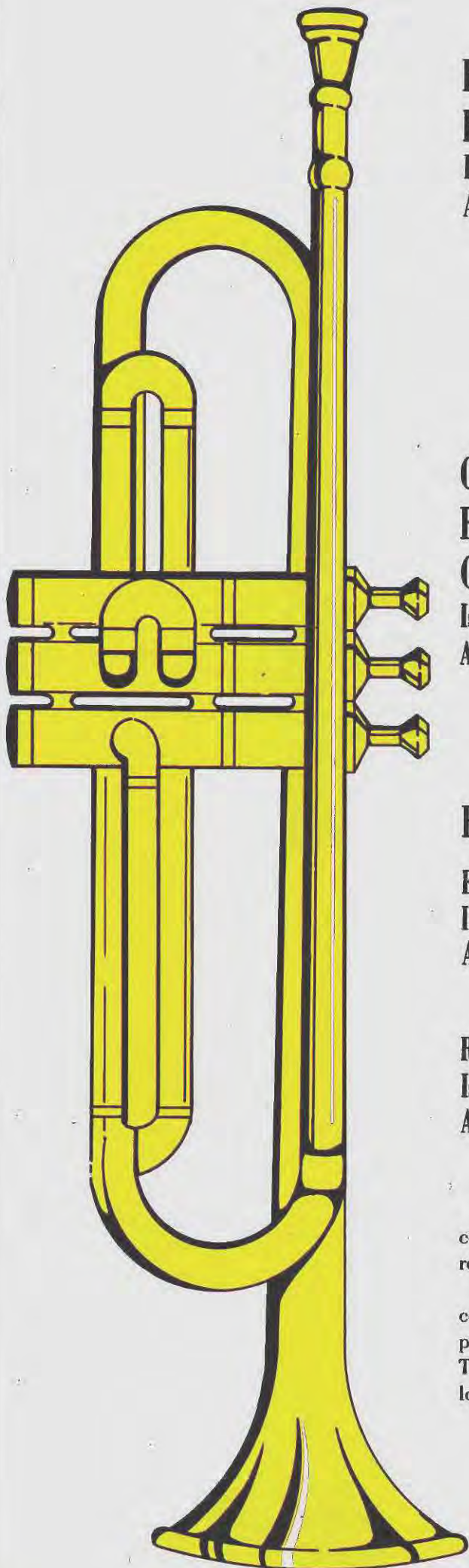
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RIMS NEW ORLEANS



RIMS

PREVIEW

Issue: April 22

Ad Closing: April 9

The first note on RIMS '91 will be played by Business Insurance in its annual RIMS Preview 'take-out' section.

Leading with last minute details and updated program and speaker changes, BI's 'take-out' section will contain valuable notes for everyone heading for New Orleans: a floor plan and list of exhibitors; a map of Conference hotels; transportation info; a message center phone number; a New Orleans entertainment and restaurant guide; and weather watch. There will also be highlights on the Spencer Educational Foundation's silent auction, the RIMS softball game, and other major hospitality functions.

Plus — increased exposure — the RIMS Preview 'take-out' section will be distributed from BI's booth #1024-1026.

CAPTIVES/ RISK MANAGER OF THE YEAR

Issue: April 29

Ad Closing: April 16

Business Insurance plays an important role — getting news and information into the hands of decision makers whether they're in their offices or attending the RIMS conference.

BI's feature on Captives will announce the 14th annual Risk Manager of the Year and the Risk Management Honor Roll. This issue also includes BI's exclusive Directory of Captive Managers.

Advertisers in this issue will be listed with their ad page numbers in a special wrap-around for bonus issue distribution at RIMS. BI advertisers who exhibit at RIMS will be listed with their booth number also. It's a once a year opportunity for you from BI ... in concert at RIMS.

RIMS REPORTS

Employee Benefits

Issue: May 6

Ad Closing: April 23

BI readers responsible for their companies' employee benefits will rely on this issue. From new perspectives to industry insights, BI editors will detail all the vital information covered at the RIMS employee benefits sessions.

Risk Management

Issue: May 13

Ad Closing: April 30

Wrapping up coverage of RIMS '91, BI editors will deliver an information-packed issue on the risk management sessions. Every corporate insurance buyer responsible for risk management will be sure to read this final RIMS feature cover-to-cover.

Business Insurance is the one publication conducting the most timely, comprehensive news coverage before, during and after one of the most important meetings of the year for its readers.

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Reliance Specialty Programs, Inc.

Continued from page 42
1990 gross revenues: \$300 million total.

Principal officers: Peter E. Friedes, chief executive officer.

I

Information Science Inc.

95 Chestnut Ridge Road, Mcntvale, N.J. 07645; 201-391-1600; fax: 201-391-2739

Year founded: 1965.

Software products:

• SAAvi: Unbundled hardware and software; personal computer or mainframe; first installation, 1988; 50 total installations. Functions include payroll, personnel, flex compensation, benefits, pension; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

• InSciPersonality: Unbundled hardware and software; personal computer; first installation, 1986; 125 total installations.

Functions include human resource management; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

• Pension Administration: Unbundled hardware and software; mainframe; first installation, 1976; 110 total installations. Functions include pension administration applications; can be used to communicate benefit programs to employees.

• Essential: Unbundled hardware and software; personal computer; first installation, 1979; 130 total installations. Functions include payroll, personnel, flex compensation, benefits applications; can be used to communicate benefit programs to employees; is designed to administer claims under COERA.

User support: User groups/meetings, telephone assistance available 12 hours per day, on-site support.

Clients: 500 employee benefit information system clients. Sold systems to 10 clients in 1990. Corporate employee benefit clients include 50% with gross revenues less than \$200 million, 20% with \$200 million-\$499 million, 15% with \$500 million-\$999 million, 10% with \$1 billion-\$3.5 billion.

with \$500 million-\$999 million, 10% with \$1 billion-\$3.5 billion, 5% exceeding \$3.5 billion.

Branch offices: Atlanta; Oakbrook, Ill.

1990 gross revenues: \$13.7 million total; all from employee benefit information systems, including 18% from software sales, 82% from software services.

Principal officers: Bruce Coleman, president/chief executive officer; Doug Salmon, executive vp; Robert Edwards, vp/general counsel-secretary; George E. O'Brien, vp-finance/administration.

Insurance Software Packages Inc.

5118 N. 56th St., Tampa, Fla. 33610; 813-621-6069; fax: 813-621-0652

Year founded: 1985.

Software products:

• ISP HealthStar: \$40,000; unbundled hardware and software; personal computer; first installation, 1986; 35 total installations, 15 in employee benefit departments. Functions include employee enrollment, payment, automatic claims adjudication, code validations, reports.

User support: User groups/meetings, telephone assistance available nine hours per day.

Staff: 65 total, 48 professionals.

Clients: 35 employee benefit information system clients. Sold systems to five clients in 1990. Corporate employee benefit clients include 50% with gross revenues less than \$200 million, 20% with \$200 million-\$499 million, 20% with \$500 million-\$999 million, 10% with \$1 billion-\$3.5 billion.

Branch offices: West Palm Beach, Fla.

1990 gross revenues: \$3 million total; \$250,000 from employee benefit information systems, including 85% from software sales, 15% from software services.

Principal officers: A. Allan Machesney, president; Janet M. Machesney, treasurer; Monique Knox, account executive.

K

Kwasha Lipton

2100 N. Central Road, Fort Lee, N.J. 07024; 201-592-1300; fax: 201-592-9012

Year founded: 1944.

Software products:

• Int-Act: \$20,000 and up; bundled hardware and software; personal computer; developed, 1986. Functions include benefits modeling for flexible benefits enrollment; can be used to communicate benefit programs to employees.

• Customer-designed, Micro Computer Benefits Administration System: \$8,000 and up; bundled hardware and software; personal computer; first installation, 1982; 60 total installations, all in employee benefit departments. Functions include recordkeeping, Social Security calculations, special benefits reports, data transfer and entry.

• Group Benefits Administrative System: \$15,000 and up; bundled hardware and software; personal computer; first installation, 1988; one total installation in an employee benefit department. Functions as a data base for administering all group benefit plans, flexible benefit enrollments for Section 125 accounts; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available 10 hours per day, updates, manuals.

Staff: 350 total, 30 professionals.

Clients: 60 employee benefit information system clients. Sold systems to 10 clients in 1990. Corporate employee benefit clients include 10% with gross revenues less than \$200 million, 15% with \$200 million-\$499 million, 40% with \$500 million-\$999 million, 35% with \$1 billion-\$3.5 billion.

1990 gross revenues: 60% from software sales, 40% from software services.

Principal officers: David A. Skovron, chief executive officer; Robert S. Byrne, chief operating officer; R.T. Whitman, partner-marketing.

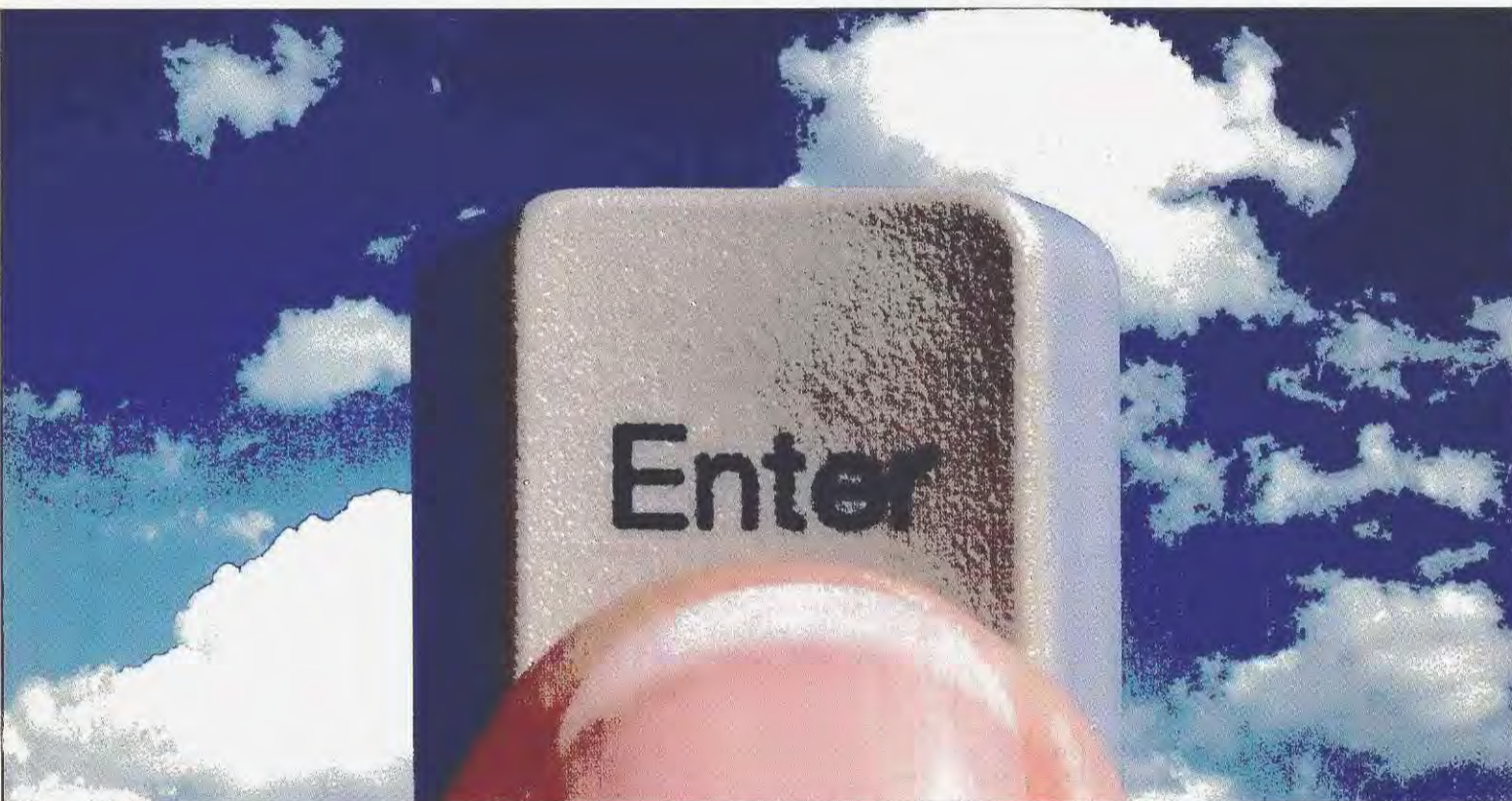
M

M&R Services

1301 Fifth Ave., Suite 3600, Seattle, Wash. 98101-2605; 206-624-7970; fax: 206-622-5643

Year founded: 1968.

Continued on next page



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Continued from previous page

Parent company: Milliman & Robertson Inc.

Software products:

• EBCOM: \$25,000; unbundled hardware and software; personal computer; first installation, 1988; five total installations, all in employee benefit departments. Interactive benefit communication tool; provides individual and general benefit information, projection capabilities; can be used to communicate benefit programs to employees.

User support: Telephone assistance available nine hours per day.

Staff: 58 total, 21 professionals.

Clients: 10 employee benefit information system clients. Sold systems to three clients in 1990. 2,700 corporate employee benefit system clients.

Branch offices: Albany, N.Y.; Atlanta; Boston; Chicago; Cincinnati; Dallas; Denver; Hartford, Conn.; Houston; Indianapolis; Los Angeles; Milwaukee; Minneapolis; New York; Omaha, Neb.; Philadelphia; Phoenix; Portland, Ore.; San Diego; San Francisco; St. Louis; Washington D.C.

1990 gross revenues: \$7 million total; \$500,000 from employee benefit information systems, including 5% from software sales, 95% from software services.

Principal officers: J. Lynn Peabody, chief operating officer; Kurt T. Corbin, vp-communications services; Carl R. Peterson, vp-computer services; Brian S. Pollack, vp-employee benefit services; Steven D. Sommer, vp-software services.

Magnus Software Corp.

2500 Windy Ridge Parkway, Marietta, Ga. 30067; 404-952-7854; fax: 404-952-7857

Year founded: 1976.

Software products:

• MaxCare: Unbundled hardware and software; mid-range computer; first installation, 1990. Functions include relational database, optional image processing, premium administration, claims adjudication, pre-certification, self-fund management, PPO processing; can be used to administer COBRA claims.

• RESPONSEplus: Unbundled hardware and software; personal computer; first installation, 1986. Functions include fully integrated claims adjudication and administration for the Wang VS platform; can be used to administer claims under COBRA.

• FASTRAK: Unbundled hardware and software; mainframe; first installation, 1981. Functions include on-line, realtime mainframe health claims administration and coverage for medical, dental, short-term or long-term disability; can be used to administer claims under COBRA.

• FLEXTRAK: Unbundled hardware and software; mainframe; first installation, 1986. Functions include realtime flexible benefits administration for IBM mainframes, including discrimination testing, flexible spending accounts, personalized enrollment forms; interfaces directly to certain payroll/personnel systems.

User support: User groups/meetings, telephone assistance available 12 hours per day, on-site support on request.

Staff: 90 total, 75 professionals.

Clients: 112 employee benefit information system clients.

1990 gross revenues: \$12 million.

Principal officers: Jay Hillebrand, president/chief executive officer; Phyllis Gray, vp; Michael Jenkins, vp-finance.

Mayer Hoffman McCann

420 Nichols Road, Kansas City, Mo. 64112; 816-968-2055; fax: 816-531-7695

Year founded: 1954.

Software products:

• Cafeteria Plan Management System: \$2,450-\$3,950; unbundled hardware and software; personal computer; first installation, 1985; 535 total installations, 225 in employee benefit departments. Functions as an accounting system for Section 125 flexible spending accounts; can be used to communicate benefit programs to employees.

• Cafeteria Plan Proposal System: \$495; unbundled hardware and software; personal computer; first installation, 1987; 615 total installations, 125 in employee benefit departments. Enrolls employees in Section 125 plans; can be used to communicate benefit programs.

User support: User groups/meetings, telephone assistance available eight hours per day.

Staff: 135 total, 100 professionals.

Clients: 225 employee benefit information system clients. Sold systems to 50 clients in 1990. Corporate employee benefit clients all have gross revenues

less than \$200 million.

1990 gross revenues: 100% from software services.

Principal officers: Miles Ross and Seven Baker, partners.

MEDSTAT Systems Inc.

777 E. Eisenhower, Ann Arbor, Mich. 48108; 313-996-1180

Year founded: 1981.

Software products:

• MEDSTAT System2: \$160,000; bundled hardware and software; personal computer; first installation, 1983; 68 total installations, all in employee benefit departments. Analyzes claims data to support cost containment.

User support: User groups/meetings, telephone assistance available nine hours per day, annual client conference.

Staff: 150 total, all professionals.

Clients: 68 employee benefit information system clients, all with gross revenues less than \$200 million.

Branch offices: San Francisco; Boston.

1990 gross revenues: \$13 million total; all from employee benefit information systems.

Continued on next page

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Continued from previous page
mation systems, including 100% from software sales.

Principal officers: Ernest G. Ludy, chairman/chief executive officer; Laurence J. Hagerty, president; Jennifer S. Ponski, vp/chief financial officer; Dennis J. Becker, senior vp; J. Dennis Bush, Ross L. Coffey, Michael Karaman and Deborah Gage, vps.

William M. Mercer Inc.

1417 Lake Cook Road, Deerfield, Ill. 60015; 708-317-7513; fax: 708-317-7416

Year founded: 1975.

Parent company: Marsh & McLennan Cos. Inc.

Software products:

- **Pension Express (Benefit Calculation System):** Unbundled hardware and software; personal computer; first installation, 1986; 100 total installations, 50 in employee benefit departments. Calculates defined benefit pensions; can be used to communicate benefit programs to employees.

- **FlexKey:** Unbundled hardware and software; personal computer, mainframe; first installation, 1984; 80 total installations, 45 in employee benefit departments. Functions as system for flexible benefit program enrollment, administration and reimbursement account processing; can be used to communicate benefit programs to employees.

- **Social Security Calculation System:** Unbundled hardware and software; personal computer, mainframe; first installation, 1979; 100-120 total installations, all in employee benefit departments. Calculates OASDI benefits under Social Security law.

- **MasterKey:** Unbundled hardware and software; mainframe; first installation,

1984. Functions as a participant accounting system for all aspects of defined contribution plan administration; can be used to communicate benefit programs to employees.

- **Allocation Express:** Unbundled hardware and software; personal computer; first installation, 1989; 50 total installations. Functions include accounting for all aspects of defined contribution plan administration; can be used to communicate benefit programs to employees.

- **LoanKey:** Unbundled hardware and software; personal computer; first installation, 1986; 100 total installations, 85 in employee benefit departments. Administers loan provision of any defined contribution plan; can be used to communicate benefit programs to employees.

- **DataKey:** Unbundled hardware and software; personal computer; first installation, 1987; 25 total installations, 10 in employee benefit departments. Collects and manages the flow of information in defined contribution plans.

- **TestKey:** Unbundled hardware and software; personal computer; first installation, 1987; 35 total installations, two in employee benefit departments. Performs discrimination tests in accordance with the rules established by the Tax Reform Act of 1986.

- **415 Express:** Bundled hardware and software; personal computer; first installation, 1988; 50 total installations, 5-10 in employee benefit departments. Functions include testing for compliance with Section 415 combined limits.

- **Mercer's TouchSource:** Unbundled hardware and software; personal computer, video disk player and touch-screen monitor; first installation, 1989. Functions as an interactive video disk system for flex enrollment, 401(k) modeling, company orientation, employee

attitude surveys; can be used to communicate benefit programs to employees.

- **Data Reconciliation System:** Unbundled hardware and software; personal computer; first installation, 1988; 50 total installations, 15 in employee benefit departments. Functions include reconciliation of yearly census data, incrementing of service fields.

- **Retirement Administration/Management System (RAMS):** Unbundled hardware and software; personal computer; first installation, 1987; 10 total installations, four in employee benefit departments. Builds and maintains a pension data base, calculates pension benefits, reports benefit information; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available.

Staff: 3,923 total.

Clients: 9,000 corporate employee benefit clients.

Branch offices: Albuquerque, N.M.; Anchorage, Alaska; Atlanta; Baltimore; Birmingham, Ala.; Boston; Charlotte, N.C.; Chicago; Cincinnati, Cleveland and Columbus, Ohio; Dallas, Fort Worth and Houston, Texas; Denver; Detroit; Indianapolis; Kansas City and St. Louis, Mo.; Los Angeles, Orange, San Francisco and San Jose, Calif.; Louisville, Ky.; Memphis and Nashville, Tenn.; Milwaukee; Minneapolis; Morristown, N.J.; New Orleans; New York, White Plains and Rochester, N.Y.; Philadelphia and Pittsburgh, Pa.; Portland, Ore.; Richmond, Va.; Seattle; Stamford, Conn.; Tampa, Fla.; Tulsa, Okla.; Washington D.C.; San Juan, Puerto Rico.

1990 gross revenues: \$448 million total.

Principal officers: Peter Coster, president; Robert A. Brochu, Ronald M. Walker and Thomas R. Waylett, executive vps.

P**P&W Software Inc.**

5655 Lindero Canyon Road, Suite 403, Westlake Village, Calif. 91362; 818-707-7690; fax: 818-707-9097

Year founded: 1984.

Software products:

- **POWERPLUS:** \$12,500; unbundled hardware and software; personal computer; first installation, 1987; 51 total installations, 28 in employee benefit departments. Functions include complete administration of flexible benefits; can be used to communicate benefit programs to employees.

User support: User groups/meeting, telephone assistance available 15 hours per day, newsletters, mailings.

Staff: Five total, three professionals.

Clients: 28 employee benefit information system clients, all corporate. Sold systems to nine clients in 1990.

Principal officers: Thomas E. Philipp, president; Michael C. Wilson, vp.

Parkside Data Services

205 W. Touhy Ave., Suite 200, Park Ridge, Ill. 60048; 708-698-4848; fax: 708-698-4804

Year founded: 1980.

Parent company: Parkside Health Management Corp.

Software products:

- **Caseplex/PC:** \$7,500; unbundled hardware and software; personal computer; first installation, 1990; seven total installations, one in employee benefit departments. Monitors and evaluates utilization, cost, quality of health care services; can be used to communicate benefit programs to employees.

User support: Telephone assistance available 10 hours per day.

Staff: Seven total, six professionals.
Clients: Seven employee benefit information system clients. Sold systems to seven clients in 1990.

Branch offices: Cleveland.

Principal officers: Marsha Ballard, president; Lee Green, vp-sales/marketing; Jay Gore, director-technical services.

Parsons, McKee, Sommers and Co.

1991 Crocker Road, Suite 350, Westlake, Ohio 44145; 216-871-8611; fax: 216-871-7485

Year founded: 1976.

Software products:

- **Benefit Computation System:** \$25,000-\$40,000; unbundled hardware and software; personal computer; first installation, 1979; 10 total installations, all in employee benefit departments. Computes all values, prepares forms for defined benefit plan claims and inquiry requirements; can be used to communicate benefit programs to employees.

- **Touchscreen Information System:** \$10,000-\$20,000; unbundled hardware and software; personal computer; first installation, 1990; one installation in an employee benefit department. Functions as an interactive information center for welfare, benefit plans and pensions; can be used to communicate benefit programs to employees.

User support: Telephone assistance, operator manuals, regular systems, other updates.

Staff: 17 total, nine professionals.

Clients: 20 employee benefit information system clients. Sold systems to three clients in 1990. 200 corporate employee benefit clients, including 50% with gross revenues less than \$200 million, 45% with \$200 million-\$499 million, 5% with \$1 billion-\$3.5 billion.

Continued on next page



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Continued from previous page

1990 gross revenues: \$1.5 million total; \$300,000 from employee benefit information systems, including 2% from hardware sales, 13% from software sales, 85% from software services.

Principal officers: John R. Parsons, Mark S. Sommers.

Pentabs

520 E. Montecito St., Santa Barbara, Calif. 93103;
805-963-8881/800-736-8227;
fax: 805-962-3106

Year founded: 1973.

Parent company: Corbel & Co.

Software products:

• **Defined Contribution/401(k)/ESOP System:** Unbundled hardware and software; personal computer; first installation, 1984; 650 total installations. Performs record keeping and administration of 401(k), ESOP and defined contribution plans; can be used to communicate benefit programs to employees.

• **Defined Benefit/Defined Contribution System:** Unbundled hardware and software; personal computer; first installation, 1979; 500 total installations. System administers defined contribution and defined benefit plans.

• **Government Forms System:** Unbundled hardware and software; personal computer; first installation, 1986; 200 total installations. System prepares and prints government forms for retirement plans.

User support: User groups/meeting, telephone assistance available 11.5 hours per day, regional and on-site client training.

Staff: 55 total.

Clients: 850 employee benefit information system clients.

Branch offices: Flint, Mich.; Cranford, N.J.; Marietta, Ga.; Chicago; Jacksonville, Fla.

Principal officers: Jim Thompson, general manager.

Policy Management Systems Corp.

One ASA Plaza, P.O. Box 385,
Bloomington, Ill. 60108;
708-893-9055; fax: 708-351-7605

Year founded: 1974.

Software products:

• **CAS II Claims Administration System:** Unbundled hardware and software; mainframe; first installation, 1982; 34 total installations, 27 in employee benefit departments. Functions include health claims administration, multiple claims edits, benefit payment calculation, dental claims processing, generates correspondence; is designed to administer claims under COBRA.

• **CAPS Claims Administration and Payment System:** Unbundled hardware and software; mainframe; first installation, 1978; 41 total installations, one in an employee benefit department. Administers and adjudicates claims covered under medical, dental, vision and other plans, administers cost containment programs including precertification, second surgical opinion, concurrent review and PPO programs.

• **CAPSule Health Claims Reporting System:** Unbundled hardware and software; mainframe; first installation, 1983; 18 total installations, one in an employee benefit department. Functions include group health claims reporting, including client, cost containment and management reports.

User support: User groups/meeting, telephone assistance, client advisory board, client magazine, customer information conference.

Client: Sold systems to three clients in 1990.

Branch offices: Columbia, S.C.

Principal officers: G. Larry Wilson, chief executive officer/president; Bernard C. Mazon and Robert Hoyt, executive vps.

PRO*Systems Inc.

26361 Curtiss Wright Parkway 2-F,
Richmond Heights, Ohio 44143;
216-289-7272; fax: 216-289-1564

Year founded: 1972.

Software products:

• **Pro*Claims Complete:** \$39,500; unbundled hardware and software; mini or micro computer; first installation, 1987; 20 total installations, nine in employee benefit departments. Processes medical, dental, disability, flexible benefits and workers compensation claims; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

User support: Telephone assistance, modem support.

Staff: 25 total, six professionals.

Clients: 20 employee benefit information system clients. Sold systems to 20 clients in 1990.

Branch offices: Euclid, Ohio.

1990 gross revenues: \$1.1 million total; \$665,000 from employee benefit information systems, including 25% from hardware sales, 50% from software sales, 25% from software services.

Principal officers: Vincent A. Loparo, chief executive officer/president; Harold E. Musick, vp.

Professional Computer Services

One Civic Plaza, Suite 350, Carson,
Calif. 90745; 213-330-1072; fax:
213-830-4235

Year founded: 1964.

Software products:

• **Medical Claims Adjudication:**

\$35,000; unbundled hardware and software; personal computer; first installation, 1975; 40-60 total installations, 15 in employee benefit departments. Functions as a fully automated, table-driven claims system.

• **Enrollment-employee & dependent:** \$5,000; unbundled hardware and software; personal computer; first installation, 1964; 40-60 total installations, all in employee benefit departments. Functions include on-line entry, viewing and update of employee census.

• **Payroll interfaced eligibility:** \$10,000; unbundled hardware and software; personal computer; first installation, 1964; 40-60 total installations, all in employee benefit departments. Functions as a payroll interfaced system to establish monthly eligibility; is designed to administer claims under COBRA.

User support: User groups/meeting, telephone and on-site assistance.

Staff: Seven total, five professionals.

Clients: 45 employee benefit information system clients. Sold systems to two clients in 1990.

1990 gross revenues: \$650,000 total; all from employee benefit information systems, including 20% from software sales, 80% from software services.

Principal officers: J. Patrick Broman, president; Michael E. Smith, vpmarketing.

R

Resource Information Management Systems Inc.

500 Technology Drive, P.O. Box
3094, Naperville, Ill. 60566-7094;
708-369-5300; fax: 708-369-5168

Year founded: 1981.

Software products:

• **QicClaim/2 Health Claims Processing System:** Unbundled hardware

and software; personal or min. computer; first installation, 1989; 73 total installations, 16 in employee benefit departments. Functions as an employee benefits administration system for processing group health claims.

• **QicClaim Health Claims Processing System:** Unbundled hardware and software; mini computer; first installation, 1981; 279 total installations, 30 in employee benefit departments. Functions as an employee benefits administration system for processing group health claims.

User support: User groups/meetings, telephone assistance available 24 hours per day, consulting services, continuing education programs.

Staff: 132 total, 77 professionals.

Clients: 352 employee benefit information system clients. Sold systems to 42 clients in 1990. 31 corporate employee benefit clients including 96% with gross revenues less than \$200 million, 4% with \$200 million-\$499 million.

Branch offices: Troy, N.Y.

1990 gross revenues: \$19.9 million total; \$18.9 million from employee benefit information systems, including 45% from hardware sales, 29% from software sales, 26% from software services.

Principal officers: Terry L. Kirch, chief operating officer; Thomas H. Heimsoth, chief executive officer; Thomas J. Colgan and Howard P. Downs, executive vps.

S

SBC Systems Corp.

