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Update

Outhwaite to pay $49.3 million to settle with Lloyd's syndicate

LONDON—Lloyd's of London underwriter Richard Outhwaite will pay $49.3 million to settle a dispute concerning runoff reinsurance ceded by fellow Lloyd's underwriter David Beaumont.

In return, Mr. Beaumont will re-assume all future liabilities stemming from the business reinsured by Mr. Outhwaite's syndicate.

The sum covers "more than $40 million of reported losses," plus some in-

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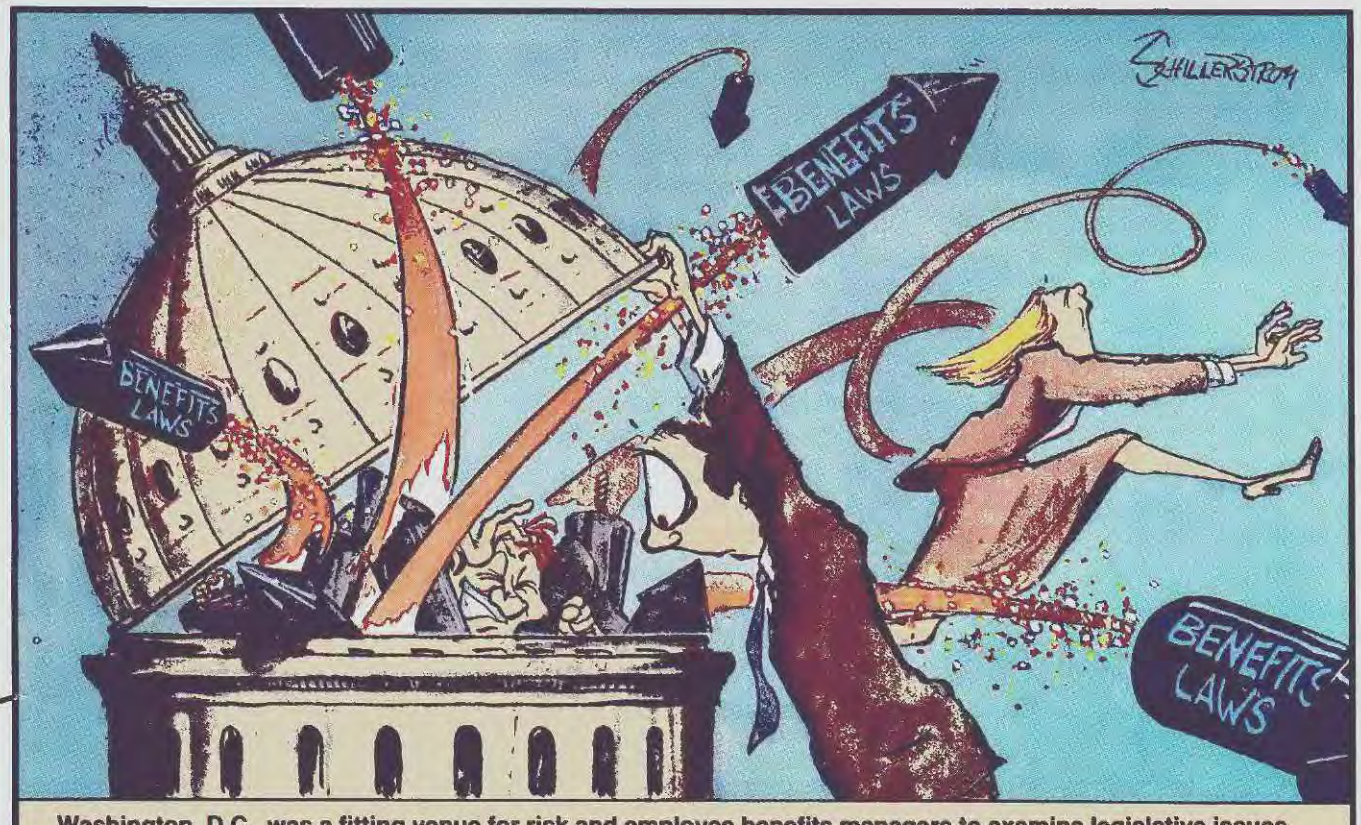

Washington, D.C., was a fitting venue for risk and employee benefits managers to examine legislative issues during the 26th annual Risk & Insurance Management Society conference last week. Reports on benefit sessions begin on page 3. Reports on risk management sessions begin on page 38 and will continue next week.

Antitrust suit

Litigation puts focus on state regulations: RIMS

The Risk & Insurance Management Society Inc. last week issued the following response to the massive antitrust litigation filed against the property/casualty insurance industry by eight state attorneys general last month in U.S. District Court in San Francisco:

In late March, eight attorneys general filed an antitrust suit against a number of insurers and reinsurers, trade associations and brokers.

Regardless of the eventual outcome of the suit, the litigation will raise public policy questions of great importance to the membership of RIMS.

It is these public policy issues, and not the merits of the allegations, that RIMS addresses.

There are individuals who see the filing of this suit as an opportunity to undermine necessary civil justice reform. To those individuals RIMS unequivocally states that the problems of our present tort system—inequity, unpredictability and huge transaction costs—exist regardless of the conduct of the insurance industry.

We urge our state and federal legislators not to permit the filing of this suit to thwart tort reform initiatives.

There are other groups which will attempt to use the filing to modify or repeal the McCarran-Ferguson Act. To such groups RIMS suggests that repealing or modifying this act would not have prevented the last market crunch and will not moderate future market cycles.

On the other hand, RIMS recognizes that Congress gave insurance companies a limited antitrust exemption under the act to develop common policy forms so that the public good would be served. As risk managers and consumers we are acutely aware that common coverage policy forms provide benchmarks that enable insurance buyers and regulators to compare coverage among insurers.

Without such forms, securing excess and umbrella liability coverage would be exceedingly difficult. A wide variety of forms would produce more litigation, more conflicting judicial interpretations and lead to more confusion in the marketplace.

However, we also recognized, long before this suit was filed, that the development of these common forms is largely controlled by an organization totally funded by the insurance industry. The policy form development process must not be allowed to deteriorate into a one-way street where coverages are narrowed and required to be bought back in the form of expensive endorsements. Strict state regulatory scrutiny of common policy form development and filing is an absolutely essential counterbalance to ensure the public good is being served.

For example, due to the efforts of several state regulators, the National Assn. of Insurance Commissioners succeeded in moderating some of the anti-consumer features of ISO's (The Insurance Services Office's) initial claims-made commercial general liability (CGL) form filings.

RIMS believes that any public debate surrounding the filing of this suit would most productively be directed toward enhancing state regulatory scrutiny in the development and approval of common policy forms.

Our state insurance departments must be properly funded to provide meaningful scrutiny and to adequately monitor the solvency of insurance companies. As risk managers and citizens we must convince our state governments that a significant portion of the millions of dollars in premium taxes we pay should go toward funding insurance departments so they can do their jobs effectively.

Mentor suit may be tried in Bermuda

By ROGER SCOTTON

NEW ORLEANS—The massive fraud lawsuit filed against the parent and officers of the failed Mentor Insurance Ltd. by Mentor's liquidators may be headed to a Bermuda court following its dismissal by a New Orleans federal judge.

U.S. District Judge Marcel Livaudais Jr. earlier this month dismissed the liquidators' lawsuit against Ocean Drilling & Exploration Co.—Mentor's ultimate parent—and 10 other defendants on the grounds that the Bermuda Supreme Court—which appointed Mentor's liquidators in June 1985—would be the more convenient forum for the 25-month-old litigation.

In a 17-page decision released April 15, Judge Livaudais granted a motion to dismiss the action, filed jointly last September by all 11 defendants named in the lawsuit, on several conditions, including:

- The dismissal order is subject to a six-month stay to allow all parties to complete discovery in the United States rather than in Bermuda, where discovery rules are more restrictive.
- The defendants stipulate to the court by May 16 that they will submit to the jurisdiction of a Bermuda court if Mentor's liquidators re-assert their claims there.

Judge Livaudais rejected several arguments against dismissal offered by Mentor's liquidators, including that the liquidators would be unable to press treble damage claims

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Benefit managers scrutinize HMOs

By DONNA DiBLASE

Employers' war against escalating health care costs is shifting to a new front as more employers implement a variety of measures to control the premiums they pay to health maintenance organizations, benefit experts say.

As HMOs become the health plan of choice for greater portions of most employee populations, and employers realize how much flexibility they have under federal law to control HMO costs (see story, page 12), employers are turning to such cost-containment measures as:

- Reducing the number of HMOs offered. For example, Morristown, N.J.-based Allied-Signal Inc. replaced all of its many HMO and indemnity plans with a single national managed health care program under which all of Allied-Signal employees will be enrolled in a single HMO network. The plan administrator, CIGNA Corp. of Hartford, Conn., guarantees to contain the conglomerate's health care costs over the next three years (*BI*, Feb. 22).
- Negotiating HMO premiums.
- Demanding group-specific health care utilization data from HMOs to use in negotiating HMO premiums and as a basis for reducing employer contributions to HMO costs.

These actions by employers will become more common for several reasons, according to benefit consultants.

"One of the things employers have discovered is that they now have to manage their HMO costs," said Lawrence B. Leisure, principal and national practice leader for group benefits in the New York office of TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

"They've never had to do that, but now most employers have a greater employee population enrolled in HMOs than in indemnity plans," he said. And, "some employers are seeing that the cost for employees enrolled in HMOs on a per-employee basis seems to be out of sync with

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Update

Runoff policy liability capped

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curred-but-not-reported losses, Mr. Beaumont said.

Under the terms of the agreement, reached last week, syndicate 661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. will pay 10% of the settlement immediately to syndicate 660, managed by Wellington Underwriting Agencies Ltd. The remaining 90% will be paid before the end of July.

In return, Mr. Beaumont has agreed to re-assume all future liabilities related to the book of business, effectively canceling an unlimited liability runoff policy he ceded to Mr. Outhwaite in 1982 for the underwriting years 1954 through 1978.

The Outhwaite agency now hopes other underwriters will agree to cap unlimited liability runoff policies ceded to syndicate 661 to settle "at least 13 disputes" over run-off policies Mr. Outhwaite wrote in the early 1980s (*BI*, April 18).

Last year, Mr. Outhwaite agreed to pay claims filed by Lloyd's syndicate 219, managed by Edwards & Payne (Underwriting Agencies), on a runoff reinsurance policy in return for an additional premium (*BI*, Sept. 14, 1987). However, the unlimited liability runoff policy was not capped, sources say.

Hall's Corde joins RBH

CHICAGO—George E. Corde, former executive vp at Frank B. Hall & Co. Inc., has joined Chicago-based Rollins Burdick Hunter Co. as an executive vp, overseeing the broker's national property/casualty accounts and market relationships.

Mr. Corde, who had been with Hall for 25 years, joins former Hall executives Thomas McCaffrey and William McCaffrey at RBH. Former Hall Chairman John F. McCaffrey also has become a senior vp at Chicago-based Aon Corp., RBH's parent company. The McCaffreys left Hall in March (*BI*, March 7).

Mr. Corde described the switch as a "personal move," calling RBH "a company that's growing. But, I wish Frank B. Hall all the very best."

California clears IIE syndicates

CHICAGO—Three Illinois Insurance Exchange syndicates can again write surplus lines risks in California following five months of negotiations with California insurance officials over their eligibility, according to IIE President James M. Skelton.

The California Insurance Department temporarily has "suspended its objections" against the three syndicates: LUI Insurance Syndicate Inc., Britamco Underwriters Inc. and First Oak Brook Corp., an IIE statement said (*BI,* Nov. 30, 1987; Nov. 23, 1987).

"The department suspended its judgment until the end of 1988 after the IIE arranged to have the Illinois Insurance Department conduct exams of all member syndicates and agreed to file actuarial opinions of loss reserve adequacy for 1987 annual statements," the IIE's statement said (*BI,* Jan. 25).

The IIE also will make certain that only syndicates meeting California's capitalization standards of $2.8 million in capital, reduced from $3 million, will do business in the state, Mr. Skelton said.

Welfare fund trustees settle suit

WASHINGTON—The trustees, benefit plan administrator and others involved with a union welfare fund's dental plans will pay restitution of $3.85 million to settle federal charges that they caused union workers to be overcharged for dental benefits.

The money will be returned to the Hotel Employees and Restaurant Employees International Union Welfare Fund by current and former trustees of the fund; William L. Meyers Inc. of Naperville, Ill., administrator of the union's benefit plans; and several other service providers. A unit of CNA Financial Corp. will pay about $2.8 million on behalf of the union trustees and William L. Meyers, according to a Department of Justice spokeswoman, who did not know the types of coverage CNA provided.

The payments will settle two Justice Department lawsuits filed in federal district court in Camden, N.J., in 1985, and Las Vegas, Nev., in 1986 charging that the defendants violated the Employee Retirement Income Security Act.

Smelter protests OSHA citation

NEW YORK—ASARCO Inc. plans to challenge the $1.6 million in fines proposed by the Occupational Safety and Health Administration last week for more than 200 alleged safety violations.

OSHA alleges that the New York-based company's lead smelter in East Helena, Mont., is guilty of repeated "egregious (and) willful" lead and arsenic violations as well as failing to correct previously cited hazards, according to a statement.

OSHA says the smelter's most serious violations include exposing employees to excessively high levels of lead and arsenic.

Smelter Manager J. Bryan Davis called OSHA's position "unnecessarily rigid" and its proposed solutions "impractical."

Tobacco maker cover-up eyed

NEWARK, N.J.—A New Jersey federal judge has refused to dismiss a claim in product liability litigation against three tobacco manufacturers that the companies illegally conspired to misrepresent facts about the health risks of smoking.

However, U.S. District Court Judge H. Lee Sarokin last week dismissed charges that the companies—Liggett Group Inc., Philip Morris Inc. and Loews Corp.'s Lorillard Inc. unit—should have marketed less dangerous cigarettes, according to an assistant to plaintiff's attorney Marc Z. Edell of Short Hills, N.J.

The charges were in a suit brought by the family of Rose Cipollone, who died of lung cancer in 1984 after smoking for 40 years.

Judge Sarokin also dismissed a claim that Philip Morris and

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Court ruling could widen OSHA investigators' reach

By MEG FLETCHER

RICHMOND, Va.—Employers in five Eastern states may be more vulnerable to document requests from Occupational Safety and Health Administration investigators in the wake of a recent federal appeals court decision.

The 4th U.S. Circuit Court of Appeals in Richmond, Va., upheld an OSHA investigator's authority to require an employer to provide OSHA-mandated injury and illness records without obtaining a search warrant or administrative subpoena.

The March 23 decision stems from a 1984 incident in which an A.B. Chance Co. manager in Parkersburg, W.Va., refused to show an OSHA investigator two agency-required forms that listed workplace injuries and illnesses and provided supplemental information.

However, the 4th Circuit's decision conflicts with a late 1987 decision by the 11th U.S. Circuit Court of Appeals in Atlanta that a company related to A.B. Chance could refuse to provide those same records to an OSHA investigator who did not have a warrant (*BI,* Feb. 1).

OSHA officials are reviewing the 4th Circuit's decision and are expected to decide within 30 to 60 days to what extent, if any, the decision will affect field procedures nationwide, said Stanley Elliott, OSHA's deputy field coordinator.

Currently, OSHA's general policy requires an investigator to obtain a search warrant or administrative subpoena when an employer prohibits an inspector from entering a plant or balks at producing records, Mr. Elliott said.

In light of the 4th Circuit's decision, OSHA could decide to maintain its current policy nationwide or adopt the 4th Circuit's anti-warrant approach in the states within that court's jurisdiction, Mr. Elliott said.

Those states are Virginia, West Virginia, Maryland, North Carolina and South Carolina.

OSHA officials have some options in the matter because the appellate courts issued conflicting decisions, Mr. Elliott said. Had the courts' decisions been uniform, they would have had "a major impact" on the agency, because OSHA would have changed its policy to conform with the decisions, he explained.

The Labor Department is litigating the access issue in a third, unrelated test case that was argued last month before the 6th Circuit Court of Appeals in Cincinnati, pointed out Ellen Beard, an attorney with the U.S. Department of Labor, which oversees OSHA. No decision has been announced in that case.

The 6th Circuit covers Kentucky, Michigan, Ohio and Tennessee.

A.B. Chance, which manufactures electronic transmission and distribution equipment from its headquarters in Centralia, Mo., is asking the 4th Circuit Court to rehear the decision, said William Weidle Jr., an attorney in St. Louis who represented A.B. Chance.

However, because the federal appeals courts rendered conflicting decisions, it will probably take a U.S. Supreme Court decision to resolve the issue, he said.

The A.B. Chance case stems from an April 1984 visit by an OSHA investigator to the company's ceramic electrical insulator facility in Parkersburg, W.Va.

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Asbestos firm to test scope of property damage cover

By STACY ADLER

CHICAGO—In one of the most comprehensive asbestos coverage cases to date, a federal court will decide whether third-party asbestos property damage claims can be covered under property damage, bodily injury or other provisions of an asbestos producer's comprehensive general liability insurance.

The case involves Chicago-based asbestos manufacturer UNR Industries Inc., which is seeking a judgment in U.S. Bankruptcy Court that its primary and excess liability insurers have a duty to defend and indemnify the company against mounting third-party asbestos property damage claims.

Judge David H. Coar will begin hearing testimony today on a variety of issues involving asbestos property damage—some of which have never been addressed by a court—including:

- Does asbestos in buildings constitute property damage under CGL policies?
- If it does, is insurance coverage triggered at the time a building owner is aware of the hazards of asbestos or at the time it was installed?
- Do the standard CGL exclusions—including the owned property exclusion, the loss of use exclusion, the sistership exclusion, the pollution exclusion or the asbestosis exclusion—bar recovery for third-party asbestos property damage claims?
- Can asbestos in buildings be considered trespass and nuisance claims, which are insurable under the bodily injury provisions of UNR's CGL coverage?
- Are claims alleging that the manufacturer of asbestos is the equivalent of a hazardous waste generator under the Comprehensive Environmental Response, Compensation and Liability Act, better known as the Superfund Act, insurable outside of the property damage provisions of UNR's insurance?

"This is the most expansive asbestos property damage case ever filed," said UNR attorney Kirk Pasich, a partner with Paul, Hastings, Janofsky & Walker in Los Angeles.

The suit originally was filed in state court and later consolidated with UNR's bankruptcy proceedings.