30 Perimeter Center E., Suite 203,
Atlanta, Ga. 30346; 404-399-5321;
fax: 404-399-5322

Year founded: 1977.

Continued on next page

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issue: April 15
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 demographic section: Insurer Topics: Loss Control & Catastrophe Planning

issue: April 22
 closing: April 9
 editorial feature: RIMS Preview

issue: April 29 — Reader Service Bonus Distribution: RIMS
 closing: April 16
 editorial feature: Captives/Risk Manager of the Year — Directory: Captive Managers

issue: May 6
 closing: April 23
 editorial feature: RIMS Report: Employee Benefits
 demographic section: Agent/Broker Topics: Advertising/Sales Promotion/Community Relations

issue: May 13 — Reader Service Bonus Distribution: PRIMA
 closing: April 30
 editorial feature: RIMS Report: Risk Management

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SET YOUR DATES

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Software products:

- Full Flexible Benefits Administration System: \$20,000; unbundled hardware and software; personal computer; first installation, 1985; 60 total installations, 24 in employee benefit departments. Functions include credit calculations, enrollment, spending accounts, employee statements; can be used to communicate benefit programs to employees.
- 401(k)/Defined Contribution Administration System: \$20,000; unbundled hardware and software; personal computer; first installation, 1984; 40 total installations, 19 in employee benefit departments. Functions include contributions, investments, loans, non-discrimination testing, retiree payroll; can be used to communicate benefit programs to employees.
- Defined Benefit Administration: \$20,000; unbundled hardware and software; personal computer; first installation, 1979; 40 total installations, 19 in employee benefit departments. Functions include valuation capabilities, benefit calculations, retiree payroll; can be used to communicate benefit pro-

grams to employees.

• Employee Communications System: \$15,000; unbundled hardware and software; personal computer; first installation, 1990. Provides comprehensive statements to employers, user defined text, input from any source; can be used to communicate benefit programs to employees.

• SBC Talk-Voice Response System: \$15,000; unbundled hardware and software; personal computer; first installation, 1990; one total installation in an employee benefit department. Functions include using touch-tone phones to answer benefit questions with customized "what if" calculations; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available 12 hours per day, on-line diagnostic assistance through the use of telecommunications.

Staff: Nine total, all professionals.

Clients: 120 employee benefit information system clients. Sold systems to 40 clients in 1990. Corporate employee benefit clients include 10% with gross revenues less than \$200 million, 15% with \$200 million-\$499 million, 25% with \$500 million-\$999 million, 50% with \$1 billion-\$3.5 billion.

Principal officers: Murray Goldman, president; Eva Chang, executive vp; Margaret King, vp-product services.

SBPA Systems Inc.

10777 Westheimer, Suite 125,
 Houston, Texas 77042;
 713-974-7272; fax: 713-974-5990

Year founded: 1975.

Software products:

• GBAS: Unbundled hardware and software; mini computer; first installation, 1975; 35 total installations, eight in employee benefit departments. Functions include administering Section 125 claims, determining eligibility for benefit plan, claims adjudication; is designed to administer claims under COBRA.

User support: User groups/meetings, telephone assistance available eight hours per day, training, installation, system analysis, custom training.

Staff: 17 total, 15 professionals.

Clients: 33 employee benefit information system clients. Sold systems to two clients in 1990. Seven corporate employee benefit clients, including 43% with gross revenues less than \$200 million, 43% with \$200 million-\$499 million, 14% with \$500 million-\$999 million.

1990 gross revenues: \$1.2 million total; all from employee benefit information systems, including 10% from hardware sales, 40% from software sales, 50% from software services.

Principal officers: Arnold Heinrich, president; Tim Stunz, executive vp.

SW Systems Inc.

P.O. Box 6453, Santa Barbara, Calif.
 93160; 805-963-5959;
 fax: 805-967-9526

Year founded: 1980.

Software products:

• Claims Work: \$45,000; unbundled or bundled hardware and software; mini computer; first installation, 1980; 45 total installations, 40 in employee benefit departments. Functions include automatic medical, dental, vision, short-term disability claims administration and adjudication module; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

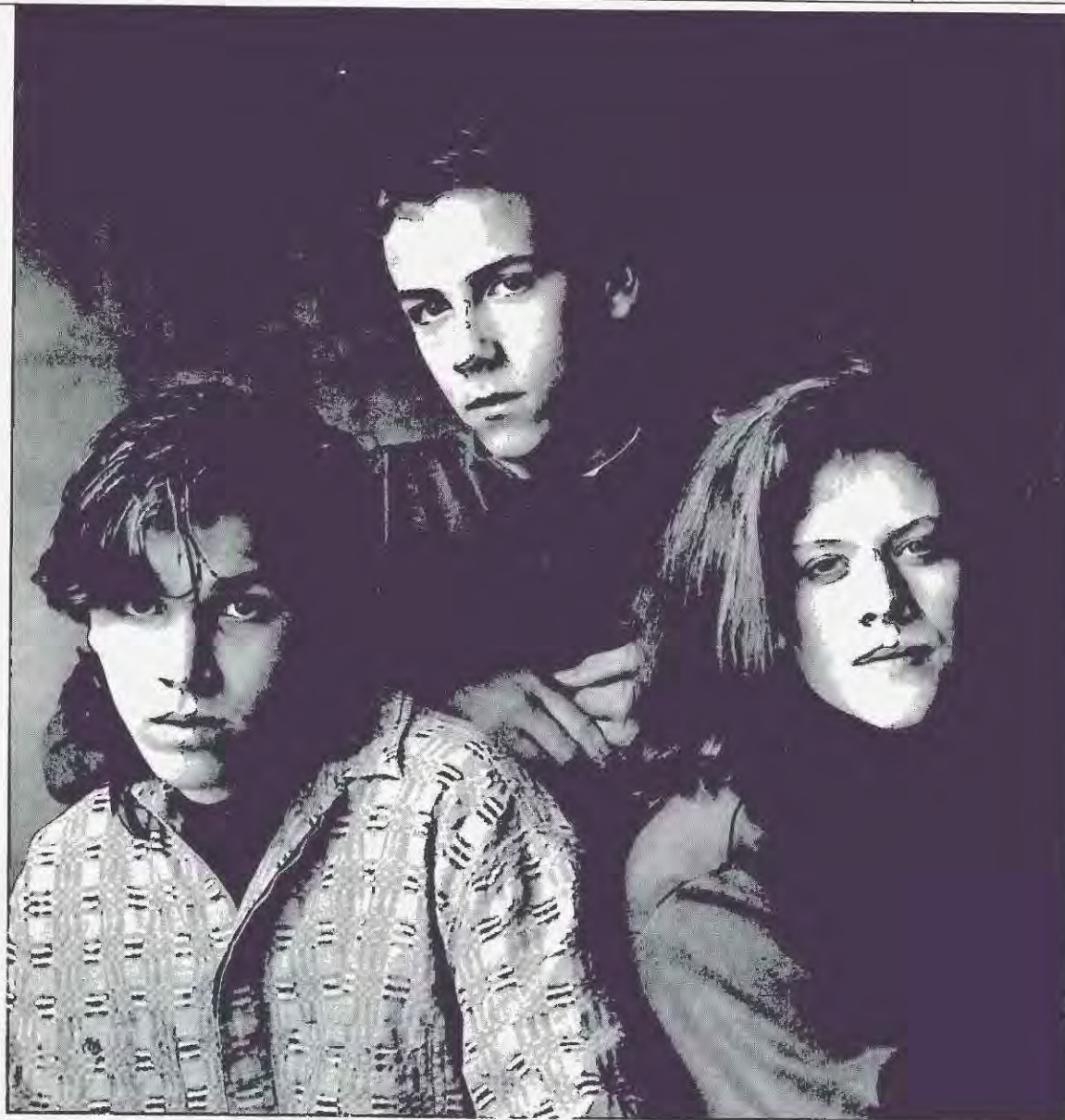
• Cost Work: \$5,000; unbundled or bundled hardware and software; mini computer; first installation, 1980; 15 total installations, 10 in employee benefit departments. Functions include pre-certification, second and third surgical opinion, savings calculations and reporting; can be used to communicate benefit programs to employees.

• HMOWork: \$10,000; unbundled or bundled hardware and software; mini computer; first installation, 1985; four total installations. Functions include IPA administration, capitation, risk pools, withhold accounts, gatekeeper, primary care provider, specialty referral tracking and authorization; can be used to communicate benefit programs to employees.

• BillingWork: \$5,000; unbundled or bundled hardware and software; mini computer; first installation, 1982; six total installations, five in employee benefit departments. Functions include group and individual billing, cash posting; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

• EAPWork: \$25,000; unbundled or bundled hardware and software; mini computer; first installation, 1991; one total installation. Employee assistance program administration system, in-

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**The revolving door stops
 at San Marcos Treatment Center.**

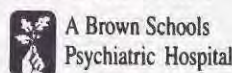
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San Marcos Treatment Center



Continued from previous page

cludes functions and screens for intake, authorization, utilization review and facilities; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available 10 hours per day, on-line assistance.

Staff: 35 total, four professionals.

Clients: 45 employee benefit information system clients. Sold systems to five clients in 1990.

1990 gross revenues: \$1.5 million total; all from employee benefit information systems, including 10% from hardware sales, 40% from software sales, 50% from software services.

Principal officers: William Whitmore, president.

SOTRISS Corp.

945 E. Paces Ferry Road, Suite 1910, Atlanta, Ga. 30326; 404-261-6313; fax: 404-231-9541

Year founded: 1983.

Parent company: Lincoln National Corp.

Software products:

• IS-5 Health: Unbundled hardware and software; mid-range computer; first installation, 1990. Functions include benefits plan development and redefinition, utilization review, contracting, eligibility, billing, claims processing, commissions, cost containment, management reports; is designed to administer claims under COBRA.

User support: User groups/meetings, telephone assistance available eight hours per day, enhancements, systems consulting.

Staff: 80 total.

Branch offices: Los Angeles; Fort Wayne, Ind.

Principal officers: Paul Harrison, president/chief executive officer; Don Taylor, vp.

Spectrum Human Resource Systems Corp.

1625 Broadway, Suite 2800, Denver, Colo. 80030; 303-534-8813; fax: 303-595-9970

Year founded: 1986.

Software products:

• HR/2000: \$7,625; unbundled hardware and software; personal computer; is designed to administer claims under COBRA.

• HR/1200: \$1,195; unbundled hardware and software; personal computer.

• TD/2000: \$4,495; unbundled hardware and software; personal computer.

• AM/2000: \$5,495; unbundled hardware and software; personal computer.

User support: User groups/meetings, telephone assistance available 12.5 hours per day, data conversion, implementation, customization, toll-free hotline, on-going training.

Staff: 65 total.

1990 gross revenues: \$4 million total.

Principal officers: James E. Spoor, president; Nancy E. Spoor, vp-marketing/sales; Sally Burton Thompson, sales manager.

Stellar Software Inc.

19406 E. Floyd Ave., Aurora, Colo. 80013, 303-680-9408

Year founded: 1987.

Software products:

• FLEX-STAR-Flexible Spending Account System: \$2,295; unbundled hardware and software; personal or mini computer, mainframe; first installation, 1987; three total installations. Calculates and processes flexible spending accounts and survey information.

• Bill-Star-Group Insurance Premium Billing System: \$4,995; unbundled hardware and software; personal or mini computer, mainframe; first installation, 1987; one total installation. Bills employers for group insurance premiums as well as billing for COBRA participants.

User support: Telephone assistance available eight hours per day.

Staff: Three total, all professionals.

Clients: Three employee benefit information system clients. Sold systems to one client in 1990. Corporate employee benefit clients include 100% with gross revenues less than \$200 million.

Principal officers: Otto F. Feiler, president.

Stop Loss

International Corp.

3333 Founders Road, Indianapolis, Ind. 46268; 317-876-0399

Year founded: 1983.

Software products:

• ULTRAPLUS: \$25,000; unbundled hardware and software; local area network or personal computer; first installation, 1987; 10 total installations, two in employee benefit departments. Functions include administering flexible benefit plans; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available eight hours per day, on-site client training.

Staff: 65 total.

Clients: 15 employee benefit information system clients, 100% with gross revenues less than \$200 million. Sold systems to three clients in 1990.

Principal officers: Laurence B. Day, chairman; William Black, president; Sharon Day, vp-marketing; Steve Hendrixson, vp-select software division.

T

TALX Corp.

1850 Borman Court, St. Louis, Mo. 63146; 314-434-0046; fax: 314-434-9205

Year founded: 1979.

Software products:

• The TALX System: \$35,000-\$60,000; bundled hardware and software; proprietary processor; first installation, 1986; 30 total installations, all in employee benefit departments. Functions include flexible benefit enrollment, 401(k) information, stock and savings information, loan information;

can be used to communicate benefit programs to employees.

User support: Telephone assistance available 24 hours per day, consultation services.

Staff: 70 total, 64 professionals.

Clients: 30 employee benefit information system clients. Sold systems to 20 clients in 1990.

Branch offices: Boston; Irvine, Calif.

1990 gross revenues: \$5.5 million total; \$1.65 million from employee benefit information systems, including 75% from hardware/software sales, 10% from software services, 15% from maintenance.

Principal officers: William W. Canfield, president; John E. Tubbesing, vp-sales; Michael E. Smith, vp-marketing; W. Gary Lowe, vp-business development.

TPF&C

Centre Square W., 1500 Market St., Philadelphia, Pa. 19102; 215-246-6000; fax: 215-246-6251

Year founded: 1934.

Parent company: Towers, Perrin, Forster & Crosby Inc.

Software products:

• Pension Manager: Unbundled hardware and software; personal computer; first installation, 1986; more than 80 total installations, all in employee benefit departments. Maintains a database of defined benefit plan information and performs pension and Social Security calculations using a parameterized pension calculation module; can be used to communicate benefit programs to employees.

• PenCalc: Personal Computer; Unbundled hardware and software; first installation, 1986.

Continued on next page



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Spotlight report

Continued from previous page
 installation, 1985; 85 total installations, all in employee benefit departments. Mainframe: unbundled hardware and software; first installation, 1974; 50 total installations, all in employee benefit departments. Calculates defined benefit pension plans; can be used to communicate benefit programs to employees. Can be integrated into PensionManager.

- **SSCalc: Personal Computer:** Unbundled hardware and software; first installation, 1984; 200 total installations, all in employee benefit departments. Mainframe: Unbundled hardware and software; first installation, 1974; 90 total installations, all in employee benefit departments. Calculates Social Security benefits; can be used to communicate benefit programs to employees. Can be integrated into PensionManager.

- **Account Manager:** Unbundled hardware and software; mainframe; first installation, 1983; 201 total installations. Functions include total administration, recordkeeping and reporting requirements for defined contribution plans, participant statements and check-writing components and real-time telephone access.

- **FlexManager:** Unbundled hardware and software; personal computer; first installation, 1987; 40 total installations, all in employee benefit departments. Administers flexible benefit plans and flexible spending accounts; can be used to communicate benefit programs to employees.

- **Telephone Voice Response System:** Unbundled hardware and software; personal computer and mainframe; first installation, 1988; 40 total installations. Provides benefit plan enrollment, flexible benefits, defined contribution plan account balances, loan modeling and transactions, defined benefit plan

values and projections, voice response benefit statements, surveys and meeting registration.

- **Interactive Software:** Unbundled hardware and software; personal computer; first installation, 1985; 15 total installations. Provides retirement planning information, savings plan modeling, flexible benefit enrollment, electronic benefit statements.

User support: User groups/meeting, telephone assistance, on-site services.

Staff: 5,000 total, 3,700 professionals.
Clients: More than 8,000 corporate employee benefit clients.

Branch offices: 66 locations worldwide.

Principal officers: John T. Lynch, chairman/chief executive officer-Towers, Perrin, Forster & Crosby Inc.; J. Russell Southworth, managing director-TPF&C.

Tesseract Corp.

150 Spear St., San Francisco, Calif. 94105; 415-543-9320; fax: 415-543-5927

Year founded: 1971.
Parent company: The Prudential Insurance Co. of America.

Software products:

- **Tesseract's Benefit/Flexible Benefit Plan Administrator:** \$100,000-\$200,000; unbundled hardware and software; personal computer or mainframe; first installation, 1982; 122 total installations, all in employee benefit departments. Tracks data for legislative compliance; can be used to communicate benefit programs to employees; is designed to administer claims under COBRA.

- **Tesseract's Investment Plan Manager:** \$100,000-\$200,000; unbundled hardware and software; personal computer or mainframe; first installation, 1987; 44 total installations, all in em-

ployee benefit departments. Functions include defined contribution plan administration, 401(k), ESOP, after-tax savings; can be used to communicate benefit programs to employees.

- **Tesseract's Retirement Plan Manager:** \$100,000-\$200,000; unbundled hardware and software; personal computer or mainframe; first installation, 1990; five total installations, all in employee benefit departments. Functions include defined benefit plan administration for any retirement type and all forms of optional payments; can be used to communicate benefit programs to employees.

- **Tesseract's Claims Processing System:** \$100,000-\$200,000; unbundled hardware and software; personal computer or mainframe; first installation, 1983; 15 total installations, all in employee benefit departments. Functions include employer processing for medical, drug, dental, vision and hospital claims and cost containment; can be used to communicate benefit programs to employees.

User support: User groups/meetings, telephone assistance available 24 hours per day, consulting, training, maintenance, enhancement releases.

Staff: 220 total, 110 professionals.

Clients: 122 employee benefit information system clients, including 10% with gross revenues less than \$200 million, 10% with \$200 million-\$499 million, 10% with \$500 million-\$999 million, 30% with \$1 billion-\$3.5 billion, 40% exceeding \$3.5 billion. Sold systems to 21 clients in 1990.

Branch offices: Boston; Dallas; Detroit; Inverness, Ill.; Paramus and Voorhees, N.J.

1990 gross revenues: 70% from software sales, 30% from software services.

Principal officers: William R. Leckonby, president; Ronald Ellis, vp-sales; Lyn Jensen, vp-finance; MaryKay Mar-

vin, vp-marketing; Fran Swanson, vp-technology; Mike Green, vp-consulting division; Gary Durbin, founder/executive vp.

3M Health Information Systems

575 W. Murray Blvd., Murray, Utah 84157; 800-367-2447; fax: 801-261-3751

Year founded: 1981.
Parent company: 3M Co.
Software products:

- **DRG Grouper Code 3/HSI Systems:** Unbundled hardware and software; personal computer, mini computer or mainframe; first installation, 1983. Assigns DRG Group in hospitals.

- **All-patient Refined DRG Grouper:** Unbundled hardware and software; mainframe. Addresses cost, effectiveness and quality.

User support: Telephone assistance available 24 hours per day.

Staff: 300 total.

Branch offices: Wallingford, Conn.
Principal officers: A.E. Eggert, general manager; Ron Bernier, business unit manager.

Travelers Cos. Risk Management Information Services

One Tower Square, Hartford, Conn. 06183-4063; 203-277-1679; fax: 203-277-2876

Year founded: 1864.
Parent company: The Travelers.
Software products:

- **INFORM:** Unbundled hardware and software; mainframe; first installation, 1988; 70 total installations, 64 in employee benefit departments. Functions include employee benefit claim financial and statistical reporting and analysis; can be used to administer claims under COBRA.

- **Group CARMA:** Unbundled hardware and software; mainframe. Functions include identification of workers compensation and employee benefit double-dipper claimants; can be used to

administer claims under COBRA.

User support: User groups/meetings, telephone assistance.

Staff: 17 total, all professionals.

Clients: 70 employee benefit information system clients, including 10% with \$200 million-\$499 million, 10% with \$500 million-\$999 million, 60% with \$1 billion-\$3.5 billion, 20% exceeding \$3.5 billion. Sold systems to 22 clients in 1990.

Branch offices: Brea, Calif. and Naperville, Ill.

Principal officers: Jack Gardner, vp; Matthew Carden, director.

Travis Software Corp.

1001 S. Dairy Ashford, Suite 206, Houston, Texas 77077; 713-496-3737

Year founded: 1986.

Software products:

- **Corporate COBRA Manager:** \$1,295; unbundled hardware and software; personal computer; first installation, 1986; 2,506 total installations, 2,153 in employee benefit departments. Administers claims under COBRA; can be used to communicate benefit programs to employees.

- **TravisFlex:** \$1,295; unbundled hardware and software; personal computer; first installation, 1987; 568 total installations, 418 in employee benefit departments. Administers flexible benefit plans; can be used to communicate benefit programs to employees.

- **Group Premium Billing Manager:** \$3,995; unbundled hardware and software; personal computer; first installation, 1989; 68 total installations; functions include premium billing.

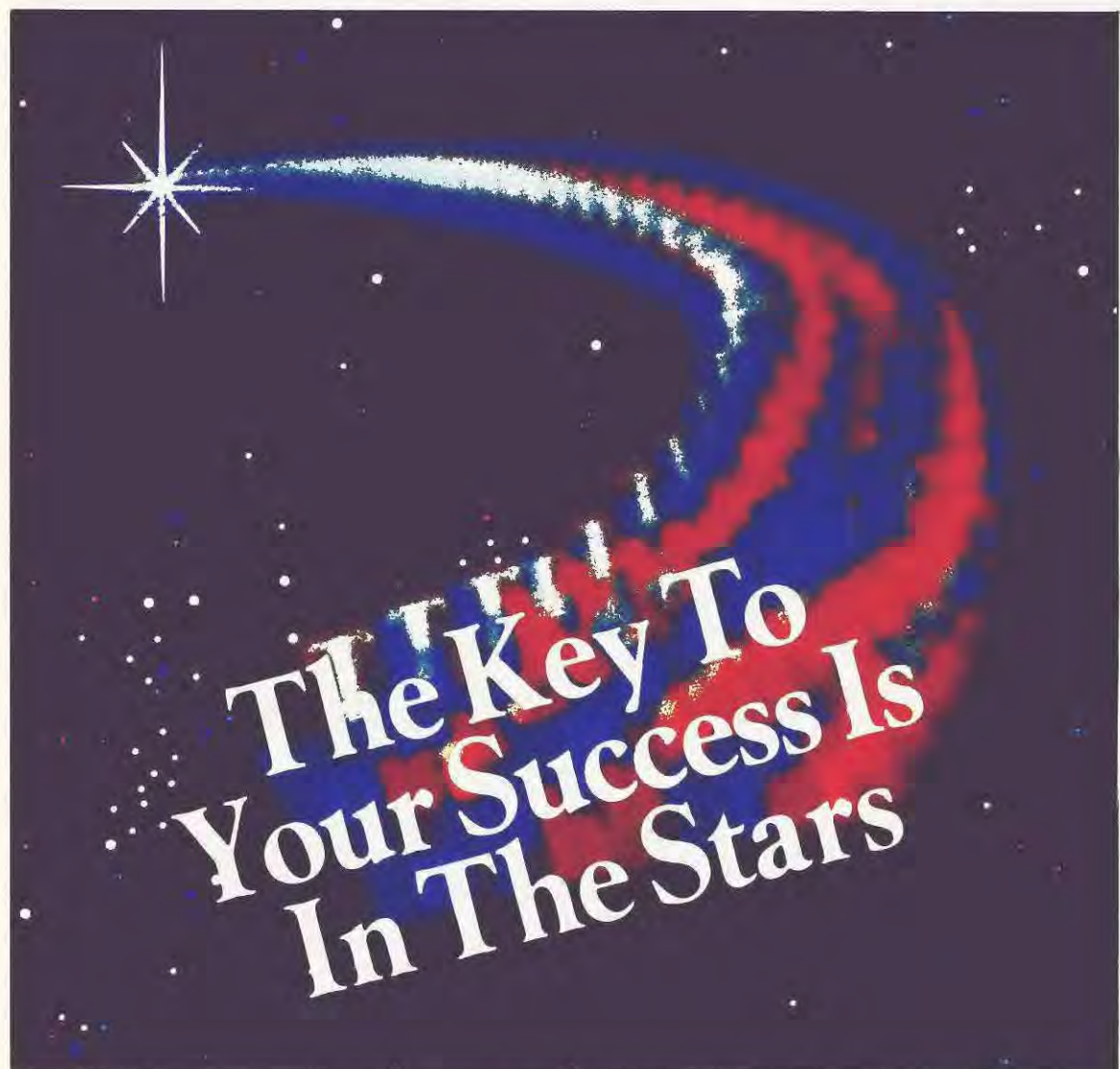
User support: Telephone assistance available eight hours per day.

Staff: 22 total, 11 professionals.

Clients: 2,571 employee benefit information system clients. Sold systems to 388 clients in 1990.

1990 gross revenues: \$1.9 million total; all from employee benefit information systems, including 54% from hardware sales, 46% from support systems.

Continued on next page



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Agent/Broker

A monthly editorial section sent exclusively to agents and brokers

Overpaying staffs plagues agencies

Their failure to change with the times 'spells disaster,' principals cautioned

By LAURA MAZZUCA

Slumping agency commissions are making it more important than ever to reassess producer compensation. Commissions, by one consultant's estimate, have dropped to 13% from 22% of premium volume in the last 15 years, and many agencies have failed to react.

"It's very easy to slip into the overspending philosophy," said Roy Phillips, partner at King-Smith Insurance Consultants in Houston. "Agents are getting better about it, but they still can't analyze how they spend their money."

Overly generous principals run the risk of eroding the agency's bottom line and often end up having to skimp on their own compensation.

"Owners are without question taking too little in the way of return," by, for instance, drawing only a salary and getting no return on their equity, said Larry Marsh, president of Marsh, Berry & Co. Inc. in Mentor, Ohio.

"That's why thousands of agencies are going through the sale process right this minute," he said.

As a result, principals are taking a long, hard look at compensation, especially for producers, who absorb a significant amount of a typical agency's revenues.

According to a 1989 compensation survey by the National Assn. of Professional Insurance Agents, producers on average take 38% of agency commission on new accounts, 27% on renewals, and 31% for additional business for existing accounts, said Miriam Meister, executive vp of the PIA Insurance Foundation.

"Most agency principals realize they have to scale back on their producer compensation," noted Charles E. Coyne, a senior consultant with Business Management Group, an agency consultant in Hartford, Conn. "They can't pay 45% splits on renewal business and still make a 15% profit."

The problem is much more urgent today than it was only a few years ago, said Mr. Coyne. The soft market has worn on now for almost five years, resulting in less business and shrinking commissions, even as agency revenues are depleted by rising overhead expenses.

In 15 years, the average commission an insurer granted an agency has shrunk more than a third—to about 13% from 22%, said Tom Williams, an agency consultant and president and chief operating officer of Noack & Dean Insurance Agency in Sacramento, Calif.

"So if you're still operating the way you did 15 years ago, it spells disaster," Mr. Williams added.

In the mid-'80s, many agencies were still paying producers as much as 50% of commissions for new business. But forward-thinking principals tightened their belts by cutting commissions and eliminating traditional perks like company cars and country club memberships (A/BT, April 4, 1988).

Austerity programs were further honed as the market, defying all odds and predictions, stayed soft. By 1990, a typical producer compensation structure was 40% of commissions for new business and 25% to 30% on renewals (A/BT, April 2, 1990).

Today that percentage is even lower for locally owned, smaller agencies, which pay producers an average 35% of commission for both new and renewal business, said Lee Schexnayder, president of Insurance Resource Consultants in Fair Oaks, Calif.

"That's about all they can afford to pay these days and still make a buck," he added.

Mr. Phillips of King-Smith Insurance Consultants specializes in financial analyses for agencies in "dispute situations," such as bankruptcy, split-up of principals and tax problems.

'Agents are getting better about it, but they still can't analyze how they spend their money.'

— Roy Phillips

King-Smith Insurance Consultants

All of these "stressed" agencies share one trait: They overcompensate non-owner producers.

The temptation to overcompensate is especially prevalent for agencies with older producers, who are carrying commission splits from more lucrative times, said Mr. Phillips.

These splits grew more impractical as books of business got "skinnier" in the early '80s, he said.

And because many traditional perks like trips, company cars, country club fees and other goodies have long gone out the window, many producers expect a big commission split to make up for it.

Most principals continue to use "extravagant formulas" to pay producers for both new and renewal business, but those formulas are rapidly becoming outdated, he said. Variables like customer service representatives taking on an increasing workload and agencies seeking specific lines of business make it impossible to apply the formulas of old.

Consultants put the "average" commission split at 40% for new and 25% for renewal business, yet they caution that all producers are not created equal.

Producers today are generally "a hybrid between an account executive and a dynamic new business generator," said Timothy J. Cunningham, senior consultant with Hales & Associates of Oak Brook, Ill. While an account executive is a "business keeper," a new business generator is "driven by selling" and is not interested in maintaining renewals.

That disparity requires agencies to offer several compensation plans; otherwise, "you end up with a big compromise for everyone," Mr. Cunningham said.

When CSRs, account executives and other "paraprofessional support staff" handle a lot of administrative work, producer compensation should be lowered, he advised (see story, page 50B).

Conversely, agencies with smaller, less productive support staffs should give producers higher commission percentages, he said.

Commission splits for producers must also be tied to overall business goals, said Mr. Marsh of Marsh, Berry.

As more agencies shift their focus to larger commercial policies, for instance, they tend to give no commission split for renewals on personal lines. Small commercial account renewals also bring little or no split. Depending on the agency, "small" may mean less than \$500 or \$1,000 in commissions, though larger agencies sometimes define it as high as \$5,000, he said.

Other agencies take a different tack. To encourage handling of larger policies, they specifically reward producers who bring in that size business.

At Noack & Dean, producers earn 60% of commission on new accounts that exceed \$50,000, but only 40% on smaller accounts, said Mr. Williams. This process helps offset overall reductions in commissions.

Commissions on referrals can present dicey problems for primarily commercial agencies that have life and health departments.

To foster cooperation between producers from the

Continued on next page



Pay cut revolts averted, but only narrowly

By LAURA MAZZUCA

Agencies that have cut producer compensation compare the ordeal to visiting the dentist. It's time-consuming, painful and initially expensive, but it's good for you.

Each agency principal has a different story to tell. Most, however, went through similar steps: They decided they were overcompensating; formulated a replacement system; put that system into place and dealt with the ensuing fallout.

Finally, they say, they saw some improvements.

THE DECISION

Confronting the numbers

A lingering soft market may have

been partially responsible for some principals cutting back. But many only had to take a closer look at their competition to know they were paying producers too much.

"We were just plain out of line," said John Welch, president of Wallace, Welch & Willingham, a second-generation, \$30 million annual premium volume agency in St. Petersburg, Fla.

Although his agency was becoming financially overextended because of the soft market, the real reason he wanted to reduce producer commissions was because his producers were paid more than others in the region, he said.

A long, hard look at the dollars coming in and going out was

enough to convince consultant and agency principal Tom Williams to restructure producer commissions.

Based on the industry's standard of 15% annual return, Mr. Williams could plainly see that his 50%-35% commission splits were too rich for the agency's blood.

"All I had to do was show them the numbers; they knew I was right," said Mr. Williams, the president and chief operating officer of Noack & Dean Insurance Agency in Sacramento, Calif.

Any established agency with more than \$15 million in annual premiums could confront the problem of overcompensation, said Mr. Williams.

Rapid expansion can magnify the

problem. "As you get bigger, you start realizing that there is a narrow margin of profit," he said. About nine years ago, with 25 producers scattered at acquired agencies throughout the Southeast, Mr. Williams said, he really began to feel the pinch.

Compensation problems plague some principals from the time they attain ownership.

This was the case with Greg Morris, president of the Morris & Dee in San Luis Obispo, Calif., a \$34 million annual premium volume agency.

Four years ago, when Mr. Morris retired the stock of his retiring partner—doubling his stake to 80%—he inherited an agency that

was disorganized and suffering from a lack of focus, he said.

Commercial lines producers were taking up to 50% of commission on both new and renewal business, and insurers were sharply cutting back commissions or pulling out of California altogether.

High producer commissions clearly had to go, said Mr. Morris. "I had to create levels of responsibility for our people."

Other principals decide to alter commission structures to target specific types of business—and to dodge the soft-market bullet.

Thoits Insurance of Palo Alto, Calif., is now phasing in lower commissions to specifically reward producers who bring in larger accounts, said Chief Executive Don Way.

"The soft market may have spurred it, but this change is one we would have made sooner or later," said Mr. Way, whose agency has \$40 million in annual premium volume.

THE PROCESS

Back to basics or on to new markets?

Before changing commission structures, principals should have a good idea of where they want to take their agencies, and how doing so will help.

For Don Reize, president of Insurance Exchange Inc. in Rockville, Md., the highest priority is motivating producers who have grown fat and lazy on a commission-plus-draw system.

"If salary is too high, the comfort level is too high," said Mr. Reize, whose agency has annual premium volume of \$15 million.

As a 30-year veteran of the business, "there isn't a formula I haven't used," Mr. Reize said. But to make his eight producers more aggressive, "I'm going back to what I used when I started—straight commission."

Paying commissions only "when the business is there" is especially important in a soft market, he added.

Because the producers at Insurance Exchange already have contracts with the agency, the new system will be gradually phased in over the next several years as the contracts expire.

Salaries will be reduced gradually over a year. Draws will continue for three months, but then be phased out over nine months.

At Wallace, Welch & Willingham in St. Petersburg, Fla., the primary focus was adding larger accounts.

Four years ago, when Mr. Welch decided to alter producer compensation, producers were getting 40% of commissions on both new and renewal commercial property/casualty business; 60% on new and renewal life business; and 60% on group business.

To encourage them to land larger accounts, he set commercial property/casualty producer commission at 35% on accounts over \$5,000, and 17% on accounts between \$5,000 and \$2,500. Accounts below that level carry no commissions. New and personal lines commissions were also cut to 10%.

Support services were bolstered to free up producers—an expensive step in restructuring producer compensation. The agency set up a marketing and telemarketing department and gave customer service representatives more responsibility for account rounding, paying them a bonus for new business based on account size.

And a commercial lines sales manager was hired "to give these producers all the help they can get

Continued on next page

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Despite these and similar success
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and maximize their time on the street," said Mr. Welch. The sales manager's job is to develop niche marketing plans, go out on calls with the producers and delegate the collections and servicing tasks that had bogged down producers in the past.

The agency also continues to pay business-related expenses to the producers, including some country club dues and auto allowances, he said.

Morris & Dee, the San Luis Obispo, Calif., agency, altered its commission structure to tighten the organization of its sales department.

Mr. Morris began by reducing commercial lines commissions to a flat 30% on both new and renewal, and reorganizing the producer stables. The agency now has six full-time commercial lines producers; two in-house personal lines producers; two group producers; and two CSR/account executives.

One other major change—paying less for renewal business—was soundly vetoed by the producers. "I proposed it four years ago, and I had a revolution on my hands," said Mr. Morris.

Thoits Insurance, which is phasing in lower producer commissions, will vary the rates among departments, and also will gear rewards toward landing bigger accounts.

Commercial property/casualty commissions will be 50% for new accounts and 30% for renewals. Accounts with less than \$2,500 in annual commissions, for which producers used to get 50% on new business and 10% on renewals, will carry no commissions, said Mr. Way, president of the Palo Alto, Calif., agency.

Producers also receive incentive compensation at year-end, depending both on how the agency performed and how their own books of business performed, Mr. Way said.

THE FALLOUT

'Things got a little snarly around here'

Asked if any of his 13 producers were unhappy about having their

commissions cut, Mr. Welch laughed and said, "That's the understatement of the year! Things got a little snarly around here for about two or three months."

No producers quit, he said, largely because Wallace, Welch & Willingham had been paying more than other area agencies.

About 16 employees have left since the new system was instituted, though most were clerical staff whose jobs were phased out after the agency added transactional computer filing.

"When somebody leaves, we ask the department if we need to replace them; but we haven't had to yet," Mr. Welch added.

Not all principals are that lucky. At Morris & Dee, commission cuts have caused an "ongoing problem" with a top producer.

An offer of an increased ownership stake has not assuaged the

bad feelings. "He wants to go back to getting 50% of commissions," Mr. Morris said.

Yet the agency does not want to lose him: He generates more than \$700,000 a year in agency commissions.

Mr. Way, who advises principals to reason with producers, said he has had no problems with attrition.

"We have not lost any producers because of this," he said. In fact, most successful producers appreciate the current system, since it focuses on the business the agency really wants, he added.

THE OUTCOME

Encouraging signs, but problems linger

After the initial pain, the compensation cuts definitely produced positive results, said Mr. Welch.

The cuts were one reason behind a 73% rise in per-employee reve-

nues, from \$48,000 before the cuts in 1984 to \$83,000 today, he said. Automation systems were also improved and the number of employees cut from 67 to 51.

Although Morris & Dee has fared well—revenues are up to \$4 million from \$3 million in four years—Mr. Morris believes that producers are still the "weak link."

Negotiations continue with his recalcitrant producer. And some hard-working CSRs have grown to resent having work dumped on them by highly paid producers.

But since some of the agency's lackluster producers are still well compensated, "they couldn't go anywhere else, so they're stuck—and we're stuck," Mr. Morris said.

Restructuring has also failed to ease other problems. While he and his current partner continue to carry the agency in terms of production, producer complaints have

prevented him from further tightening commissions to 35% from 55% on new business, and a flat 25% on renewal, Mr. Morris said.

Mr. Way's agency has continued to grow since he bought into the ownership in 1975. Today, the agency has \$40 million in annual premium volume, and has gone from five to 52 employees with revenues per employee of \$100,000. All 13 producers, including Mr. Way, are fairly compensated, with each of the agency's 38 non-salespersons salaries proportionally allocated to specific producers, depending on who does what for whom, he said.

Although this system, which is produced on the agency's computer system, took several weeks to set up and takes several days per quarter to figure, it is the most equitable way to compensate employees, he said. ■

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IIAA President Bill Bailey, left, confers with Speaker of The House, Thomas Foley.



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Agencies trim away fat from producers' benefits

By LAURA MAZZUCA

Many company cars have long since been sold, and more than a few golf clubs have undoubtedly gone to rust since some insurance agencies stopped paying country club dues.

But commercial lines producers still enjoy a cornucopia of benefits.

Vacations and tuition reimbursement for work-related schooling are two of the common benefit offerings, a recent survey found.

And staples like group health and life insurance are offered by 80% to 90% of surveyed insurance agencies.

Other benefits include client entertainment, retirement plans, equity sharing and deferred compensation, the National Assn. of Professional Insurance Agents found in its most recent survey in 1989.

But, the recession since then has forced some agencies to cut back benefits, according to Larry Marsh, president of consultant Marsh, Berry & Co. Inc., based in Mentor, Ohio.

For example, agencies typically are requiring staffers to pick up a greater portion of their health care coverage costs by paying higher premiums for dependant care or paying higher deductibles, he said.

And while the PIA survey showed that agency-paid pension plans are popular, they are predominantly offered by larger agencies.

Eighty percent of agencies with annual premium volumes exceeding \$10 million offer such plans, compared with only 39.9% of those in the \$1 million to \$3 million category and 29.7% of those with less than \$1 million in annual premium volume.

Some agencies also have cut corners by scaling back profit-sharing and pension plan contributions, Mr. Marsh added.

But many mid-sized and large agencies apparently are trying to make that up to top producers with deferred compensation plans.

Such plans, which typically pay a retiring agent about 15% of what is renewed on his book of business over five years, are growing more popular, said John Jaques, president of John H. Jaques Inc., an agency financial consultant in Novato, Calif.

This retirement benefit pays for itself if the agency is using a separate commission structure for "house" accounts, since the retiring producer's business will be split up among existing producers for servicing and therefore subject to lower commission rates, he said (see story, page 50A).

Deferred compensation programs were offered by only 6.5% of all respondents and were most popular among the largest agencies. Commercial lines agencies were more likely to offer the benefit—8.4% than personal lines agencies—3.2%.

More agencies also are adopting a plan that allows producers to become part owners of a book of business after they have been with an agency for many years, said Lee Schexnayder, senior vp of Insurance Resource Consultants in Fair Oaks, Calif.

For example, if the producer has placed business totalling \$500,000 in revenues, the agency can contract to give him as much as a 50% ownership in that amount for re-

tirement or other purposes, which is generally paid over five or six years.

Agencies also are interested in bringing in new owners by extending partnership to producers, Mr. Schexnayder said. Equity serves the dual purpose of spurring the producer's interest in the agency and providing the basis for a perpetuation plan, he added.

Like paid retirement and deferred compensation plans, equity-sharing plans remain more popular with larger agencies than with

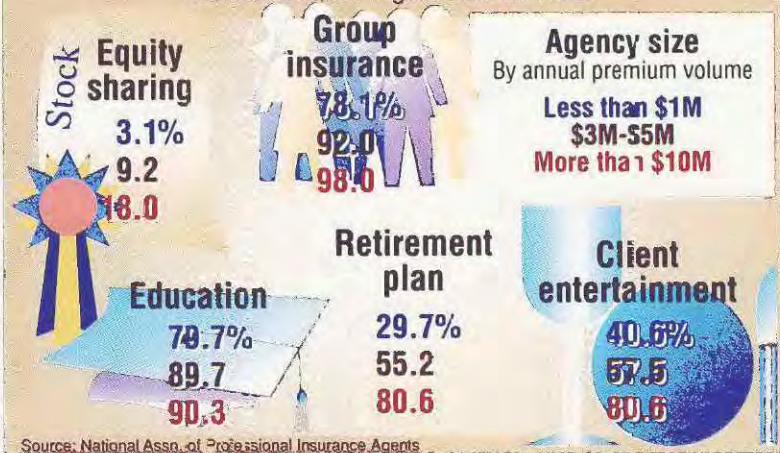
smaller ones, the PIA survey found.

Equity sharing was offered by only 3.1% of agencies with premium volumes of \$1 million or less. But 9.2% of agencies with premium volumes of \$3 million to \$5 million offered equity sharing, and 18.1% of agencies with premium volumes exceeding \$10 million offered equity sharing.

Commercial lines agencies were more likely to offer equity sharing—14%—than were personal lines agencies—3.2%.

Where the perks are

Be they staples like group insurance policies or newer innovations like retirement plans, those offered by larger agencies tend to be more extensive. Figures are for 1989.



GRAPHIC BY JOHN SMITHER



Agency chiefs not on road to riches

Owners claim smaller piece of agency revenue pie: Survey

By LAURA MAZZUCA

The rich did not get richer at insurance agencies in 1990—at least not much.

Owners of both suburban/urban and rural agencies reported that they received 25% of total agency revenues in salary and bonuses on average in 1990, according to a recent survey.

Although previous compensation surveys by The Middleton Group, an agency consulting firm in Lisle,

Ill., did not ask agency owners to provide this information, Middleton President Carol A. Hammes said the survey's results, taken together with results of other studies, indicate that owners are taking a smaller slice of the agency revenue pie than last year.

However, compensation for non-owner employees at agencies increased this year 4% to 6%, the survey reports.

About 800 independent agencies nationwide participated in the

firm's annual compensation survey. Salary information was sought for all employees, from light clerical help to producers.

About 72% of the responding agencies were located in urban or suburban areas, while the remaining 28% were located in rural areas.

Among agencies in both areas, managers and other personnel comprised 77% of the staff, and the remaining staff members were salespeople.

Suburban and urban agencies have 16 employees and \$6.5 million to \$7 million of premium volume on average.

Rural agencies have eight employees and \$3.5 million to \$4 mil-

lion of annual premium volume on average.

Urban/suburban agencies reported pretax profit margins of 8% in 1990, compared with 12% at rural agencies.

The variance is directly related to the larger portion of revenues that go to staffs at urban/suburban agencies, according to Ms. Hammes.

However small agencies in many areas must pay what larger ones pay to attract and retain quality employees, Ms. Hammes said.

Among agencies in both areas, salaries and bonuses for owners declined, with owners taking a smaller percentage of stable revenues for salaries and bonuses than

in 1989, according to Ms. Hammes.

Though the 1990 survey does not report any comparative data on this point, Ms. Hammes pointed out that other recent studies by Middleton showed that owners' salaries and bonuses as a percentage of total agency revenues have dropped a couple of percentage points from 1989.

The agency president or chief executive officer—who also is almost always an agency owner—last year drew a salary and bonus of \$95,530 in the urban/suburban agencies and \$51,210 in rural agencies, on average, the survey reports.

The industry-touted sales manager position has not caught on in either urban/suburban agencies—15% of which had a sales manager—or rural agencies—12% of which had sales managers.

Average sales manager salaries were \$57,730 and \$41,210, respectively. The survey did not provide comparative data.

However, other agency employees fared better, according to the survey.

Non-owner salaries and commissions consumed a larger percentage of revenues at urban/suburban agencies than at rural agencies, the survey found:

- 36% at urban/suburban agencies—14% for non-owner salespeople and 22% for other staff.
- 31% at rural agencies—11% for non-owner salespeople and 20% for other staff.

In both urban/suburban and rural agencies, office managers have become more prevalent and their pay has increased.

Forty-three percent of the urban/suburban agencies have office managers, who earn \$40,540 on average, up 22% from \$33,150 in 1989.

And, 38% of the rural respondents have an office manager, whose salary averages \$31,135, up 19.9% from \$25,971 in 1989.

Method of producer payment varied widely among urban/suburban and rural agencies, the survey found. Forty percent of urban/suburban agencies pay straight commissions, while 27% of rural agencies do.

Only 10% of the urban agencies compensate their producers with salary alone, while 20% of the rural agencies pay only salaries.

When compensating producers with a percentage of commission, these percentages are the same for both urban/suburban and rural agencies: In personal lines, the average commission rates are 45% for new business and 36% for renewals; for commercial lines, the average rate is 44% on new business and 35% on renewals. The average percentage paid for handling accounts produced by other salespeople is 26%.

The survey noted other differences between urban/suburban and rural agencies in their hiring and payment practices for several other categories of employees:

- Light clerical personnel.
- A "dramatic" increase was found in the number of agencies that have hired individuals to specifically perform "light clerical" work to free up others for more complex tasks.

Eighty-six percent of urban/suburban agencies and 67% of rural agencies had such personnel in 1990, compared with 72% and 62%, respectively, in 1989.

Thirty-four percent of the suburban/urban agencies in 1990 paid "light clerical" workers less than \$12,000, while 63% of rural agencies paid those workers less than \$12,000. In 1989, 58% of the urban/

Continued on next page

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Agency pay study

Continued from previous page
suburban and 80% of the rural agencies paid light clerical workers under \$13,000.

- Word processing personnel.

Salaries were rising in this area, Ms. Hammes noted.

Word processors at 15% of urban/suburban agencies earned \$12,000 or less in 1990, compared with 17% in 1989.

But 25% of the urban/suburban agencies paid word processors \$19,000 or more in 1990, up from 20% in 1989, according to Ms. Hammes.

Among rural agencies, 45% paid word processors less than \$12,000 in 1990, compared with 42% in the previous.

- Customer service representatives—personal lines.

The number of CSRs and their sa-

larities increased in 1991.

The number of personal lines CSRs at agencies has grown so much over the past several years that virtually every agency responding to the survey employs a CSR with at least two years' experience, the survey reported.

Ninety percent of agencies employed personal lines CSRs in 1990, compared with 89% in 1989 and 70% in 1988, the survey found.

Salaries for this position continued to grow faster than in any other category, with 58% of the urban/suburban agencies paying \$19,000 or more and 80% paying \$17,000 or more in 1990. In 1989, only 70% of the urban agencies paid \$17,000 or more.

Among rural agencies in 1990, 28% paid \$19,000 or more, and 49% paid their personal lines CSRs \$17,000 or more. A year earlier, only 38% paid \$17,000 or more.

Better pay reflects growing professionalism among staff long considered mere clerical assistants, Ms. Hammes noted.

Even salaries for CSRs with less than two years' experience grew in 1990, though less than for their more experienced counterparts.

- Customer service representatives—commercial lines.

They are not as prevalent as personal lines CSRs, but virtually all urban/suburban agencies—96%—had at least one.

Sixty-nine percent of them made more than \$24,000 per year.

And, higher salaries are on the increase for commercial lines CSRs at urban/suburban agencies. About one-quarter made more than \$32,000 in 1990, compared with 16% the year before.

Some 57% of the rural agencies have commercial lines CSRs.

Sixty-nine percent made less than \$24,000, and one-fifth made more than \$27,000.

The survey also found that more than half of the agencies pay group health care insurance and education expenses for producers.

Almost half pick up business travel, and 38% of urban agencies and 26% of rural pay business entertainment expenses.

Many agencies provide either a car or a monthly auto allowance for business use, averaging \$290 per producer per month at urban/suburban agencies and \$254 per month in rural agencies.

The compensation survey costs \$10, and members of associations that subscribe to The Middleton Letter can obtain specific state results. The survey is available from The Middleton Letter, P.O. Box 1347, Lisle, Ill. 60532; or call 708-515-1044.

Pats on the back and smaller raises for the 'forgotten'

By LAURA MAZZUCA

Producers and customer service representatives aren't the only hard workers in an insurance agency. Clerical workers, bookkeepers, accountants and other sometimes "forgotten" staffers are an integral part of the operation.

While it isn't necessary to deal with complex formulas and commission structures used to compensate producers and CSRs, support staffers still demand compensation and recognition for a job well done.

Support staffers are motivated by a straight salary, structured to reflect job descriptions and tenure, said Timothy J. Cunningham, senior consultant with Hales & Associates in Oak Brook, Ill.

As wage/salary cost control becomes more important in the soft market, agencies will rely more on an employee's job performance to assess his compensation, rather than blindly handing out raises, said John Jaques, president of John H. Jaques Inc. in Novato, Calif.

Since commercial lines commission are only projected to rise 3% to 5%, average pay raises for support staffers should not exceed this, he said. "We're seeing a much lower average raise being given this year."

But money isn't the only thing that attracts and motivates staffers—in

fact, consultants say in some cases it's far down on the list.

Recognition and reinforcement, by way of periodic performance reviews and daily interaction with management are often more important—or at least as important—to staffers, Mr. Cunningham said. "People want to be patted on the back when they do something good and kicked in the butt when they muck up."

The most successful agencies typically are not those that pay the highest salaries or award the biggest bonuses, Mr. Jaques said, but are those that have "created an environment where people like to show up and make their job easy to perform."

This means having a pleasant office, an efficient automation system, in-depth job descriptions, good communication between management and staff and a policy of "treating people with a high amount of respect," he said.

Staffers also appreciate perks—like flexible work hours, additional days off or weekend stays at a local hotel—that are tied to good job performance. And many of these can cost an agency little or nothing.

But the first step an agency should take to improve staff efficiency, performance and motivation is to carefully structure job descriptions and salaries, Mr. Cunningham said. Too often, compensation is inconsistent and "uncoordinated," especially in larger agencies that have "great discrepancies (in pay) between positions" and departments and sometimes between job titles, he said.

To avoid this, agency principals must formulate job descriptions and stick to them, said Robert E. Kurdziel, president of Kurdziel & Associates, an agency and an agency consultant in Atlanta. "This will prevent you from hiring people for the wrong reasons," according to Mr. Kurdziel.

Mr. Kurdziel also recommends that the principal or another agency offi-

Continued on next page



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Continued from previous page
cial write an operations manual to help staffers do their jobs.

Job descriptions should be tied directly to salary, with bonuses or raises in order when the staffer's performance exceeds the description. Agents and consultants advise.

For example, employees at Morris & Dee in San Luis Obispo, Calif., from mailroom clerks to managers, are salaried on a grade level from 1 to 14, said President Greg Morris.

Mr. Kurdziel recommends a performance review every 30 days during a staffer's first 90 days of employment and a review every six months thereafter. Salary reviews should be held annually.

Raises and bonuses should be given only if a staffer's job performance warrants it, Mr. Cunningham said, to prevent falling into "the trap of just giving salary increases, which tend to grow geometrically."

If an agency feels it must give a "flat" raise to all employees, they should be held to 2% or 3% to keep pace with inflation, as opposed to the 8% or 10% annual raises that many agencies pay, he said.

To reward good job performance, the principal must measure the staffer's annual performance against the existing job description, said Don Way, chief executive officer of Thoits Insurance in Palo Alto, Calif.

At Thoits, a staffer must service a set amount of business, exceed a certain policy count, make a minimum number of client contacts or meet revenue "benchmarks," he said. Some agencies encourage cooperation within departments by using "team incentives," said Charles S. Watson, president of Watson Associates, a management consultant in Wethersfield, Conn. Under this method, performance goals are set for

a department, and employees are measured by their performance and that of their peers, he said.

Agencies may also boost staffers' performance by constructing the agency's accounts to minimize transactions, he said. "To improve performance in an agency, examine the work flow, and part of this is to examine account construction."

By working with insurers and underwriters, agencies can, for example, reduce the processing of premium-bearing endorsements to once a year, or fold commercial package coverages into a single renewal, he said. Chances are that the insurer branch office will be happy to accept any method that will cut down on the administrative load, he said.

While it is a good idea to reward quality job performance with a bonus, some agencies have abused bonuses, because few principals understand how to link them to job performance, Mr. Jaques said.

The soft commercial property/casualty market has forced many agencies to eliminate Christmas and other "standard entitlement" bonuses, he said. If these are paid for three consecutive years, employees expect them; but in a bad year, it's hard to explain why they're cut, he added.

Incentive bonuses should not be given out randomly, since 50% to 75% of the agency's employees probably won't qualify for such awards since "their job performance during the year won't change," Mr. Jaques said.

But, even if the agency does not give cash bonuses, it can reward staffers with other perks. Some perks, like employee stock ownership plans, can be a big agency expense, while others cost virtually nothing.

Employee stock ownership programs can benefit both the agency and its employees, said John Welch,

president of Wallace, Welch & Wiltingham in St. Petersburg, Fla.

Mr. Welch credits much of his agency's success to the ESOP it offers to all employees. Wallace, Welch employees now own 30% of the agency under the ESOP program, he said.

Employees are eligible to participate in the ESOP after one year on the job, he said. An employee is fully vested after six years. The ESOP—the agency's principal retirement benefit plan—motivates employees because "they're all owners," he said.

But, other perks can be easier to establish and don't have to cost the agency a dime.

One agency offers airline tickets as a performance reward. The perk costs the agency nothing: The agency's president pays for them through his vast frequent flier accrual.

A perk for Kurdziel & Associates' 10 employees is a company car that can be used by any staffer for work-related business if his or her car breaks down, said Mr. Kurdziel.

At Morris & Dee, employees can take a day off per month in addition to sick leave, Mr. Morris said. And, they are paid for any unused sick leave, he said.

Flextime is another popular way to attract and retain good staffers, Mr. Welch said. His agency expanded the flextime system traditionally used during vacation months to a full-time program last July.

Employees work from 8 a.m. to 5 p.m. on weekdays, and get their choice of Monday, Wednesday or Friday off, Mr. Welch said. Each employee also works a three-hour shift one Saturday every six weeks.

So far, the agency's absentee rate has dropped from 20 hours per employee per year to 10 hours he said.

More importantly, "morale here is 100% better," he said. ■

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California agents protest 'efficiency' proposals

By LAURA MAZZUCA

SAN FRANCISCO—Insurer "efficiency standards" contained in California Insurance Commissioner John Garamendi's proposed rules implementing Proposition 103 could imperil independent agencies in California, agent trade groups say.

Under the proposed standards, state regulators would only consider a certain amount of an insurer's expenses when determining rates for individual lines of coverage. Mr. Garamendi said in comments accompanying the proposals that capping the amount of expenses—including agent commissions—that an insurer can claim in rate hearings will give insurers an

incentive to become more efficient.

The proposed regulations outline four standards, of which presumably only one would be adopted.

While two of the proposals would set different maximum expense allowances for insurers with different types of distribution systems—direct writers, insurers with captive agents and insurers using independent agents—two proposals would group all insurers together for purposes of setting an efficiency standard.

In comments that accompany his proposed regulations, Mr. Garamendi said it may be fair to compare the expenses of direct-writing insurers and insurers with independent agency forces.

"The claim is that the most

costly form of distribution, through independent agents, also provides the highest-quality service to the customers," Mr. Garamendi wrote. "Yet a variety of sources, including the Department of Insurance, in examining complaint records, finds no discernible difference in customer satisfaction among the three (direct writer, independent agent and captive agent) methods. That suggests it is appropriate to set a common efficiency standard for all methods of distribution."

The Independent Insurance Agents & Brokers of California has filed a brief with the Department of Insurance opposing the proposed regulations, charging that the proposed efficiency standards would reduce competition and harm consumers, said Stephen L. Young, staff counsel for the San Francisco-based IIABC.

Comparing insurers that have independent agency forces with direct writers is "like comparing a grape to a watermelon," he noted.

In its brief filed with the Department of Insurance, the IIABC "strongly urges" the commissioner to rethink the efficiency standards, calling the proposed system "nonsensical or, at best, confusing" in

part because of vague wording and undefined terms.

Because of the ambiguity of much of the proposed regulations' language—including undefined terms like "good service" and "reasonably efficient insurer"—the Department of Insurance is now holding hearings "to put some meat on the bones of these regulations," Mr. Young said.

The IIABC contends that the proposals could cause some insurers to stop using independent agents, forcing some agents out of business.

"If all companies are held to the same cost standard—irrespective of their size, the type of coverage they write or their marketing and distribution system—all will have to move toward the lowest common denominator to survive," noted the IIABC's brief. "In all likelihood, this means that all carriers will have to become more like the large, direct writers that serve only easily accessible, high-profit markets."

In addition, the brief says problems that independent agents already face "will be magnified and distorted by regulations that create disincentives to carriers that utilize independent agents."

The brief later notes that "there

are millions of policyholders who buy insurance through independent agents, who renew their policies through independent agents and who willingly bear the cost. . . It would be presumptuous indeed to tell consumers that their choices no longer will be respected."

Representatives of the Professional Insurance Agents of California & Nevada in Van Nuys, Calif., have testified at several hearings against the proposed efficiency standards and have launched a letter-writing campaign to urge Mr. Garamendi to set separate efficiency standards for different methods of distribution, said James W. Johnson, executive vp of PIACN.

PIACN also has petitioned the Department of Insurance for copies of its consumer complaint records to determine whether there is support for Mr. Garamendi's contention that there is no discernible difference between the quality of service provided by insurers represented by independent agents and by direct-writing insurers.

Meanwhile, Mr. Garamendi was expected last week to issue changes in the Proposition 103 rulings (see story, page 2). ■

Insurers turning the tables, finding fault with agents

By MARK A. HOFMANN

While agents often criticize insurers (*A/BT*, March 4), property/casualty insurers complain that a small group of agents are not exactly angels, either.

These are agents who do not:

- Prepare perpetuation plans.
 - Differentiate among insurers.
- Instead, these agents sell strictly on price.
- Understand an insurer's marketing goals.
 - Provide value-added service.
 - Understand that insurers need agent support in the legislative

arena.

Insurers believe that most agents that represent them hard-working and competent.

It is the minority that cause most of the headaches, and, in some cases, the gulf between agents and insurers may be widening.

Good agents seem to be trying to get closer to companies, while not-so-good agents are taking anti-insurer stands, observed Mike Policastro, vp-agency support for Travelers Corp. in Hartford, Conn.