"We developed these theories, and it is the first time a judge will address all these theories," Mr. Pasich said.

Robert Sayler, an attorney with Covington & Burling in Washington, D.C., who represents asbestos manufacturer Armstrong World Industries Inc., agreed. He said UNR is trying to claim coverage in ways that never have been litigated.

In fact, Mr. Sayler thought UNR's arguments had enough merit that he tried to amend Armstrong's case, which is part of the coordinated asbestos coverage proceedings in San Francisco (*BI,* June 1, 1987), to include some of the arguments.

However, California State Superior Court Judge Ira A. Brown Jr., who is hearing the case, ruled it was too late in the trial for such a move.

Chicago-based UNR, which filed for reorganization under Chapter 11 of the U.S. Bankruptcy Code in 1982, stopped manufacturing asbestos-containing insulation products in March 1970.

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RIMS benefit report

Coverage mandate debate rages on

By JERRY GEISEL

WASHINGTON—Requiring all employers to offer health care coverage is bad medicine for employers and employees, says the Senate's chief opponent of a federal benefit mandate.

But another key congressman says it is a disgrace that 35 million Americans lack group health care coverage.

Sen. Orrin G. Hatch, R-Utah, who opposes federally mandated health care coverage, and Rep. Fortney (Pete) Stark, D-Calif., chairman of the House Ways and Means Health Subcommittee, who supports the concept, outlined their respective positions on the highly charged subject last week at the 26th annual Risk & Insurance Management Society conference.

"Trying to impose the same program on every employer will not work," Sen. Hatch asserted.

A federal benefit mandate could inflate employers' costs between $39 billion and $100 billion a year, and the economic consequences of that huge cost increase would be even more disastrous, according to Sen. Hatch.

Enactment of a federal health care mandate would lead to the loss of hundreds of thousands of jobs and higher inflation, he predicted.

Mandating coverage is "back-door national health insurance. It is too big, too costly and it will certainly be ineffective. It is a typical liberal solution," he said.

"Surely, we can develop a program that does not cost $39 billion to $100 billion a year."

But, Rep. Stark noted that "outside the Third World, no industrialized country has a lower percentage of people covered by health care programs" than the United States.

Logically, employers already providing health care coverage should be backing universal health care coverage as economic good sense, Rep. Stark said.

Those companies, in a sense, are subsidizing employers that refuse to provide coverage. That subsidy occurs when hospitals pass along the cost of uncompensated charity in the form of higher charges to insured patients. Presumably, if everyone were covered by a group health care program, this cost-shifting problem would be reduced, he said.

"There is no free lunch in the medical care delivery system," Rep. Stark said. "You pay more for insurance or self-insurance to cover the uncompensated."

Although the RIMS session was planned as a debate between Sen. Hatch and Rep. Stark, a Senate roll call vote forced Sen. Hatch to leave early, so the two congressmen delivered their remarks separately.

While a face-to-face debate between the very conservative Sen. Hatch and the liberal Rep. Stark was not possible, their presentations showed how far apart some members of Congress are on the issue of access to health care.

Interest in improving health care coverage for both employees and the elderly has intensified during the current congressional session.

For example, the Senate Labor and Human Resources Committee in February approved legislation, S. 1265, backed by

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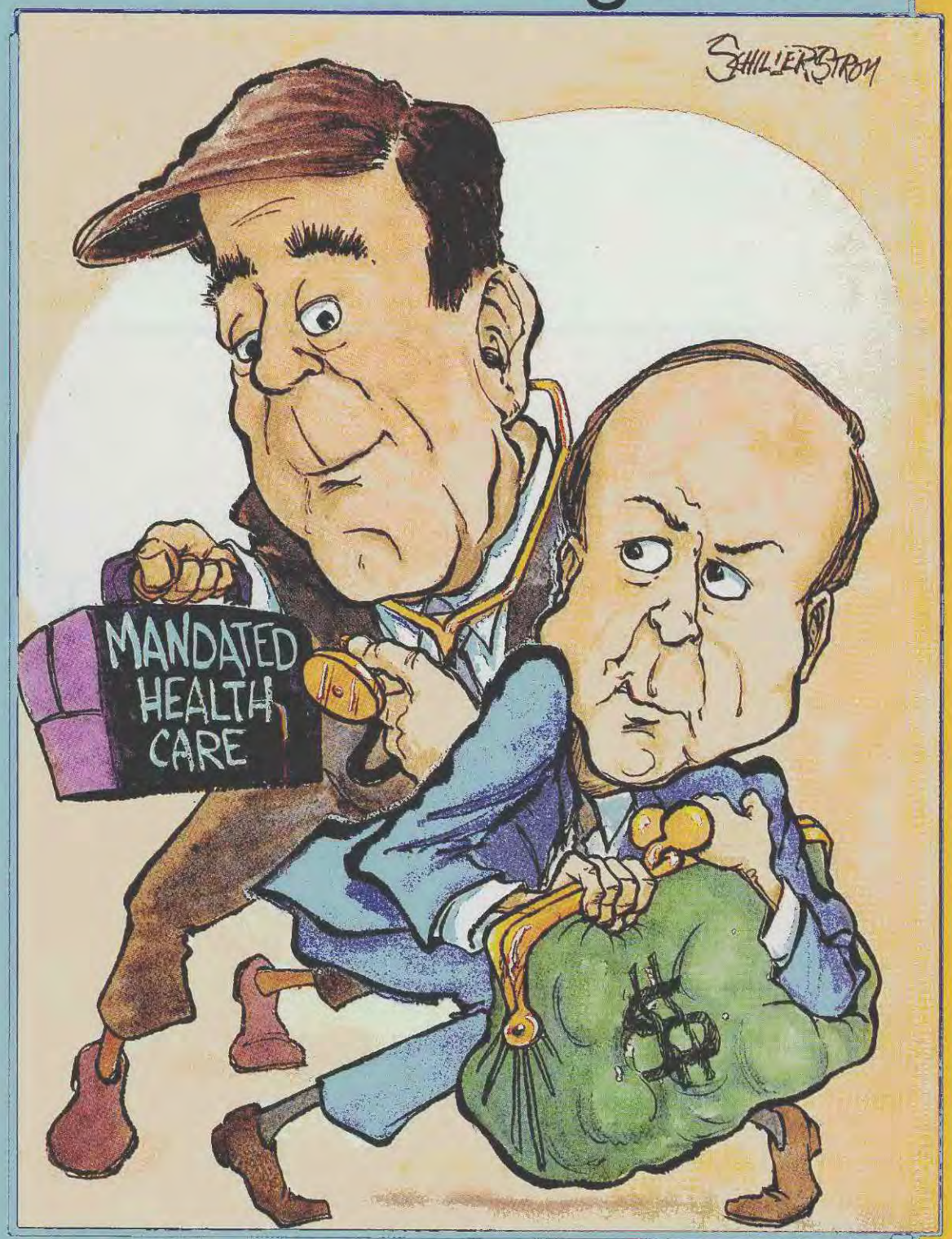

Case management prescribed for AIDS

By DONNA DiBLASE

WASHINGTON—Case management is essential for employers to control the cost and quality of care delivered to employees with AIDS, health care and benefits experts say.

These cost containment programs also are the most effective way to manage psychiatric and substance abuse cases, experts say.

However, case management programs require an organized, cooperative approach on the part of the employer, health insurer and case manager, according to speakers at the 26th annual Risk & Insurance Management Society conference last week.

Case management is particularly important in acquired immune deficiency syndrome cases because the number of persons afflicted with the deadly disease is increasing and the illnesses and infections associated with AIDS are increasing in number and severity, said Dr. Scott R. Strickland, an AIDS specialist in the department of internal medicine at Park Nicollet Medical Center in Minneapolis.

AIDS is a breakdown in the human immune system caused by the human immunodeficiency virus. This leaves the body susceptible to many unusual infections and tumors that would not usually affect a person with a healthy immune system, he explained.

"The future of AIDS is that it will continue down the route we see now. However, we are expecting a slight shift in the epidemic, in terms of the most frequent and the the most debilitating illnesses associated with the syndrome," he said.

For example, "there recently has been a shift to HIV damage to the brain and nervous system, independent of the damage to the immune system. With this, the AIDS patient develops a slow progressive dementia, similar to what happens in people with Alzheimer's disease," Dr. Strickland explained.

"This is a very difficult to handle long-term affliction because some patients with AIDS-related dementia require 24-hour home care to help them get their nutrition, bathe, etc. These patients may be looking at years of their lives like this," he commented.

"We've also seen an auto-immune phenomenon in which the immune system attacks the body. This can become a very confusing disease to deal with," he added.

Unless custodial and medical home health care is coordinated for AIDS patients, they can remain in the hospital for long periods of time, which is the costliest and perhaps most dangerous for the patient, he said.

While the Centers for Disease Control in Atlanta estimate that there currently are 60,000 AIDS cases in the United States, "that represents at least a 10% underestimate. But, regardless of the estimates you look at, we're going to see a lot of AIDS

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Broken promise hurts Kennedy bill: Beadle

By JERRY GEISEL

WASHINGTON—Massachusetts Sen. Edward Kennedy "shot himself in the foot" by expanding legislation that would require all employers to offer health care coverage that meets minimum federal standards, a consultant says.

Had the Democratic chairman of the Senate Labor and Human Resources Committee stuck to his promise that he would not seek to enrich the basic health care package that he wants employers to offer, his legislation would have gained more business support, said Carson Beadle, a managing director with William M. Mercer-Meidinger-Hansen Inc. in New York.

After promising he would not add new benefits to the package, Sen. Kennedy proposed and convinced the Labor and Human Resources Committee to accept a revised bill that adds mental health care coverage as a mandated benefit (*BI*, Feb. 22).

Mr. Beadle, speaking last week at the 26th annual Risk & Insurance Management Society conference, said Sen. Kennedy probably succumbed to pressure from mental health provider special interest groups in adding mental health as a covered benefit.

That decision has been costly. Aside from possibly losing business support for the proposal, the mental health amendment is arousing concern even among the most outspoken advocates of mandated health care coverage.

"Mental health makes it more than a minimum bill. We do have some concerns," said Karen Ignagni, associate director at the AFL-CIO's Department of Occupational Safety, Health and Social Security in Washington.

While the Kennedy bill has no chance of gaining congressional approval this year, employers should not kid themselves that legislative efforts to mandate employer-provider health care coverage will disappear from the Congressional agenda, another speaker said.

"You do have to watch the Kennedy bill. That bill addresses an issue —increasing access to coverage to the uninsured—that will not go away," said Howard Greene, RIMS' associate legislative director for governmental affairs in New York.

Mr. Beadle, checking off a list of major pieces of legislation, such as Internal Revenue Code Section 89 non-discrimination rules for welfare-type plans and the health care continuation rules in the Consolidated Omnibus Budget Reconciliation Act of 1985, said employers have too much at stake to stay out of the legislative benefit arena.

When benefit proposals are introduced, employers should take the initiative and suggest alternatives if they do not like the proposals, rather than simply opposing them, Mr. Beadle said.

Turning to the future, Mr. Beadle said employers can expect Congress to continue to turn to the private sector to expand benefit coverage for workers.

"Employers can be cast as the ideal private sector vehicle for reaching millions of Americans without having to increase government spending and without having to administer them," he said.

For example, after passing COBRA to ensure that workers can continue health care coverage with their former employers after leaving, some members of Congress now want to increase employers' commitment to employees.

Mr. Beadle said an amendment to the Technical Corrections Act of 1988 would amend COBRA so that employees could keep COBRA coverage even when they become covered under a new employer's health care plan (*BI*, April 11).

"Because some people may be leaving companies with more generous benefits or may have continuing health conditions covered under the old plan, employers are now being asked in a new proposal to make coverage available under both the old and new plan," he said.

While congressional initiatives will shape benefit plans, demographic changes also will influence benefit programs (see story, page 53).

Mr. Greene noted that by the year 2000 women will comprise half of the work force, and more women will be holding senior management responsibilities.

As a result, women will press companies for such programs as parental leave and child care benefits, Mr. Greene said.

At the same time, an aging work force also will affect benefit plans and costs. With a growing pool of retirees and a smaller number of workers, Social Security taxes will have to be increased or benefits cut, Mr. Greene said.

"Something has to give," Mr. Greene said.

At the same time, with retirees over age 65 comprising as much as 20% of the population by the year 2020, retiree health care coverage will become a much bigger issue at companies and in Congress, he said.

Workers in the future are likely to retire at earlier ages but live longer, putting new financial pressures on pension plans, Mr. Greene said.

"Those retirees will collect retirement income over a longer period of time, and that will affect your pension plans financially," Mr. Greene said.

Ms. Ignagni said that in the future white collar workers retiring at earlier ages may later seek to return to their former employers or seek new careers elsewhere.

But, she doubts whether blue collar workers will want to rejoin the workforce after retirement.

"They tend to be burned out after working on assembly lines for 20 or 30 years," she said.

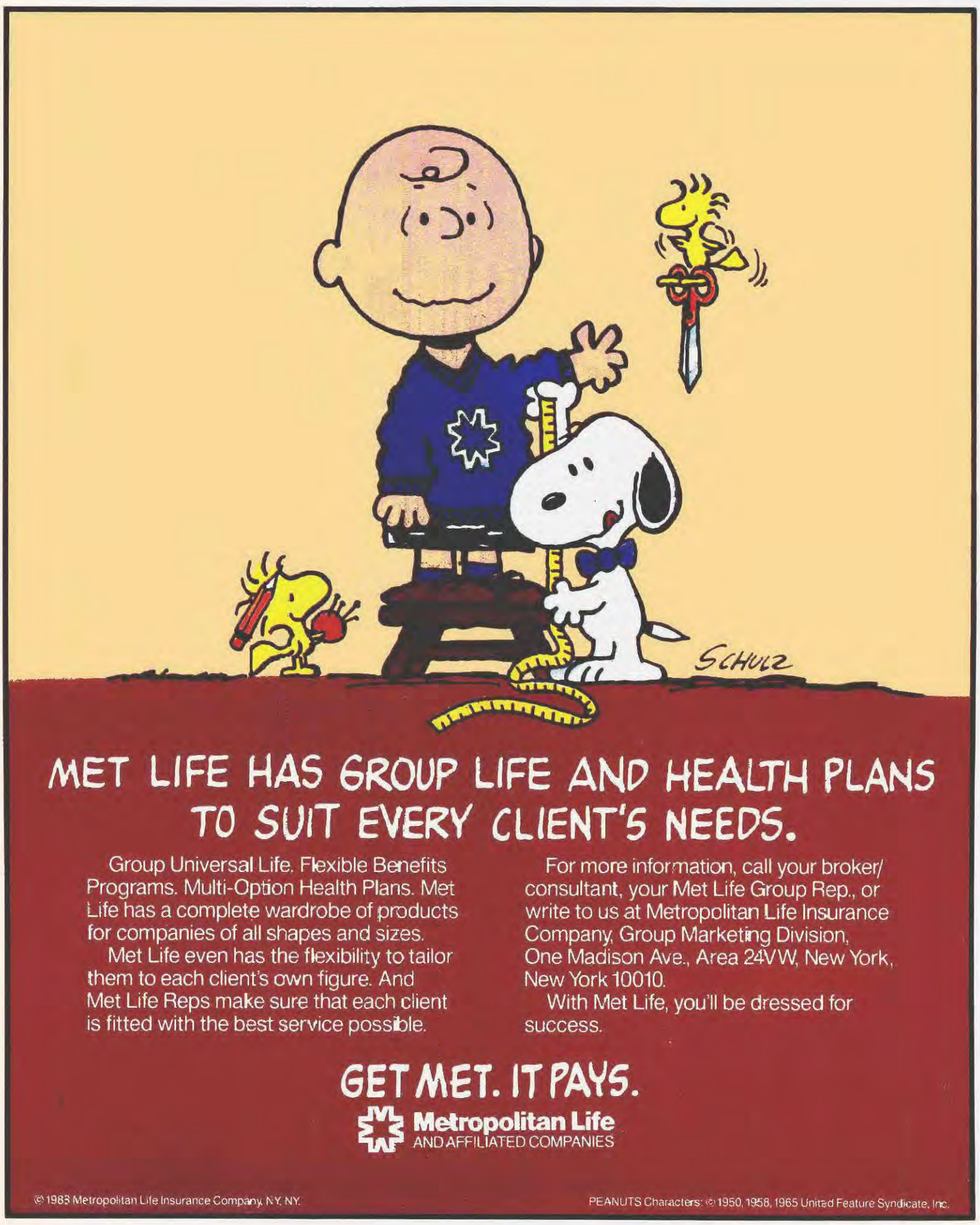
In addition, as the "baby bust" generation enters the workforce, there may be a shortage of workers, and employers may have to offer financial incentives to attract the best talent, Mr. Greene said.

One possible financial incentive could be offering to pay a student's college tuition in exchange for the student agreeing to work for the company for a certain number of years after graduation.

Ms. Ignagni said that Congress eventually will pass legislation to require vesting of retiree health care plans. To sweeten that requirement, some kind of tax incentive will be given to encourage prefunding of health care benefits.

In response to skyrocketing health care costs, Ms. Ignagni expects employers to expand their efforts to control claims costs, like those associated with acquired immune deficiency syndrome, through case management.