Market pressures, regulatory burdens and consumer groups have left relations "somewhat strained,"

said Robert J. Vairo, chairman of Crum & Forster Inc. of Basking Ridge, N.J.

Insurers take some blame for the deterioration. Some insurers freely admit that withdrawing from certain lines of business and territories has strained their relationships with agents.

But there is plenty of blame to go around, they say.

Insurers have concluded they cannot afford to do business with agents who will not meet volume requirements, Mr. Policastro said.

"Remember, the company is the one that accepts the long-term risk," Mr. Vairo said.

Some agents seemed to understand this economic fact of life when Crum & Forster announced its total withdrawal from personal lines insurance last spring, he said.

"Obviously, the personal lines agents weren't pleased," he said.

Although some personal lines business was sold to a Metropolitan Life Insurance Co. subsidiary, agents had to replace much of the Crum & Forster coverage with other insurers, he said.

Mr. Vairo said the decision was made after Crum & Forster decided it could no longer afford to stay in personal automobile insurance. Taking the analysis one step further, the company decided that it "can't make a personal lines market without personal automobile" and began a total withdrawal from personal lines insurance, he said.

Mr. Vairo estimated that less than 20% of the agents handling the insurer's commercial business also represented the personal lines division. Commercial and personal lines business had been split into separate divisions in 1982.

Despite the impact on personal lines agents, "we got a lot of understanding of why we had to pull out of personal lines" from commercial agents, he said. The agents realized that "if we had to sell our product at a loss, we're not going to do it."

Travelers has made every effort to make its intentions known long

Continued on next page



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The 126,000-member State Bar, a public corporation within the judicial branch of government, is an arm of the California Supreme Court. All lawyers practicing in California must be active members of the State Bar.

To obtain a "Request for Proposals" — which provides requirements for proposed programs and information on the existing State Bar-approved Select Group Disability Income Insurance Program — contact: Kathleen Eichler, Office of Support Services, State Bar of California, 555 Franklin Street, San Francisco 94102-4498, 415/561-8200 on or after April 1.

Continued from previous page

before it actually withdraws from certain lines of business in a state, Mr. Policastro said. "We give a lot of notice. We have agent meetings."

But despite giving agents 120 days' notice that the insurer will not write any more new business in a market as well as writing a year of renewal business after that, "it's not an easy thing for any agent," he conceded.

Countering agent complaints about insurer withdrawals, insurers say agents themselves are withdrawing from the business without planning for the survival of their agencies.

As a result, insurers must compete more vigorously for the survivors, said Charles Dudek, a marketing vp with Zurich-American Insurance Group, a Zurich Insurance Co. unit in Schaumburg, Ill. "We need to grow our producer plant," he said.

"Carriers spend a lot of time and dollars in the development of individual producers," said Mr. Dudek, who works in the commercial insurance division. All that effort is wasted when an agent dies or retires without a perpetuation plan. Often an agency is acquired by another agency that transfers the purchased agency's book of business to other insurers, he explained.

"We're looking for survivor agents," he said, explaining that survivors have both perpetuation and business plans. "They need a road map to where they're going with their business."

"Perpetuation is a significant problem," agreed Frederick H. Jarvis, chairman, president and chief executive officer of Branchville, N.J.-based Selective Insurance Group Inc., a regional insurer that writes primarily in the mid-Atlantic and southeastern states.

"The problem is the owner who refuses to admit he's mortal."

Agency perpetuation is crucial, agreed Loren Shoemaker, vp-agency and brokerage group for Continental Corp. in Cranbury, N.J.

"Who are we going to do business with in the year 2000?" he asked. "We want that book of business to thrive over the years."

Insurers also complain that agents who sell strictly on price assure that neither they nor the insurers they represent will thrive.

"Many producers really don't sell one company against another," Zurich's Mr. Dudek said.

Those agents present a customer with five insurers that charge five prices for the same amount of coverage and tell the customer to decide, Mr. Dudek said. Customers are left to decide based on one criterion: price, he said.

"They really don't understand the product," he said.

"It's a common phenomenon—quote all companies," agreed Travelers' Mr. Policastro.

But as he sees it, the agent is only hurting himself. "When you're selling just on price, that client's going to leave the agent when he gets a better price," Mr. Policastro said. The agent and the company just end up wasting time and money, he said.

Zurich has tried attacking the problem directly.

An underwriter/marketing representative and sometimes a claims handler or loss-control specialist is sent along with producers to explain the insurer's product.

The approach lets the insurer sell its value-added services to large insurance buyers—like large-scale commercial farms, apparel manufacturers and jewelry manufacturers—that would generate at least \$50,000 in annual premiums, Mr. Dudek said.

The success rate has been about 90% on new and renewal accounts, he said.

Selective's Mr. Jarvis also noted that when the same agents and underwriters work together over an extended period, they develop relationships that enhance understanding. And agents come to better under-

stand insurers' products.

Such stability may give regional insurers like Selective an advantage in relations with agents, he said.

At Selective, that philosophy has been exported to its branches, Mr. Jarvis said.

But as branches proliferate, they can spawn new corporate subcultures that long-time agents may find unresponsive, he cautioned. "As regional companies grow, we run the risk of becoming part of the large gray mass."

Failing to prepare for the inevitable and taking a lazy approach to sales were only two of the most common agent failings insurers cited. The list touches on virtually every area of the agent/company relationship.

For example, Zurich's Mr. Dudek said some agents run "off track" with target marketing, though he admits that in large part the problem stems from the insurer not specifying just

'Many producers really don't sell one company against another.'

— Charles Dudek
Zurich-American
Insurance Group



what target marketing entails.

To illustrate a poor target marketing program, Mr. Dudek offered the example of an insurer that presents an agent with a list of three classes of business it considers target markets. No explanation is given.

With only the list and no explanation, the agent thinks the insurer is interested in writing only those classes. But the agent soon realizes that there is no great market, or

maybe no market at all, for these classes of business in his or her community.

Under the mistaken impression that the insurer does not want any business not on the list, the agent ignores that insurer and pushes the products of a competitor, he said.

Producers also must begin taking a value-added approach to their agencies, said Greg Georgieff, national marketing manager for the

property/casualty units of Warren, N.J.-based Chubb Corp.

To that end, agents must focus on customer needs better, become better problem solvers and work more with insurers to customize products and services to meet customer needs, according to Mr. Georgieff.

"You have to decide: 'What is my agency prepared to offer?'" he said.

"The greatest need most companies see is the need for more sales discipline," said Mr. Shoemaker. A lack of discipline is reflected in a lack of focus on targeted classes; a lack of sales management, which leads to agents setting their own agendas; and high ratios of unsuccessful closes.

With soft market conditions persisting, both insurers and agents have to work more closely together or both lose, he said.

But insurance companies should be approaching agents with solutions to
Continued on next page

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What affects will the growing recession have on advertising, sales promotion and marketing budgets for agents and brokers? BI editors will report on less costly, and in some cases free, alternatives such as charitable events. Plus a look at how agents can help cultivate a good image for the insurance industry in their community.

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A federal 'role,' yes, but should it take the lead?

By LAURA MAZZUCA

WASHINGTON—Conceding that federal involvement may bolster state-by-state insurer solvency regulation, insurance industry officials vary widely on just how involved in regulation the federal government should become.

Options like a federal self-regulating organization, a voluntary national guaranty fund and federal solvency standards—though all feasible—should only augment and not replace the current system of state regulation, argues David Pratt, vp of federal affairs for the American Insurance Assn.

At a panel discussion sponsored by the National Assn. of Profes-

sional Insurance Agents last month in Washington, D.C., Mr. Pratt echoed congressional testimony last year by Robert E. Vagley, AIA president.

Mr. Vagley criticized state regulators for lacking the "will" to act against troubled companies. He also caused a stir in industry circles by saying federal intervention may be needed to "enhance" solvency regulation (*BI*, Sept 24, 1990).

Mr. Pratt said that recent model laws approved by the National Assn. of Insurance Commissioners, and now being considered by at least 29 states (*BI*, March 25), has helped improve state regulation.

And with state oversight im-

proving, even Rep. John D. Dingell, D-Mich., whose subcommittee last year sharply criticized state regulation, would not favor a total federal takeover of solvency regulation, Mr. Pratt said.

"They don't want, nor could they productively manage, the 'Federal Department of Insurance' here on the Potomac, because it would be the disaster that we all imagine it would be," Mr. Pratt contended.

Other panelists looked more favorably on a limited federal role in solvency regulation.

A federal role could augment undeniable state problems, like lack of funding and expertise, said Peter Lefkin, vp of government affairs for Novato, Calif.-based Fireman's Fund Insurance Co.

Both the states and the NAIC do a credible job tracking solvency, he said. But widespread factors, like the growth of residual market mechanisms and rate rollbacks in several states, "have an invidious effect on solvency" and must be addressed nationally, Mr. Lefkin said.

One alternative is to greatly expand the NAIC's regulatory powers. Doing so would not solve all the problems regulators face, but it could help take out potentially insolvent insurers before problems arise, he said.

Fireman's Fund and other insurers also support the concept of a federally-chartered self-regulatory organization, separate from the NAIC. Such a body would address other national concerns, like rates and expanding liability exposures, particularly in problem lines of coverage like environmental impairment liability, he said.

A voluntary national guaranty fund mechanism—which would allow insurers to decide whether to participate in a federal guaranty fund or individual state funds—is a possible third option. Such a mechanism could prove especially valuable in complex failures, like that of Mission Insurance Co., which affect several state guaranty funds, Mr. Lefkin said.

However, state regulators warn against the voluntary national

Insurer relations

Continued from previous page
soft market pressures, Mr. Shoemaker said.

More face-to-face meetings between agents and insurer branch office representatives would help each better understand the other's concerns, he said.

Another area where insurers would like to see a strengthening of agent/insurer relations is in the legislative and regulatory arena.

"I'd like to see the agent associations take a more statesmanlike view of the industry," Selective's Mr. Jarvis said.

Agents cannot look only at how insurance-related legislation will affect them. They also must consider how it will affect insurance companies, since agents depend on them for their livelihood, he said.

"I'd like to see more aggressive activities on the state level," Mr. Shoemaker agreed. Agents have more impact on state legislatures than insurers do, he said.

Travelers' Mr. Policastro also complained that a minority of agents "promote an anti-company atmosphere." They fail to educate the public on factors that drive up the cost of insurance, he said.

"Sometimes they blame the company for things they know is not the company's fault," he said. "It's the agents who have to be the advocates with legislators, regulators and the public."



Franklin Nutter, left, says the Alliance takes a 'pragmatic' view of federal oversight, while James Long wants only a limited federal role.

guaranty fund idea.

It could backfire against insurers by "skimming off the cream of the crop" and leaving state funds burdened with smaller insurers that are less able to pay assessments, argued James Long, North Carolina's insurance commissioner and president of the NAIC.

The NAIC supports only a limited federal role in solvency regulation, Mr. Long noted.

To support his case for state regulation, Mr. Long cited Rep. Dingell, who has criticized state regulation as woefully deficient.

Rep. Dingell, according to Mr. Long, points to five central areas of solvency regulation: adequate solvency standards; complete information; timely monitoring for solvency; vigorous enforcement of all laws and regulations; and effective procedures to certify the solvency of international reinsurers and excess/surplus writers.

But Mr. Long maintained that these criteria can be met on a state level with the help of the NAIC's state accreditation program. Under that program, state insurance departments have until January 1994 to meet solvency regulation standards or else they would not receive certain regulatory incentives

(*BI*, Dec. 3).

Another member of the panel criticized the federal government's record in financial regulation.

In both the savings and loan crisis and recent securities criminal prosecutions, regulators have actually weakened financial industries, contended Franklin W. Nutter, president of the Alliance of American Insurers of Schaumburg, Ill.

Though favoring "enhancement of the state-based system," the trade group is "pragmatic" about federal intervention, Mr. Nutter said. "We shouldn't give Congress a blank check to redefine solvency regulation" and possibly undermine the existing system, he said.

However, the panelists agreed that the insurance industry must be open to new solutions—even an increased federal regulatory role—to improve solvency monitoring.

"We cannot go to Congress and stonewall them," Mr. Pratt said. "Instead, we think we can perform a vital role in educating the Congress."

"The feds are not the panacea, but on the other hand, they are not universally the enemy," he said. "The answer lies somewhere in between."



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Business
Insurance

FASB rule to blast bottom lines

Many firms not aware of impact

By COLLEEN JOHNSON

Companies face a potentially mammoth hit to their balance sheets as a result of changes in how they account for retiree health care liabilities, and should begin planning now to minimize the impact.

Many companies have yet to estimate the extent of their retiree health care liabilities under the new rules. Others, however, have begun to look at structuring their plans to minimize the financial impact of the changes (see story, page 54).

Financial Accounting Standard 106—approved late last year by the Norwalk, Conn.-based Financial Accounting Standards Board (FASB, Dec. 17, 1990)—will require employers to accrue as an expense against earnings non-pension retiree benefit liabilities from the date employees are hired until they become eligible for benefits.

Employers now only report as an expense item their pay-as-you-go costs for retiree benefits.

In addition, FAS 106 will require employers to either fully recognize their accumulated retiree liabilities in the first year after the rule takes effect, or to amortize them over up to 20 years.

FAS 106 is scheduled to take effect in 1993 for most companies, although small, non-public employers and those with fewer than 500 participants in their retiree health care plans have until 1995 to comply.

The Securities and Exchange Commission also is requiring companies to disclose the potential impact of the new rule, if known, on their 1990 financial statements.

The accounting rule applies to all retirees benefit plans other than pensions, although it is expected to have its greatest impact on retiree health care liabilities.

Consultants offer varying estimates of the rule's potential impact on a company's net earnings, but say it could range from a fraction to an amount greater than annual earnings. Expenses for retiree health care will increase dramatically, they agree.

"Many companies' expenses are going to jump from two to 10 times or more under this standard," said Harper Garrett, managing director and chief actuary for Alexander Consulting Group in Lyndhurst, N.J.

"Most of our clients' initial reaction has been, 'What's the cost?'" said Bert H. Peterson, a managing consultant with A. Foster Higgins & Co. Inc. in Atlanta.

But clients increasingly realize that the accounting change is a benefits issue, not just an accounting or actuarial issue, and that it will have to be dealt with by controlling costs, he said. "I think it's very important this not become a pure numbers issue."

Mr. Peterson said it's also important that employers realize the accounting rule change will create a massive new liability. "This balance sheet entry will become enormous in a few years," he said.

Many companies are talking about how they can modify retiree health care plan design or funding to minimize the increased costs, noted Daniel L. Klein, an attorney and a principal in William M. Mercer Inc.'s Chicago office. But, he added, "It's a small percentage of companies that have made a change" in their plans in response

to the FASB rules.

"FASB has really acted as a catalyst in causing people to look at what these emerging costs could be" if health care inflation continues, noted Mr. Garrett of Alexander Consulting. "This is really one of the most difficult problems managements have had to face in the benefits area," he said. He added that he has urged clients to look at the problem of growing retiree obligations since 1984, when FASB first asked employers to footnote in their financial statements either the potential liability for retiree medical costs or the current pay-as-you-go costs.

"Unfortunately, this is not something they can wait until the last minute to do," Mr. Garrett said. Companies that don't look at the

potential liabilities in advance of the compliance deadlines might be in for a big shock the first year they have to put those liabilities on their books, he said.

"Some people think this is so terrible the (Securities and Exchange Commission) will step in and roll this back," he said. "Don't think this is going to happen."

Benefit consultants say that in order to estimate their liabilities under FAS 106, employers must figure out what benefit plans will be affected by the rule, how much the accounting change will cost, if plan changes are warranted and how those changes will be accomplished.

Employers must realize that they may have a variety of plans that provide non-pension benefits to

retirees—including old plans that have since been changed or replaced, plans offered by different company divisions and plans that came with acquisitions, consultants stress.

"Certainly the first step is go through all of your plans, and that's not a minor job," Foster Higgins' Mr. Peterson said.

"Just knowing what plans are there is going to help management control costs," Mr. Peterson said, noting that "you can't control costs if you don't know (the plan) exists."

The larger the company, the more research it will have to do to determine how many plans will be affected, said Michael Johnston, an actuary and partner with Hewitt Associates in Cleveland.

One large company reported it apparently had about 175 retiree medical plans, Mr. Johnston said. "That's an extremely messy thing."

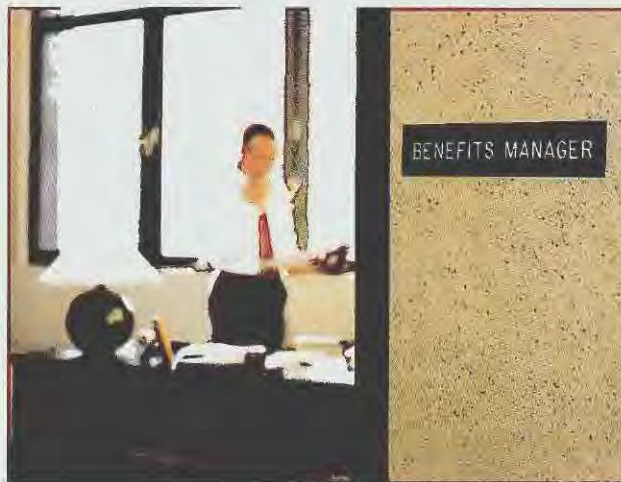
In addition, employers have sometimes "kind of offered these things from the back of an envelope" and never formalized the plan, Mercer's Mr. Klein said. As a result, employers and employees may disagree on what a plan's provisions are, he said.

If the plan is not written, someone from the human resources department probably will have an idea of what employees were told, Mr. Klein said.

Unwritten provisions also can be discovered by looking at what current retirees are actually getting, noted Charles J. Sherfey, a Mercer

Continued on next page

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FASB rule causes two firms to take action

The impending Financial Accounting Standards Board retiree health care accounting rule is causing some companies to change their retiree health care plans.

The Vons Cos. Inc., a supermarket chain based in Arcadia, Calif., realized about 1½ years ago that it "would have to make significant changes in retiree plans" because of the expected impact of the rules, said Dick Gonzales, director of compensation management.

A study showed that expenses for Vons' retiree medical plan in place at that point would be about \$6 million annually under the new rules, he said.

To reduce costs, Vons established health care account for retirees instead of a traditional retiree health care plan. The amount in each account is based on the retiree's length of service multiplied by the annual cost of medical care per employee at the time of retirement, with a factor for inflation, Mr. Gonzales explained.

"The old program would have cost 50% more

(under FASB) than the new program is going to cost," Mr. Gonzales said. The liability will be about \$3 million under the new program, which covers about 2,500 non-union employees, he said.

To qualify for an account, a retiree must be at least 55 at the time of retirement and have worked for the company at least 10 years, Mr. Gonzales said. However, the age and years of service must total at least 75, so a 55-year-old retiree would need at least 20 years of service, he said.

Announced in November 1989, the changes took effect July 1, 1990. Prospective retirees were given six months to retire under the old plan, which covered all hospitalization costs and 80% of other major medical costs, with no premium for retirees, said Mr. Gonzales.

Daubert Industries Inc. in Westchester, Ill., first looked at the potential impact of the new accounting rules about a year ago, said Kathy Herold, compensation and benefits manager.

Since the firm has only about 400 employees, it doesn't have to implement the accounting changes until 1995, she noted.

Daubert had been contemplating improving its retiree benefits. But after an actuarial study showed the improved plan would cost \$409,000 the first year under the new FASB rules if accumulated liabilities were amortized over 20 years—or \$2.4 million if the obligation was fully recognized in the first year—the company decided it couldn't continue the current plan, much less improve it, she said.

Daubert is now reviewing a number of options, including implementing defined contribution-type retiree health care plan or an "HSOPs," Ms. Herold said.

An HSOP is similar to an employee stock ownership plan, but when an employee retires, a portion of the plan is distributed as a medical benefit rather than stock, she explained (see story, page 40).

—By Colleen Johnson

FASB rule

Continued from previous page principal in Chicago.

After an employer uncovers any and all plans affected by the rule change, the next step generally is to calculate retiree health care liabilities, consultants say.

Employers should look at cost-sharing and whether there has been a pattern of shifting costs to retirees in past years, recommended Mr. Peterson.

Employers should obtain data including a breakdown of retirees and active workers, birthdate, sex, plan participation and selection of options in any cafeteria-type plans, Mr. Peterson said. Companies should begin looking at data that will be used in actuarial assumptions on rate of death, rate of termination, number of dependents an employee is likely to have at retirement age, rate of turnover before retirement and rate of retirement before retirement age.

The ages at which employees typically retire are "critically important" in estimating liabilities because an employer-sponsored plan typically bears the medical costs of persons until age 65, when they become eligible for Medicare, he pointed out.

Claims experience also must be calculated in order to accurately gauge liabilities, he said. And doing so is difficult because many employers have not separated data on the experience of active employees from that concerning retirees, he noted.

But Rich Ostuw, a Cleveland-based vp at TPF&C, a division of Towers, Perrin, Forster & Crosby Inc., recommends that smaller companies keep the process of analyzing plan data fairly simple. For those companies, "it's not cost-effective to get into a great deal of precision in this exercise," he said.

"There's not much a small employer can do other than pull the data together," he said. Lacking the in-house expertise to project health care liabilities, most work with consulting actuaries or insurance companies.

Another potential obstacle is that the pool of retirees from which a smaller employer determines its claims experience might not be large enough to use in making actuarial predictions, so outside data might be needed, according to Mr. Peterson. A data bank from Foster Higgins can be used independently or combined with a company's own data to more accurately project retiree liabilities, he noted.

Employers might want to look at the assumptions used in making the actuarial calculations, recommended Mr. Garrett of Alexander Consulting. "The sensitivity to the assumption used in this is just tremendous," he said.

Assumptions are supposed to be an employer's "best estimate" of its non-pension retiree obligations and the actuary should tell the employer if the assumption could be seen as questionable by an auditor, Mr. Garrett said.

Once the employer has calculated how much its various plans cost, it must decide how it will account for past liabilities, and if it wants to change its plans to cut current and future costs, consultants say.

Employers can recognize the past liability immediately, or spread it out over 20 years or employees' average remaining service period, whichever is longer.

If a company recognizes the past liability immediately, that will cut expenses in future years by about one-third, said Mr. Peterson. "Unfortunately, the cost is going to be so big, it's going to be a fortunate few that can afford that kind of change," he added.

"I don't think that there are
Continued on next page



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Continued from previous page

many companies, large or small, that can absorb this at one pass," Mr. Peterson said. "None of my clients are contemplating absorbing it" in one year, he said.

The decision will vary with individual firms, and might depend somewhat on what competitors are doing, Hewitt's Mr. Johnston said. He also noted that while accounting for past liabilities in one year reduces future burdens, a company may not want to spoil a good year.

By accounting for the liabilities in one year, "you take one humongous hit that might totally wipe out your profits for that year," Mr. Garrett of Alexander Consulting agreed. Nevertheless, a company taking this approach may have lower expenses in the future than will its competitors, he said.

"If it's simply going to magnify a loss (in one year), that isn't so bad," observed Mercer's Mr. Sherfey. This could be a better option than facing several years of smaller losses with amortization, he said.

"Some companies will choose to take it all at once because they feel it's appropriate to get it over with," said TPF&C's Mr. Ostuw.

For example, if a company is making a big acquisition, that might offset the loss sustained in accounting for the liabilities in one year, observed Beth F. Vorhaller, an actuary and associate with Mercer in Chicago.

Once a company figures out the liabilities from its non-pension retiree benefit plans, it may want to change those plans to lessen future liabilities, consultants observed.

If a company believes its retiree plan will cost too much, "until they change benefits, they're going to continue to have people retiring with these benefits," Mr. Garrett pointed out.

"We're seeing very, very few people who are considering or would consider terminating the plan," Mr. Peterson said. But, he added, he's seeing few companies start new retiree plans.

Companies can control retiree medical costs by turning an "open-ended" promise into a "closed-end" one, Hewitt's Mr. Johnston said.

Capping promised benefits can control the impact of future inflation, he said. However, the cap should be set "well in excess" of current costs, he added.

Another option may be to contribute cash to a fund that workers could draw from to pay medical expenses when they retire, rather than promising specific medical benefits, Mr. Peterson said.

Setting up such a defined contribution plan "avoids the nasty implications of FAS 106," he said. "The key there is to make sure the fund will be adequate."

This funding idea might not be feasible for older employees, because there won't be enough time to accumulate sufficient funds to meet their needs, he added.

"Employees love this," Mr. Peterson said. "They see dollars instead of this promise."

Another way to avoid the sting of FAS 106 would be to prefund retiree benefits for current employees in the form of improved pension plans, said Peter J. Riemer, an actuary with The Wyatt Co. in Wellesley Hills, Mass.

Companies also are using Employees' Retiree Medical Accounts, a funding vehicle developed by Wyatt. One company using them is Muncie, Ind.-based Ball Corp., where employees can tax-effectively fund their retiree health care benefits using a group annuity contract, Mr. Riemer said (BI, Feb. 18; Nov. 26, 1990).

Employers might also consider restricting eligibility for retiree benefits based on length of service, Mr. Johnston said. "In years past, retirement eligibility was smeared on like butter."

"We're expecting companies will say they've been much too generous to short-service retirees," agreed TPF&C's Mr. Ostuw.

And, employers should also beware of the medical costs for employees who retire early, because they won't receive Medicare until they reach 65, Mr. Johnston said.

Although some companies continue to encourage early retirement to cut costs, others are beginning to think they want to keep employees past the traditional retirement age because of a shrinking labor pool, Mercer's Mr. Klein said.

Another option to employers for cutting back on retiree health care costs is reducing spousal subsidies,

Mr. Riemer noted.

He stressed, however, that benefit plan changes will mainly affect future retirees, and that it's rare for benefits to be cut back for current retirees.

If a company wants to change its retiree benefits, it's not too soon to start, Mr. Johnston said, adding that a company's ability to do this is partially determined by legal precedent.

"Certain cases seem to be hinging on what the employees were told," Mr. Johnston pointed out. "Many companies have reserved the right to adjust plans even after retirement. The legal thing, most companies have gotten smart

enough to get around."

If an employer is considering changing its retiree medical plan to minimize the impact from FAS 106, it should review options with attorneys to determine if it has reserved the right to change the plan, Mr. Peterson suggested. One indicator is whether this right has been pointed out in employee exit interviews, he explained.

Most companies have reserved the right to change their retiree plans, according to Mr. Ostuw.

Nevertheless, there are risks involved. "If you come in and change your plan, there's a chance of your being sued," Mr. Klein noted. However, he added, if a company

has documented that it reserved the right to change its plan, "the chance of losing your suit isn't very good right now."

Although changing benefits for current retirees is not always possible, "clearly an employer can change benefits for an active employee who hasn't reached retirement yet," Mr. Garrett noted.

Before making any changes, employers should consider what they are trying to accomplish by providing retiree benefits, Mr. Klein said. If they are trying to maintain retirees' standard of living, they should "look whether they will be short-changing retirees" by reducing benefits, he said. ■

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Employers expect FASB rule to cost dearly

By COLLEEN JOHNSON

More than one-fifth of the employers that have calculated their retiree health care expenses under new accounting rules expect these annual expenses to increase eightfold, according to a new study.

And, all respondents expect their retiree health care expenses to at least double under the new Financial Accounting Standards Board rule compared with how the costs currently are figured, says the survey by William M. Mercer Inc.

The survey of 2,036 employers found that 1,139—or 55.9%—offered retiree health care coverage.

Of those, 908—or 79.7%—provided coverage to Medicare-eligible and non-Medicare-eligible retirees. Only 165 employers—or 14.5%—provide coverage to only non-Medicare-eligible retirees, and 66—or 5.8%—cover only Medicare-eligible retirees.

The number of employers providing health insurance to retirees under age 65, when they become eligible for Medicare, "doesn't surprise me," said Thomas Ferguson, a Mercer principal in Stamford, Conn. "Before 65 it is much more expensive, but there are no other options," he said. "I think employers responded much more to the need issue, rather than cost, and that's how we got into this thing in the first place."

And, the survey found, employer costs and liability will grow under FAS 106, the new retiree accounting rule adopted last December, which takes effect in 1993 for large firms and 1995 for small firms.

Under the new rule, employers will have to accrue as an expense against earnings retiree health care liabilities from the date an employee is hired until the employee is first eligible for benefits. Differences between accrued expenses and actual payments for retiree health care benefits would have to be recognized as a liability on balance sheets (see story, page 53).

Forty-one percent, or 342, of employers offering health coverage to younger and older retirees that responded to a question about the impact of FAS 106 on their retiree health care costs said they have calculated the rule's costs. And about a fifth—72—said annual costs for retiree health care under FAS 106 would increase more than eightfold.

The greatest percentage—46%, or 157—expect retiree health care costs to increase three to five times current costs. Eighteen percent—or 62—expect costs under the new rule to increase six to eight times, while 15%—or 51—say costs will double.

The survey found that small employers generally expect greater increases. Among firms with 5,000 or fewer workers, 45% expect retiree health care costs to be six or more times greater under FAS 106, compared with 31% of firms with 5,000 or more workers.

However, noting that the greatest percentage of respondents expected costs to increase three to five times, Mr. Ferguson said: "My reaction was people were underreacting to the impact a little bit."

He said he usually sees cost increases of five to six times among all employers he works with.

Mr. Ferguson also said he found the number of employers that hadn't calculated the cost increases—59%—"shocking, given the publicity this has had."

The survey says 80%—or 206—of the 257 employers with fewer than 1,000 employees that answered the question have not yet determined the cost impact of the FASB rule.

In contrast, 41%—or 103—of the 251 employers with more than 5,000 employees that responded to the question said they had not yet calculated the rule's impact.

Among 902 employers responding to a question about what they have done or plan to do to reduce retiree

medical liabilities, the greatest percentage, 37%—or 334—said they raised coverage contribution requirements, while 25%—or 226—said they planned to do so.

In a separate question, 53% of more than 800 respondents said retiree contributions cover less than 20% of the cost of coverage. For 21% of plans covering younger retirees and 22% of those covering older retirees, contributions cover 80% or more of the coverage cost.

Examining other efforts to reduce retiree health care costs, the survey found that:

- 28%—or 253—of respondents have raised deductibles or copayments, and 16%—or 144—intend to do so.

- 20%—or 180—said they have reduced benefits, and 11%—or 99—said they plan to do so.

- 4%—or 36—said they canceled retiree medical benefits for some or all active employees, and 3%—or 27—said they plan to do so.

- About 1%—or nine—said they have canceled all retiree medical benefits, and the same number said they plan to cancel them.

The survey found that only 8%—or 71—of the 881 firms that responded to the question now are prefunding retiree health coverage.

Employers would not likely prefund these plans if were uncertain about continuing to offer them, said Daniel L. Klein, a Mercer principal in Chicago, noting there is no tax advantage for prefunding.

In addition, if a company discontinues its prefunded retiree medical plan, an employee or retiree could argue in court that the prefunding showed an intention to continue the

plan, Mr. Klein explained.

Prefunding was more popular among larger employers, with 14%—or 38 of 273—of firms with more than 5,000 employees saying they prefund. Seven percent—or 24 of 336—of firms with 1,000 to 5,000 employees prefund, while 3%—or eight of 272—of employers with fewer than 1,000 employees do so.

The most common pre-funding method was 501(c)(9) trusts, used by 54%—38—of pre-funding employers.

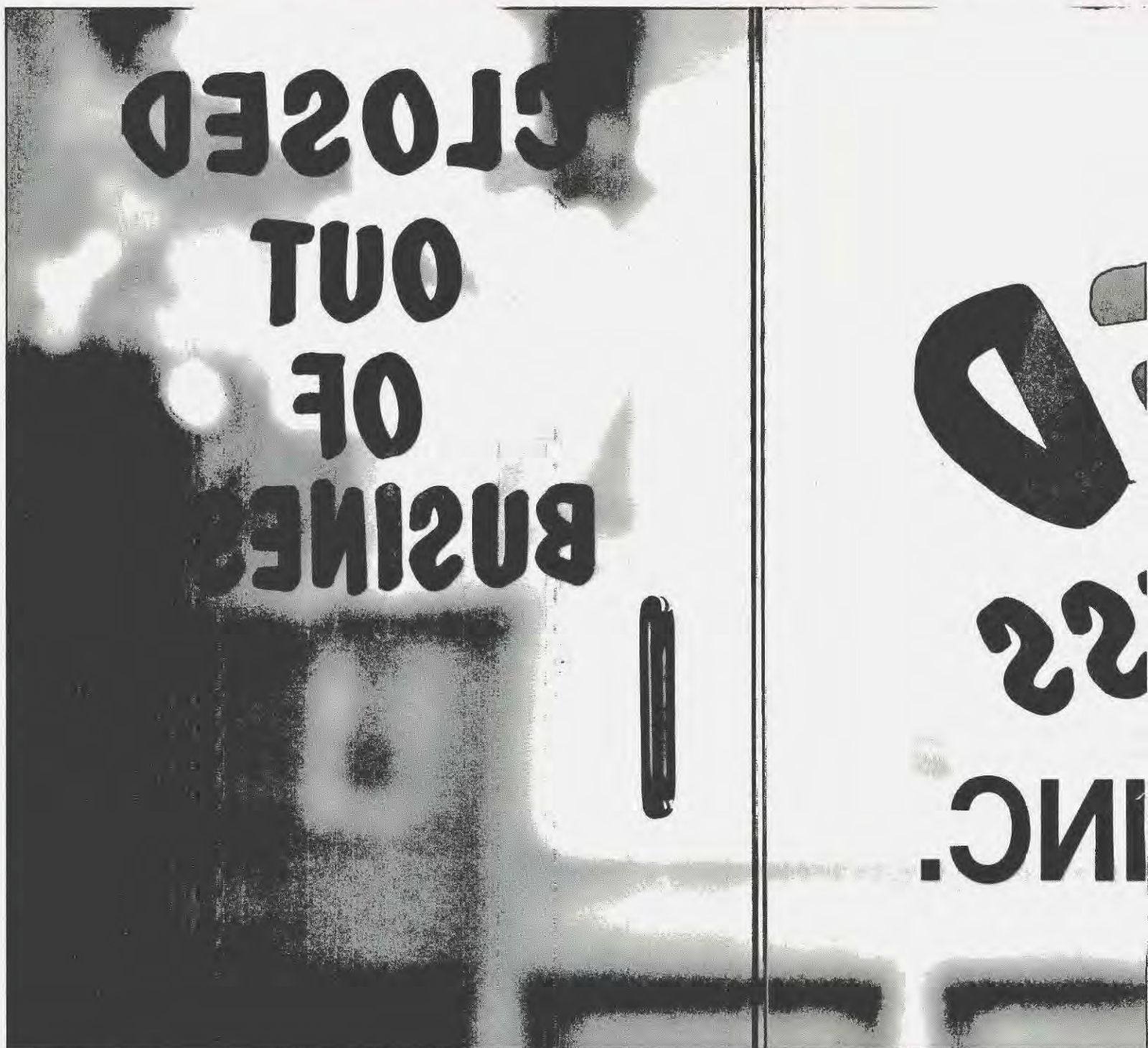
The survey found that 24%—or 17—of the 71 employers that prefund retiree health care do so solely through employee contributions. But, this was more popular with small firms. Of employers with fewer than 1,000 workers, 38% use employee contributions to prefund, compared with 19% of those with 5,000 or more workers.

And, retiree health care was prefunded through 401(h) plans at 22%—or 16—of the employers that prefund, the survey found. However, no employer with fewer than 1,000 workers reported using 401(h) accounts for prefunding.

The survey found that 62%—or 748—of 1,206 respondents with or without retiree plans would be more inclined to prefund if there were greater tax benefits for doing so.

Larger companies would be more inclined to prefund with a tax incentive, with 74% of employers with 5,000 to 25,000 workers and 73% of employers with more than 25,000 workers saying they would.

The survey found that 67% of employers with 1,000 to 5,000 workers and 50% of employers with fewer than 1,000 workers would prefund if they had a tax incentive to do so. ■



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Life insurers offer their own antitrust reforms

By JERRY GEISEL
and ADRIENNE C. LOCKE

Washington

WASHINGTON—The American Council of Life Insurance says life insurers would be willing to be regulated under two longstanding federal antitrust acts as long as they are exempt from Federal Trade Commission oversight.

The ACLI has suggested this proposal as an alternative to legislation that would repeal the exemptions from federal antitrust laws that all insurance companies enjoy under the McCarran-Ferguson Act of 1945.

"We've given very serious thought to the steps we are taking. We felt very strongly that now is the time to do something," said a spokeswoman for the Washington, D.C.-based trade group.

The ACLI emphasizes that it still

strongly opposes H.R. 9, introduced in January by Rep. Jack Brooks, D-Texas, that would eliminate the key antitrust exemptions for all insurance companies (BI, Jan. 7).

The Senate companion bill is S. 430.

However, the spokeswoman said the Brooks bill is on a "very fast track," so the group wanted to have substitute legislation ready to take to a representative who might be looking for an alternative proposal.

"One would hate to wait to the last minute and not have anything ready," she said.

Under the ACLI proposal, the insurance industry would fall under

the authority of two antitrust acts: the Sherman Act of 1890 and the Clayton Act of 1914.

Plaintiffs claiming that an insurer violated the Sherman Act would have to prove that the purpose and effect of a questioned activity constituted an unreasonable restraint of trade.

The Clayton Act prohibits mergers that could be made with the intention of substantially reducing competition or creating a monopoly.

However, the ACLI proposal would exempt insurers from oversight by the Federal Trade Commission, which regulates commercial practices under the Sherman and Clayton acts.

The trade group instead recommends that states continue to regulate the insurance industry, as currently provided for under the

McCarran-Ferguson Act.

Meanwhile, the American Insurance Assn. in Washington, D.C., is working on its own McCarran-Ferguson reform measure (BI, March 11).

Medicare expansion

Medicare benefits would be expanded to retirees beginning at age 62 as well as to their spouses and dependents, under legislation introduced earlier this month in the House.

The bill, H.R. 1444, sponsored by Rep. Fortney (Pete) Stark, D-Calif., also would eliminate the waiting period for Medicare benefits for younger retirees who are receiving Social Security disability benefits.

Individuals of any age who receive Social Security disability

benefits are eligible for Medicare benefits after a two-year waiting period.

Rep. Stark says 400,000 of the younger retirees are without health insurance, while an estimated 600,000 spouses of younger retirees and 300,000 dependents lack coverage, he said.

And, 75,000 Social Security disability beneficiaries are uninsured because they have not met the two-year waiting period for Medicare benefits, Rep. Stark said.

While the House health subcommittee "continues its consideration of comprehensive (health care) solutions, we must work simultaneously to fill the gaps and expand coverage where and whenever possible," he said.

The panel, chaired by Rep. Stark, has held one hearing on the legislation.

H.R. 1444 also has been referred to the Ways and Means Committee for review.

401(k) withdrawals

Legislation introduced in the Senate last month would allow employees to make penalty-free withdrawals of their contributions from 401(k) plans to cover the cost of purchasing their first home or paying children's higher education expenses.

Under current law, in-service withdrawals of 401(k) contributions towards the down payment on a home or children's college tuition are permitted, but a 10% penalty is imposed.

Only withdrawals to cover high medical expenses are exempt from the 10% penalty on pre-retirement distributions.

The legislation, S. 612, proposed by Sens. Lloyd Bentsen, D-Texas, chairman of the Finance Committee, and William Roth, R-Del., also would allow all employees to make tax-deductible contributions of up to \$2,000 annually to Individual Retirement Accounts.

Under current law, workers without employer-provided pension coverage can make tax-deductible \$2,000 annual contributions to their retirement accounts.

However, employees with pension coverage and filing an individual tax return can make the full \$2,000 tax-deductible contribution only if their adjusted gross income is less than \$35,000.

Employees covered by a pension plan and filing a joint return can make the \$2,000 contributions if their adjusted gross income is less than \$50,000.

Health care hearings

The House Ways and Means Committee will hold five days of hearings this month on a broad range of health care issues, including access to care and the cost of coverage.

"These hearings will provide the opportunity for the committee to step back and explore thoroughly this critical issue apart from immediate fiscal concerns and budget deadlines," said Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill.

When hearings open on April 16 the committee will examine how health care is provided in other countries.

During the four remaining days—April 17, 23, 24, and 25—the committee will focus on health care costs, health insurance and proposals to revise the health care delivery system.

The committee hearings will be in the Ways and Means Committee's main hearing room in the Longworth House Office Building on Capitol Hill. The sessions are scheduled to begin at 10 a.m. each day.



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UR standards

Continued from page 1

is a very important study. It points out an important flaw that needs to be addressed"—namely that medical review criteria currently in use may not be the best, said Dr. Roger Taylor, president of the Utilization Review Accreditation Commission, a coalition representing the UR industry, employers, insurers and the medical community.

However, merely publishing the data won't do much to solve that problem, said Dr. Taylor, who also is national leader of The Wyatt Co.'s national health care consulting practice based in Washington, D.C. Instead, a national set of standards should be developed, he said.

"Physicians should know how they are being evaluated," contends Dr. Shirley E. Kellie, a senior scientist in the technology assessment department of the Chicago-based AMA and one of the authors of the study. "We don't know what private UR firms use as medical criteria because they say that information is proprietary. That secrecy is not very useful."

Sharing of review criteria would "be useful for physicians and patients" and could result in improved medical care and fewer inappropriate procedures, said Dr. Kellie, who studied the Medicare PRO program with Dr. John T. Kelly, director of the AMA's office of quality assurance.

Releasing UR criteria would give doctors "an assurance that as there is more effort at cost control, we are doing something to maintain quality of care."

And, because physicians will

know in advance why a certain procedure cannot be approved, "they may very well not ask to have that procedure done," Dr. Kellie said.

Pre-procedure review programs, including the Medicare PRO program, were developed to control costs by discouraging inappropriate and unnecessary utilization of medical and surgical services.

There are 48 Medicare PROs around the country that judge the appropriateness of certain medical procedures financed by the Medicare program. Like commercial UR firms, the PROs use both doctors and nurses to review attending physicians' recommendations.

More than three-quarters of employers have implemented some type of hospital preadmission or precertification program in an effort to control group health plan costs, according to A. Foster Higgins & Co. Inc. (BI, Feb. 18).

Review standards are used to evaluate the appropriateness of medical care before it is provided and can strongly influence what services physicians provide to patients, Dr. Kellie explained. But, she said, "currently there are no uniform guidelines for developing either the content or the format of the review criteria."

The AMA study examined pre-procedure review criteria for the three most frequently reviewed procedures by Medicare PROs: cataract removal; carotid endarterectomy, or restoring blood flow to clogged arteries; and cardiac pacemaker implants. The review standards were compared to national practice guidelines developed by the American Academy of Ophthalmology, the American College of Physicians and the American College of Cardiology.

The study found wide variation between the PRO criteria and the medical groups' guidelines.

For example, for cataract removal the AAO recommended that only patients with a visual acuity level of 20/50 or worse be eligible for cataract removal surgery. That level is consistent with the vision standard required to obtain a driver's license. However, the visual acuity standards used by Medicare PROs ranged from 20/30 to 20/300, the study found.

The study also noted that Medicare PROs required levels of artery obstruction ranging from 50% to 90% before a carotid endarterectomy would be certified. ACP guidelines say the procedure may be appropriate for patients who have obstructions of 70% or greater.

While many UR experts agree that there are problems with the Medicare PRO process, they say standards developed by private UR companies—those that monitor group health plans—are of a much higher quality.

And, they say, publishing review criteria used by at least 300 UR firms in the nation will not make review criteria more uniform. Rather, they recommend that the federal government help finance the development of publicly available medical appropriateness guidelines doctors could follow.

The AMA study authors "are absolutely right that there are problems with the (Medicare) PRO process—they don't use the very best clinical criteria," said the president of a leading independent UR company. However, he said, the AMA report really implies the urgency that "we should as a society have the funding for a major medical guideline development process—spearheaded by a national consortium that includes experts on clinical outcomes and medical appropriateness."

The AMA report "should be used as a springboard for developing national practice guidelines, not as a way to put individual UR firms out of business," by releasing proprietary information, he said.

"There is no doubt that the instruments to measure medicine ought to be in the public domain," said Dr. Robert Brook, director of health sciences programs at the Rand Corp. in Santa Monica, Calif. But, he said, "no one has taken the initiative to develop good publicly available guidelines."

As a result, private UR companies spent a great deal of time and money developing their own criteria and it's not surprising that they want to protect them, he said.

But, the people on whom the guidelines are used "ought to be able to see them," Dr. Brook said. Rather than have individual UR firms release their expertise to competitors, the government should either purchase privately funded criteria from UR vendors or a "rigorous publicly funded process should be implemented to develop appropriateness guidelines. Then the UR companies that can develop smart ways to incorporate them will survive."

UR executives say the reason private UR firms have had to create their own appropriateness criteria is because the medical community has not done so.

"Medical societies have come very late in defining medical necessity," noted Dr. Walter Hollinger, vp of medical affairs at Parkside Health Management Corp. in Park Ridge, Ill. As a result, the UR industry created its own guidelines and "we have a responsibility to make sure our definitions are credible and reflect current medical knowledge."

"If you look at the Blue Cross/Blue Shield system, there isn't anything secret about the criteria we use. It's all nationally recognized and well-known criteria," noted Mary Ellen O'Donnell, director of utilization management for BC/BS Assn. in Chicago.

"Having private companies come up with their own sets of effective criteria is not the best of all worlds," said the UR company president. "But, given that the federal government won't take the initiative" to establish national standards "and given that society isn't satisfied with the status quo, it's the next best solution."

And, UR experts say that merely publishing review criteria would not correct differences in the criteria. "I understand that physicians want to know by what yardstick they are being measured—that's a valid concern," said Ms. O'Donnell. "But just to publish the criteria doesn't get at the variability."

And, she said, some variability in review criteria is to be expected.

"If there is variability in different criteria sets used by private UR firms, I think it speaks to the variability in practice patterns" by doctors in different areas of the country," Ms. O'Donnell said. For example, doctors on the East Coast traditionally practice more conservatively than doctors in other areas of the country, she said.

"Criteria will inevitably differ because they reflect different levels of interpretation" by various panels of physicians and even by nurse and physician reviewers within a particular review firm, explained Dr. Hollinger.

Most UR companies say they would allow the AMA to review the medical criteria they use if the organization requested it. And, they say, keeping review criteria proprietary does not mean attending physicians cannot find out why a procedure is being denied.

The standards exist for non-physicians—like nurses and medical records technicians—to use during the first level of review, explained Michael Garrett, director of utilization management and marketing for Seattle-based Professional Review Organization for Washington, which is both a Medicare PRO and a commercial UR company. ■

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NAIC reviews model for broker control of insurers

By COLLEEN JOHNSON

A National Assn. of Insurance Commissioners committee is recommending that regulators stop requiring states seeking NAIC accreditation to adopt the group's model law on producer-controlled insurers until the law is clarified.

The NAIC's Financial Regulations Standards Committee did not recommend specific changes to the model law. However, committee member Earl Pomeroy, North Dakota's insurance commissioner, says he would recommend changes similar to those passed last week by the North Dakota Legislature.

Gov. George Sinner is expected to sign the law.

The North Dakota legislation, among other things, considers a broker with a 10% stake in an insurer to be controlling the insurer.

compared with a majority stake under the NAIC model law.

Proposed changes to the NAIC model law would be recommended by the NAIC's Special Insurance Issues Committee.

"The National Assn. of Insurance Brokers is pleased the NAIC task force has taken this action" calling for review of the model law, said Michael J. Muller, executive director of the Washington, D.C.-based broker group.

The model law is vague and unfair in how it imposes liability on brokers, Mr. Muller said.

Brokers are concerned about a provision in the NAIC model law that calls for determining broker liability for the insolvency of insurers they control through an administrative proceeding conducted by the insurance commissioner rather than through civil court

proceedings.

North Dakota's Mr. Pomeroy said in his view, regulators also could face problems in enforcing a judgment against a broker found liable for an insurer insolvency if the judgment was obtained through an administrative hearing rather than through a court proceeding.

In addition, language in the current model law relating to when a broker controls an insurer is "foggy," an NAIB spokeswoman said.

For example, she said, the model law suggests that regulators can find that a broker without an ownership stake in an insurance company still controls the insurer if the broker produced a large amount of business for the company.

As states have begun to consider adopting the producer-controlled

insurer model law—along with other NAIC model laws—"obvious areas of improvement have been identified," Mr. Pomeroy said. State regulators have begun to push for adoption of the NAIC's various model laws as a step toward becoming accredited by the NAIC (BI, March 25).

The North Dakota Legislature, for example, made several changes to the NAIC model law.

The North Dakota law, if signed, will allow a broker's liability for an insurer's solvency to be determined through a civil court proceeding rather than through an administrative proceeding, as is called for in the NAIC model.

However, in a change that is much stiffer than the NAIC model law, the North Dakota law states that a broker that has a 10% ownership interest in an insurance

company "controls" the insurer.

Brokers could contest the finding of control with the insurance department, according to Mr. Pomeroy.

In addition, the North Dakota law spells out penalties that brokers face for violating other provisions of the law.

If a new NAIC model law on producer-controlled insurers is eventually adopted, states that already have been accredited or are seeking accreditation would have two years from the date of its passage to adopt the revised model law, said Nebraska Insurance Director William H. McCartney, another member of the financial regulation standards committee.

After proposed changes are developed, they will be presented at the NAIC meeting in June, Mr. Pomeroy said. ■

Georgia bars disclosure of insurance

ATLANTA—The Georgia Supreme Court has thrown out a provision of the state's 1987 tort reform law that permitted disclosure of collateral sources of income for plaintiffs.

The court ruled March 15 that the provision violated the state constitution. Georgia courts "have consistently held that neither the wealth of the plaintiff nor the defendant is relevant," the high court said.

"Because inherently prejudicial evidence is allowed only to show the plaintiff's sources, juries will be misled," the ruling said.

"If, for example, both the plaintiff and the defendant are insured, but the jury is only informed of the plaintiff's coverage, it may assume that only the plaintiff has insurance and the plaintiff's insurance should pay for the loss," the court ruled.

As part of a 1987 tort reform bill, the state allowed disclosure of collateral sources so that payments made to plaintiffs from other sources could be introduced as evidence and used to reduce an award (BI, March 2, 1987). That law, among other things, also caps many punitive damages at \$250,000 and allows judges to apportion joint and several liability awards when it is established that the plaintiff contributed to an injury or property damage.

One business lobbyist claimed the high court ruling "destroys the most effective part of our act."

The collateral source provision had several times prevented a Georgia plaintiff from recovering higher damages or even reaping a double recovery, said John Poole, senior vp of governmental affairs for the Georgia Business Council in Atlanta.

Plaintiffs' attorneys, who had faulted the rule for creating "an inherently unfair situation," praised the decision.

"The fact that someone has been responsible enough to provide some coverage for themselves certainly should not be used to sway a jury," said Charles M. Searcy, executive director of the Georgia Trial Lawyers Assn. in Atlanta.

In its ruling, the Supreme Court court combined appeals of two cases. One involved a trial judge's ruling that the rule was unconstitutional. The other was a challenge of the constitutionality of the use of the rule in a trial, said plaintiff's attorney Hubert E. Hamilton, a partner with Bennett & Hamilton in Rossville, Ga.

—By Colleen Johnson

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California

Continued from page 2

aside regulations adopted by his predecessor, Roxani Gillespie, in June 1990.

Ms. Gillespie had established a benchmark allowable 11.2% rate of return for insurers for determining the 20% rollback and "a target return on equity between 11.2% and 19%" for determining future rates (BI, June 18, 1990).

Mr. Garamendi in January asserted that his proposed regulations would not permit insurers rates of return as high as those Ms. Gillespie would have allowed.

But, insurers blasted Mr. Garamendi's original proposed regulations in February hearings, claiming the regulations would defeat the purpose of Proposition 103 by, among other things, driving some insurers out of California (BI, Feb. 18).

Mr. Garamendi's revised proposal suggests an alternate mechanism for ratemaking for large commercial lines of insurance, particularly specialty coverages.

The regulations state: "In addition to the computation of projected losses specified" in the originally proposed regulations, an insurer may submit "an alternative

computation of projected losses for the specialty category, which the commissioner may approve if he finds the projection to have been made in a sound actuarial manner."

"We're looking for ways to treat specialty commercial insurance differently from more homogeneous, Main Street insurance," Mr. Garamendi said last week at the hearing.

"Specialty insurance is defined as those sub-lines, classes and coverages that exhibit characteristics justifying special treatment. These include lines with extreme volatility and lines sold to large sophisticated buyers for whom intense regulatory scrutiny is less necessary," the commissioner said.

The new proposed regulation states: "Specialty insurance shall include: all policies having an annual premium over \$100,000; all excess and umbrella liability policies in which the policy covers risks in excess of a self-insured retention or the policy of an unaffiliated insurer covering at least the first \$500,000 in losses; retrospectively rated or loss-sensitive insurance where the total standard premium for all policies for the account of a single insured is greater than \$250,000."

Another section of the regulations states that specialty insurance includes "all policies for nuclear risks, pollution legal liability, malicious product-tampering, kidnap and ransom, political risks, professional liability or errors and omissions, directors and officers liability, boiler and machinery in-

Mr. Sitrin emphasized in the February hearings that specialty lines insurers would be forced to leave the state if the insurance commissioner's original regulations were adopted.

Gary Fontana, a partner with Theen, Marrin, Johnson & Bridges in San Francisco, who represents

because they still take a "public utility approach" to regulating insurance by limiting rates of return and setting up efficiency standards, according to Mr. Fontana.

Regulations based on that approach will have "unfortunate results," because they will not promote competition and they will lead to higher insurance rates, Mr. Fontana charged.

"We welcome the commissioner's recognition" of the differences between commercial and personal lines coverages, "but his characterization fails to recognize that no insurance is actually a commodity," said Karen Morris, assistant counsel for Allstate Insurance Co. in Northbrook, Ill.

The regulations also should take into account "the vast differences," notably in loss projections, among companies writing personal lines coverages, she said.

Voter Revolt's Mr. Rosenfield said the amended regulations appear to be "a sensitive approach" to ratemaking for commercial lines. But he warned regulators to make sure no "abuses" result from the special treatment afforded commercial lines insurers under the revised proposal.

Mr. Rosenfield, though, was not pleased with Mr. Garamendi's proposed changes in efficiency standards used to determine insurers' rate of return for ratemaking purposes.

"This single issue would cost consumers billions of dollars in rollbacks," he said at the hearing last week.

The revised proposed regulations state: "The efficiency standard shall be set separately for each insurance line and coverage, and separately for insurers distributing through independent agents and brokers, through exclusive agents, and through employees of the insurer not functioning as agents." The standard for each category will be based on the industry average within that category.

In opting for this efficiency standard, Mr. Garamendi rejected an alternative favored by Voter Revolt: a standard "pegged to the most efficient companies" instead of to the industry average, Mr. Rosenfield said.

The new proposed regulations also would no longer exclude insurers' charitable contributions as an expense category in ratemaking.

However, the AIA and the ACIC still "object to the nature of these proceedings for ratemaking," which were not authorized by Proposition 103, Mr. Fontana testified.

Nearly 80 insurers plan to file suit in Los Angeles Superior Court on Wednesday in an effort to halt Mr. Garamendi's hearings on the proposed rollback regulations (BI, March 25).

The Insurance Department filed a motion last week asking the court to dismiss the insurers' planned suit.

In a related development, the department plans to appeal a March 21 decision by Los Angeles County Superior Court Judge Dzintra Janavs upholding a law enacted last year that exempts surety bond writers from Proposition 103's rollback and prior approval provisions.

Mr. Garamendi's revised proposed regulations would not totally exempt surety business.

Judge Janavs ruled that legislative analyses in the course of debate on the legislation, A.B. 3798, revealed "the relative stability of surety insurance rates, competitiveness of the market and availability of the insurance."

Noting that the legislation was passed by a unanimous vote of both houses, Judge Janavs ruled: "The Legislature's conclusion that A.B. 3798 furthers the purpose of Proposition 103 is supported by the record before the court." ■

'We're looking for ways to treat specialty commercial insurance differently from more homogeneous, Main Street insurance,' Mr. Garamendi says in testimony at a hearing last week on his proposed regulations.

surance, fidelity insurance, financial guarantee insurance, mortgage guarantee insurance and employer liability under the U.S. Longshoremen's and Harbor Workers' Act."

The revised proposal also states that insurers could classify other lines—"except homeowners multiple peril, private passenger automobile liability and private passenger automobile physical damage"—either as "commodity" or "specialty" lines.

Homeowners multiperil and private passenger auto lines, in addition to other lines that insurers do not treat as specialty lines, would have to be considered commodity lines. Those lines would be subject to the ratemaking guidelines Mr. Garamendi initially proposed.

"While the regulations are still under study, they appear to give commercial insurers the flexibility to continue to serve the public in specialty lines of insurance" and in writing large commercial risks, said Sherman A. Sitrin, a vp and associate general counsel-domestic companies for American International Group Inc. of New York.

the American Insurance Assn. and the Assn. of California Insurance Cos., said that Mr. Sitrin's February testimony persuaded the Insurance Department to revise its regulations.

Mr. Fontana testified at last week's hearing that the new proposals are "an improvement in some areas, but in others they are less productive" than Mr. Garamendi's original proposal.

"All it appears to do at first blush is to permit insurers to file rates for specialty lines according to any generally accepted method," in addition to filing rates for "commodity" lines according to the method specified in Mr. Garamendi's previous proposal, Mr. Fontana explained.

However, only "the biggest companies have resources to put up with this accounting nightmare," Mr. Fontana said. "The fact that the largest writers can survive the chaos" is small comfort for other insurers, he added.

In addition, the amended proposal still is essentially flawed—as were Ms. Gillespie's regulations—

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INTERNATIONAL



Photo by Kathryn J. McIntyre

A campaign is underway to promote Bermuda's strengths as an insurance and financial center.

Promoting Bermuda Government, industry join forces

By ROGER SCOTTON

HAMILTON, Bermuda—Bermuda's public and private sectors are teaming up in an unprecedented \$250,000 campaign to promote the island as an international insurance domicile and business center.

The prime objective is to increase direct and indirect revenues from the island's insurance industry, which is facing increasingly stiff competition from other domiciles.

Intermediate goals of the campaign call for a net 1.5% increase in the number of insurance-related companies incorporated in Bermuda, a 12.5% gain in the annual volume of international business-related visits to Bermuda and much greater use of local banks, law firms and financial services.

The campaign will effectively kick off April 28 in New Orleans at the Risk & Insurance Management Society Inc.'s annual conference.

Other activities planned this year include seminars in selected U.S. cities organized through local RIMS chapters, aggressive advertising and the education of local industry staff to equip them to argue the strengths and weaknesses of Bermuda.

The marketing drive, which is being organized under the banner of the newly formed marketing committee of the government's statutory Insurance Advisory Committee, will in-

clude a more coordinated effort to represent the industry at international insurance conferences.