The session was moderated by Steve Rades, vp and corporate risk manager for BankAmerica Corp. in San Francisco. ■



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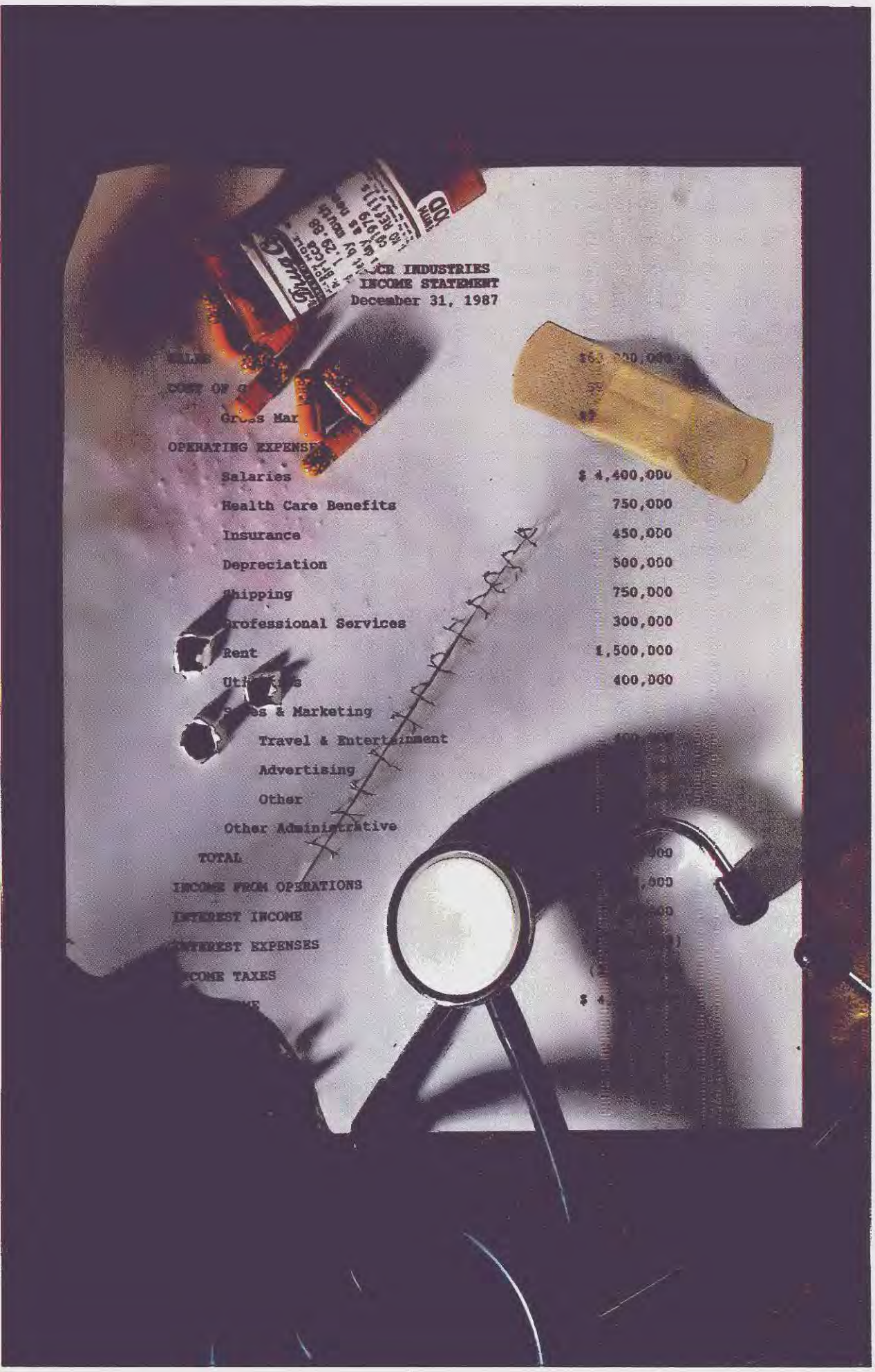
MOST CEO'S ARE SUFFERING FROM A SERIOUS HEALTH PROBLEM.



There's an epidemic sweeping the country that is causing considerable pain to upper management.

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Lifestyle tied to health care costs: Study

By MICHAEL BRADFORD

WASHINGTON—Helping employees change their lifestyles could help slash health care costs, according to a panel of experts.

Conventional health care cost-containment methods have not been effective, agreed members of a panel at the 26th annual Risk & Insurance Management Society's conference last week.

However, the panelists pointed to evidence they say indicates that if workers can be persuaded to take up healthier habits, benefit costs will decline.

Changing lifestyles "has the potential to be a major breakthrough" in the effort to control health care costs, said Stephen D. Brink, an actuary with consultants Milliman & Robertson Inc. in Brookfield, Wis.

Mr. Brink said that available data indicates that "if everybody were to practice a healthy lifestyle, the overall (health care) costs would be reduced 50%. That's a big number."

Milliman & Robertson conducted a study with Control Data Corp. of Bloomington, Minn., that showed that Control Data employees who did not have healthy lifestyles were responsible for the bulk of the company's health care costs.

The study of Control Data employees at 27 locations examined seven lifestyle factors: exercise, weight, smoking, hypertension, alcohol use, cholesterol and seat belt use. The findings showed that:

- Employees who smoke a pack or more of cigarettes per day had health care costs that are 18% higher than the health care costs of non-smoking workers.
- Overweight employees generated 48% more claims larger than $5,000 than their more svelte counterparts.
- Workers with high cholesterol levels produced 24% more claims larger than $5,000 than employees with lower levels.
- Employees who do not wear seat belts when driving had annual health care costs that were 13% higher than the health care costs of people who buckle up. And, those who do not wear seat belts spent 54% more days in the hospital than those who did wear the belts, according to the study.

"There is a lot of money tied into lifestyle," pointed out David R. Anderson, manager of research and development at Control Data.

He estimated that health care costs can be cut in half by changing the living habits of workers.

Mr. Anderson said the joint study with Milliman & Robertson led Control Data to implement its Stay Well wellness program, which offers workers an incentive to change their bad habits by lowering the health care contribution for employees with healthier lifestyles.

He pointed out that the study showed that "the best way to manage costs in an organization is to control or eliminate the risks that are causing them, before the fact as opposed to after the fact."

The study also led to a business opportunity for the Minnesota company. Once Control Data developed Stay Well, it began offering the system to other businesses, Mr. Anderson explained.

"We saw it as something we could do for other organizations as well," Mr. Anderson he said.

Another panelist pointed out that the effort to lower health care costs by encouraging healthy lifestyles is not limited to the private sector.

Marianne M. Chillas, ratings analyst with the Delaware Insurance Department, said the department is considering regulations that would allow insurers to award premium discounts or cash bonuses to policyholders with healthy lifestyles.

Ms. Chillas explained that Delaware Commissioner of Insurance David Levinson was responsible for developing the model regulation, which lists several criteria a policyholder would have to meet to be eligible for a discount or cash payment. After a task force assigned to study the problem reported that incentives to promote healthier lifestyles probably would help lower health care costs, Mr. Levinson proposed a program, Ms. Chillas said.

"Commissioner Levinson is a businessman," she pointed out. "He's a liberal, but he's also a businessman. And he thought that the best way, the most effective way, to encourage the adoption of healthy lifestyle behaviors was to use an incentive: money."

That philosophy has been translated into the model regulation that would allow insurers to reward policyholders if they:

- Do not use tobacco products.
- Exercise regularly.
- Consume only moderate amounts of alcohol.
- Maintain proper blood pressure.
- Control their weight.
- Do not abuse drugs.
- Use seat belts while driving.

Although Ms. Chillas acknowledged that policyholders would be bound only by their own honor in answering the lifestyle questions, she said she believed most would be truthful.

She pointed out that penalties would be assessed if a policyholder were found to have lied to gain a premium discount or bonus under the program.

Penalties could include forfeiture of benefits or a fine in the amount of the discount or cash received, Ms. Chillas said.

"I just don't think most people are going to take that chance," she said. ■

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Opinions

BI lauds communication efforts

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The deadline for entering the competition is May 6. To request a nominating form, write or call Barbara Dalton, Registrar, Business Insurance, 220 E. 42nd St., New York, N.Y., 10017; 212-210-0780.

Letters

Critics of IRIS program don't understand tests

To the editor: I have read yet another article critical of the Insurance Regulatory Information System. Why is it that Thomas S. Bloom (*BI*, March 21) and other critics of IRIS never seem to adequately explain how the system works or what it is intended to accomplish?

First, Mr. Bloom is inaccurate in saying, "Any company failing four or more of the tests in any one year becomes a candidate for immediate examination." Many years ago IRIS worked that way, but no longer.

For some time now the most important element of IRIS has been the examiner team review. A group of experienced state financial examiners gathers each spring to analyze IRIS results *and the annual statements of those companies having unusual test scores*. At this point, the examiner team certainly looks at the makeup of an insurer's business, the quality of its reinsurance, its cash flow and many other financial features. The analysis is written up and sent to every insurance department, and two lists are compiled, one for companies "targeted" for examination and one for companies needing "immediate attention." Nothing happens automatically when an insurer is outside the normal range on a given number of IRIS tests.

Obviously, no set of criteria perfectly identifies all the companies that are financially troubled—or all companies that are *not* financially troubled. IRIS is a tool to get the examiner team started. I might add the IRIS tests have been modified through the years, and the National Assn. of Insurance Commissioners' Property and Liability Financial Ratios and Profitability (EX4) Working Group is constantly monitoring them and considering what changes might be appropriate.

It really has not been difficult to obtain IRIS test results. Several services have applied the formulas and made them available. It is absolutely essential, however, that the examiner team's analyses be kept from public distribution. The examiners must be allowed to candidly set forth their conclusions—and even their suspicions—without the threat of possible litigation.

It has been my perception that most of those publicly condemning IRIS rarely explain how the system really works. Perhaps the NAIC should provide additional public relations in support of one of its finest products.

Richard P. Hefferan
Associate Vp and
General Attorney-Tax and Finance
Alliance of American Insurers
Schaumburg, Ill.

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Impact of EC directive will be less than feared

To the editor: While welcoming Jerry Karter's update on the European Community directive, "EC Developments: Directive Will Trigger Improvements in Product Safety" (*BI*, April 4), it is perhaps misleading in certain aspects.

First, it is most unlikely any premium increases will be directly attributable to the directive and certainly not in the area of pharmaceuticals, when the directive goes some way to limiting damages per person and capping the long-tail liability.

Secondly, it is not the directive that will induce U.S. multinationals to provide better and safer products. They already face far more stringent duties of care in the United States, and product safety and design are integral to most multinationals' business strategy.

Third, the EC directive does not replace a mass of existing national codes and legal precedent, all of which will ensure a complex and confused picture until at least the turn of the century. There is no concern by corporations in Western Europe that the directive will bring more onerous burdens than they generally face today.

R. Patrick Thomas
Vp/Manager, Multinational
Business Development
Alexander & Alexander
International Inc.
New York

Attorneys general's suits: Are they a conspiracy?

To the editor: I have read with interest your report "Lawsuits Rock Industry" (*BI*, March 28). You say, "Seven largely identical lawsuits were brought by attorneys general from Alabama, California, Massachusetts, Minnesota, New York, West Virginia and Wisconsin."

Seems everybody's conspiring against everybody somewhere in this country.

Is there an antitrust law protecting the insurers against this conspiracy of the attorneys general? Probably not, because each attorney general is only in one state and not subject to interstate commerce.

I am sure several lawyers will make a lot of money out of all this foolishness.

Kenneth E. Newburger
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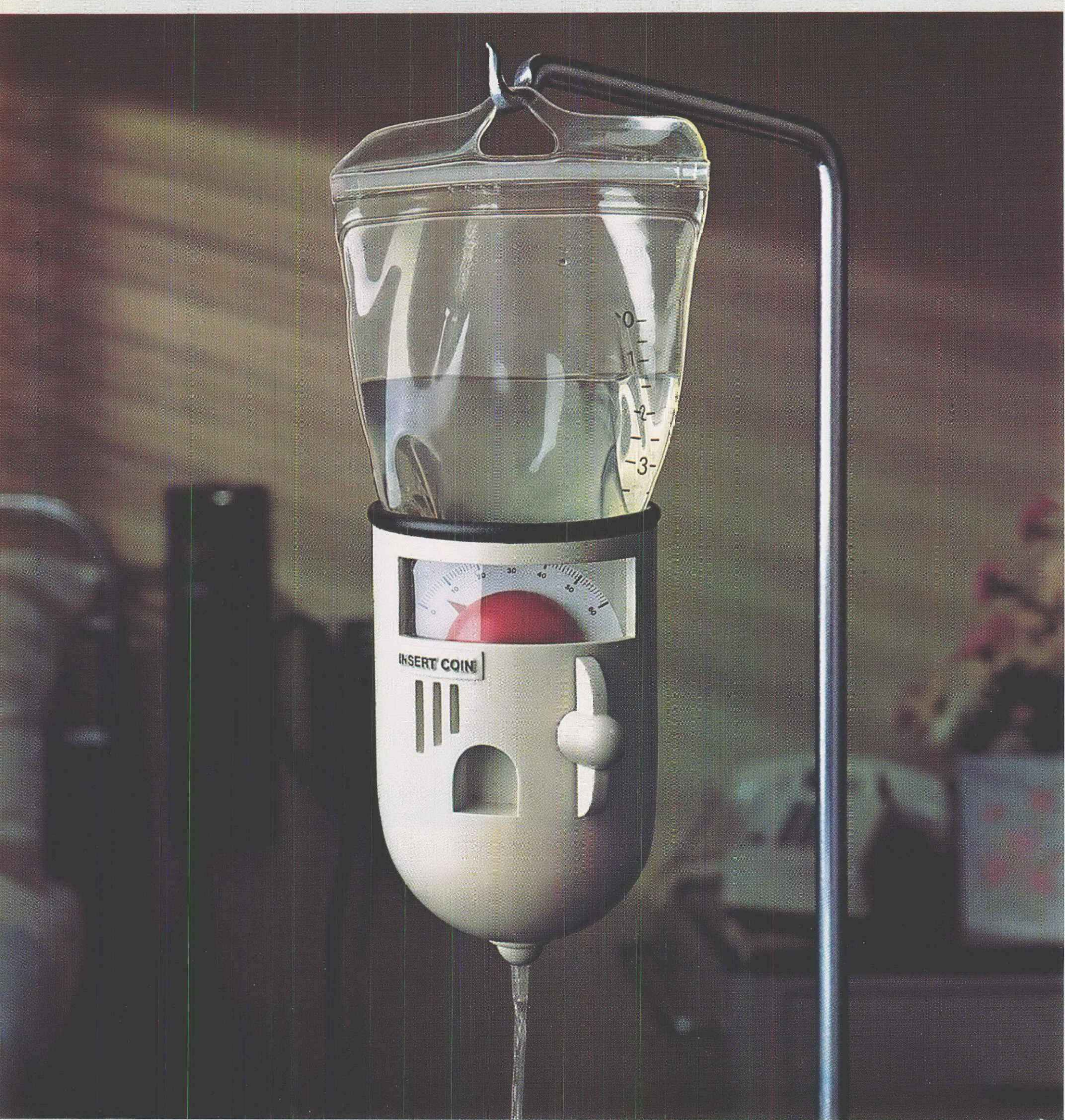

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CIGNA

Employers told to monitor HMO plans

By DONNA DiBLASE

WASHINGTON-Employers must actively manage the cost and quality of the health maintenance organizations they offer to their employees, benefits managers say.

"Gone are the days when an employer could purchase services from an HMO, PPO, insurer, etc., and then think these will provide benefits without any supervision from the employer," said James Proffitt, director of health care for St. Louis-based McDonnell Douglas Corp.

Employers can adjust their premium contributions to HMOs to better reflect their employees' experience, work to obtain group-specific data from HMOs and get more involved in legislation regarding HMOs, experts told a session last week at the 26th annual Risk & Insurance Management Society conference.

"The number of employers offering HMOs, as well as the number of employees enrolling in HMOs is increasing. However, employers have mixed reactions as to whether HMOs are able to effectively manage health care costs," explained Dennis J. Becker, vp of MEDSTAT Systems Inc. in Ann Arbor, Mich. MEDSTAT offers employers an online health care claims data base.

For example, only 39% of 2,000 employers surveyed by A. Foster Higgins HealthGroup Inc. said they thought the HMOs they offered were effective in controlling health care costs, he said. And, 46% said they thought the HMO rates were too high for the risks assumed by the HMOs, while more than 50% said HMOs attract better risks, creating adverse selection against their indemnity plans.

However, HMO premiums increased an average of 4.5% in 1986 for the 2,000 employers surveyed, compared with a 7.7% increase in indemnity plan premiums, Mr. Becker noted.

"Employers' concerns about HMO pricing include issues such as adverse selection, the equal premium contribution to HMOs and indemnity plans and shadow pricing," he noted.

Employers are concerned that they sometimes pay an HMO premium that is too high and does not accurately reflect the health care utilization experience of the younger, healthier employees enrolled in HMOs, he explained.

In addition, employers are concerned that the equal contributions they are required by the federal HMO Act of 1973 to make to HMOs and indemnity plans may cause adverse selection.

"Contributions based on company averages may not be appropriate. These amounts can be too high if HMOs are receiving the favorable risks or if the HMOs are located in low cost communities relative to the employer's average costs," Mr. Becker said.

Finally, shadow pricing occurs when HMOs price their plans for an employer at a rate that is equal or almost equal to the employer's indemnity plan premium, even if the cost experience of the employer's HMO enrollees is better than that of the indemnity plan participants, he said.

To address these concerns, McDonnell Douglas studied the health care costs of each sex and age group in its employee population under its indemnity plan, Mr. Proffitt said.

The aerospace company offers 100 HMOs and has 56,300 employees—or 43% of its population—enrolled in HMOs. The average age of employees enrolled in HMOs is between 36 and 45, he said.

The company then developed HMO premium contributions based on the cost of health care under the indemnity plan for each age and sex group.

The company told its HMOs that for one age and sex group, for example, "we anticipated the indemnity premium for employees in that group to be $162.52 a month. We planned to contribute that amount to the indemnity plan and that much toward the HMO premium, which totaled $180.11, with the employee paying the difference," Mr. Proffitt said.

However, "when the HMOs found out that this was what we intended to do, they reduced their premiums to $170," so that their plans would still be as attractive to employees as the indemnity coverage he said. Employees were required to contribute the $7.48 difference toward the HMO and $10.40 toward the indemnity plan.

Along with adjusting their HMO premiums, employers also must become familiar with and active in legislative issues concerning HMOs, said Kevin E. Moley, director of the U.S. Department of Health and Human Services' Office of Prepaid Health Care, which oversees federally qualified HMOs.

"Employers, as the entities that deliver health care as part of benefits packages, are the least-represented group in Congress. They are well-represented as manufacturers of widgets or cars, but not as providers of these benefits and payers of health care," he said.

"Just look at the federal HMO Act. What other relationship exists out there like this, where an organization—the HMO—can go to the employer and say, 'You have to offer me and you have to pay me the same amount as you pay your indemnity plan because I'm a federally qualified HMO,' " Mr. Moley said.

He noted a proposal that would repeal the HMO Act within a few years after the proposed legislation would be passed. However, he said major employer groups are either opposed to this proposal, offered by Sen. Dan Quayle, R.-Ind., or have not taken a stance.