These meetings include this month's RIMS conference, the World Insurance Congress in London in July, the Captive Insurance Companies Assn. Inc. meeting held last week in Phoenix, the biennial International Risk & Insurance Management Assn. conference in Monte Carlo and the annual meetings of local captive associations in Vermont, the Cayman Islands and Luxembourg.

"We have tended to do things rather piecemeal in the past, while our competing domiciles have picked up their marketing efforts. All of that is going to stop," said Robin Spencer-Arscott, chairman of the marketing committee. Mr. Arscott is chairman and chief executive officer of Anchor Underwriting Managers Ltd., a unit of Aon Corp.

"From now on, we will fully coordinate our efforts with the result that each venue or project will be the responsibility of an individual on the marketing committee or in the industry. We're no longer going to be seen as a group which just organizes cocktail parties and display booths," he said.

Organizing an annual Bermuda conference is one key project of the IAC marketing team. In fact, talks are under way with the Tillinghast

division of Towers, Perrin, Forster & Crosby Inc. about assuming the organization and management of the annual International Captive & Reinsurance Forum sponsored by the consulting firm, according to Roger Gillett, vice chairman of the IAC marketing committee. Mr. Gillett is a vp of captive manager Johnson & Higgins (Bermuda) Ltd.

The talks, which were initiated by Tillinghast, are at an early stage, and it is by no means certain what their outcome will be, he said. However, one way or another, the marketing group's objective is that the island's insurance and reinsurance industry should stage a conference, he said.

Although some of the language used to describe the new marketing campaign sounds familiar to Bermuda observers, the new effort began in earnest in January.

"We just got to the stage where we asked ourselves whether we were going to talk forever or actually do something about it," Mr. Gillett said.

The Bermuda government was among the first to support the move. It is allocating \$65,000 to cover the travel and related costs of civil servants—primarily Malcolm Butterfield, the registrar of companies—to attend these meetings and has indicated it is prepared to contribute more in the future.

"I think government accepts that

Continued on page 63

CODA may move to allay brokers' concerns about its 1990 results

By ROGER SCOTTON

HAMILTON, Bermuda—Corporate Officers & Directors Assurance Ltd. is considering steps to bolster market confidence in the company after reporting its first underwriting loss ever.

The directors and officers liability insurer reported an underwriting loss of \$63.2 million and a decline of almost \$40 million in shareholder equity for the year ended Oct. 31, 1990.

CODA provides up to \$25 million of either primary or excess personal coverage to directors and officers for risks that their corporations are either unwilling or unable to indemnify. CODA officials say they became aware of producer concerns about its health after the February release of its 1990 financial report.

The report blames the underwriting result on a \$91 million increase in loss reserves to \$116.6 million. CODA posted an underwriting profit of \$13.6 million in 1989 (*BI*, April 30, 1990).

After investment income of \$27.1 million, the insurer finished the year with a net loss of \$38.6 million, compared with a profit of \$35.8 million in 1989. The report shows earned premiums rose 19% last year to \$31.8 million. Shareholder equity dropped to \$180.6 million in 1990 from \$219.2 million the previous year.

A financial viability memorandum to brokers, policyholders and shareholders is among the measures that could soon be taken by the insurer to bolster market confidence, said Donald Snyder, its chairman and chief executive officer.

Meetings have already taken place with CODA's two largest producers in Bermuda with the aim of increasing their "comfort level," he said.

According to Mr. Snyder, the 1990 loss provision reflects the insurer's highly conservative approach to reserving. "Our actuaries gave us a range of projections and CODA's audit committee took the highest end of that range so that we could get the bad news behind us as quickly as possible," he explained.

The bad news involved one shareholder derivative action and several

insolvencies among CODA policyholders last year. Two of the failures were financial institutions, one of which "came out of the blue" when an investment-grade corporation entered Chapter 11 bankruptcy, Mr. Snyder said.

According to the annual report: "The major claim exposure which CODA has experienced to date has been the insolvency of insured companies and the resulting liability of those companies to indemnify directors and officers for claims made against them."

"These events partly reflect the economic climate we're in," said Mr. Snyder, who added that he cannot divulge details of claims and policyholders' coverages. "But our exposure due to bankruptcies is far greater than we'd anticipated. And, as a result, we're devoting more resources to improving our ability to analyze this exposure," he said.

Mr. Snyder, a former retired treasurer of Eastman Kodak Co. who likes to describe CODA's products as the ultimate in "sleep insurance for Fortune 500 executives," said Bermuda-based ACE Ltd. will continue to provide management and administrative services to CODA. But, he said ACE now is focusing on measures intended to improve its assessment of CODA's exposure to policyholders' bankruptcies.

"It's important to bear in mind that we still haven't paid a major loss, though we've paid under a million dollars for some legal fees and expenses. We're taking a very conservative approach and have reserved \$116.6 million for four or five events. These events may not lead to a major claim. We hope this will all turn out to have been an anomaly, but only time will tell. Certainly, if it were not for these claims, we'd have a very good book," Mr. Snyder said.

So far, the 4½-year-old company has processed 232 notices of events likely to produce claims, 90 of which have been closed.

CODA had 162 policyholders on its books at the end of January, compared with 148 in January 1990.

"We are aware of some of the stone

Continued on page 63

Outhwaite tries to bar arbitration appeal

By STACY SHAPIRO

LONDON—The British Court of Appeal has asked Britain's highest court to expedite a ruling on whether Lloyd's of London underwriter Richard Outhwaite can bar another Lloyd's underwriter from appealing an arbitration decision that would limit asbestos-related losses to Mr. Outhwaite's syndicates.

The underwriter, Robert Hiscox, is appealing in London's High Court an arbitrator's decision that runoff reinsurance policies Mr. Outhwaite wrote for his syndicate 33 do not have to pay some asbestos-related claims settled by the now-defunct Asbestos Claims Facility under the Wellington Agreement.

When Mr. Hiscox's appeal of the arbitration is heard April 9 in London's High Court, it will mark the first time that a dispute over whether

a reinsurer must pay all claims settled by the Asbestos Claims Facility is argued in open court (*BI*, March 25).

However, the decision will be sealed until a separate issue raised by Mr. Outhwaite in the case is decided. If Mr. Outhwaite wins his argument, then the Hiscox appeal will be quashed and the decision never heard.

The separate issue involves efforts by Mr. Outhwaite to derail the Hiscox appeal by arguing that British courts have no jurisdiction over the arbitration decision, which was signed in France.

A London High Court disagreed, so Mr. Outhwaite appealed the point to the British Court of Appeal. The appellate court also disagreed with him and said Mr. Hiscox's appeal could proceed, resulting in Mr. Outhwaite's current appeal to the House of Lords,

Britain's highest court.

In allowing Mr. Hiscox's case to proceed, the Court of Appeal also ruled last week that Justice Hirst—the High Court judge who first ruled against Mr. Outhwaite's appeal—should not also hear the Hiscox appeal. It also ruled that the High Court decision should be sealed until the outcome of Mr. Outhwaite's appeal is known.

The Court of Appeal last week also asked the House of Lords to "expedite" Mr. Outhwaite's case and hear it as soon as possible, noted attorney Clive Boxer, a partner of Fishburn Boxer, who is representing Mr. Hiscox.

Syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., in 1982 wrote 100% of an unlimited runoff reinsurance policy for syndicate 33, managed by Roberts & Hiscox Ltd.

The policy covers losses on underwriting years prior to 1974 in excess of \$7.5 million. Paid losses and outstanding liabilities likely to fall under the policy total at least \$20 million (*BI*, July 3, 1989).

But, according to court documents, underwriter Richard Outhwaite contends he wrote a letter to syndicate 33 in September 1987 that voided or rescinded the syndicate's runoff reinsurance policy. Mr. Outhwaite tried to void the policy claiming non-disclosure or alternatively misrepresentation on the part of syndicate 33, court papers show.

Messrs. Hiscox and Outhwaite agreed to settle the dispute through arbitration, as provided for in a clause in the runoff reinsurance policy. They chose one arbitrator, qualified British trial lawyer R.A. MacCrimble, to decide the case. Mr. MacCrimble heard the arbitration in

England, court papers say.

On June 30, 1989, Mr. MacCrimble rejected Mr. Outhwaite's argument and ruled that the unlimited runoff reinsurance policy was enforceable. Although Mr. MacCrimble practiced law in England and had offices in London, he signed the order in Paris, where he also worked, court papers show.

Messrs. Hiscox and Outhwaite also had asked Mr. MacCrimble to decide on the amount that Outhwaite should pay syndicate 33 under the runoff policy.

Mr. MacCrimble last August made an award in the form of a declaration and later wrote his decision, which he signed in November in Paris, court papers show.

The details of how much Outhwaite was to pay syndicate 33 are confidential, said Mr. Boxer, who

Continued on next page

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INTERNATIONAL

Outhwaite dispute

Continued from previous page
represents Hiscox.

But the syndicate is concerned that Mr. Outhwaite's syndicates will not pay some asbestos claims because Mr. MacCrindle "disallowed Wellington as a loss contract," Mr. Boxer said.

Under Mr. MacCrindle's decision, only part of the claims settled under the Wellington Agreement are recoverable, Mr. Boxer said.

Mr. MacCrindle's decision incorporates an arbitration decision made by Lord Wilberforce in 1989 in a dispute between syndicate 317/661 and syndicate 347/570, which was managed by M.H. Cockell & Partners, an Outhwaite spokesman said.

Lord Wilberforce had ruled that the Outhwaite syndicate need not reimburse the Cockell syndicate for "gaps and surcharges" or the share of the costs the Cockell syndicate incurred in setting up the Asbestos Claims Facility and the claims the syndicate paid for facility members on behalf of insurers that were not facility members (*BI*, July 3, 1989).

The Wilberforce decision, if unchallenged, should save Outhwaite millions of dollars in losses from various runoff reinsurance policies, the Outhwaite spokesman said.

Because Mr. MacCrindle's decision limited asbestos claims paid under Wellington, Mr. Hiscox in December sought leave to appeal the arbitration in London's High Court under the British Arbitration Act of 1979. Mr. Hiscox asked for a court order directing Mr. MacCrindle "to state further reasons for his award" and for the court to "seek remission of the award," court papers say.

Mr. Outhwaite objected to Mr. Hiscox's appeal and found a loophole in arbitration law on which to hang his objection, according to court papers.

Mr. Outhwaite alleges that because Mr. MacCrindle signed his decisions in Paris, the arbitration award was "made" in France and not in London where the arbitration was heard.

As a result, Mr. Outhwaite contends, the arbitration is governed under the New York Convention—an international treaty among 50 countries that spells out the jurisdictions of arbitrations between people of different nations—and not British arbitration law.

Therefore, the English court has no jurisdiction over the award. Mr. Outhwaite argues.

"He is leaving no stone unturned" to protect the Hiscox arbitration—and, hence, the Wilberforce decision—from being challenged, the Outhwaite spokesman said.

"Going to a French court is probably not an option, though that is not clarified. But if the court finds in favor of Outhwaite, it will block (Hiscox's) appeal," the spokesman said.

Under the New York Convention, signed by France and the United Kingdom, the English court only can enforce the decisions of a French court in an arbitration award that was "made" in France, Mr. Outhwaite argues. A British court cannot rule on the merits of the award or change it in any way, he says.

Mr. Hiscox, though, argues the arbitration was made in England and is therefore governed under British arbitration laws, which allow him leave to appeal to London's High Court.

And even if the arbitration were decided in France, Mr. Outhwaite was prevented from using the argument that the award was not governed under British arbitration laws because he originally agreed to the arbitration under British law, Mr. Hiscox argues in court papers.

Earlier this year, Justice Hirst in London's High Court concluded that the arbitration decision was not made in France but in London and was governed under the British Arbitration Act of 1975, which incorporates the New York Convention into British law. Justice Hirst also accepted Mr. Hiscox's contention that even if it were a French award and governed under the New York Convention, Mr. Hiscox could appeal in British courts because the arbitration was initiated in England.

However, on March 11 the British Court of Appeal said that because Mr. MacCrindle signed the arbitration decisions in France, the arbitration was "made" in France and was governed by the New York Convention.

Nevertheless, the appellate court ruled 2-1 that this did not stop Mr. Hiscox from appealing the arbitration in a British court and gave him leave to proceed with his appeal in London's High Court.

The majority of the Court of Appeals also said the issue of France's jurisdiction was made academic because Mr. Outhwaite had earlier agreed to abide by English law.

Master of the Rolls Lord Donaldson of Lymington, one of the three Court of Appeal judges, wrote that under the convention, enforcing courts—in this case London's High Court—can set aside or suspend awards that are made in another country governed by the convention. "I do not accept that the authors of the convention or Parliament could or did intend to achieve the result which flows from (Mr. Outhwaite's attorney's) submission," he wrote.

Lord Donaldson also concluded that Messrs. Outhwaite and Hiscox already had "quite clearly" agreed that the arbitration would be in London and therefore governed by British arbitration law.

Letters from lawyers on both sides show "that both parties assumed that the fact that an award was dated at Paris was no obstacle to the exercise by the English courts of their supervisory jurisdiction under the Arbitration Acts (of) 1950 and 1979," Lord Donaldson said. "The only cause for surprise is that it has been thought of at all."

He dismissed Mr. Outhwaite's appeal saying: "In my judgment, it would be unconscionable now to allow Mr. Outhwaite to renege from the common assumption" that the arbitration would be governed by British courts.

Another Court of Appeal judge, Lord Justice McCowan, concluded that under the New York Convention, the English Court would not be able to hear the arbitration appeal. Quoting clauses from the convention, he noted that the arbitration

Continued on next page

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INTERNATIONAL

Continued from previous page
is "enforceable" and "shall be treated as binding for all purposes."

However, Lord McCowan agreed with Lord Donaldson that this argument is made academic by the fact that both parties agreed to an arbitration under English law. "On this ground, therefore, I would dismiss the appeal."

Among the three judges, only Lord Justice Leggatt agreed with Mr. Outhwaite on both points. "The result of the rival arguments is either that the English court cannot do anything to a convention award except enforce it or that the English court retains all its powers to interfere with

such an award before considering enforcement," he said.

"Having anxiously considered this dilemma, I do not feel able to construe the (Arbitration) Act so as to preserve a locus for the English court when acting in its supervisory capacity. . . The act does not envisage that the award will be subject to the supervisory jurisdiction of the English court."

Justice Leggatt said he could only conclude that the convention award was "outside the realm of enforcement" of English courts.

Justice Leggatt also concluded that although originally it was common ground by both parties that the

award was subject to English Arbitration Acts, the situation changed after the award was signed in Paris.

"In short, there was here no common assumption about the effect of the award having been made in France," Justice Leggatt said.

"There was a mutual failure to appreciate that that fact was material and why it was. I therefore do not consider that Mr. Hiscox can, by raising an estoppel, prevent the award from having effect as a convention award. I would allow the appeal."

Mr. Outhwaite is appealing this Court of Appeal's majority decision to the House of Lords. ■

CODA loss

Continued from page 61
throwing that's been going on since our 1990 financials came out and we're going to be looking at the possibility of putting out a financial viability memorandum," Mr. Snyder said. "We're also hoping that our conservative approach to reserving will serve to provide some added assurance to our insureds. But it has to be pointed out that, so far, we have had only three years of commercial underwriting activity beyond our original sponsors' risks, so our book is still in the process of seasoning." CODA, which was launched by 53

sponsor corporations in October 1986, offers coverage in \$5 million increments, protecting directors and officers on a primary basis or excess of other insurance on a difference-in-conditions basis. Up to \$10 million in fiduciary liability coverage also is available.

Though Mr. Snyder concedes that CODA faces more competition now than it did at the outset, he pointed out "there's still no form as broad as ours."

"Our insureds represent a cross-section of corporate America. Our market is still the Fortune 500 corporations and we have plenty of room to grow," he said. ■

Bermuda

Continued from page 61
it will have to do more to promote the island generically. We have a partnership with the insurance industry, and we need to work together in a proactive way, rather than just react to changes," said Walwyn Hughes, Bermuda's financial secretary.

The marketing project has a budget of \$250,000, about half of which has already been raised. Pledges have been secured from all sectors of the industry—captive managers, brokers and underwriters—as well as from support businesses like banks, law firms, auditors and actuaries.

Some industry groups are levying a surcharge on members to contribute to the campaign. Others are handling it differently, but each sector is providing various degrees of support.

"The support has been just tremendous," Mr. Spencer-Arscott said. "People are not only encouraging us with verbal expressions but with written checks, too."

However, there are still some missing pieces in the marketing drive.

"We need to look a little more closely at our intermediate goals. For example, we're looking to increase the industry's gross premium income by 10%, and we'll measure increased use of local service providers by watching to see if their work force expands by monitoring the government's manpower reports. But measuring the number of international business visits here may be more difficult," Mr. Gillett said.

A market analysis will be another key part of the campaign. Mr. Gillett said this analysis will be completed soon and will identify product niches, target countries, target U.S. cities and target industries for Bermuda. This, together with a proposed new data base of all Bermuda company owners, contacts and prospective owners, will provide the campaign with an information foundation.

"It's not as easy as it used to be," Mr. Spencer-Arscott said. "We're no longer just a captive domicile. We now have a financial reinsurance market and one of the world's most important excess liability markets with ACE Ltd. and X.L. Insurance Co. Ltd. Things have changed."

But with the property/casualty insurance market still mostly soft, is the campaign's timing right?

"Yes, no question of it," said Mr. Gillett. "This is the perfect time so that when the market does turn, we'll be ready and waiting."

"We want to promote ourselves from a position of strength, not when we're declining," said Mr. Spencer-Arscott.

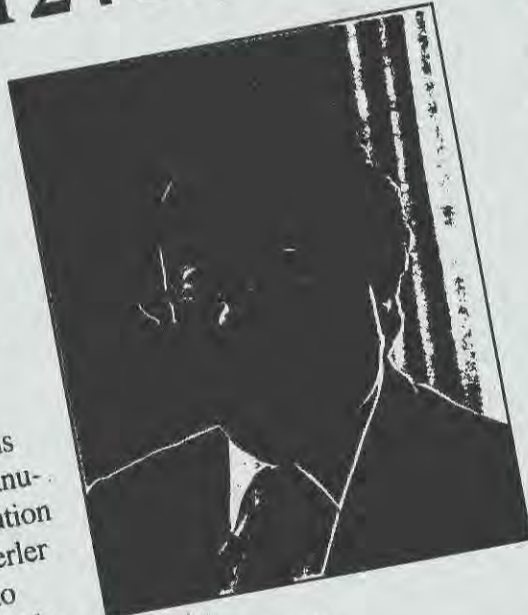
Bermuda had 1,312 captives as of year-end 1990, up 4% from 1,261 in 1989, government figures show. And, in January and February the island added 15 new captives, compared with only 12 new captives in the entire first quarter of 1990.

But Bermuda's share of the captive pie has been slowly shrinking. In 1990, Bermuda had 40.2% of all captives incorporated in Barbados, Bermuda, the Cayman Islands and Vermont, according to the government. That share is down from a high of just more than 50% of all captives in these domiciles in 1986. ■

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P/C results

Continued from page 1

sales of portions of its extensive equity and junk bond portfolio (BI, March 4).

The Home, which had a \$218.3 million loss, also posted significant losses last year stemming from realized capital losses on its junk bond portfolio. The company was sold earlier this year to a group led by Swedish insurer Trygg Hansa SPP Holding (BI, Feb. 18).

And C. Ronald Riley, chief financial officer for Royal, blamed a \$46.3 million loss on a combination of inadequate rates, reserve increases for prior-year business and "strategic in-

itiatives," including enhancing computer systems and staff training.

While insurers' profits slid last year, their combined ratios did not. The insurers surveyed by *Business Insurance* posted a 110.7% combined ratio for 1990, the same as in 1989.

But, when 1989 catastrophes like Hurricane Hugo and the Northern California earthquake are accounted for, insurers' 1990 underwriting performance actually deteriorated.

"You have to adjust 1989 for the catastrophes. You'd see that 1990 shows substantial deterioration because there wasn't the same level of catastrophes," said Ed Santos, chief financial officer for Transamerica Insurance Co. in Woodland Hills, Calif.

The uninspiring performance turned in by property/casualty insurers last year is becoming too familiar, complain industry observers.

"It really wasn't a good year and yet, in some ways, it was too good a year," commented Gloria Vogel, associate director at Bear Stearns & Co. Inc. in New York.

It was not good in the sense that price cutting and underwriting deterioration continued, she said. But the year was too good in the sense that the results "were not ugly enough to cause a turn in the cycle. They were ugly. They just weren't ugly enough."

"It's pretty sleepy out there," said David Wells, an analyst with Fitch

Investors Service in New York. Rates are not in a downward spiral, but they are still lower than loss costs. "In this case, no news is bad news."

"We continue to see results pretty much moving along—not getting very much worse or much better," said Barbara Stewart, president of Stewart Economics in Chapel Hill, N.C.

"The results that I've seen obviously leave room for improvement," said Marvin Shulman, an analyst with Moody's Investors Service in New York. "I think that pricing, while not deteriorating significantly, is not recovering, so I think it's tending to remain flat."

But as long as loss costs rise, Mr.

Shulman said, insurers lose ground.

Rates generally have stopped declining and most insurers are able to raise some rates, though these increases are not enough to make up for the cumulative deficiencies of the past two to three years, said the Royal's Mr. Riley.

Observers note that insurers' results were also affected by costs tied to the withdrawal from certain markets and corporate restructurings.

CIGNA Corp., for instance, has reduced its regional offices to four from 22, and changed its mix of business, including reducing its workers compensation business and withdrawing from the personal automobile insur-

Continued on next page

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COUNTY DEPARTMENT, CHANCERY DIVISION
IN THE MATTER OF THE LIQUIDATION OF PROVIDENT INSURANCE COMPANY F/K/A ILLINOIS LIFE & ACCIDENT INSURANCE COMPANY
NO. 91 CH 00227

NOTICE OF CLAIMS DATE AND PROCEDURES
PLEASE TAKE NOTICE, that on January 9, 1991 an Agreed Order of Liquidation With a Finding of Insolvency was entered against Provident Insurance Company ("Provident") by the Honorable Arthur L. Dunne, Judge of the Circuit Court of Cook County, Illinois. James W. Schacht, Acting Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Provident.

TAKE FURTHER NOTICE, that pursuant to the Order of the said Court, all rights and liabilities of Provident and all other persons interested in its assets are fixed as of January 9, 1991, unless otherwise provided by such other Order of the Court.

TAKE FURTHER NOTICE, that pursuant to the Order of the said Court, all direct policies or contracts of insurance previously issued by Provident (formerly Illinois Life & Accident Insurance Company) are cancelled as of January 9, 1991, except those policies or contracts of insurance which are "covered policies within the meaning of the Illinois Life and Health Insurance Guaranty Association Law (Ill. Rev. Stat. 1989, Ch. 73, par. 1065.80-1, et seq.), or any similar law of any other state, or the obligations, or any part thereof, of which the Illinois Life and Health Guaranty Association, or any similar organization in any other state, is obligated to assure payment of, which shall remain in full force and effect until cancelled, or until they expire, in accordance with their terms.

TAKE FURTHER NOTICE, that the form of and required content of all Proofs of Claim are described in Illinois Revised Statutes 1989, Chapter 73, Paragraph 821. Proofs of Claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Special Deputy Liquidator, Provident Insurance Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of Provident concerning such claim. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR AT HIS ABOVE-MENTIONED OFFICE IS SEPTEMBER 9, 1991 AT 4:30 P.M., CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS, CONTINGENT OR OTHERWISE, AGAINST PROVIDENT INSURANCE COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH AND RECEIVED BY THE LIQUIDATOR ON OR BEFORE SEPTEMBER 9, 1991 AT 4:30 P.M., C.D.T.; AND IF ANY SUCH CLAIMS ARE CONTINGENT CLAIMS, THEY MUST BE LIQUIDATED PURSUANT TO SECTION 209 OF THE ILLINOIS INSURANCE CODE (ILL. REV. STAT. 1989, CH.73, PAR. 821) ON OR BEFORE SEPTEMBER 9, 1991 AT 4:30 P.M. C.D.T.

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Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,606
Sub-total 24,591
Associations 488
Government, Unions and Educational Institutions 1,275
Commercial Consumers
Sub-total 26,354
Insurance Agents and Brokers 9,651
Insurance Companies 8,074
Accountants, Actuaries, Attorneys & Consultants 3,438
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,294
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TOTAL 50,176
* Source: Business/Occupational breakdown of qualified circulation, November 26, 1990 issue, as submitted to BPA for December 1990 BPA Publisher's Statement.

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National Council on Compensation Insurance

Continued from previous page
ance market in Massachusetts.

The insurer is no longer "all things to all people," said a spokesman.

CIGNA posted aftertax charges of \$98 million last year related to its field office consolidation and the Massachusetts withdrawal, as well as the integration of its EQUICOR health insurance operation.

"I think property/casualty companies have come to the conclusion that in order to improve their profitability, they need to take a very hard look at their expenses," said Mr. Shulman.

"More or less, the companies are adjusting their operations to the realities of the marketplace" rather than just focusing on undercutting the competition, said Ms. Stewart.

Observers note that insurers' results also hinge on their mix of business. Chubb Corp., for instance, which is known as a specialty niche underwriter, posted a 24.1% increase in its net income to \$522.1 million. It also reported a 99.7% combined ratio, compared with 101.5% for 1989.

"It's really more or less a function of the company's long-run strategy, which has certainly paid off, in its emphasis on specialty lines," said James Guenther, assistant vp for rating agency Duff & Phelps in Chicago.

On the other hand, Continental Corp., whose business observers describe as more commodity-oriented, reported a 7.8% decline in net income to \$141.1 million. It posted a 114.3% combined ratio in 1990, compared with 115% in 1989.

Analysts describe Continental as more vulnerable to market forces, though they say the company should be well-positioned to take advantage of an eventual hard market.

A Continental spokeswoman responded that observers "overstate the case" when they label Continental's commercial package business as a commodity. "I think they're missing the value in our very strong market position in the package business" that enables the company to write the "cream" of that business, she said.

She said, however, that she agrees Continental is well-positioned to take

Property/casualty industry's profit declines by 9.4%

NEW YORK—The U.S. property/casualty insurance industry's net income fell 9.4% last year to \$11.1 billion from \$12.2 billion in 1989, according to the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

This compares with a 27.4% drop in the net income reported by 26 major commercial property/casualty insurers surveyed by *Business Insurance* (see story, page 1).

The insurers ISO and the NAI surveyed, which account for 96% of the country's property/casualty premium volume, posted a 109.4% combined ratio for the year, up slightly from 109.2% in 1989. This compares with the 110.7% combined ratio reported in both 1989 and 1990 by the major commercial insurers surveyed by *BI*.

The overall property/casualty industry reported an 11.3% increase in pretax operating income during 1990 to \$11.5 billion from \$10.4 billion. However, pretax underwriting losses increased 6.4% last year to \$20.9 billion from \$19.6 billion.

Net written premiums for the industry grew 4.7% to \$218.6 billion in 1990 from \$208.8 billion. This compares with a 3.2% growth rate in 1989 compared with 1988.

Net investment income, excluding capital gains, increased 5.4% last year to \$32.9 billion from \$31.2 billion.

The U.S. property/casualty insurance industry's policyholder surplus increased 3.4% to \$138.6 billion at year-end 1990 from \$134 billion at year-end 1989.

—By Judy Greenwald

advantage of a hard market. "We definitely feel we can get some wind in our sails from prices firming."

The insurer that showed the biggest increase in profits last year—Reliance Group Holdings Inc.—benefited from a \$245.5 million aftertax gain from the sale of its General Casualty Insurance Co. subsidiary to Winterthur Swiss Insurance Co., a Reliance spokesman noted.

Partly offsetting the gain were \$173 million in pretax losses on investments, including a fourth-quarter pretax provision of \$75 million to cover probable future losses on bond holdings.

Even though Reliance's net income increased more than 513% in 1990, its combined ratio jumped to 109.9% from 107.7%.

Besides the industrywide decline in net income, other year-end results among the insurers surveyed by *Business Insurance* include:

- Underwriting losses remained relatively flat, growing 2.7% to \$9.7 billion in 1990 from \$9.4 billion in 1989. This compares with a 3% decline for the first nine months of 1990 and a 22.6% decline for the first half of the year.

Year-to-year underwriting results

At some point, insurers will 'probably have to pay the piper,' says Gloria Vogel.

did not deteriorate as quickly as in the past in the second half of 1990 because of the huge catastrophe losses in the second half of 1989.

- Net written premiums grew a modest 1.8% to \$93 billion in 1990 from \$91.5 billion in 1989. This compares with a 1.3% increase in premiums for the nine months and a 1.8% rise in the first half.

- With slower premium growth and relatively low interest rates, investment income grew by 4.8% to \$15.2 million from \$14.5 billion. That was a slide from a 5.2% rise in the first nine months of 1990 and a 5.8% increase in the first half.

- Policyholder surplus for the 29 insurers providing the data rose 4.1% to \$45.6 billion from \$43.8 billion. This compares with a 5.4% decline for the nine-month period, when 26

insurers reported their surplus.

Unlike some years, there were no significant reserve increases among the surveyed insurers during the final quarter of 1990, observers noted. However, insurers typically underreserve in a soft market in the expectation of making up for it when rates begin to rise, they say.

Some observers believe insurers' results would have been worse had insurers posted more adequate reserves.

"I think the results represented were better than the results produced," said Robert A. Anker, president and chief executive officer of American States Insurance Co., a Lincoln National Corp. unit in Indianapolis.

He said the industry's loss reserve deficiency deepened in 1990, and this will become apparent in 1991.