In addition, while the ability of federally qualified HMOs to require companies to offer their plans is the biggest complaint of employers, most are inactive on measures to repeal the mandate.

And, while the HMO industry notes that most HMOs no longer impose this mandate, it opposes repeal of the mandate.

Along with playing a role in shaping legislation, employers also should shift the risk for providing cost-effective health care to insurers, similar to the action recently taken by Morristown, N.J.-based Allied-Signal Inc., Mr. Moley said (see story, page 1).

The company recently entered into a contract with Hartford, Conn.-based CIGNA Corp. under which the insurer will administer a managed care plan that guarantees that Allied-Signal's costs will not increase more than a specified amount over the three years of the contract (*BI*, Feb. 22).

"More and more insurers are getting involved in the health care delivery system by offering HMOs and PPOs, and it's time to make insurers begin to assume the risk again," Mr. Moley explained.

Most importantly, "It is crucial to continue to assess HMOs because this is an area that can be managed," said Robert F. Rasmussen, president and chief executive officer of Prime Health, a Kansas City, Mo.-based HMO.

Mr. Proffitt of McDonnell Douglas moderated the panel. ■

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Experts say managed care too often doesn't curb costs

By STACY ADLER

WASHINGTON—The fact that employers' health care costs continue to rise suggests that managed care programs designed to curb costs may not be working, an insurance company official says.

"Health care costs will increase 17% to 22% this year," said James D. Motz, vp-group insurance at Great-West Life Assurance Co. in Englewood, Colo., quoting a March survey by CNA Insurance Cos. of Chicago. CNA surveyed 25 leading group insurers and asked them to predict future health care costs.

Mr. Motz said the 17% to 22% estimate "is as high as this trend factor has ever been, and that suggests that managed care is not working."

John J. Mahoney, vp-health strategies group of Alexander & Alexander Services Inc. in Westport, Conn, also forecast escalating employer health care costs.

Based on 1985 data from the U.S. Department of Commerce, he said, "employers' contributions to health care benefits will double every five years."

Mr. Motz and Mr. Mahoney helped benefit managers judge "Is Managed Care Working for You?" during a session at last week's 26th annual Risk & Insurance Management Society conference.

Mr. Motz said benefit managers seeking to judge whether a company's managed program is working should conduct detailed studies of the cost and utilization rate of each health care service provided.

He performed such a study of Great-West policyholders, which included 1,400 employers with 15 to 150 employees whose indemnity plans included utilization review. Mr. Motz found, for example, that while the number of days employees spent in hospitals rose only 0.7%, the cost of care per day rose 19% between 1986 and 1987.

Similarly, he found that the number of hospital-based surgeries increased only 4.8%, while the cost per surgery increased 15.9% between 1986 and 1987.

Mr. Motz said this study led his company to realize that while its UR program was cutting down on unnecessary hospital visits or surgeries, it was not controlling the cost of care.

To solve the problem, Great-West implemented a preferred provider organization—in addition to

Continued on page 47

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Scholarship fund gains as J&H tightens belt

By MARK A. HOFMANN

WASHINGTON—A scholarship fund for students who plan careers in risk management was beefed up as a result of a pared-down hospitality suite for Johnson & Higgins at last week's 26th annual Risk & Insurance Management Society conference.

J&H saved $30,000 by hosting a less lavish hospitality suite this year than it has at past RIMS conferences, and donated the savings to the Robert S. Spencer Memorial Foundation Inc., an educational assistance program sponsored by RIMS.

The broker also is giving the foundation an additional $29,500 as part of its employee gift-matching program, J&H Chairman Robert V. Hatcher Jr. announced at the Spencer "beach party" on April 17 at the Washington Hilton and Towers.

The gifts will be used to provide college scholarships to students studying risk management, insurance and employee benefits, Mr. Hatcher said.

"This year, Johnson and Higgins decided to do something unusual to help rekindle enthusiasm and support from everyone here—risk managers, underwriters and brokers—because we all depend on the quality of the young men and women entering our field.

"We call our effort 'Food for Thought' because we've taken funds that would ordinarily go for food at our J&H hospitality suite—that's $30,000—and are donating that money to the Spencer Foundation scholarship fund," Mr. Hatcher said.

The gifts were meant to underscore the fact that the annual RIMS conference is an educational meeting and not an occasion for "overly luxurious hospitality suites," pointed out Seth S. Faison, J&H vp.

Education is the "lifeblood of our industry," Mr. Hatcher said. The scholarships made possible by the gifts will go to the "best and brightest students interested in becoming risk management professionals" in an effort to "pass the torch to a younger generation."

Mr. Hatcher said that "by making this gesture, we're trying to ensure that the Spencer Foundation scholarship program endures."

In addition to the J&H gifts, more than $85,000 has been raised this year by the Spencer Foundation's fund-raising committee, which is chaired by *Business Insurance* Publisher Alfred Malecki. The foundation awarded five $2,500 scholarships this year.

In addition to the money raised by not providing what Mr. Hatcher called "tables overflowing with lavish hors d'oeuvres," every J&H director, branch manager as well as many employees made personal donations to the educational organization, he said.

J&H matched the money raised through individual donations on a 2-for-1 basis, bringing the personal gifts total to $29,650.

Mr. Faison explained after the award announcement that the 2-for-1 matching gift program applies to all donations of up to $500 made to accredited colleges by J&H employees.

The announcement of the gifts was made amid a scene more reminiscent of an early 1960s beach weekend than that of a cloistered university, but it was still in keeping with the emphasis on youth made by Mr. Hatcher in his brief address.

Although neither Annette Funicello nor Frankie Avalon made an appearance, the dress of many in attendance was definitely more Beach Boys than Brooks Brothers, and their mood was more Myrtle Beach than Connecticut Avenue.

Amid Boardwalk-like game booths, partygoers munched beach fare such as foot-long hotdogs and soft pretzels, while a band blasted out summertime hits such as Tommy James and the Shondells' "Mony, Mony."

After Mr. Hatcher's announcement, beach balls filled the air over the crowded dance floor.

Spencer Foundation Chairman James C. Newton Jr. called the event "one of the benchmarks in the history of the Spencer Foundation." ■

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Spotlight report

Exhibits offer overview of benefit options

By DONNA DiBLASE

WASHINGTON—Risk and benefits managers will find themselves better armed to fight rising health care costs after touring a benefit management exhibit last week.

Everything from wellness programs and health risk appraisals to utilization review and prescription drug cost containment programs were displayed at the 26th annual Risk & Insurance Management Society conference.

Vendors lured benefit managers to their booths in the exhibition hall with attractions ranging from wildlife and roses to interactive video kiosks and pill bottles filled with candy.

Omaha, Neb.-based Mutual of Omaha Cos. entertained booth visitors with a menagerie that included an eagle, a bear cub and an owl, reinforcing the insurer's reputation as sponsor of the television series "The Wild Kingdom."

Mutual of Omaha also offered advice and information to benefit managers on its group health and employee benefit services.

Control Data Healthcare Services of Richardson, Texas, which offers a variety of health care cost containment services, offered visitors silk roses and candy.

Control Data Healthcare, a division of Minneapolis-based Control Data Corp., offers benefits claims administration complete with cost management reports, financial analysis reports and special dental cost and savings reports, according to Alan S. Jones, executive director of benefit services.

The company also offers utilization review services and a health promotion program called StayWell. In addition, an employee assistance program known as EAR—a voluntary confidential counseling and referral program—is available from the company.

The Travelers Corp. of Hartford, Conn., unveiled its HealthTouch health promotion interactive video at the meeting.

The kiosk features a touch-sensitive video screen that takes participants through a series of short video sequences on subjects such as managing stress, losing weight, dieting and exercise.

"The application of HealthTouch will be for fitness centers and employers with corporate wellness centers," explained Craig S. Russell, national marketing director for the Center for Corporate Health Promotion, a unit of Travelers.

Travelers also offered benefit managers a health risk appraisal. An interactive personal computer program included questions about weight, diet, stress and chronic illnesses, and then informed the user of his or her overall health status.

Visitors to a booth sponsored by Thrift Drug Co. could enjoy a "dose" of M&M chocolate candies as they used a computer program to project savings under a mail-order prescription drug program.

The company, a division of New York-based J.C. Penney Co., offers a program under which employees who use maintenance drugs—such as insulin or high blood pressure medication—can order a 90-day supply of the drug by mail. The mail-order program, called Express Pharmacy Services, saves the employee and the employer pharmacy dispensing costs because the drug is ordered in bulk.

In addition, money-saving generic drugs are substituted for name-brand drugs in most cases.

Employers save on prescription drug costs under the program because employees order directly from Thrift Drug, which charges employers no start-up or administrative fees, according to Laurie L. Archer, regional sales manager in the Newport Beach, Calif., office.

The company's employer clients include large employers, such as San Francisco-based Chevron Corp.

America's Pharmacy of Des Moines, Iowa, also provided information on its mail-order prescription program as well as a kit including throat lozenges, aspirin, dental floss and Band-Aid brand adhesive bandages.

"We dispense a 90-day supply at one time, so there are less claim forms and only one dispensing fee. This is an important cost containment program because maintenance prescriptions account for about 10% of the average employer's health care dollar," explained Wally Throndsen, regional vp for the firm.

Benefit managers that administer self-insured health plans learned of a new "niche" service offered by Dallas-based Liaison Inc.

The firm, which specializes in workers compensation rehabilitation services, now offers Liaison Corporate Care. The new service includes a cost containment audit, which identifies an employer's cost containment needs.

Then, based on the findings of the audit, Liaison offers its own in-house occupational health nurses to work full-time on the employer's grounds. Under the program, the employer has the benefit of having an in-house health care coordinator for group health and workers compensation cases without having to hire its own occupational nurse, explained Catherine Marrs, Liaison president.

Employers pay from $25,000 to $40,000 for the cost containment audit. A management contract, which provides the employer with an appropriate number of occupational nurses to coordinate care, costs employers $120,000 and up annually, she said.

Large group health insurers also were on hand to discuss their group health care offerings.

For example, Hartford, Conn.-based CIGNA Corp. offered information on its managed mental health and substance abuse program and its group universal life insurance plans.

Benefit managers learned about these programs as they stepped down from CIGNA's golf putting green, which was complete with golf tournament sound effects like "oohs" and "aahs" and applause.

CIGNA's managed mental health care plan includes utilization review administered by its Wayne, Pa.-based Intracorp unit and an employee assistance program.

Intracorp offered benefit managers a comfortable place to sit and review the variety of utilization review and cost containment services it provides.

The firm, which has provided inpatient utilization review services since the early 1980s, is now developing outpatient review services, according to Richard J. Calhoun, vp of rehabilitation.

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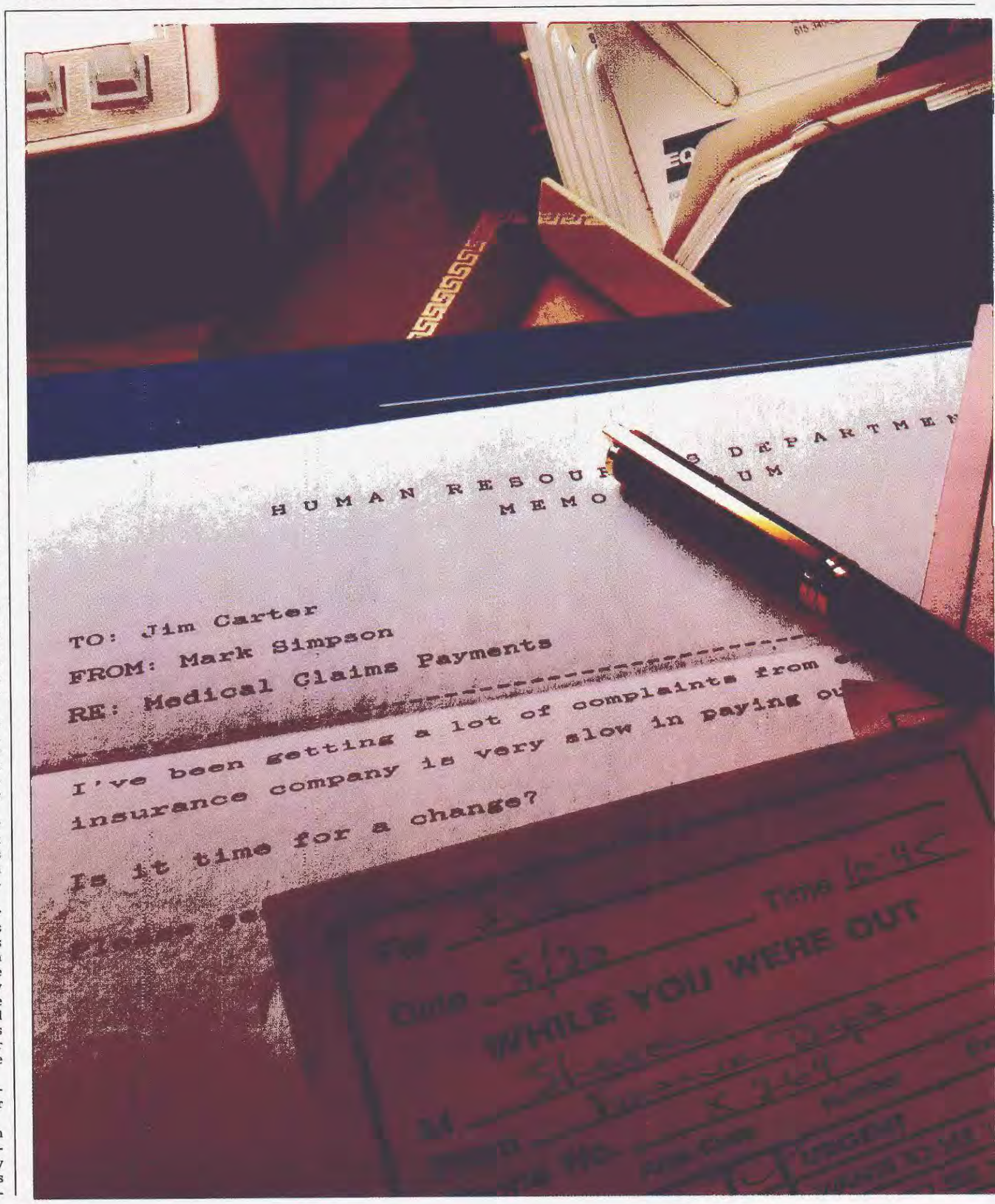

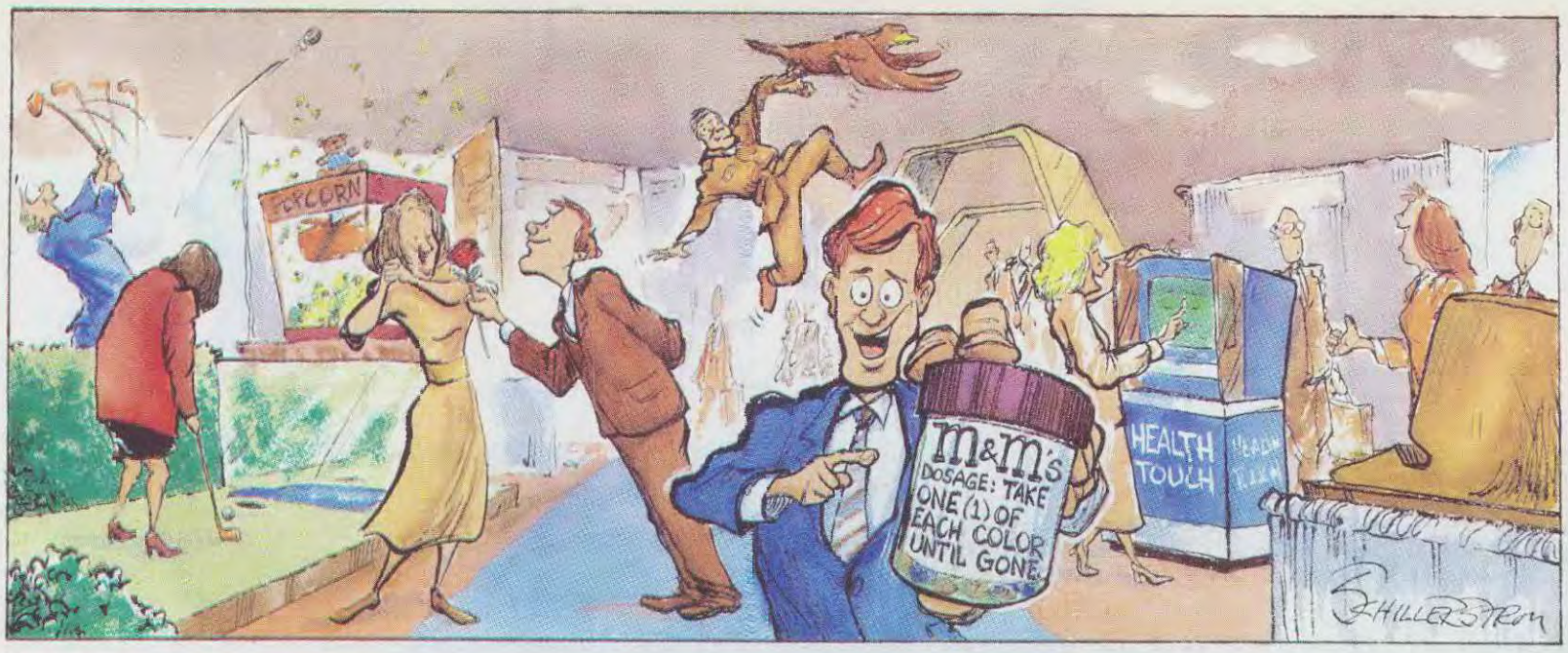

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Continued from previous page

The Managed Health Services division of Boston-based John Hancock Mutual Life Insurance Co. offered information on its Patient Advocate Program, which includes a range of utilization review services and assistance for employees with benefit questions.

Blue Cross and Blue Shield marketing representatives were on hand to discuss the non-profit health insurer's HMO USA national network, as well as its other managed care services.

In addition, Equicor, the joint venture between New York-based Equitable Life Assurance Society of the United States and Nashville, Tenn.-based Hospital Corp. of America, offered literature on its managed health care offerings.

Equicor currently is building HMO and PPO networks in several states. The company also offers UR services and publishes a variety of surveys on health care trends and benefits concerns.

Utilization review vendors also participated in the exhibition.

Minneapolis-based Health Risk Management Inc. presented information through both a video and brochures about its ReviewPlus program and other services.

Representatives of HealthCare COMPARE of Downers Grove, Ill. were on hand to discuss the company's venture into preferred provider organizations. The firm, which has provided UR services since the early 1980s, is awaiting regulatory approval of a joint venture with Affordable Health Care Concepts, a Sacramento, Calif. PPO contracting firm.

Benefit managers also had a chance to learn about the health claims data base and information systems of Ann Arbor, Mich.-based MEDSTAT Systems Inc., which targets employers with 15,000 or more employees.

These employers supply MEDSTAT with their indemnity plan claims information, which is loaded into a computer data base.

Employers then can use a personal computer to access their health care cost information, as well as normative data built from the claims information of all the employers participating in the data base, explained Laurent Schor, regional director for the firm's Boston office. MEDSTAT's data base has information on more than 50 million lives, he said.

Benefit managers also can use the data base to do benefit plan modeling, which is projecting the cost effects of increasing deductibles or UR, he said.

The Alexander Consulting Group Inc., the benefit consulting division of Alexander & Alexander Services Inc., presented its interactive benefits video. The touch-sensitive video screen housed in a kiosk is designed to help employers communicate benefit plans and workplace safety programs, said Thomas W. Hourihan, vp and manager of special services marketing in Baltimore.

The consulting firm displayed an interactive video designed for Detroit-based Chrysler Corp. The automobile manufacturer used the video to communicate workplace safety procedures.

The consulting firm also demonstrated its personal computer program for administering continuation of benefits coverage. The program helps employers to comply with the reporting and notification requirements of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

The Alexander Consulting Group also offers an employee research consulting practice in conjunction with the Gallup Organization Inc. that helps employers to survey employees on benefits or workplace changes so that the most effective programs can be implemented. ■

Spotlight report

Benefits experts offer cost-cutting advice

By GLENN HUNTLEY

WASHINGTON—Benefit managers should use every possible weapon in the battle against endlessly rising health care costs, according to a panel of experts.

An effective benefit plan design takes advantage of all available alternative health care delivery and administrative services, according to speakers at a seminar held during the 26th annual Risk & Insurance Management Society conference last week.

In fact, one of the relatively few areas in which employers can exercise control over health care costs is in the selection of a delivery system, said Rik D. Lindahl, senior manager of Peat Marwick Main & Co. in Dallas.

The panel also said that switching to a self-insured health care plan can reduce employers' health care costs.

For example Trammell Crow Co. saved $400,000 the first year after switching from an indemnity health plan to a self-insurance plan and purchasing stop-loss insurance over a $1.25 million retention, said Steven J. Cataldo, risk manager for the Dallas company.

In addition, Rosewood Resources Inc., which owns a hotel group, saved about $300,000 annually by self-insuring its health plan for its 1,500 employees, said Steve Williams, employee relations manager for the Dallas-based company.

But, the panelists stressed that even under the most efficient benefit plans, someone must pay the bills.

And, cost-shifting to employees through higher deductibles and copayments probably will continue as medical costs continue to soar, Mr. Williams said. "I think most of us are going to ask our employees to share the burden in future years."

The insurer or third-party administrator selected to handle claims also can have an influence on the total benefit bill, the panelists said.

However, employers too often jump from one administrator to another, searching for the most cost-effective one, the panelists said.

Letting competitive bids for administrative services has been "abused" by employers, Mr. Lindahl asserted.

He explained that many employers have handled problems with TPAs by repeatedly going out for new bids.

But, companies that change administrators frequently get a bad reputation among TPAs and insurers, he pointed out.

The panelists suggested that instead of changing administrators frequently, employers should make sure they get the right help in the first place.

For example, Mr. Cataldo said his company set specific requirements for a TPA before asking for bids.

Switching to a self-insured health care plan can reduce employers' health care costs.

Employers should look for quality claims handling, which includes more than just speedy payment, Mr. Williams said.

"If it's speed that you want, there are some claims administrators out there that who will pay as fast as you want," but it may not be the most cost-effective TPA, Mr. Williams said.

Mr. Lindahl also warned that many TPAs and insurers can now provide comprehensive data about claims experience, but it will be of little use to employers unless the numbers provided are compared with national norms and previous experience.

"Data is not the same as information," he said.

Performance standards can be included in claims administration contracts to assure that claims are handled accurately and with a close eye to possible overcharges, the panelists said.

For example, in January, Rosewood Resources added implemented claims handling standards under which the administrator is fined for errors in payments, Mr. Williams said.

Audience members asked the panel whether capping payment in cases of acquired immune deficiency syndrome could limit an employer's exposure in these cases.

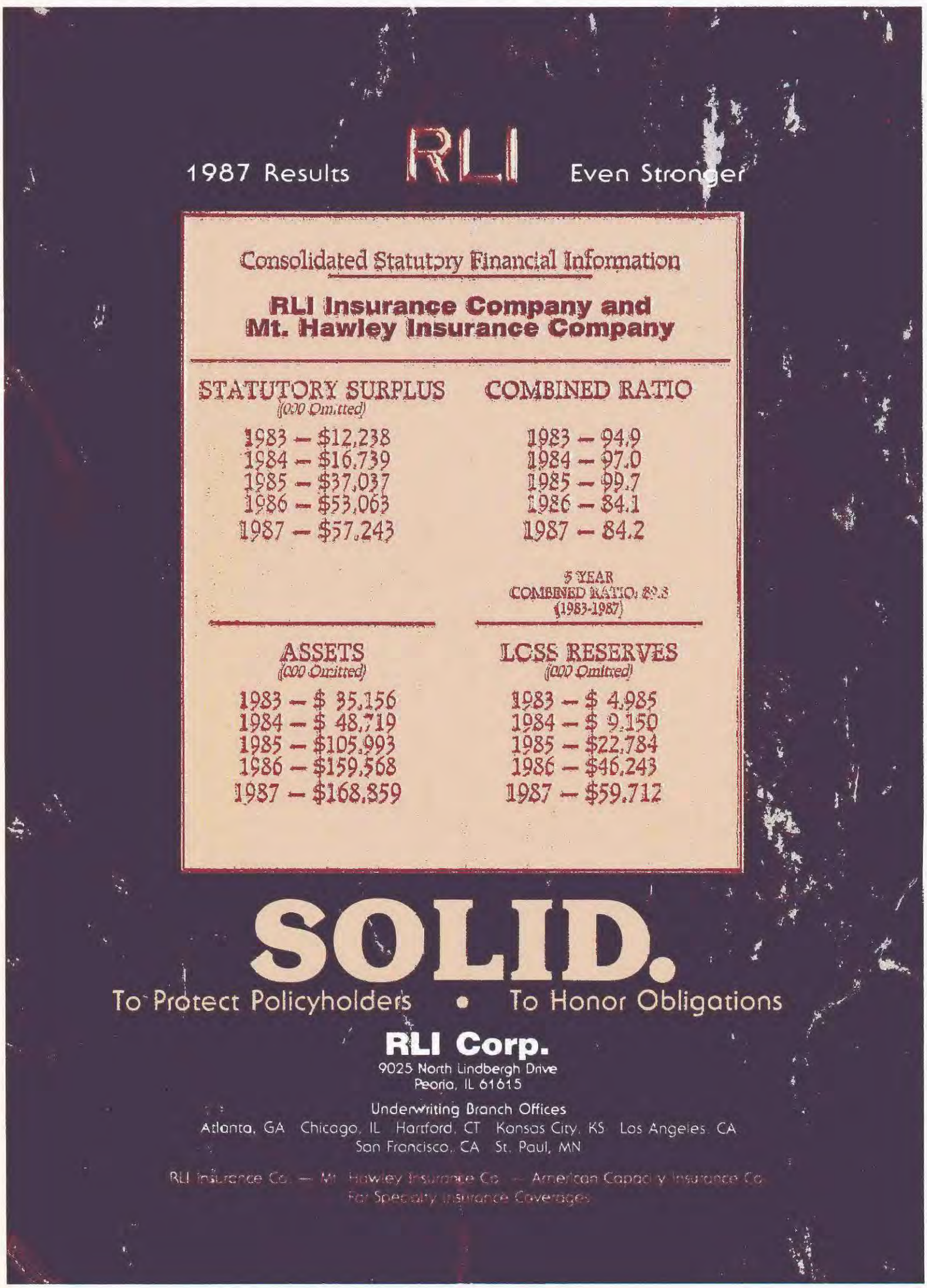
Mr. Williams said that such a specific limit is almost certain to bring a lawsuit.

"Sooner or later it's going to be challenged," Mr. Williams warned the audience.

He added that despite frequent stories about the high costs of treating AIDS, the costs of each of Rosewood Resources' six AIDS-related claims has been a relatively modest $70,000 to $100,000 from diagnosis to death.

Len Vinsko, a consultant with the Exeter Group in Richardson, Texas, also was a speaker at the session.

Mr. Cataldo moderated the discussion. ■



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Spotlight report

Non-discrimination rules confusing for all

By JAMES M. BURCKE

WASHINGTON—Benefit managers must begin preparations immediately to comply with the tough non-discrimination rules for welfare plans that take effect Jan. 1, a benefit manager and a consultant advise.

And, that preparation is likely to be a tough job because of the reams of data employers will need to determine whether their plans are discriminatory and because the rules themselves are "in the realm of the unintelligible," explained P. Joseph Walshe, with Coopers & Lybrand partner in Washington.

"The more I read the rules, the more confused I get," said Lawrence A. Cavanaugh, director of employee benefits at United Technologies Corp. in Hartford, Conn. "Yesterday was not too early to get started in regard to collecting data," he added.

Mr. Cavanaugh and Mr. Walshe explained the welfare plan non-discrimination rules contained in the Tax Reform Act of 1986 at a session during last week's 26th annual Risk & Insurance Management Society conference.

Members of the audience bombarded the two speakers with queries about the provisions and how their companies could comply with the extremely complicated rules. Many members of the audience moaned as Messrs. Cavanaugh and Walshe detailed the rules.

"I don't know who thinks up these things," said Mary Castro, director of insurance and employee benefits manager at IGA Inc. in Chicago, who was skeptical of the need for the tests. "Who's going to benefit other than the government? The employee isn't going to benefit from these rules."

A coalition of employers and insurers currently is lobbying Congress to delay and simplify the rules, whose purpose, according to Mr. Walshe, is to "prevent discrimination in favor of highly compensated employees" (*BI,* April 18).

But, until the rules are changed, employers must prepare for their Jan. 1 compliance date, Mr. Walshe and Mr. Cavanaugh agreed.

"There is one heck of a lot of work to do before you can even begin the tests," Mr. Cavanaugh pointed out.

"The biggest thing that employers can do now is to try to gather the data," Mr. Walshe said after the session.

The non-discrimination rules apply on a mandatory basis to employer-provided health care plans —including dental plans—and to group term life insurance plans.

According to Mr. Walshe, the rules define highly compensated employees as:

- Employees that own at least 5% of the company.
- Workers earning more than $75,000 annually.
- Workers among the highest-paid 20% of the workforce who earn more than $50,000 annually.
- Corporate officers who earn more than $45,000 annually.

The law subjects welfare plans to three tests, according to Mr. Walshe: The so-called 80% test, which is also known as the alternative coverage test; the eligibility test; and the benefits test.

The 80% test is the "easiest to understand, but the hardest to pass," he said. He also noted that if a plan passes the 80% test, it does not have to undergo the others.

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

It will be difficult for most companies, especially those with coverage options like health maintenance organizations, to pass this test because it is unlikely that one plan would cover 80% of a company's employees, he said. "When you have more than one option, it is almost impossible to pass the 80% test."

In addition, he suggested that employers probably would consider individual coverage, coverage for a worker and one dependent and coverage for a worker and more than one dependent as three different plans under the rules.

However, he noted that a company can combine two plans under the rules if the value of the plans differs by 5% or less. For example, an indemnity plan and an HMO option could be tested together if the value of the indemnity plan was set at $1,000 and the value of the HMO was $950, he explained.

But when asked how a benefit manager can determine the value of a plan, Mr. Walshe replied: "That's a good question." He said the Treasury Department has not yet issued rules governing plan valuation (*BI,* April 11).

Mr. Walshe also pointed out that employers must include part-time employees working more than 17½ hours a week.

"That's ridiculous," shouted one member of the audience.

If a plan does not pass the 80% test it must then undergo the eligibility test. That test consists of three parts, each of which must be passed.

- The so-called 50% test. At least 50% of those eligible for a plan must be non-highly compensated employees.
- The so-called 90/50 test. At least 90% of non-highly compensated employees must be eligible for a plan whose value is at least 50% of that of the most generous plan available to highly compensated employees.

"This is going to be a problem for your executive benefits plans," Mr. Cavanaugh said.

- The so-called non-discrimination provision or, as Mr. Cavanaugh labeled it, the "facts and circumstances" test. Under this test, an employer must prove that benefits are not directed at a limited number of employees.

For example, a plan that covered heart transplants only after it is learned that the company's chairman needed such a procedure could flunk this test, Mr. Walshe explained. "I don't think many plans will be hurt by this provision," he said.

If a plan passes all three eligibility tests, it still must pass the benefits test before it is ruled non-discriminatory, Mr. Walshe said.

Under the benefits test the value of the average benefit provided to non-highly compensated employees must be 75% of the value of the average benefit provided to highly compensated employees.

Mr. Walshe noted that it will be difficult for employers to use the eligibility and the benefits tests until the Treasury releases guidelines on plan valuation.

"If the Treasury can't do it, how can employers?" he asked. ■

Treating mental illness, drug abuse costly

By DEBORAH SHALOWITZ

WASHINGTON—The costs of treating employee mental illness and substance abuse are only a fraction of the price paid by employers, and employers must better control those costs, benefit experts say.

"The cost that we see in benefit programs is often only a fraction of the total cost to your corporations," said William Sharkey, vp of health benefits marketing for CIGNA Corp. in Hartford, Conn.

"Mental illness and substance abuse are problems that cannot be measured completely in dollars," agreed John D. Butler, general director of employee benefits for Detroit-based General Motors Corp. He pointed out that lower productivity and lost work time also are costs related to these problems.

However, employee assistance programs—commonly referred to as EAPs—can help 'determine the degree of illness'' and control costs, pointed out Charles S. Sapp, assistant vp of the corporate employee assistance program for CIGNA Corp.

And managed care approaches can be used to cut costs, said Edward G. Meads, regional director of marketing for the MCC Cos. Inc., a Minneapolis-based firm that manages prepaid mental health and substance abuse services for health organizations and companies.

The benefit experts, speaking at the 26th annual Risk & Insurance Management Society conference last week, agreed that employee benefit managers should pay attention to the treatment of substance abuse and mental illness because the incidence of these problems is growing.

'The prevalence of these disorders is increasing," said Mr. Butler, who moderated the session.

He noted that approximately 40 million people—about one of every six people in the United States—have mental disorders and that alcoholism is the No. 3 cause of death for adults.

And, about 10% to 20% of all benefit dollars are spent to treat mental illness and substance abuse. Mr. Sharkey said.

Mr. Butler noted that General Motors spent approximately $78 million to treat substance abuse among its employees last year.

However, the real annual cost of substance abuse to the company is about $600 million, because of increased accident rates, workers compensation claims, absenteeism and use of health care benefits, he explained.

Thus "early identification (of these problems) is of the utmost importance," Mr. Sharkey said.

One option for employers is adding an EAP to their benefit programs, he suggested.

Mr. Sapp of CIGNA said the primary purpose of an EAP "should be to make it easier for the consumer to access the system."

Furthermore, an EAP—acting as the "informal part" of the health care system—can educate people, improve morale and act as an ombudsman, he added.

After the session, Mr. Sapp explained that EAPs can be particularly helpful in providing an objective assessment of a situation and sometimes can help to defuse employee anger—and prevent employee discrimination lawsuits.

He said that an internal EAP would be most appropriate for an organization with more than 3,000 employees, while a smaller company probably should consider hiring an outside EAP manager.

Mr. Meads of the NCC Cos. said there are two approaches to cutting the costs of mental health and substance abuse programs.

First, employers can try administrative techniques, such as changing the design of their benefit programs, negotiating provider agreements and instituting utilization review programs.

Employers also can try to control how care is provided to employees, he said.

For example, it is important to limit an employee's length of a stay in the hospital, Mr. Meads emphasized. "The rate of admission is not nearly as critical as the length of stay," he maintained. Costs can really skyrocket with long inpatient hospital stays, he warned.

Also, whenever possible, employers should try to avoid inpatient care and choose outpatient care instead, he suggested.

He noted that outpatient care is much less intrusive and much less expensive than inpatient care. "We can do a lot of outpatient care for $300—which is probably about one day in a hospital."

Mr. Meads predicted that 80% to 85% of treatment for mental illness and substance abuse eventually will be provided in an outpatient setting.

Another "highly effective" and cost-efficient way to treat mental illness and substance abuse is group therapy, Mr. Meads said.

Employers can "build in copayments and deductibles" so employees have incentives to keep their treatment cost-effective, he added.

All of the speakers emphasized that in addition to getting the right treatment in the first place, it is important to keep the rate of relapse down.

Mr. Butler said that GM requires employees who have completed a substance abuse treatment program to participate in another program to keep them from relapsing. There is a $500 penalty levied against those employees who do not complete the follow-up program, he noted.

Collecting data on the effectiveness of these cost-cutting approaches is difficult but important, the speakers agreed.

"The need for data is paramount," said Mr. Sharkey of CIGNA. But "the data is difficult to segregate."