"I think we're feeling better than we ought to feel from an industry standpoint," he said.

Insurers' results are "dirty. They're not real numbers. They're compromised. The real numbers would be a lot less," said Myron M. Picoult, senior vp at Oppenheimer & Co. in New York. "It'll all come home to roost, hopefully."

"There's no question that the industry is putting aside a lot lower level of reserves as a percentage of premium," said Charles Ronson, an analyst with Baird, Patrick & Co. in Chicago.

"I think at some point they'll probably have to pay the piper," said Ms. Vogel. "How long they can delay the day of reckoning, I don't know."

Duff & Phelps' Mr. Guenther noted that results were slightly better than he expected. Though catastrophes played a role in this, "I was expecting a little bit more on reserves and it wasn't there."

"I think (insurers) will probably get worse in terms of their under-reserving" because the market is still in a downward cycle, said Mr. Wells.

Most observers now say the downward cycle will continue until at least 1992.

And some, like Ms. Vogel, "haven't a clue" as to when the market will turn. Next year "would be my best guess," she said, though "it is possible it could go on for a long time."

Mr. Guenther also has "reasonable expectations" that rates finally will rise in 1992. "You look at cash-flow constraints, you look at what's occur-

Continued on next page


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Summary of major property/casualty insurers' 1990 results

Ranked by change in net income. All amounts in thousands of dollars.

Rank 1990	Corporate				Property/casualty operations									
	Consolidated revenues 1990	Net income 1990	Percent increase (decline) 1989-1990	Combined ¹ ratio 1990	Combined ¹ ratio 1989	Net premiums written 1990	Percent increase (decrease) 1989-1990	Pretax underwriting income (loss) 1990	Percent increase (decline) 1989-1990	Pretax investment income 1990	Percent increase (decrease) 1989-1990	Policyholders surplus 1990	Percent increase (decrease) 1989-1990	
1	Reliance Ins. Co. & subs.	3,683,794	133,423	513.7	109.9 ²	107.7 ²	1,694,706	(5.5)	(133,700)	10.5	216,290	(5.6) ¹	846,440	26.6
2	Fireman's Fund Ins. Cos.	275,220	152,591	108.3	117.2 ²	123.6 ²	2,727,765 ²	2.6	(424,136) ²	28.4	485,284 ²	3.6	1,420,474	(0.4)
3	Fremont General Corp.	573,390	26,828	52.9	102.1	100.4	409,822	36.5	(8,530)	(526.7)	75,744	45.7	207,447	3.0
4	Berkshire Hathaway Group	918,587	267,677	32.9	104.5	106.2	574,290	93.9	(26,647)	(9.2)	327,047	34.3	N/A	N/A
5	Chubb Corp.	4,247,600	522,100	24.1	99.7 ²	101.5 ²	2,919,700	6.8	(1,400)	96.7	494,800	11.3	1,410,700	9.1
6	Argonaut Insurance Co.	540,624	82,130	15.7	104.9 ²	103.5 ²	419,037 ²	13.4	(22,951) ²	(49.6)	133,388 ²	18.5	397,574	3.7
7	Hartford Insurance Group	8,836,000	291,000	7.4	109.7	107.7	6,082,000	(0.4)	(662,000)	(26.3)	938,000	6.1	2,739,000	6.7
8	Sentry Insurance Cos. ²	1,438,593	59,619	7.0	106.6	108.4	1,135,193	10.0	(71,240)	5.7	152,322	2.6	663,987	8.2
9	Old Republic Int'l	1,242,717	104,683	5.8	105.7 ²	109.3 ²	684,229	9.3	(65,206)	22.3	158,345	6.7	776,693	19.1
10	American International Group	15,702,067	1,442,294	5.5	99.6 ²	100.0 ²	9,267,201	3.7	75,184	31.7	1,059,161	10.9	5,192,388	14.1
11	General Re Corp.	2,993,200	613,600	2.5	99.0 ²	99.6 ²	2,149,600	13.3	(9,900)	(135.0)	706,100	4.9	2,901,500	7.1
12	Hartford Steam Boiler	562,373	78,748	1.5	88.0	83.9	306,642	6.9	35,876	(22.4)	42,403	1.7	355,251	5.9
13	The St. Paul Cos. Inc.	4,005,237	391,270	(1.7)	104.2	106.6	3,052,032	8.7	(120,730)	38.5	629,242	2.5	1,466,736	(4.4)
14	SAFECO Corp.	3,178,490	278,409	(7.3)	107.2	103.3	1,688,032	5.8	(119,173)	(128.1)	283,248	7.5	1,026,468	1.4
15	Continental Corp.	5,705,200	141,100	(7.8)	114.3 ²	115.0 ²	4,522,900 ²	(5.3)	(636,000)	9.5	740,000	0.6	1,940,900	(9.1)
16	Royal Group (U.S. subs.) ²	N/A	(46,300)	(7.9)	127.2	121.5	1,835,100	(17.7)	(489,600)	(4.2)	341,600	8.5	823,000	(6.1)
17	Aetna Life & Casualty Co.	19,020,500	614,100	(9.2)	113.4	114.9	6,290,800	(3.9)	(845,100)	13.1	1,084,200	5.8	2,706,600	(0.5)
18	Ohio Casualty Corp.	1,637,535	84,100	(17.2)	105.3 ²	103.7 ²	1,468,404 ²	6.6	(79,353)	(26.8)	176,686	(5.9)	465,821	(12.4)
19	Transamerica Ins. Group	2,129,894	61,137	(18.4)	111.8	110.4	1,818,825	9.6	(221,335)	(25.2)	252,702	14.2	1,046,140	3.5
20	Lincoln National Corp.	8,489,500	191,400	(28.8)	109.2 ²	106.7 ²	2,354,800	(0.3)	(207,800)	(23.8)	286,600	(9.9)	1,245,300	(15.3)
21	CNA Financial Corp.	9,940,000	366,500	(40.7)	115.0 ²	116.0 ²	6,580,000 ²	16.7	(1,015,000) ²	(9.9)	1,160,000 ²	12.6	3,150,000	1.0
22	CIGNA Corp.	18,164,000	330,000	(41.3)	115.9	115.8	5,932,000	1.1	(959,000)	(3.2)	858,000	0.6	1,860,000	(7.6)
23	Crum & Forster Inc.	4,342,600	157,100	(49.0)	114.2	117.6	3,166,800	(5.4)	(465,100)	20.9	597,300	(1.6)	1,271,800	(16.9)
24	Travelers Corp.	11,313,400	(178,400)	(139.2)	115.9	116.1	4,256,300	(7.3)	(680,600)	1.2	766,200	3.4	1,904,800	(13.9)
25	Home Insurance Co.	2,340,000	(200,000)	(218.3)	109.7 ²	109.0 ²	1,957,000	(4.3)	(215,000)	(8.6)	321,000	(10.8)	786,000	(6.4)
26	USF&G Corp.	4,605,000	(569,000)	(578.2)	115.3 ²	109.9 ²	3,631,000 ²	(1.8)	(522,000)	(59.1)	576,000	(7.5)	1,352,000	(4.6)
—	Commercial Union Ins. (U.S.) ²	N/A	N/A	N/A	110.7 ²	112.0 ²	1,289,400	3.8	(146,700)	5.5	168,900	3.9	584,500	(2.3)
—	Nationwide Mutual Ins. Co. ²	N/A	N/A	N/A	111.6	108.2	5,595,629	(3.4)	(488,863)	(32.5)	739,241	6.2	3,083,778	3.6
—	Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	114.1	115.5	6,267,529	0.1	(678,281)	14.3	1,070,139	5.7	2,570,287	5.3
—	Kemper National P/C Cos. ²	N/A	N/A	N/A	115.9	110.5	2,997,562	16.2	(484,743)	(67.8)	320,648	6.9	1,432,568	(14.3)
	Cumulative	135,885,521	5,396,109	(27.4)	110.7	110.7	93,074,298	1.8	(9,689,028)	(2.7)	15,160,590	4.8	45,628,152	4.1

¹ After dividends

² Statutory

³ Before dividends

N/A—Company did not provide data

P/C results

Continued from previous page
ring in the reinsurance market, you look at what's occurring in London and one has to believe that's going to play a future role eventually," said Mr. Guenther, who added he expects a U-shaped rather than a sharp turn.

If the market does turn this year it will be at 11:59 p.m. on Dec. 31, quipped Joanne Morrissey, a principal with Firemark Inc. in Morris-town, N.J.

"I don't think it's going to be much before then," she said. "I don't see

this as being a real good year."

"I guess I continue to look at the results of all the major players and they're really not that bad, which leads me to believe we're not going to see a turn that quick," commented George Yonker, assistant controller at SAFECO Corp. in Seattle. He added that 1992 "looks like the year we have to look to now. We don't see it happening before then."

Rates will not harden until 1992, said Oppenheimer's Mr. Picoult. "Nobody's got their hands wrapped around it, nobody—least of all insurance companies' managements," Mr.

Picoult pointed out.

The market could harden "some-time next year" though a turn could come sooner if there are major stock market losses or catastrophes, Mr. Wells said.

With insurers' combined ratios, cash flow and return on equity all suffering, "you would have to think" the market would turn "by the end of the year" said Dennis Busti, president of Reliance National Insurance Co. in New York.

But, with capital still strong and market share still an important part of insurers' strategy, the turn is more

likely to come in early 1992, he said.

Others, however, perhaps wary of earlier predictions that have not materialized, refuse to predict when rates will harden.

"Frankly, I can't think of one thing now that would make any change in the market," said Ms. Stewart.

It conceivably could be years before the market turns, she said.

"I don't know because I don't see what's going to turn it," said Robert Branche of Branche Research Group in Morrisville, Pa.

The market could continue to drift as it has been indefinitely, he said.

"Why would it change?"

"I really don't have the faintest idea" of when the market will turn, said Lincoln National's Mr. Anker. "It's clear it is a long way from wanting to turn right now."

"There are too many players in the market who are deciding they can make money doing things they have not done before or have not done for years," he said, noting there are insurers willing to write American State's business sight unseen for 10% less premium. "That's dumb. It was dumb yesterday and it will be dumb tomorrow." ■

Group health profits may not hit '90 levels

By JUDY GREENWALD

Group health insurers are looking forward to another profitable year in 1991, even though their performance this year may not be able to top a banner 1990.

"The group health market appears to be a market that was showing relatively good numbers and seems to be topping out," says Michael A. Lewis, first vp with Dean Witter Reynolds in New York.

"I think the margins in the business are pretty close to full at this point," agrees Gloria Vogel, associate director at Bear, Stearns & Co. in New York. "My impression is we sort of level off here a little bit and then turn downward," she adds.

"I think they'll make less money in '91," commented Paul Fleischacker, a vp in New York with the Tillinghast unit of Towers, Perrin, Forster & Crosby Inc.

The Blue Cross/Blue Shield Assn. reported that the non-profit plans around the nation together reported a \$1.9 billion gain in 1990, up from a \$1.1 billion gain in 1989.

"If history repeats itself, it would be reasonable to conclude" that the gain in 1991 will be in the vicinity of \$1 billion, said Leonard E. Wood, senior vp for national marketing for the

BC/BS Assn. in Chicago. "I think margins have peaked and you're at a point where I think companies are looking to grow their customer base—their insured lives—to cover the cost of investments in managed care and make it efficient," said James Guenther, assistant vp of rating agency Duff & Phelps in Chicago.

There is pressure, for instance, on managed care firms like health maintenance organizations to expand the number of participants to take advantage of economies of scale.

"I think the formula is there for price pressure," said Mr. Guenther. "It's going to be difficult, I think, to maintain strong earnings."

Competition is heating up in some markets, he noted. With existing players fighting for market share and employers trying to cut costs, pricing pressures will hold down premium increases—and health insurers' profits—this year, he said. "There'll probably be reduced margins in '91."

While employers faced group health insurance premium increases in the 20% to 30% range in 1990, "I would expect rate increases more in the 15% to 20% range this year, and maybe even lower in some cases," said Mr. Fleischacker of Tillinghast (BI, Dec. 17, 1990).

"We're still getting price increases

that reflect the realities of the life in that business and that will sustain margins," said a CIGNA Corp. spokesman.

The Philadelphia-based insurer's group life and health benefits segment reported \$291 million in operating income in 1990, a 24.9% increase from \$233 million in 1989.

William Caulfield, senior vp of group benefit services at John Hancock Mutual Life Insurance Co. in Boston, noted that Hancock's group business—which includes group health, disability and life insurance—generated \$15 million in operating income in 1990, up from \$10 million in 1989.

"Things are going well for us," he said, noting that Hancock acquired a utilization review firm, Cost Care Inc. of Huntington Beach, Calif., June to meet rising demand for managed care services (BI, June 11, 1990).

A slowdown is expected in 1991. "You can't keep up 50%," said Mr. Caulfield, but "we'll continue to grow very nicely."

Mr. Caulfield said he expects group health premiums to become less volatile "because I think we're beginning to understand how to control health care costs."

"Some of us have figured it out, but not the entire industry by a

stretch," Mr. Caulfield said.

Paul Glover, senior vp for managed care and employee benefits operations for Travelers Corp. in Hartford, Conn., said operating profits on its group business rose 35% to \$104.2 million from \$75.9 million in 1989. At the same time, revenues from group operations rose 10% to \$9.54 billion.

Travelers "really turned around" its small group book of health insurance business, in particular its association business, in 1990, he said.

Group profits also rose in 1990 because heavy investments in managed care operations during the previous several years depressed profits in those years, Mr. Glover explained. As the company's managed care networks grew, operating margins improved. And these profits "offset the pressure on the margins in the guaranteed-cost, small group indemnity market."

In 1991, "we expect to increase both revenues and operating income about 10%," Mr. Glover said.

Sixty percent of Travelers' group profits are generated by health insurance and 40% by group life business, said Mr. Glover.

Charles T. Bell, a vp in the employee benefits department of Aetna Life & Casualty Co. in Hartford, Conn., noted that group health insur-

ers' profits primarily are based on how well they estimate health care cost inflation in the coming year.

"This year, there's probably more risk that we've underestimated than overestimated," he said, since insurers are not increasing employers' premiums as much as they have the past several years.

Aetna's health and life insurance and services business, which reflects both group and individual business, reported \$302 million in earnings in 1990, a 24.8% increase over \$242 million in 1989.

While most group health insurers expect 1991 results to be slightly down from last year, Prudential Insurance Co. of America in Newark, N.J., is expecting margins to be a little higher than they were in 1990, said Joe Maginnis, vp-group indemnity.

Profit margins in Prudential's traditional group health business are expected to remain the same, but margins for managed care business should rise, he said. Prudential does not break out results for individual lines of business, he noted.

Because of competitive pressures, however, "nobody, I don't think, is going to make a lot of money in this business in 1991. It's kind of a way of life with us," Mr. Maginnis said. ■

Pan Am

Continued from page 1

award of punitive damages," the appellate court said. "Thus, we hold that these plaintiffs may not recover such damages."

The 2nd Circuit's decision marks the first time that an appellate court has ruled specifically on whether punitive damages can be recovered from airlines under the Warsaw Convention, said George S. Tompkins Jr., a partner at Condon & Forsyth in New York and an attorney for Pan Am.

The decision could affect the outcome of a pending case, now on appeal. The survivors of 137 passengers killed aboard Korean Air Lines Flight 007 were awarded \$50 million in punitive damages after a KAL Boeing 747 was shot down by Soviet fighters when it strayed into Soviet air space, said Mr. Tompkins, who also represents that airline (BI, Aug. 7, 1989).

The U.S. Court of Appeals for the District of Columbia currently is considering the appeal in the KAL case following oral arguments in January.

Meanwhile, the plaintiffs in both Pan Am cases are "hopeful" that the entire 2nd Circuit will rehear the case, said Mr. Kreindler. If they are unable to secure that hearing, however, they say they will seek Supreme Court review.

"The Supreme Court may or may not hear it," said Mr. Tompkins. "The Supreme Court is touchy now on punitive damages."

In early March, the high court refused to set specific limits on the ability of juries to award punitive damages, but did rule that the Constitution requires proper instruction of juries and significant judicial review of juries' punitive damage awards (BI, March 11).

Later last month, the justices remanded for lower court review seven cases challenging punitive

damages (BI, March 25).

Having previously ruled on the Warsaw Convention, the Supreme Court may decide to hear the Pan Am cases, Mr. Tompkins said. The court ruled in April 1989 that KAL's protection from unlimited claims should not be voided because it printed notification of the liability limit in smaller type than the treaty required (BI, April 24, 1989).

In its 52-page decision on the Pan Am cases, the three-judge panel of the 2nd Circuit unanimously agreed that the Warsaw Convention does not allow plaintiffs in international aviation disasters to recover punitive damages.

The decision, written by U.S. Circuit Judge Richard J. Cardamone, rejects plaintiffs' assertion that the Warsaw Convention allows state law to govern lawsuits stemming from international flights. Rather, the Warsaw Convention pre-empts causes of action brought under state laws, Judge Cardamone said.

The 57-year-old convention does not consider the legal subdivisions of the countries that signed the agreement, he noted. "We therefore decline to read into the convention any attempt to preserve a right to a state law cause of action in addition to the action provided under the convention itself."

The existence of state causes of actions "would not only result in the inconsistent application of law to the same accident, but also would cause enormous confusion for airlines in predicting the law upon which they would be called to respond," Judge Cardamone said. Paraphrasing John Milton's poem "Paradise Lost," he added that "would sink federal courts into a Syrtis bog where they would not know whether they were at sea or on good, dry land."

Rather, the source of the right to

sue under the Warsaw Convention "is the Convention itself—a treaty that only the federal government has the power to make. Consequently, the source of the right is federal law."

Under this body of law, punitive damages can only be assessed to punish or deter certain kinds of conduct, the ruling said. Therefore, the court only had to consider whether the Warsaw Convention intended to permit punitive damages "to punish a defendant and deter certain kinds of conduct," said Judge Cardamone.

Article 17 of the Warsaw Convention, which establishes an air carrier's liability, only refers to liability for "damage sustained," he noted, interpreting this to mean "monetary or compensatory damages only."

Looking at the origins of the convention, Judge Cardamone noted that "nothing in the convention's drafting history points to the drafters contemplating that the convention would be used to punish or deter tortious behavior on the part of airlines. Rather, all of the drafters' actions point to the conclusion that they sought to limit recovery simply to compensation."

Even if willful misconduct is proven and the convention's liability limit is lifted, the plaintiff can recover only unlimited compensatory damages, not punitive damages.

"We think lifting the monetary limit on compensatory damages is the convention's sole response to willful misconduct, and that it stems not from the wish to punish the defendant but from the idea that a party cannot rely on exclusions to escape from his wrongdoing," said Judge Cardamone.

Interpreting the convention to allow punitive damages to be recovered would "severely hobble most of the aims the convention sought

to accomplish: establishing a uniform carrier liability regime, limiting carrier liability to ensure a viable industry, ensuring the carrier's ability to insure against losses and adequately compensating injured passengers quickly and with the minimum of litigation."

"The decision is correct because the parties who drafted the convention did not contemplate punitive damages in their discussions," said David Berg, senior attorney for the Air Transport Assn. of America in Washington, D.C., which represents airlines.

"It would have been antithetical to allow punitive damages," he said. "The purpose of the convention was to limit liability at a time when the industry was in its infancy."

"The Warsaw Convention is very clear on what the damages are," agreed John Martin, an aviation attorney with Bigham, Englar, Jones & Houston in New York. "If the people who framed the Warsaw Convention intended there to be punitive damages, they would have said so."

However, a plaintiffs' attorney attacked the ruling.

"The decision... adds a further layer of protection to airlines at the expense of passengers," said Marc S. Moller, another Kreindler & Kreindler attorney representing plaintiffs in the case.

"It has the potential to undermine air safety," said Mr. Moller, who also is chairman of an American Bar Assn. panel on aviation and space law. "This completely insulates airlines from judicial punishment."

A trial on damage claims stemming from the Lockerbie disaster will begin June 18 in the U.S. District Court of the Eastern District of New York regardless of whether the full 2nd Circuit or the Supreme Court agrees to review the appellate ruling, said Mr. Kreindler.

Survivors of the victims are attempting to prove that Pan Am exhibited willful misconduct in failing to detect a suitcase packed with Semtex explosive that was loaded onto a Pan Am jetliner in Frankfurt, Germany, and later transferred to Flight 103 at Heathrow Airport in London. If the plaintiffs can prove willful misconduct, they can recover more than the \$75,000 per person damage cap set by the Warsaw Convention.

Pan Am's leading aviation underwriter, United States Aircraft Insurance Group, has offered to pay \$100,000 per victim to settle the cases. Only a handful of survivors have accepted the offer, said Mr. Kreindler.

The families of the Lockerbie victims altogether are seeking \$350 million in compensatory damages, plus "\$350 million or more in punitive damages if the 2nd Circuit's decision is reversed."

Mr. Kreindler said the plaintiffs will use as evidence the recently published public inquiry report on the disaster by Scottish Sheriff Principal John Mowat, which states that inadequate security measures contributed to the explosion of Flight 103.

The 99-page report says that Pan Am's security was far below the standard the airline had claimed.

Pan Am will argue, however, there was no willful misconduct because it had "no proximate cause" to allow a bomb on board an aircraft, Mr. Tompkins said.

"There is no evidence developed so far which proves how the bag got on the airplane," he said. And no airline to date is able to detect Semtex in a suitcase, he said, so "there is no evidence of willful misconduct."

Associate Editor Stacy Adler in New York contributed to this story.

Multipiece tire rims

Continued from page 2

pain and suffering. Akron, Ohio-based Goodyear and Troy, Mich.-based Budd argued in a motion to dismiss them from the suit that marketwide product liability is applicable only when the actual maker of a widely manufactured product cannot be determined.

However, the appellate court ruled that the two companies must remain in the discovery process of the case to determine whether there is enough evidence to prove the plaintiff's allegations of an industrywide conspiracy.

The appellate court said it agreed with Goodyear and Budd's definition of marketwide product liability.

But—applying a "concerted action theory of recovery"—the court ruled that the possibility raised by the plaintiff that a collective agreement by multipiece tire rim manufacturers "to aid and abet each other" in breaching their duty to provide a safe product "could similarly give rise to joint liability."

Under the concerted-action theory, one person may be held liable for the conduct of another if both are engaged in a "tortious act in concert or pursuant to a common design with the other person, or giving substantial assistance or encouragement to the other person with the knowledge that the other's conduct constitutes a breach of duty."

The appellate court found that the plaintiff made a strong enough case in opposing Goodyear's and Budd's summary judgment motion to dismiss the company from the litigation "that further discovery may disclose an express agreement or tacit understanding" among the manufacturers of the multipiece tire rim "to prevent public awareness of the extreme propensity of

all such rims to explode."

The appellate court also ruled that the plaintiff's allegations that multipiece tire rim manufacturers may have acted together to block governmental action that might have resulted in a recall of all "RH5-degree multipiece tire rims" warrant further investigation.

Goodyear also argued that, as a manufacturer of a tire for the rim, it has no duty to warn consumers about the rim, because its own product was not dangerously defective.

But, the court said: "The manufacturer knew the purpose for which the chattel might be used

and was aware of the dangers surrounding its use under at least one of the invited conditions. In such circumstances, the manufacturer has a duty to bring to the knowledge of those who are to use the chattel such directions as would make it reasonably safe for the use for which it was declared suitable."

Goodyear attorney Alan D. Kaplan of Gallagher & Gosseen in Mineola, N.Y., acknowledged that the concerted action theory is well established in the state.

However, "we have never seen it applied to a product liability case before," he said.

Tire rims produce many lawsuits

WASHINGTON—More than 70 product liability suits alleging injuries have been filed against one manufacturer of multipiece tire rims, a plaintiffs attorney says.

And it's likely there are even more suits pending, he adds.

In a product liability trial in a federal court in Kentucky, it was revealed during discovery that Akron, Ohio-based Firestone Tire & Rubber Co. has had more than 70 suits filed against it involving "substantially similar" incidents with its multipiece tire product, says plaintiff's attorney W. Carl Reynolds of Reynolds & McArthur Trial Lawyers in Macon, Ga.

Discovery for the case was limited, though, to the type of multipiece tire rim failure that the plaintiff in the Kentucky case experienced—in which the rim exploded on a mounted wheel while being inflated, he said.

Product liability cases involving other types of multipiece tire rim failures, like those on moving vehicles or on the assembly line, were not included in that count, according to Mr. Reynolds.

In the Kentucky case, Danny Webb of Mount Sterling, Ky., suffered brain damage and was paralyzed and disfigured in a 1985 accident in which the tire rim exploded while he was putting air in a deflated truck tire.

Last month, the U.S. District Court for the East-

ern District of Kentucky in Lexington awarded Mr. Webb \$10.4 million in compensatory damages and \$8 million in punitive damages.

The three defendants named in the case—Firestone, General Motors Corp. of Detroit, and Kelsey-Hayes Co. of Romulus, Mich.—were each assessed a percentage of the compensatory damages. GM, which was assessed 25%, was sued because the tire rim was assembled on a GM truck, while Kelsey-Hayes, which was assessed 10%, and Firestone, which was assessed 65%, were the designers of the tire rim, a "RH5-degree multipiece rim."

However, Firestone, as the product manufacturer, was ordered to pay the entire punitive damage award.

Firestone is appealing the verdict, said a company spokesman, who could not comment on Firestone's insurance.

Mr. Reynolds says that the injuries involved in these multipiece rim cases are very serious and often fatal.

According to expert testimony for the plaintiff, a tire rim explosion creates 85 pounds per square inch of pressure. "That much force can lift a 3,000-pound car 20 feet in the air," he said.

The RH5-degree tire rim was last manufactured in 1974, but it is estimated that more than 3 million are still in use, Mr. Reynolds said.

—By Adrienne C. Locke

stances exist to use it.

However, Mr. Schwartz said it is not clear whether the judge in the New York case will do so.

"If this judge does not apply those standards in a meaningful way during the trial, the court has changed the law and changed it for the worst," he said.

Neil A. Goldberg, a defense attorney with Saperston & Day in Buffalo, N.Y., said he sees the potential for significant abuse if the theory is applied similarly in other cases as it has been in the multipiece tire rim case.

"The trouble in a situation such as this is that the court allows the discovery process to continue just because there is an allegation that a company conspired with someone else" to commit a crime, said Mr. Goldberg, who also is president of the Defense Research Institute.

In allowing this, the court imposes upon the defendant oppressive pre-trial discovery cost "when they didn't even manufacture the product in question," Mr. Goldberg said.

However, Susan Corcoran, an attorney with Birbrower, Montalbano, Condon & Frank in New York who represents Ms. Rastelli, said, "product manufacturers cannot continue to market products that they know are unsafe."

She said she strongly believes a conspiracy exists among multipiece tire rim manufacturers to "keep silent" about the dangers of the product.

Goodyear and Budd "are being held accountable for their own wrongful act of allowing these products to remain on the market," she said.

Attorneys for Budd were not available for comment.

Ms. Corcoran said discovery in the case is expected to continue for another eight months. No trial date has been set.

Antitrust suit

Continued from page 2

visory rates on behalf of insurers to providing estimates of future claims as a way to help insurers determine and justify independent rate filings.

However, state law must be amended to allow for this change since the law currently calls for all insurers operating in Texas to use advisory rates submitted by ISO and approved by the Texas State Board of Insurance.

The rate reform called for in the Texas settlement already is being implemented in other states.

ISO in 1989 decided to stop providing insurers with fully developed rates and instead furnish only advisory loss costs. ISO is currently phasing in the loss cost recommendations in all states that do not require it to file advisory rates (*BI*, April 10, 1989).

The ISO spokesman confirmed that the organization will continue to provide advisory rates in Texas until the law is changed to permit it to provide only loss costs.

The spokesman noted that if the law is amended to allow ISO to provide future claims costs to insurers instead of setting advisory rates, greater price competition could result.

In addition, insurance buyers would have more options if the state allows insurers to use more than one version of the general liability policy form, he said.

Mr. Morales heralded the settlement as one that will produce significant change in the way insurers do business in Texas.

"We have obtained major concessions from the insurance industry that will lead to broad reforms in the way the industry does business in the state," said Mr. Morales. "This is an historic settlement."

However, insurers do not foresee

major changes.

A spokeswoman for Hartford Insurance Group in Hartford, Conn., one of the defendants that settled last week, said that except for the changes in the insurer's relationship with ISO, "we will essentially continue to do business and compete the way we always have in Texas."

A spokesman for defendant Aetna Life & Casualty Co., also in Hartford, Conn., agreed that the only change will be in the insurer's relationship with ISO, along with a more positive relationship with state regulators now that the litigation has been settled.

Of the \$4.1 million to be paid by insurance industry defendants under last week's settlement, \$3 million will fund a non-profit corporation that will educate and train state employees responsible for insurance regulation and oversight in Texas.

"We want to develop the intellectual and technical capacity to competently regulate this industry," said Mr. Morales. "We will set a new standard in this country for effective and responsible oversight of the insurance industry."

The remaining \$1.1 million will repay the state for attorneys' fees and investigative costs in pursuing the suit.

Defendants refused to say how much of the \$4.1 million each would pay.

In settling the suit, defendants denied any wrongdoing and indicated the agreement was reached as a way to avoid mounting defense costs.

"We know that we've done nothing wrong or illegal," said Michael S. Wilder, Hartford's senior vp and general counsel. "We've won our arguments at every step of the litigation process."

Christopher C. Mansfield, senior vp and general counsel at Boston-based Liberty Mutual Insurance

Co., said the amount paid to settle the litigation was "purely an economic decision based solely on the enormous waste of resources incurred by all parties, including the state of Texas, in the ongoing litigation."