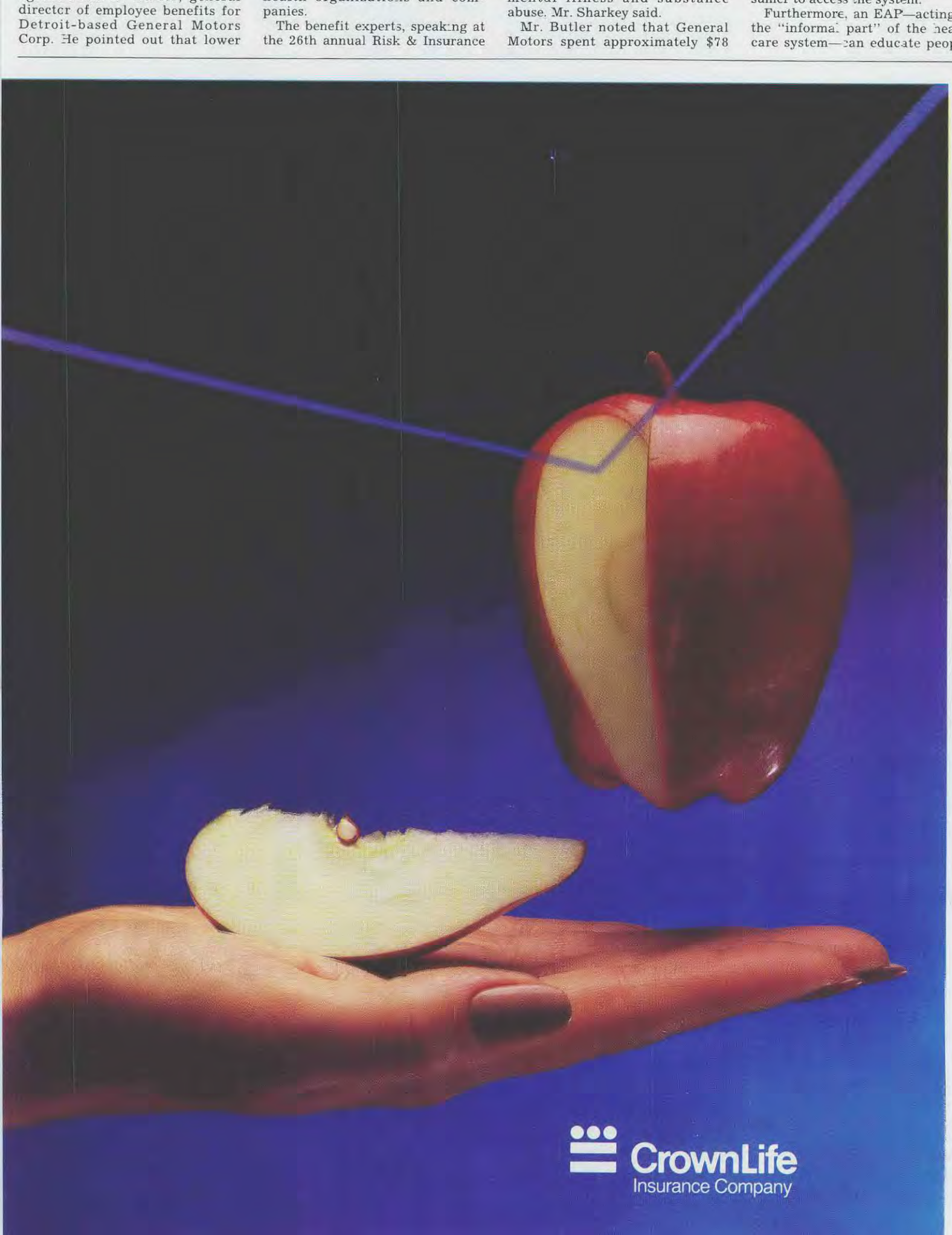
He also pointed out that costs related to substance abuse and mental illness often are buried in other health care benefit costs.

For example, some employees might not want to admit to these kinds of problems, so their treatment is handled through the regular medical benefits package, Mr. Sharkey said.

In any case, a company needs good data to analyze the effectiveness of its programs to treat mental illness and substance abuse, he said.

Mr. Butler agreed that "data is the key to this thing."

Marguerite A. Boslaugh, assistant vp in the employee benefits and health care group for Connecticut General Life Insurance Co., a CIGNA unit in Hartford, coordin-



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Quick intervention key to disability cost control

By GLENN HUNTLEY

WASHINGTON, D.C.—Long-term disability programs designed to encourage disabled employees to return to work more quickly, as well as diligent supervision by management, can control LTD plan costs, according to a panel of benefit experts.

An aging workforce and new causes of disabilities, such as acquired immune deficiency syndrome, have prompted an increasing number of employers to re-evaluate existing disability programs or offer new plans, said James Crockett, manager of risk and benefits for the Denver Board of Water Commissioners.

Some form of disability, including back injuries, spinal cord damage and arthritis, strikes about 17% of the workforce annually, Mr. Crockett said during a program at the 26th annual Risk & Insurance Management Society conference last week.

And, disability payments from state programs, Social Security, workers compensation and employer programs have grown to more than $160 billion annually, said Richard H. Wille, executive vp of Thomas L. Jacobs & Associates Inc., a disability claims management firm in Chicago.

But because long-term disability benefits typically have amounted to only 1% or 2%, of total payroll, many employers have paid little attention to their LTD programs for years, Mr. Wille said.

However, employers can design cost-effective disability plans that still meet disabled employees' needs, according to Mr. Wille.

He said those plans should include:

- Prompt rehabilitation. If rehabilitation is not begun within six months after a disability, there is little chance of ever getting the worker back to his job, he said.

Employers also should closely monitor disabled workers, including making occasional telephone calls to check on their activities.

"The worst thing you can do is wait two years and then try to do something," Mr. Wille said.

- Modified duty. Providing light duty for injured workers who are able to perform limited duties is an effective method to get employees back to work, he said.

Mr. Wille noted that a national express mail company puts disabled workers on light duty even if it means moving them to another city and paying the relocation costs, Mr. Wille said.

- Aggressive pursuit of offsetting benefits. LTD plans should require employees to apply for Social Security benefits against which the employer's benefit payments can be offset.

Denials of Social Security benefits should be appealed because denials are reversed in some cases, Mr. Wille added.

Also, some state disability programs offer extended benefits that may overlap the employer's plan, he pointed out.

- Limited benefits for disabilities resulting from pre-existing conditions. For example, some employers are limiting the amount of LTD benefits they will pay new employees who become disabled because of AIDS.

Mr. Wille also stressed that while LTD programs should be designed to provide income for disabled employees, the benefit should not be a disincentive to return to work.

For example, he said, some plans provide benefits that amount to 120% of regular pay. "It's very hard to get them back to work," Mr. Wille said.

LTD plans can generate immense liabilities when younger workers or high-paid executives become disabled, he reminded the audience.

In one case, a 41-year-old executive claimed he was unable to work, Mr. Wille said. The executive's $12,000 monthly LTD benefit represents a lifetime liability of more than $3 million to his employer.

However, employers should promptly pay benefits to disabled workers, Mr. Wille emphasized. "Pay benefits due. No more, no less and pay promptly," he said.

Mr. Crockett was session moderator. ■

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Operational in all Crawford & Company major Health and Rehabilitation locations, the Crawford Occupational System (COS) is an indispensable resource to the company's 700 medical services and vocational staff. Through COS, rehabilitation counselors can access a bank of over 12,300 job titles and skills descriptions from the U.S. Department of Labor's Dictionary of Occupational Titles (DOT). Its electronic skills transfer determination is a valuable tool for accurately placing disabled workers.

Since April 1985, the information provided by COS has also helped employers to modify an increasing number of jobs to accommodate disabled workers, according to Crawford Vice President G. Berk Lynch, Ph.D.

Crawford's rehabilitation counselors utilize COS through the company's entire Return-to-Work process. Through a series of screens and menus, COS aids the counselor to enter and store the worker's job history, including training, experience, education and nature of the disability.

COS then stores the job history files by DOT code, or by job title, establishing the basis for a match between the worker history and DOT files later on:

After creation of [illegible] file, the rehabilitation counselor then searches the DOT file for descriptions matching the client's abilities, experience and physical limitations. Through COS, counselors may impose restrictions on the search for appropriate occupations, such as isolating the highest *level* of an appropriate job (in terms of physical limitations or requirements) to which the worker can aspire.

"For instance, [illegible] descriptions [illegible] a medium [illegible] heavy lifting [illegible] without this [illegible] with a back injury. The system allows a counselor to rule out jobs that require more than a specific [illegible]. Counselors may also *increase* the search at the highest level of academic [illegible] experience requirements," according to Dr. Lynch.

The system then produces a printout of [illegible] appropriate occupations. [illegible] time for the process is approximately 45 minutes. [illegible] job openings [illegible] identified.

COS condenses the time spent to determine the claimant's transferable skills and appropriate occupations. "Now counselors can devote more time to the ultimate goal of the rehabilitation counseling program—finding actual work for people that takes advantage of their skills and experience. Job placement [illegible] dramatically," says Lynch. □

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G. Berk Lynch
Vice President
Health & Rehabilitation

Crawford Health & Rehabilitation Introduces New WC Audit System

A computer-based system providing audits of medical services bills for Workers Compensation cases is now available from Crawford & Company Health and Rehabilitation Services.

The provider audit program has been designed to provide effective cost containment for fees from all health care professionals, including physicians, chiropractors, physical therapists, etc. The system examines patterns of care and adherence to schedules (in WC schedule states) or "reasonable and customary" norms in the non-schedule states.

The system complements Crawford's manual hosptial bill audit program. □

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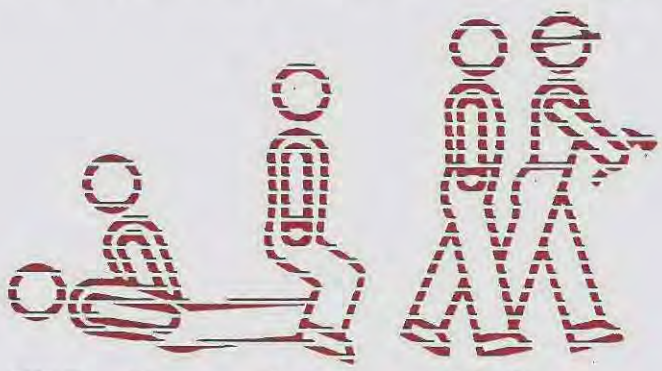

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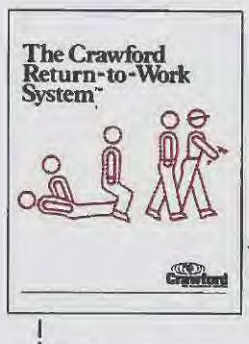

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HEALTH AND REHABILITATION

Payers urged to stop doctor overcharging

By DEBORAH SHALOWITZ

WASHINGTON—Employers, insurers and claims administrators must stop doctors from overcharging to control rising health care costs, employee benefits experts say.

While there are many reasons for escalating physician costs, one of the main factors is that many doctors are deliberately overcharging patients, the experts assert.

"Physicians are lining up at a feeding trough with a no-holds-barred attitude," said Dr. Robert K. Maddock Jr., medical director of the Medical Review Institute of America, a Salt Lake City-based claims review consultant.

"The biggest challenge" facing health care consumers today "is to eliminate the most prevalent medical procedure being practiced today—the wallet biopsy," declared Samuel X. Kaplan, chairman of the board of U.S. Administrators Inc., a Los Angeles-based third-party claims administrator.

Speaking last week at the 26th annual Risk & Insurance Management Society conference, Dr. Maddock, Mr. Kaplan and others told employee benefits managers that there are many ways physicians overcharge patients.

The task for health care consumers is to "try to discover the good guys and the bad guys," Dr. Maddock said.

To weed out the "bad guys," benefit managers need to look for several warning signs, he noted.

For example, unbundling—breaking down the components of procedures and billing them separately—can actually increase costs, he said.

He advised employee benefits managers to add up all the unbundled charges on a bill to make sure that the total does not exceed what the procedure previously cost when it was billed as one unit.

Also, doctors can change the codes on their remittance forms so that they are paid for services that are more expensive than those that were actually rendered.

"Upcoding. . .happens very frequently," Dr. Maddock asserted.

"You can't believe what physicians send you on their codes," said Dr. Robert D. Hertenstein, medical director for group insurance at Caterpillar Inc. of Peoria, Ill.

Dr. Hertenstein said the company, which is self-insured and administers its own claims, reclassifies about 30% of the codes doctors have marked on the forms.

Other problems to be aware of, according to Dr. Maddock, include: billing for services not rendered; billing for unusual services and unproven practices; billing for experimental procedures; billing for treatment for pre-existing conditions for which the beneficiary is not entitled to coverage; billing for any unusual costs; and a high level of prescriptions.

"You need to track the practice pattern of each physician," Mr. Kaplan said, advising benefits managers to check the "mundane" parts of a physician's bill, such as the number of office visits per beneficiary and the number of injections per beneficiary.

These can be clues to overcharging, he said.

Eventually, if physicians know that an employer, insurer or claims administrator is reviewing every single charge on a bill, they probably will stop overcharging that health care payer, Dr. Maddock predicted.

However, if physicians do not stop overcharging, they can be reported to the local medical association or a criminal complaint can be filed, he said.

Another way to lower physician charges is to negotiate fees on a group basis with local doctors that do not usually practice together, Dr. Hertenstein suggested. For example, he said, a major employer in a town could get a group of doctors together to come up with a reasonable range of charges for specific procedures.

"Consensus fees are far more reasonable" than individual ones, he said.

Fees that are called "usual, customary and reasonable" often are none of the three, noted Mr. Kaplan.

With new or experimental procedures, often "physicians don't know what to charge for things—they just find out what someone else charges," Dr. Hertenstein pointed out.

"You don't have to pay the most to get the best quality," asserted Joe Charles, group director of employee benefits for Ryder System Inc. in Miami, which is self-insured and administers its own claims. Ryder has compiled a data base of information on more than 1,400 doctors and all of the hospitals in Dade and Broward counties in southern Florida, said Mr. Charles, who moderated the session.

Ryder's computerized Medfacts system includes personal and professional information, such as the doctor's medical education, where a residency was done, certification status, the type of medical practice and fees for certain standard procedures.

Medfacts also contains information on the hospitals in the Miami area, including how often a certain medical procedure is performed at different hospitals, the average length of stay and the average cost of various medical procedures.

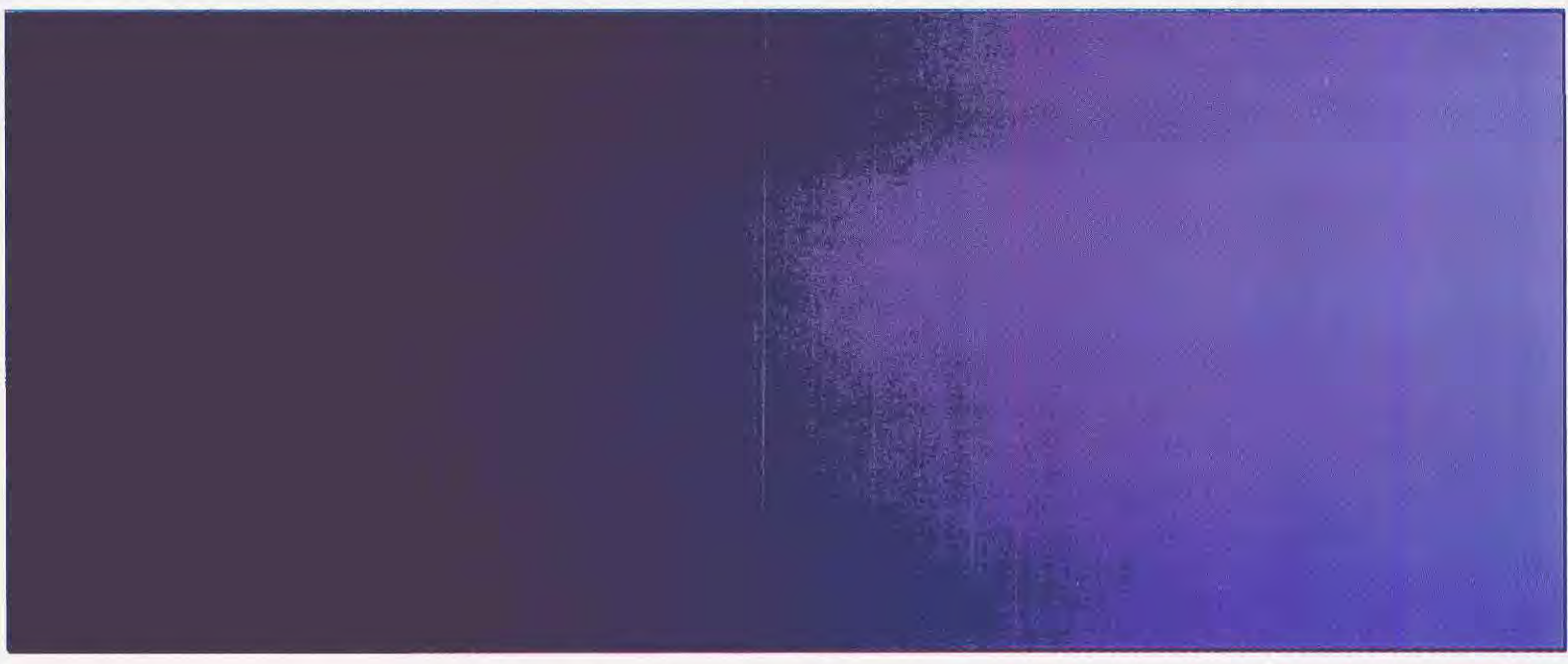
The Medfacts information indicates that physician and hospital charges vary significantly—more than 100% in some cases—for the same procedures, Mr. Charles noted. And, in many cases, physicians who are not certified by the state medical review board charge more than those who are board certified, he added.

To contain health care costs, Ryder gives employees who request Medfacts information on the five least-expensive doctors or hospitals listed by the computer for a particular medical procedure.

Although getting a second or third opinion from different doctors before treatment is often advised to help health care consumers avoid unnecessary procedures, Dr. Maddock opined: "This is rather futile because there's a buddy system" among some physicians to reinforce their judgments.

Caterpillar's Dr. Hertenstein advised the session attendees that "anybody who has a sizable number of employees should administer their own health plans," claiming that the savings do pay for the entire cost of in-house administration of the health plan.

For example, last year at Caterpillar, physician fees dropped 1.6% from the previous year and hospital fees dropped 1.8% from the previous year, he noted. ■



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Deficit is changing benefit legislation

By JERRY GEISEL

WASHINGTON—Federal budget deficits are forcing legislators to chart a new course in drafting benefits legislation, a congressional staffer says.

Back in the 1960s, the easiest way to address a social problem was to propose a program involving federal dollars.

"It was easy. The (federal) dollars were there," said G. Lawrence Atkins, minority staff director for the Senate Special Committee on Aging.

For example, Medicare, the second largest federal benefits program after Social Security, was enacted in 1965 when there was little concern about federal budget deficits.

But by the 1980s, with federal deficits at unprecedented levels, Congress turned to employers to provide benefit programs that legislators wanted but the federal government could not support.

"If the federal government can't do it, Congress will make the employer provide the benefit. That is what is going on," Mr. Atkins said.

Mr. Atkins, speaking last week at the 26th annual Risk & Insurance Management Society conference, said the federal budget crunch has had a direct impact on several pieces of benefits legislation enacted this decade.

For example, during the 1980s, Congress passed legislation shifting the health care costs of workers staying on the job past age 65 from Medicare to employer-provided health care plans.

In addition, without using any federal dollars, Congress tackled the problem of helping people who lost health care coverage when they were laid off or because of a death or divorce through the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Mr. Atkins said.

Under COBRA, employers must extend group health care coverage for up to 36 months to employees' widowed or divorced spouses and up to 18 months for former employees who quit, are laid off or fired, except for gross misconduct.

While employers can charge beneficiaries a premium equal to 102% of their costs, a COBRA premium still costs the beneficiary a lot less than what he or she would have to pay for comparable coverage in the personal lines market.

The federal budget crunch also is affecting benefits legislation is more subtle ways, Mr. Atkins said.

He pointed out that during the 1970s, when the deficit had not yet emerged as a major problem, legislators passed a series of measures giving tax breaks to encourage employers to offer new benefit programs.

For example, in 1978, Congress added Section 125 to the Internal Revenue Code to give employees the opportunity to choose between a menu of cash and non-taxable benefits without incurring any adverse tax consequences.

Also in 1978, Congress added Section 401(k) to the tax code, which, after the publication of Internal Revenue Service proposed regulations in 1981, gave employees lush tax incentives to save for retirement through salary reduction plans.

But, as deficits grew in the 1980s, legislators wanted to be sure that the rich tax breaks it gave to benefit plans were really resulting in improved coverage for a range of employees, Mr. Atkins said.

"If tax breaks were offered, the coverage had to be broad," Mr. Atkins said.

And, legislators took steps to cut back tax breaks to the highly compensated who may have "overbenefited" from benefit plans, he said.

Congressional concern that highly paid employees received a disproportionate share of the benefits resulted in the slashing—as part of the Tax Equity and Fiscal Responsibility Act of 1982—of maximum pension benefits and contributions.

Under TEFRA, the maximum annual benefit that could be funded through a defined benefit pension plan was rolled back to $90,000 from $136,425, while the maximum annual per-employee contribution that could be made to a defined contribution plan was cut to $30,000 from $45,475.

In the same vein, to promote greater equity in benefit plans, TEFRA also mandated that "top-heavy" pension plans—those plans in which at least 60% of benefits went to key employees—would have to offer rapid vesting schedules.

This congressional desire to broaden benefit coverage continues to shape more recent legislation, Mr. Atkins said.

For example, concerns of equity were directly behind adding Section 89 to the tax code in 1986. Section 89 specifies what percentage of low-paid workers must be covered or eligible to participate in a welfare-type plan for the plan to be considered non-discriminatory.

Section 89 was an effort to force employers to provide equitable benefits to the lower-paid half of the workforce, Mr. Atkins said.

"Members want broad coverage under benefit plans," he said.

But some congressional efforts to broaden coverage, however well-intentioned, are going too far, Mr. Atkins said.

For example, while Mr. Atkins said he has no quarrel with Section 89's intent of broadening coverage, he said legislators and their staffs made the law much too complex.

"It was an attempt to deal with every possible abuse" resulting in a maze of complexity, he said.

While the budget deficit and equity concerns are driving benefits legislation, employers are putting up few roadblocks to try to derail those proposals.

Indeed, Mr. Atkins labeled benefits as a kind of "free fire zone" in which legislators and staff have been able launch attacks without incurring any political repercussions.

While benefit trade groups do battle on Capitol Hill to defend benefit programs, individual employers rarely focus on benefits in their discussions with their representatives.

"A CEO meeting with a member (of Congress) would rarely discuss a benefit issue. So, members say, 'Who cares?' The fact is no one is lobbying very hard," Mr. Atkins said.

As a result, when congressional staffers come up with benefit proposals, there often is little review by congressmen, he said.

Indeed, as many benefit lobbyists in Washington know first

Continued on next page

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Benefit bills

Continued from previous page

hand, several major pieces of benefits legislation, such as COBRA and Internal Revenue Code Section 89, were drafted by congressional and administrative staffers behind closed doors with no input from employers and little scrutiny from congressmen.

However, when employers try to be heard, their voices can make a difference, says an insurer.

"One voice or two voices can't solve a problem. They (legislators and staff) have to hear from many of you," said G. Robert O'Brien, president of CIGNA Corp.'s Employee Benefits & Health Care Group in Hartford, Conn.

"With your active participation, you can have an influence," Mr. O'Brien added.

Indeed, Mr. Atkins said a wave of employer protests late last year convinced legislators to strip a provision from a House-passed deficit reduction bill that would have curbed the tax advantages of flexible benefit plans.

Under that proposal, a $500 cap would have been placed on the amount of pretax salary that employees in flexible benefit plans could contribute toward uncovered benefit expenses.

In addition, employees covered by flexible benefit plans that offer a choice between non-taxable benefits and cash would have been taxed on the amount of cash they could have received over a $500 threshold, even if they rejected the cash and selected additional tax-free benefits (*BI*, Nov. 9, 1987).

While the flex tax cap seemed likely to be accepted by a conference committee after it sailed through the House, the tide turned when hundreds of employers began to lobby against the proposal.

"It was stunning how many employers had flexible plans—not just high-tech firms, but state and local employers as well," Mr. Atkins said.

And, employer gripes about the complexity of Section 89 non-discrimination tests also are beginning to sway congressional staffers.

Mr. Atkins, for example, acknowledges there is a potential for a congressionally ordered delay of the non-discrimination rules, as a new employer/insurer coalition is seeking (*BI*, April 18).

In other areas, though, employer lobbying has yet to sway congressional thinking.

Despite lobbying efforts, Mr. Atkins believes that it is likely Congress will approve some version of an amendment attached to a Senate-passed bill to expand Medicare that would require employers that cut back their retiree health care plans—when benefits are duplicated by the expanded Medicare program—to pass any cost savings onto retirees (*BI*, Nov. 16, 1987).

Under this amendment, proposed by Sen. Donald Riegle, D-Mich., retirees would be entitled to additional cash or new benefits from their former employer that equals the "actuarial value" of any company-provided benefits employers eliminate because they duplicate Medicare benefits. Generally, these savings would have to be passed on for one year.

Mr. Atkins calls the Riegle amendment "simple social justice," noting retirees should receive some kind of rebate because they will be paying for benefits formerly provided to some extent by their employers in health care plans that supplemented Medicare.

However, Mr. Atkins believes Congress will resist efforts to expand the original Riegle amendment to require employers to pass on cost savings each time Medicare is expanded.

Mr. Atkins also said:

- While Congress is increasingly concerned about improving access to health care, legislation introduced by Sen. Edward Kennedy, D-Mass., requiring employers to offer a "minimum" health care plan is unlikely to gain steam for three or four more years.
- Congress has no plans to enact legislation that would make employer-provided retiree health care plans the primary payer of retirees' health care bills.

The cost of such a change would be unaffordable to employers and companies would move to eliminate their programs.

- If Congress gives tax breaks to employers to prefund retiree health care liabilities, legislators also will lay down vesting and participation standards for the programs.

The session moderator was C.S. Rehm, manager of health care and insurance at E.I. du Pont de Nemours & Co. of Wilmington, Del. ■

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Cost-containment short of expectations

By MICHAEL BRADFORD

WASHINGTON—Health care cost containment methods have not worked as promised, and the next decade will see some changes in those programs, experts say.

"There has been an enormous disappointment with at least the first round of cost containment programs. And it is a disappointment that we might not be reaching our goal," David L. Rosenbloom, president of The Health Data Institute in Lexington, Mass., told a group at the 26th annual Risk & Insurance Management Society conference last week.

"Our goal after all was to get better value for our medical care expenditures and many people were more blunt to say our goal was to contain the rising cost of health care," he said. "And we haven't, in fact, had material success as a society in doing that."

Health care costs, Mr. Rosenbloom pointed out, continue to outdistance the rate of inflation.

"We were given outrageous promises as to what so-called cost containment programs could do for us. And now that that hasn't happened, we're unhappy," he remarked.

Unfortunately, "Most of us are getting 18% to 60% increases in our premiums or reserves for health care costs in 1988 and, I can tell you, you're probably going to see similar numbers for 1989," he said.

Mr. Rosenbloom said he believes that if costs continue to rise and cannot be controlled by managed care programs, the task of providing affordable health care is going to fall into the lap of the federal government.

"My prediction is that utilization management, which is essentially a private-sector attempt to define and enforce medical standards of practice, is perhaps the last-ditch effort of the private sector," said Mr. Rosenbloom.

"I think most of us feel that we have shifted as much of the burden as we can to our employees and our families," he said, "and that if utilization management does not succeed. . .then I think that most of us are going to throw our hands up and tell the government that it should do it.

Mr. Rosenbloom pointed out that legislation has been passed in Massachusetts to provide minimum health care coverage for all residents in that state, and similar mandates could be passed by other states if current trends continue.

Carole L. Kennedy, senior vp of managed care programs at ALTA Health Strategies Inc. in Salt Lake City, pointed to some trends she sees emerging in the area of utilization management in the 1990s.

There will be less freedom for employees enrolled in managed care programs to choose their health care providers during the next decade, she predicts.

"Exclusive provider organizations," in which "the providers in a network are the only ones" that can provide benefits under a plan, will become more popular, Ms. Kennedy said.

One advantage of such an arrangement is that it allows more aggressive negotiations for price discounts from providers, she said.

In addition, there will be greater controls placed on utilization of medical services, Ms. Kennedy noted. For example, outpatient treatment expected to exceed a certain cost threshold may have to be pre-certified in future managed care plans the way hospital visits are pre-certified in today's plans, she said.

Ms. Kennedy also believes there will be more "specialty services contracting" with providers during the 1990s.

Such specialty contracts would provide "an area where you can ensure not only some price discounts, but you have quality control as well," she said.

There will be greater scrutiny of providers in the years to come, she said, particularly "where there is a history of inefficient treatment" or other difficulties.

And, surgery benefits in some future plans may be allocated based on the patient's ability to pay, Ms. Kennedy predicted.

One area that has been developed in recent years to help offset the cost of hospitalization has, in some cases, itself produced dramatic health care bills: The cost of home health care is getting too high, Ms. Kennedy pointed out.

"I've encountered two cases recently where it was less expensive to keep the patient in an acute care setting in a hospital" than to care for the person in the home, she said. Price discounts were later negotiated that brought the health care costs low enough to move the patient into the home, she added.

Jeffrey R. Weiner, executive vp of U.S. Biosciences in Blue Bell, Pa., said his company has developed a program that will make home health care more affordable.

U.S. Home Hospital is "a system that will bring hospital-level, hospital-quality, specialized care into the home," he said.

The program provides most hospital medical services in the home for a lower cost. But, he pointed out, U.S. Home cannot perform major surgical procedures or provide intensive care unit services or radiation therapy.

He agreed with Ms. Kennedy that in some cases "you can get so overboard" with home health care services that it costs more than keeping a patient in a hospital, but "not often. The vast majority of times, the savings is two, three and fourfold."

U.S. Home Hospital brings back a forgotten duty of the family physician, Mr. Weiner noted.

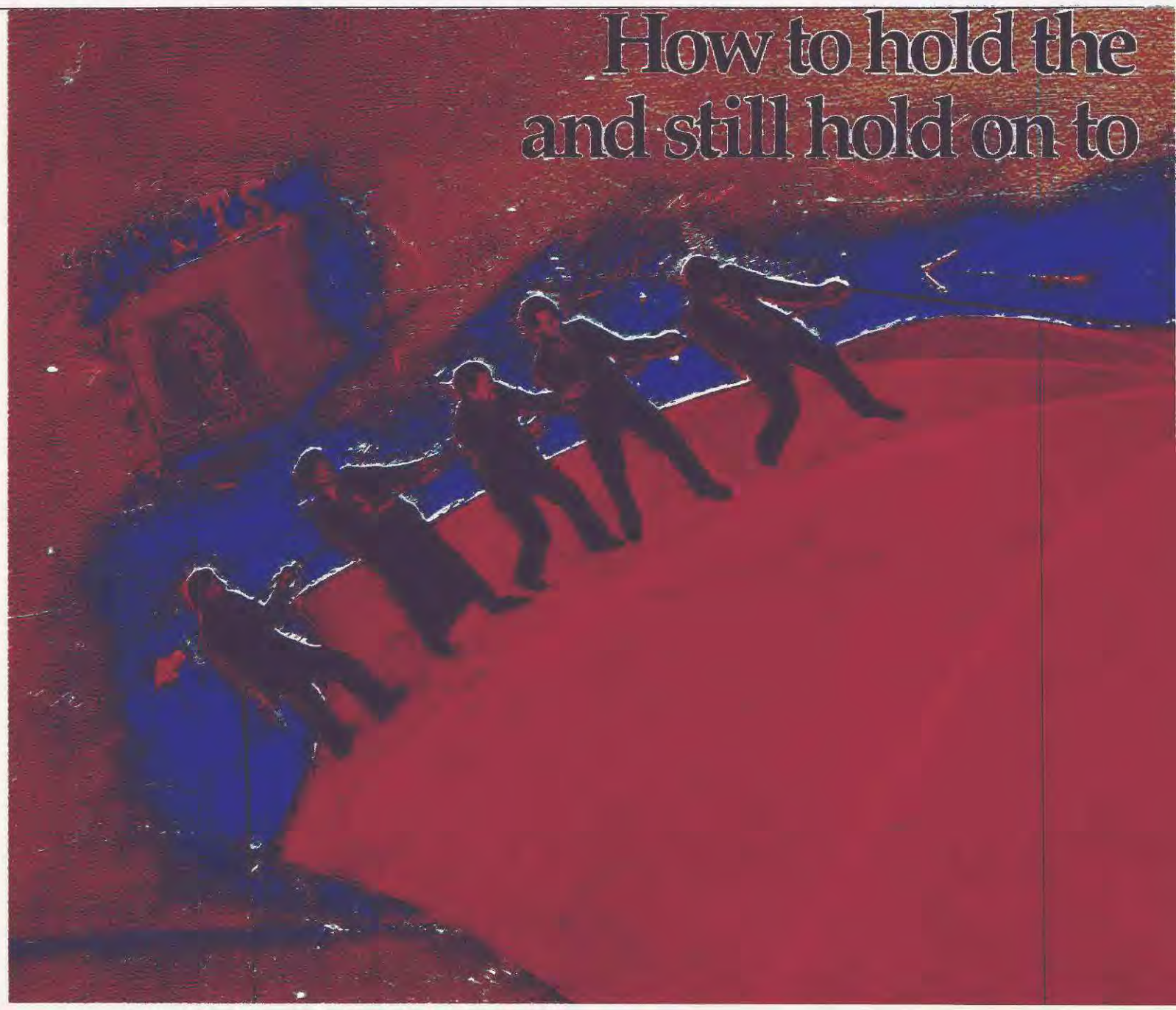
"We've basically gotten away from house calls in medicine because the doctor is ill-equipped within that little black bag to bring anywhere near a semblance of quality in today's medical environment into the home," he said.

However, hospital costs are so high today that care can be brought to the home cheaper if it is done properly, he pointed out.

Mr. Weiner's company is designing mobile vans that will be staffed with doctors and nurses who will travel to the patient's home and perform such procedures as electrocardiograms and laboratory services.

In addition, Mr. Weiner says U.S. Home Hospital will provide some "not-so-typical" services, such as diet and medical advice for elderly patients, a 24-hour patient hot line and coordination of community services that local physicians may not know exist.

The seminar was moderated by Shelli Williamson, vp of sales for The Health Data Institute. ■



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Employers urged to gather retiree data

By DONNA DiBLASE

WASHINGTON—Employers must compile claims information from their retiree medical plans so they can project their current and future liabilities under the plans, benefits experts say.

This information is especially important in light of new retiree medical plan accounting and disclosure requirements and in anticipation of congressional action on the plans, they said.

These warnings were made in a session on post-employment medical benefits during the 26th annual Risk & Insurance Management Society conference last week.

"Our estimate of employers' liabilities for current retirees' medical benefits is $80 billion. And that's considered a low estimate," said Deborah Chollet, a senior research associate with the Employee Benefits Research Institute, a Washington-based benefits think tank.

According to a U.S. Census Bureau survey of income and retiree medical program participants, some 80% of current retirees covered by employer-sponsored medical plans have a portion of that coverage paid for by their former employers, Ms. Chollet said.

Employer liabilities for these plans will continue to grow as the federal Medicare program continues to reduce the coverage it provides to retirees age 65 and over.

"A 2% reduction in Medicare spending means billions of dollars for employers," Ms. Chollet noted.

Since the federal Deficit Reduction Act of 1984 imposed restrictions on employers' ability to prefund their retiree health care plans, employers have adopted the "pay-as-you-go" approach to funding the plans.

Consequently, most employers lack reporting and identification of their liabilities under the plans, the experts said.

To limit their liabilities to future retirees, some employers—like Minneapolis-based Pillsbury Co.—have amended their retiree medical plans, defining the dollar amount they will contribute and requiring more cost-sharing by retirees, the experts noted (*BI*, May 18, 1987).

Both Congress and the Financial Accounting Standards Board, a Stamford, Conn.-based non-profit private sector accounting standards organization, are expected to take action on the funding of and accounting for these benefits.

In 1984, FASB released its Statement No. 81, which requires employers to disclose the benefits provided and groups covered by post-employment benefit plans other than pension plans.

The statement also requires employers to state the cost of the plans and their accounting and funding policy, explained Diana Scott, project manager of FASB's post-employment benefits policy group.

The group now is working on an accounting method for calculating future retiree health care costs, she said.

"The estimates we've seen of employers' future obligations for these plans range from $125 billion to $2 trillion. So, there are three major issues we are examining: whether there is an obligation that meets the definition of a liability; how this obligation should be measured and to what it can be attributed; and how employers should make the transition from pay-as-you-go to pre-funding," she explained.

The FASB policy group is examining accounting assumption procedures for these costs such as looking at the annual incurred-claim costs and adjusting this cost according to the overall health care cost trend rate and according to Medicare reimbursement, she said.

The group does not expect to have a final accounting statement prepared until the end of 1989, and Ms. Scott added that provisions of the statement probably would not be effective until 1992.