Mr. Mansfield said that insurers and regulators in Texas "can now focus on working together toward a positive resolution of the various insurance problems facing the citizens of Texas today."

"It was time to put this confrontation behind us," agreed Zoe Baird, Aetna's general counsel. "We believe that this settlement represents a constructive effort by all parties in the suit to redirect their attention to the future insurance marketplace in Texas."

Along with Aetna, Hartford, Liberty Mutual and ISO, defendants participating in last week's settlement included Insurance Co. of North America, a unit of CIGNA Corp.; the Reinsurance Assn. of America; Lloyd's of London underwriter Robin A.G. Jackson; and then-Lloyd's non-marine Syndicate No. 799 managed by Merrett Underwriting Agencies Management Ltd.

In 1989, defendants Travelers Insurance Co. and St. Paul Fire & Marine Insurance Co. cited expenses in agreeing to pay \$1 million to settle the litigation (*BI*, Oct. 16, 1989).

Fireman's Fund Insurance Co. and USF&G Corp. paid \$1.5 million earlier this year to settle the litigation. They also said they settled to avoid the continuing defense costs (*BI*, Jan. 7).

Similar antitrust litigation filed in U.S. District Court in San Francisco by attorneys general in 19 states against insurance industry defendants was dismissed in 1989 (*BI*, Sept. 25, 1989). However, the attorneys general are appealing the dismissal in the 9th U.S. Circuit Court of Appeals (*BI*, March 25). ■

Brokers form space venture

Three brokerages are launching a new joint venture in the United States to provide comprehensive brokerage services to the space and space-related industry.

Based in Rosslyn, Va., International Space Brokers Inc. is equally owned by Crawley Warren Group P.L.C. of London, Le Blanc de Nicolay Reassurance of Paris and New York-based Frank Crystal & Co. Inc.

Aside from placing coverage, the new brokerage will "provide the optimum space risk management service, combining a unique blend of financial, contract, legal, engineering and insurance expertise," according to a statement announcing the venture.

The new brokerage is headed by John Vinter, formerly a vp with International Technology Underwriters Inc., a specialty underwriter in Bethesda, Md.

A staff is still being assembled, so it is not known how many people will be employed, said Michael Hemmings, director in the aerospace department of Crawley Warren.

Crawley Warren worked closely for years with Bethesda, Md.-based Corroon & Black Inspace Inc., a subsidiary of Corroon & Black Corp., in placing space-related risks worldwide. The two firms also formed Inspace International in Bermuda to place these risks, Mr. Hemmings said (*BI*, Aug. 28, 1989).

Inspace International, however, was dissolved after the Corroon & Black Corp./Willis Faber P.L.C. merger in 1990.

The new venture again allows Crawley Warren to offer space-related service worldwide, Mr. Hemmings said.

For more information, contact John Vinter, President, Interna-

Markets

tional Space Brokers Inc., 1616 N. Fort Meyer Drive, Rosslyn, Va. 22209; 703-841-1334.

Willis Corroon unit

Willis Corroon P.L.C. has launched a new aerospace division, Willis Corroon Aerospace of New York Inc.

The New York-based division, part of London-based Willis Faber & Dumas Aerospace Group, was formed to attract more North American aerospace business, explained Rick Loughlin, chairman of Willis Corroon Aerospace of New York and executive vp of Corroon & Black Co. of New York Inc.

Corroon & Black Inspace Inc., based in Bethesda, Md., will continue to operate separately as a division of the Willis Faber & Dumas Aerospace Group, he said.

J. Bransford Wallace, a director of Willis Corroon, will be president of Willis Corroon Aerospace. Key hires include Senior Vp Kenneth MacClelland, formerly a senior vp at Johnson & Higgins; Senior Vp Charles Laible, formerly a vp at J&H; Vp George Delgado, formerly a vp at Frank B. Hall & Co. Inc.; and Assistant Vp Melissa Harder, formerly an assistant vp at J&H.

The new company can be contacted at 7 Hanover Square, New York, N.Y. 10004-2594; 212-344-8888.

New risk consultant

A new risk management consulting practice will provide clients with expertise in the areas of property, liability, crime and workers compensation risks.

Moss Adams Certified Public Accountants, a San Francisco-based accounting firm, has established The Moss Adams Risk Management Group. The consulting practice will be managed by Robert L. Wilkinson, formerly a senior vp and manager in the San Francisco office of risk management consultant Warren, McVeigh & Griffin Inc.

The new risk management group will be based in Moss Adams' San Francisco office and will offer services to Moss Adams' clients as well as to risk managers nationwide. Initially the practice will focus on risk management but may expand to include employee benefit consulting, Mr. Wilkinson said.

For more information, contact Robert L. Wilkinson, Director, The Moss Adams Risk Management Group, 601 Montgomery St., Suite 1000, San Francisco, Calif. 94111-2684; 415-956-1500.

New offices

The Halland Cos., an independent insurance agency, moved to 61 Jericho Turnpike, Jericho, N.Y. 11753; 516-333-3000.

Genesis Underwriting Management Co., moved its offices to 75 Wall St., 25th Floor, New York, N.Y. 10005; 212-908-2525.

Sorema North America Reinsurance Co. opened an office in Dallas at 2 Lincoln Center, Suite 1325, 5420 LBJ Freeway, Dallas, Texas 75240; 214-387-3942.

The Montreal office of **General Reinsurance Corp.** moved to 1002 Sherbrooke St. W., Suite 2000, Montreal, Quebec H3A 3L6 Canada; 514-288-9667.

Environmental Management Services Inc. moved to 1827 Powers Ferry Road, Building 24, Marietta, Ga. 30067; 404-916-1908; 800-388-3647. ■

Update

Alliance seeks McCarran option

Continued from page 2

While opposed to the overhaul bill proposed by Rep. Jack Brooks, D-Texas, chairman of the House Judiciary Committee (*BI*, Jan. 7), "the Alliance recognizes that it must protect the interests of member companies in a time of potential change for the McCarran Act," the trade group said.

Alliance staffers will meet with "all interested parties" to discuss McCarran-Ferguson changes, a spokesman said.

The American Insurance Assn. is drafting an alternative to Rep. Brooks' proposal (*BI*, March 11), and the American Council of Life Insurance proposed an alternative to the Brooks bill (see story, page 57).

High court to hear cigarette suit

WASHINGTON—The U.S. Supreme Court will decide whether health warnings on cigarette packages protect manufacturers from certain product liability claims.

The high court last week agreed to review a 3rd U.S. Circuit Court of Appeals ruling in a case brought by the estate of Antonio Cipollone, whose wife, Rose, died of lung cancer in 1984. The 3rd Circuit ruled that failure-to-warn claims brought under state law are barred for injuries occurring after Jan. 1, 1966, when federal law first required cigarette packages to include health warnings.

The review was sought both by Mr. Cipollone's estate and by the tobacco companies sued: Philip Morris Inc. and Lorillard Inc., both of New York, and Durham, N.C.-based Liggett Group (*BI*, Jan. 14).

A Supreme Court ruling will resolve conflicts between five federal appeals courts as well as between state courts in New Jersey and state courts in Texas, which have ruled that the federal labeling law does not pre-empt such claims. Oral arguments are expected to be held this fall, and a ruling is expected next year.

USF&G drops Louisiana lines

BALTIMORE—USF&G Corp. will stop writing most commercial lines of insurance in Louisiana after suffering heavy losses in the state for 10 years.

A \$325 million statutory loss in the state over the past 10 years led to the withdrawal, USF&G said. USF&G last month announced a similar pullout from Texas, where its statutory losses since 1980 were \$300 million (*BI*, March 18).

The Baltimore-based insurer will no longer write new business in Louisiana, although it is renewing most business for one more year. The company also will continue to write fidelity, surety and life business and will remain an admitted reinsurer of all lines in Louisiana, the same as in Texas.

USF&G reported a net loss of \$569 million in 1990, and the insurer has slashed its dividend twice in four months. Standard & Poor's Corp. now rates its debt as below investment grade (*BI*, March 4).

U.K. may probe runoff policies

LONDON—The British government's Serious Fraud Office may investigate charges of fraud surrounding the placement of runoff reinsurance policies with Lloyd's of London underwriter Richard Outhwaite.

Members of syndicates managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. allege that several Lloyd's underwriters that ceded past liabilities to the Outhwaite syndicates withheld information on asbestos losses that they had gained from their membership in the Asbestos Working Party. That group was formed by the London insurance market to coordinate information about asbestos liabilities.

The Council of Lloyd's refused last year to investigate the allegations, citing insufficient grounds for pursuing the matter (*BI*, April 23, 1990).

Lloyd's Chief Executive Alan Lord last week said Lloyd's had an "impeccable record of investigating misconduct by members."

Nevertheless, in a debate about Lloyd's last week in the House of Commons, John Redwood, the British minister for corporate affairs, said the Serious Fraud Office is "examining one such set of problems (at Lloyd's) to see whether there is a case that it should take on."

Although Mr. Redwood did not name the Outhwaite debacle, the original title for the debate referred to Outhwaite syndicate 317/661, which faces massive asbestos liabilities from runoff policies written in the early 1980s. The title later was changed by John Bowis, the member of Parliament who called for the debate, after he learned that the Serious Fraud Office was looking into the matter.

Mr. Bowis told *Business Insurance* he has several constituents "who may lose the roof over their heads" because of Outhwaite losses.

During the debate, Mr. Bowis called on Mr. Redwood to consider new government regulations if the Lloyd's self-regulatory system cannot clear up disputes with members. Mr. Redwood "should make it clear that if that is not done to the satisfaction of his department and of the House, he will consider bringing forward a system of regulation by his department," Mr. Bowis said.

However, Mr. Redwood said he did not believe that "there are grounds for a further major review of self-regulation at Lloyds."

Briefly noted

President Bush has signed a law, H.R. 555, that requires employers to reinstate health care coverage for **employees returning from military service**. The measure also will allow doctors and other professionals in the military to suspend premium payments for malpractice insurance until they return to employment without endangering their coverage (*BI*, Feb. 4). . . . Legislation, H.R. 1645, introduced in the House by Rep. Nancy Pelosi, D-Calif., would require employers to extend **COBRA health care continuation coverage** for up to 15 years to dependents of former employees who were at least 50 years old when they became eligible for COBRA coverage. The same language also is included as part of the broader Women's Health Equity Act, H.R. 1161, S. 514, introduced earlier in Congress (*BI*, March 4). . . . The receivership trial for **Bel-Aire Insurance Co.** is set to resume, at the request of the insurer's attorney. The trial was delayed in January, when both sides agreed to wait for the completion of a study by Missouri regulators on the feasibility of rehabilitating the insurer.

III withdrawals

Continued from page 1

business," commented Gerald F. Isom, who is chairman of the III's board of directors and also president and chief executive officer of Transamerica Insurance Co. in Woodland Hills, Calif.

Mr. Isom added, however, that the New York-based III "will make whatever cut-backs" are necessary in the face of defections.

In addition to the three withdrawals that took place between October and January, The Home Insurance Co. recently informed the institute that it would drop its membership at the end of June.

Another major insurer, Northbrook, Ill.-based Allstate Insurance Co., is "reconsidering" its membership, a spokesman confirmed.

Mr. Stewart said that the institute's 1991 budget already reflects the Kemper and Travelers withdrawals.

Some contributions pledged by CIGNA will be made during 1991, he said.

Neither Mr. Moore, Mr. Stewart nor Mr. Isom would say exactly what formula is used to assess III member insurers, but it is based on premium volume and is capped so that no one member company will bear an unusually large portion of the organization's operating costs.

an unprecedented three- to-five-year national image-building campaign (BI, Jan. 23, 1989).

The image-building campaign, which was financed separately from the III's operating budget, drew lukewarm support at best. The campaign was scaled back dramatically in 1990 with funding falling to about \$4 million last year from 1989's \$12.9 million (BI, Jan. 15, 1990).

"I do not see us playing a strong lead role" in large-scale public advocacy campaigns," said Mr. Moore.

The III has allowed some job vacancies to remain unfilled in its regional offices, Mr. Moore said. For example, a senior spokesman position in the Chicago office has been vacant for more than a year.

Although no one contacted by Business Insurance would be quoted criticizing the III, several insurance industry public relations professionals commented that they felt that the organization had strayed from its primary purpose of acting as a resource for the media.

Representatives of insurers that recently have dropped their III membership cited financial, rather than philosophical reasons, for their withdrawals.

"It was a matter of resources," said Charles F. Johanns, senior vp-public affairs and communications at Kemper in Long Grove, Ill.

"In balancing our priorities for 1991, given difficult market conditions and a resulting tough year in expenses, we had to put our main priority on maintaining our ability to deliver services to our customers. So, as important as the communications efforts of the III are, they came in second," said Mr. Johanns.

A spokesman for Hartford, Conn.-based Travelers stressed that the company's decision to leave the III did not reflect dissatisfaction with the organization's work.

"Travelers has had a long and rewarding association with III, and our decision not to retain our membership is not based on any programmatic or philosophical differences. It is based on a management decision to focus our leadership and dollar resources on a limited number of associations," the spokesman said.

The spokesman noted that Travelers is a member of the American Insurance Assn., the American Council of Life Insurance and the Health Insurance Assn. of America, all based in Washington, D.C. And he stressed that the decision does not necessarily signal a permanent break in ties between Travelers and the III.

"We are going to reassess our decision in

1992 to decide if we would like to rejoin in 1993," he said.

"We have informed III of our decision to withdraw from the organization at the end of the second quarter," said a spokesman for The Home in New York.

"Over the past several months, we have been reviewing our participation in a variety of insurance organizations and trade associations and decided we can't be involved in everything," the spokesman said.

'As important as the communications efforts of the III are, they came in second,' Mr. Johanns says.

"We think very highly of III, but at this time, it doesn't have as high a priority for us as some of the other organizations," the spokesman said.

The spokesman for The Home declined to identify the other organizations.

A spokesman for Philadelphia-based CIGNA Corp. would say only that "the decision to withdraw from III resulted from an ongoing analysis of our funding for trade organizations."

Meanwhile, "Allstate is reconsidering its Insurance Information Institute membership. This re-examination is part of an ongoing effort to study all of our expenditures to make sure that the money we spend provides customer value," said a spokesman for the Northbrook, Ill.-based insurer.

Mr. Isom played down the impact of the companies' withdrawals.

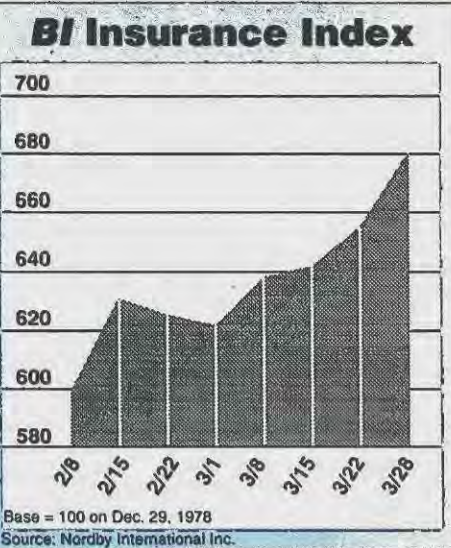
"As long as I have been associated with the III, we've had companies come and go. I don't think we should be surprised" by withdrawals during tough economic times, Mr. Isom said.

The III had 299 members at the end of 1990, down just slightly from 301 a year earlier.

In fact, the organization's membership has dropped slightly during each of the past five years. The III had 307 members in 1988, 317 in 1987 and 318 in 1986.

However, the organization's annual budget has grown consistently since 1986, when it totaled \$8.7 million.

The organization's budget grew to a total of \$9.4 million in 1987, \$10.8 million in 1988, \$11.3 million in 1989 and \$12 million in 1990.



Insurance industry stocks surged ahead last week as the Business Insurance Index climbed 25.3 points to 680.0 on March 28, from 654.7 on March 22. Advancing issues for the week were led by FHP International, up 25.3%; United Fire & Casualty, up 23.3%; and Nobel Insurance Ltd., up 23.1%. Declining issues for the week followed Tokio Marine & Fire, down 8.4%; Durham Corp., down 6.6%; and NWNL Companies, down 2.1%. The most active issue for the week was Sears, Roebuck & Co., (Allstate) with 4.2 million shares traded. The BI Index was up 3.9%; The Standard & Poor's 500 increased 2.1%; the Dow Jones 30 Industrials were up 1.9%; and the New York Stock Exchange Composite rose 2.1%.

March 27 Companies	Price	P/E	Div. %	Yield %	1 Week	
					High	Low
Comml Union	513	NM	30.7	6.0	514	511
Genl Accident	548	NM	35.7	6.5	559	548
Gdn Royal Exch	219	NM	15.9	7.3	219	218
Royal	452	NM	34.7	7.7	455	452
Sun Alliance	382	NM	18.7	4.9	382	372
Brokers						
Bradstock	157	17.8	6.0	3.8	157	155
CE Heath	531	15.7	34.5	6.5	531	524
Hogg Group	200	12.2	10.7	5.4	200	195
Lloyd Thompson	369	24.6	10.0	2.7	370	369
PWS Holdings	95	11.6	8.2	8.6	95	95
Sedgwick Grp	274	26.3	10.4	3.8	275	266
Steel Brl Jones	328	17.1	16.3	5.0	328	328
Willis Corroon	308	16.3	17.6	5.7	309	305

Source: Philip Olsen, Insurance Industry Analyst
London

The III has always seen members come and go, Mr. Isom says. 'I don't think we should be surprised' by withdrawals in tough times.

"We are thinking about maybe lowering the cap to entice other companies to come in," Mr. Isom said. And all three III officials said that the organization was discussing the possibility of membership with several insurers.

Mr. Moore said that the revenues lost from the recent defections "can be accommodated through focusing our efforts and resources on a few major priorities—press relations, background papers and things that are basically information-oriented."

"One thing that we're clearly not doing now is national advertising," Mr. Moore said.

The III in 1989 had sought tens of millions of dollars in insurer contributions to launch

BI Industry Stock Report

MARCH 25, 1991 THROUGH MARCH 28, 1991

BROKERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Alexander & Alexander	NYS	26.25	2.94	13.51	28.88	16.13	385	1.00	3.81	19	9.18	2.86
Gallagher Arthur J. & Co.	NYS	28.00	0.00	20.43	28.38	19.75	39	0.64	2.29	20	5.33	5.25
Frank B. Hall	NYS	3.75	7.14	3.45	4.25	2.00	212	0.00	0.00	-8	-2.80	-1.34
Hibb, Rogel & Hamilton	OTC	15.25	1.67	3.39	16.50	11.25	204	0.36	2.36	21	4.60	3.32
Marsh & McLennan	NYS	85.88	8.53	10.10	85.25	59.75	522	2.60	3.03	21	10.56	8.13
Poe & Associates	OTC	10.00	3.90	25.00	13.00	7.75	0	0.40	4.00	10	2.40	4.17
BROKERS AVERAGE			3.5						2.2	12		

CONGLOMERATES & HOLDING COMPANIES

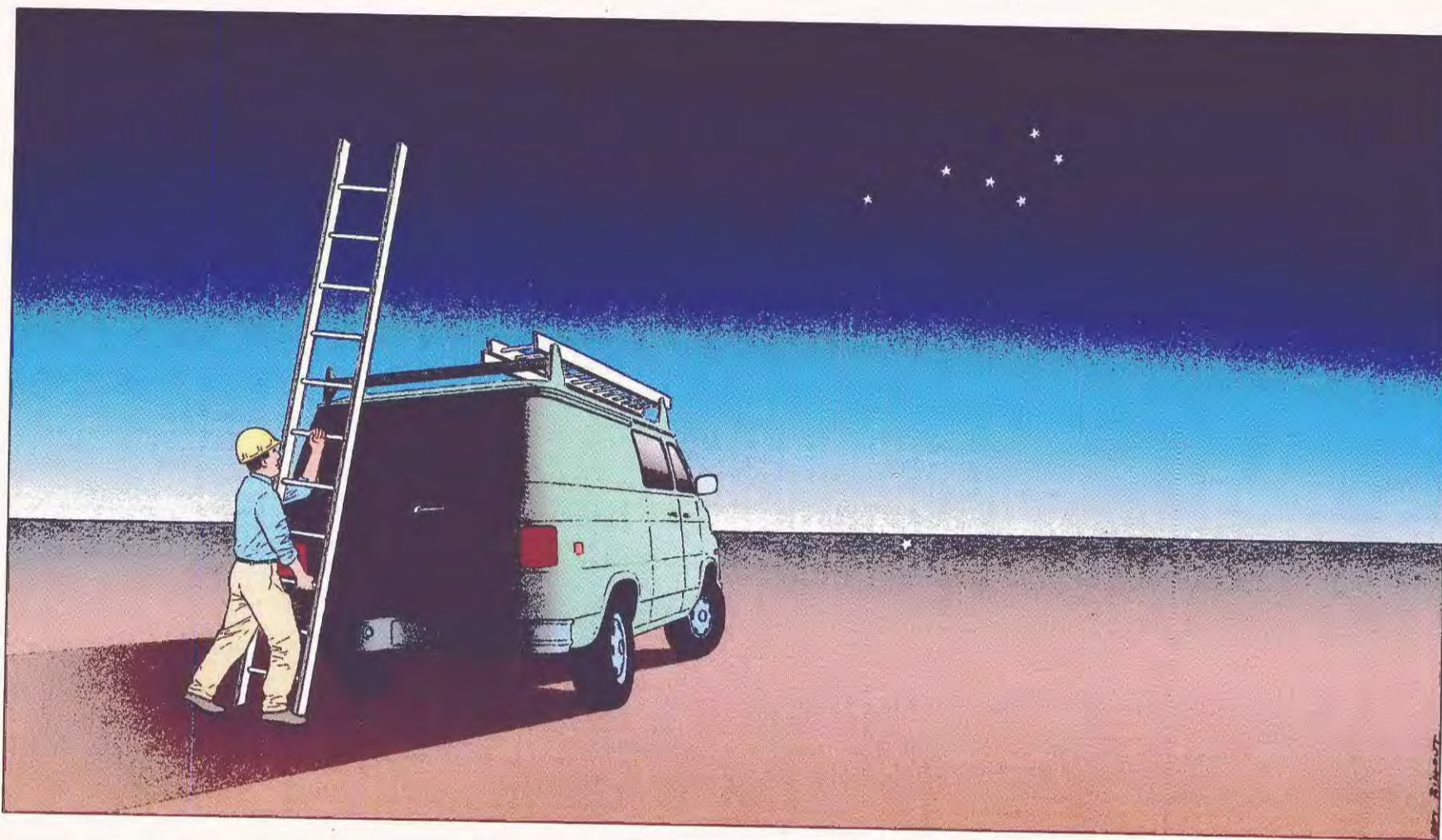
	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		
Berkley W.R. Corp.	OTC	44.00	4.14	17.33	46.50	28.50	103	0.48	1.09	14	25.06	1.76	
Berkshire Hathaway Inc.	NYS	8025.00											
ITT (Hartford Group)	NYS	56.63	4.38	1.26	20.22	8900.00	5675.00	1	0.00	0.00	-26	2869.00	2.80
Sears (Allstate)	NYS	35.00	7.28	37.93	39.38	22.00	4241	2.00	5.71	13	37.75	0.93	
CONGLOMERATES AVERAGE			4.3		23.4				2.5	2			

INSURERS/REINSURERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Aetna Life & Casualty	NYS	47.00	5.62	20.51	54.38	29.00	1045	2.76	5.87	9	58.11	0.81
American General	NYS	38.50	1.65	25.20	50.63	23.50	696	2.00	5.19	8	34.68	1.11
American Heritage	NYS	23.38	0.54	11.31	24.38	19.63	5	1.00	4.28	11	22.60	1.03
American Indemnity/Fin'l	OTC	6.50	0.00	100.00	7.00	2.75	5	0.08	1.23	-20	17.38	0.37
American International	NYS	96.38	6.34	25.37	96.25	57.00	986	0.44	0.46	14	41.92	2.30
Aon Corp.	NYS	36.88	3.51	6.12	41.38	26.75	176	1.60	4.34	10	19.62	1.88
Argonaut Group	OTC	81.00	0.00	26.56	81.00	53.00	77	1.60	1.98	8	36.83	2.20
AVEMCO Corp.	NYS	29.50	-0.42	16.83	30.13	21.13	10	0.44	1.49	18	9.52	3.10
Baldwin & Lyons Inc.	OTC	24.25	-1.02	29.33	24.50	17.00	2	0.28	1.15	9	20.80	1.17
Belvedere Corp.	ASE	2.75	0.00	10.00	4.63	1.75	2	0.04	1.45	69	8.03	0.34
Chandler Insurance	OTC	4.13	0.00	-40.00	9.25	2.75	24	0.00	0.00	-5	9.53	0.43
Chubb Corp.	NYS	71.88	6.28	32.49	72.63	34.63	1016	1.48	2.06	12	55.49	1.30
CIGNA Corp.	NYS	53.25	13.60	30.28	55.50	33.25	776	3.04	5.71	11	86.64	0.80
CNA Financial Corp.	NYS	86.50	3.44	26.05	92.50	49.50	60	0.00	0.00	15	54.87	1.58
Continental Corp.	NYS	29.25	7.83	17.59	31.38	15.75	632	2.60	8.89	12	41.36	0.71
Durham Corp.	OTC	24.75	-5.60	-11.61	34.00	23.00	18	0.92	3.72	12	26.32	0.94
Fund American Corp.	NYS	61.50	1.23	18.55	61.75	29.50	35	0.68	1.11	25	32.74	1.88
Fremont General Corp.	OTC	19.38	1.97	33.62	20.00	10.13	192	0.80	4.13	6	19.09	1.01
Frontier Insurance Group	NYS	23.00	-1.08	21.05	33.00	15.38	10	0.00	0.00	10	7.29	3.16
General RE Corp.	NYS	98.88	7.33	6.32	99.88	69.00	627	1.68	1.70	14	29.04	3.40
Hanover Insurance Co.	OTC	29.75	-0.83	12.26	30.50	21.00	49	0.44	1.48	12	32.03	0.93
Harleysville Group	OTC	28.25	0.89	23.50	30.00	13.50	9	0.64	2.27	9	18.94	1.49
Hartford Steam Boiler	NYS	59.13	2.38	21.28	62.13	43.50	68	1.80	3.04	-	18.94	3.12
Kansas City Life Ins.	OTC	33.50	0.00	8.50	36.50	30.00	0	1.20	3.58	9	39.22	0.85
Kemper Corp.	NYS	33.50	4.69	41.05	43.13	17.13	267	0.92	2.75	129	29.97	1.12
Lawrence Insurance Group	ASE	8.13	0.00	16.07	9.00	6.38	1	0.48	5.91	13	4.40	1.85

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Liberty Corp.	NYS	44.00	5.71	6.99	50.25	39.00	19	0.92	2.09	14	31.82	1.38
Lincoln National	NYS	51.13	1.24	18.90	56.50	30.75	122	2.72	5.32	12	49.19	1.04
NAC Re Corp.	OTC	37.75	0.67	14.39	39.00	25.50	362	0.20	0.53	16	22.81	1.65
Navigators Group	OTC	46.00	1.66	40.46	46.00	24.75	12	0.00	0.00	17	15.22	3.02
Nobel Insurance LTD.	OTC	4.00	23.08	33.33	3.75	2.38	113	0.00	0.00	-	7.76	0.52
NWNL Companies	NYS	29.63	-2.07	75.56	34.50	11.75	259	1.32	4.46	6	37.50	0.79
Ohio Casualty Corp.	OTC	44.00	1.15	7.32	46.50	26.75	86	2.48	5.64	10	33.30	1.32
Old Republic Int'l	NYS	29.13	2.64	27.32	29.00	19.00	73	0.76	2.61	7	30.70	0.95
Orion Capital Corp.	NYS	23.13	0.00	32.14	23.13	13.00	55	0.92	3.98	8	19.72	1.17
Phoenix RE Corp.	OTC	8.75	0.00	12.90	11.25	5.00	4	0.20	2.29	109	12.99	0.67
Protective Life Corp.	OTC	17.50	2.94	17.65	18.00	10.25	70	0.76	4.34	8	14.54	1.20
Provident Life	OTC	23.38	3.31	33.57	26.25	12.00	654	0.92	3.94	6	23.24	1.01
Re Capital Corp.	ASE	16.13	0.78	25.24	17.00	11.75	49	0.00	0.00	11	14.43	1.12
RLI Insurance Corp.	NYS	16.13	4.03	11.21	16.38	9.50	11	0.44	2.73	8	12.42	1.30
St. Paul Companies	OTC	69.63	2.77	10.96	70.25	47.00	836	2.60	3.73	8	43.47	1.60
SAFECO Corp.	OTC	40.63	7.26	23.57	40.50	25.13	848	1.36	3.35	9	24.87	1.63
SCOR U.S. Corp.	NYS	14.38	2.68	16.16	15.25	8.38	13	0.24	1.67	10	10.61	1.35
Selbels Bruce Group	OTC	6.75	1.89	58.82	11.75	4.25	45	0.36	5.33	21	13.75	0.49
Selective Ins. Group	OTC	17.00	1.49	28.30	18.25	12.50	47	1.04	6.12	7	15.72	1.08
Statesman Group Inc.	OTC	2.63	7.67	67.95	3.00	1.25	94	0.00	0.00	-15	4.19	0.63
Tokio Marine & Fire	OTC	46.50	-8.37	-1.59	56.50	34.50	11	0.26	0.56	28	70.93	0.66
Torchmark Corp.	NYS	56.63	5.35	15.86	56.25	38.00	171	1.				

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