In addition, Congress is considering several legislative measures regarding post-employment medical benefits.

However, "there are three basic issues Congress needs to consider before legislative activity begins," said Phyllis Borzi, counsel for pensions for the U.S. House of Representatives Subcommittee on Labor and Management Relations.

Mainly, Congress needs to examine "what is the nature of the employer promise to provide retiree medical benefits. After this, it must consider what is the liability of providing the benefits and then whether these benefits should be funded, and if so, how," she said.

Some of the proposals Congress is considering include:

- A Reagan administration proposal that recommends amending the tax law to permit tax-free transfers of an employer's pension funds to retiree medical plans.
- A proposal to extend the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 so that retirement would be considered a qualifying event. However, instead of the normal continuation right of 18 months, retirees would be able to continue coverage until age 65, when Medicare begins.
- Various proposals relating to pre-funding of retiree medical plans, including H.R. 2860, introduced by Rep. Rod Chandler, R-Wash. This would establish "voluntary retiree health plans" that would be designed like defined contribution pension plans and be subject to all tax and pension rules applying to defined contribution plans (*BI*, May 4, 1987).

Under the plans, employers would contribute the lower of: 25% of an employee's compensation or $1,500 for employees under age 50; 25% of compensation or $2,000 for employees aged 50 to 60; or 25% of compensation or $2,250 for employees over 60 (*BI*, July 6, 1987).

Employers need to adopt a plan of action for their retiree medical plans, said Adam Reese, an actuary in the Washington office of benefit consultant The Wyatt Co.

"Call your claims administrator to collect the needed claims information. Call your lawyer to determine your legal obligations under your retiree medical plan. And call your benefit consultant to design a plan to meet the needs of employees, retirees and the company's financial objectives," Mr. Reese suggested.

Also sitting on the panel were Don Caton, a consultant in Wyatt's Atlanta office, and moderator Richard D. Gapen, director of benefits for Contel Corp., a communications company in Atlanta. ■

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Mergers impact work comp costs

By The Insurance Institute of America

A.R.M. exercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise explores some of the ways merger activities affect risk management decisions through their impact on the overall financial condition of the surviving organization.

Q: The Woodstock Lumber Mill has just purchased a smaller firm that specializes in lumber used for hardwood flooring. This purchase has significantly decreased the liquidity position of Woodstock. In addition, the new subsidiary, Pin Oak, has had a high frequency of workers comp claims in the past year.

Explain how each of the following could reasonably be expected to affect Woodstock's decision to continue to fully retain its workers compensation exposure.

- The decrease in Woodstock's liquidity.
- The acquisition of a firm with a high frequency of workers compensation claims.

In addition to the considerations associated with the acquisition of Pin Oak, identify, and describe in detail, three other critical considerations that Woodstock should consider in deciding whether to continue its full retention or adopt an alternative risk financing technique for work comp exposures.

A:

- The decrease in Woodstock's liquidity probably would make retention of workers compensation claims less attractive because the new Woodstock would have less cash—relative to its compensation exposures—than did the former organization. Less cash would reduce the new organization's ability to endure fluctuations in compensation loss experience. Furthermore, reduced cash availability might make it more difficult for Woodstock to qualify as a self-insurer for workers compensation under the applicable state statute(s).

Under some unusual circumstances, however, reduced liquidity might make some workers compensation retention more, not less, attractive to Woodstock. Rather than paying insurance premiums before workers compensation claims arise, Woodstock might find that it is able to control larger amounts of cash over longer periods—improving its deficient liquidity—by paying claims as individual benefit payments fall due.

- Increased claim frequency could make retention of workers compensation exposures either more or less attractive for Woodstock. They would be more attractive if a larger volume of claims for the new organization made aggregate claims more predictable and, therefore, more easily budgeted for the new organization.

Higher claims frequency also could make retention less attractive if the greater number of claims increased the variability of the amounts of individual claims and, thus, reduced the predictability of Woodstock's claim payments. Furthermore, the greater claims frequency could make total compensation cost too great for Woodstock to absorb in full, thus requiring it to reduce or eliminate its retention on this exposure.

Aside from factors related to the merger, Woodstock should consider cost, administrative and regulatory matters in deciding whether to maintain or modify its current full retention of workers compensation exposures.

With respect to cost, full retention would become less attractive if insurance premium rates were to fall or if the cost of qualifying as a self-insurer were to increase. Furthermore, if retention of other exposures were to become more attractive, the opportunity cost of workers compensation retention would become greater, forcing Woodstock to reconsider more carefully its full-retention position.

Administratively, Woodstock needs to bear in mind its employees' attitudes toward Woodstock as a claims administrator, remaining alert to any signs of hostility or abuse of the system because of Woodstock's dual role as both employer and compensation payer.

Moreover, if a work comp insurer were to offer Woodstock loss control services that are technically superior to—or less costly than—those on which Woodstock now relies, access to this improved insurer service may prompt Woodstock to withdraw at least partially from its current retention strategy.

Regulatory changes also may lead Woodstock to re-evaluate its position. For example, if premium taxes on commercial coverages were to fall or if work comp self-insurers were to become subject to premium taxes as if they were insurers, Woodstock's current retention strategy could appear less attractive. The same result could stem from regulators becoming more stringent in supervising the activities of self-insurers.

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Mal–vern, Pa. 19355.

Death benefits awarded to estranged wife

Legal briefs

A wife separated from her working husband sought workers compensation benefits for the wrongful death of the husband, who died from injuries sustained on the job. The Supreme Court of Tennessee ruled that her separation from him was involuntary and, thus, she was entitled to death benefits.

Danny and Gaylon Stack were married on July 18, 1982, and for a few months lived with Mrs. Stack's mother. In March 1983, they rented a house in Hornsby, Tenn. While living there, Gaylon alleged that Danny began to drink excessively, stay out late and hit her. He also failed to pay the rent and other bills, she charged. In May 1983, when they could not pay the rent, they agreed to separate. Gaylon moved to her mother's house, while Danny first went to live with his mother and then his cousin.

Although they continued to see each other, Gaylon filed for divorce in November. After Gaylon filed for divorce, their relationship improved and she reported that Danny stopped physically abusing her. The weekend before Danny's fatal accident, they were together. On the following Monday, Danny sustained fatal injuries at the sawmill where he worked. Gaylon filed for but was denied workers compensation benefits.

The state Supreme Court found that Gaylon's separation from Danny was justified and not voluntary within the meaning of the state law. The court cited as reasons for the involuntary separation their poor economic circumstances and his physical abuse of her. Thus, the court said it was presumed that she was wholly dependent upon Danny under the workers compensation law. *Stack vs. Sawmill*, Supreme Court of Tennessee, Feb. 9, 1987 (*BI*/02/J.—$10).

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

Technology

Continued from previous page
and accessed for claim, correspondence and payments processes.

Image processing provides the opportunity to access archived information directly at the work station. This information is required by customer service, financial, audit and claim processing functions in daily activities. Advancements in terminal design, voice mail, electronic filing, text processing and printing technology combined with effective application software presents an opportunity for insurers to rethink and streamline their work flows and procedures.

The growing information system requirements in the health insurance industry relate to the:

- Complexity and diversity of product administration.
- Ability to measure product performance and utilization.
- Productivity and decision-support activities.
- Quality and accuracy of data used by functional organizations and customers.
- Accessibility for specialized support functions.
- Flexibility in management reporting systems.

As insurers view their transaction processing and back-end reporting systems, the need to establish an integrated system architecture is critical.

The informational data structures of a health insurer must integrate a wide array of claim, customer, provider, clinical and financial data.

The available mainframe and data base technology can adequately support the linking of the core systems to the back-end financial and reporting systems.

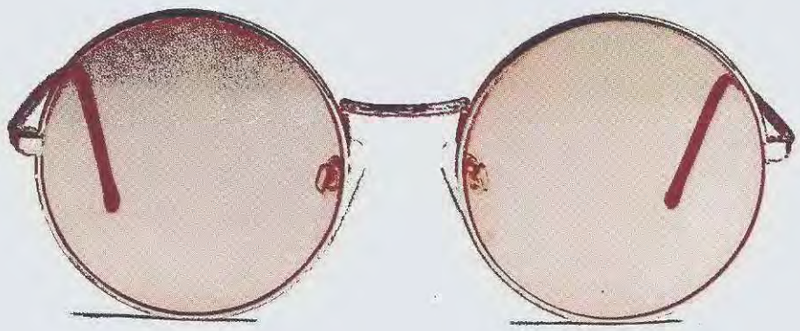
The increased processing power of microcomputers, emergence of relational technology and advancements in fourth-generation and query languages provide the end user with the tools necessary for ad hoc report writing and data analysis.

Successful insurers have met these informational requirements by:

- Designing an integrated data base architecture.
- Developing responsive real-time systems capable of accessing a wide array of data.
- Focusing on critical business data elements for reporting systems.
- Downloading mainframe data to end-user organizations.
- Leveraging data captured for automation of decision-support activities.

When approaching the development or purchase of systems to support business functions, the primary focus must be integration. Health insurers should develop a strategy to utilize and integrate advanced technologies to effectively meet their current and future business objectives. Integration will help the insurer realize the full benefits of the investment.

REINSURANCE AND THE LONG VIEW



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Risk managers go unheralded: Heydinger

By DONNA DiBLASE

WASHINGTON-Risk managers' solutions to the recent hard property/casualty insurance market as well as the explosion in tort litigation comprise the most significant chapter in risk management history, says the new president of the Risk & Insurance Management Society Inc.

"The crisis in the commercial property and casualty industry has been covered extensively by the media. However, what has not been covered is the fact that risk managers, who were faced with near catastrophe, have dealt well with these crises. This is the greatest story never told," said RIMS President Richard C. Heydinger, who also is risk management director for Hallmark Cards Inc. in Kansas City, Mo.

As the insurance market tightened, "RIMS and risk management professionals began communicating with each other through a host of media, including conferences and seminars," Mr. Heydinger said at the RIMS membership breakfast during the 26th annual RIMS conference held last week in Washington, D.C.


Mr. Heydinger

"We developed several alternatives," he said, referring to such policyholder-owned risk financing facilities as Cayman-incorporated A.C.E. Insurance Co. Ltd. and Tortuga Casualty Co., Bermuda-based Corporate Officers & Directors Assurance Ltd. and Barbados-based X.L. Insurance Co. Ltd.

In addition, RIMS has been active on the regulatory front—particularly in pushing for the amendments to the federal Risk Retention Act and working on drafting a model directors and officers liability bill—according to Arthur P. Bostwick, 1987 RIMS president and risk manager for Stone Container Corp. in Chicago.

He also pointed out RIMS' involvement in state regulatory efforts, such as the bill under review in the New York Legislature that would prohibit brokers from placing business with insurance companies that are under control of the broker (*BI*, April 18).

"I believe that the commercial insurance industry would be living with stifling legislation if it weren't for our efforts," Mr. Heydinger asserted.

"Over the 1970s and early 1980s, RIMS defined and established the risk management discipline. The secret to our success is our approach, and that is that we have enabled the profession to become a necessary and integral part of business and management," Mr. Heydinger continued.

RIMS must continue its progress by becoming "more anticipatory," according to Mr. Heydinger. "The time to really enhance RIMS' participation and action is in the soft insurance market. We ask that you give of your talent and time so that the efforts of the risk management profession will become the greatest story ever told."

Besides Mr. Heydinger, members of the RIMS executive committee are:

- Hal Johnson, vp-business and industry liaison. Mr. Johnson is director of risk management for State Farm Insurance Co. in Bloomington, Ill.
- Justin A. Murphy, vp-communications, and director of insurance for Nestle Foods Corp. in Purchase, N.Y.
- Robert W. Esenberg, vp-conference planning. Mr. Esenberg is risk management administrator for the city of Virginia Beach, Va.
- Denis A. Julien, vp-education. Mr. Julien is director of risk management for Florida Progress Corp. in St. Petersburg, Fla.
- Cheri J. Hawkins, vp-finance and treasurer. She is assistant director of insurance for Weyerhaeuser Co. in Tacoma, Wash.
- Ron Stasch, vp-governmental affairs. Mr. Stasch is corporate risk manager for Federal-Mogul Corp. in Detroit.
- J.A. Bridger, vp-member affairs and secretary. He is risk and insurance manager for Canada Packers Inc. in Toronto, Ontario.
- Barbara Fein, vp-research. Ms. Fein is vp of risk management at Nu-Med Inc. in Encino, Calif.
- H. Jay Varner, first vp, and director of risk management for Hillenbrand Industries in Batesville, Ind.
- Margaret P. Layne, chair of the insurance committee. Ms. Layne is risk manager for the California & Hawaiian Sugar Co. in Concord, Calif.
- Executive Director Ron Judd.

Also attending the breakfast was Sen. Ernest (Fritz) Hollings, D-S.C. ■

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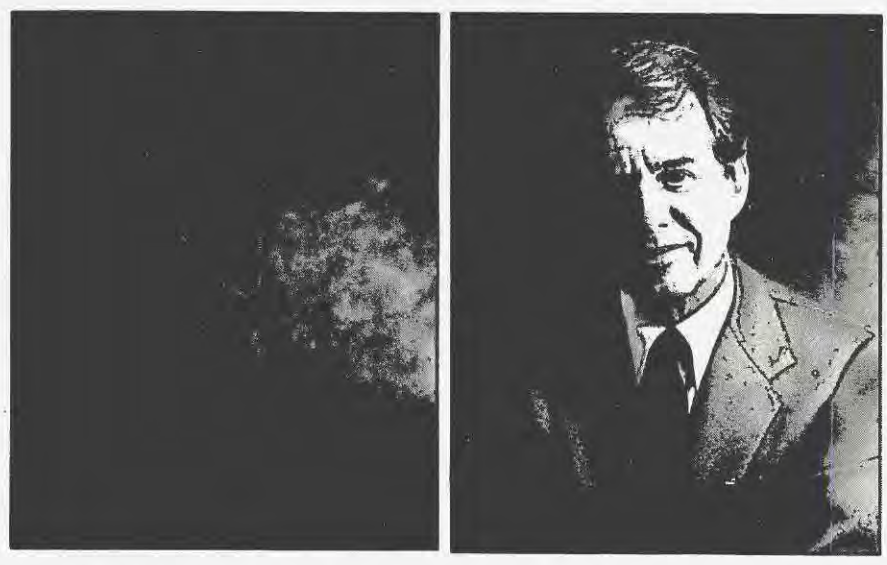

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Custodial care costs concern experts

By MARK A. HOFMANN

WASHINGTON—The cost and handling of catastrophic injuries and illness and subsequent custodial care will be among the major health care issues of the 1990s, an expert predicts.

"Custodial care is a dollar issue," said Joseph L. Romano, author of "The Legal Rights of the Catastrophically Injured," brandishing a wad of dollar bills to emphasize his point.

Mr. Romano, an attorney with Rosenstein & Romano in Norristown, Pa., cited two reasons for a heightened emphasis on custodial care: improved health care, which is allowing the severely injured to live much longer, and difficulty in obtaining government funding for custodial care.

"Ronald Reagan's programs don't want to pay for custodial care," Mr. Romano said during a session at last week's 26th annual Risk & Insurance Management Society conference.

In addition, the breakdown in the traditional family structure has forced many people who would have been cared for by their families in the past to seek care from others, exacerbating the need for custodial care, Mr. Romano said in an interview following the session.

Catastrophic injuries and illnesses are particularly costly because they often involve multiple traumas, stressed Mr. Romano and other panelists.

For example, 56% of all spinal cord injuries are accompanied by brain injuries, said Dr. Terry V. Carle, president of Englewood, Colo.-based m-RES Inc., a medical rehabilitation evaluation service.

He also noted that there are about 10,000 severe spinal cord injuries—those rendering their victims paraplegic or quadraplegic—each year. And, roughly 250,000 of these patients are currently living, requiring "several hundreds of thousands of dollars in care per life," he said.

In addition, most spinal cord injury victims are men between the ages of 18 and 25, who are disabled at the start of their careers, Dr. Carle pointed out. "They will need care throughout their lives."

"You have to accept that you have a disabled person, that it will be expensive and that you will need cost containment," he said.

Brain injuries, which occur more frequently than spinal cord injuries, are even more difficult to treat because they are diffused rather than localized, according to Barbara A. Marte, a vp at Rehabilitation Network Corp., a catastrophic case management firm in Paoli, Pa.

Ms. Marte, who has developed a home-based rehabilitation program for brain injury victims, said that one out of every 500 people sustains a head injury each year.

The key to containing costs is planning, Dr. Carle stressed. "Planning, including planning for rehabilitation, may begin in the emergency room," he added. As the patient progresses, the case manager also must plan preventive care, including regular check-ups, blood tests and assessment of rehabilitation efforts, Dr. Carle said.

Case managers must remember that by controlling costs of care, they also often improve quality of care, said Marilyn F. Sweeney, executive director of Rehabilitation Network Corp.

For example, making sure that the patient is not being dragged repeatedly from his or her house to undergo unnecessary tests and procedures results in both reduced costs and greater patient care.

And, the case manager should anticipate needs, such as determining well in advance of the patient's return home whether the house needs major physical modifications to accommodate them.

If that determination is delayed, Dr. Carle said, the patient may be forced to remain unnecessarily in the hospital for months, driving the cost of care even higher.

To keep rehabilitation costs in check, the person authorizing payment for modifications to a house should make certain that the victim's family will be able to handle the situation both psychologically and financially, Ms. Sweeney advised.

The panelists also stressed the need for family involvement in the rehabilitation process and for the case manager to recognize when the situation becomes too stressful.

Dr. Carle advocated a team approach to care for catastrophic injury, pulling together the physician, case manager, rehabilitation specialist and family to work with the patient.

"It's really important to look at the whole picture" when handling the case of a catastrophically injured patient, stressed Ms. Sweeney in an interview following the session.

She added that nurses are often the most cost-effective case managers, because they have received what she termed a "holistic" education in behavior and medicine.

Effective clinical case managers should have at least four to six years of experience in their area of expertise, she said. They also must have outstanding communications skills, because case managers act as both the agent of the funding source and as an advocate for the patient, said Ms. Sweeney.

However, "the case manager is there to do a job, not to adopt the family," she stressed.

Lisa Budnick, manager-group claims for the Guardian Life Insurance Co. of America in Philadelphia, moderated the session. ■

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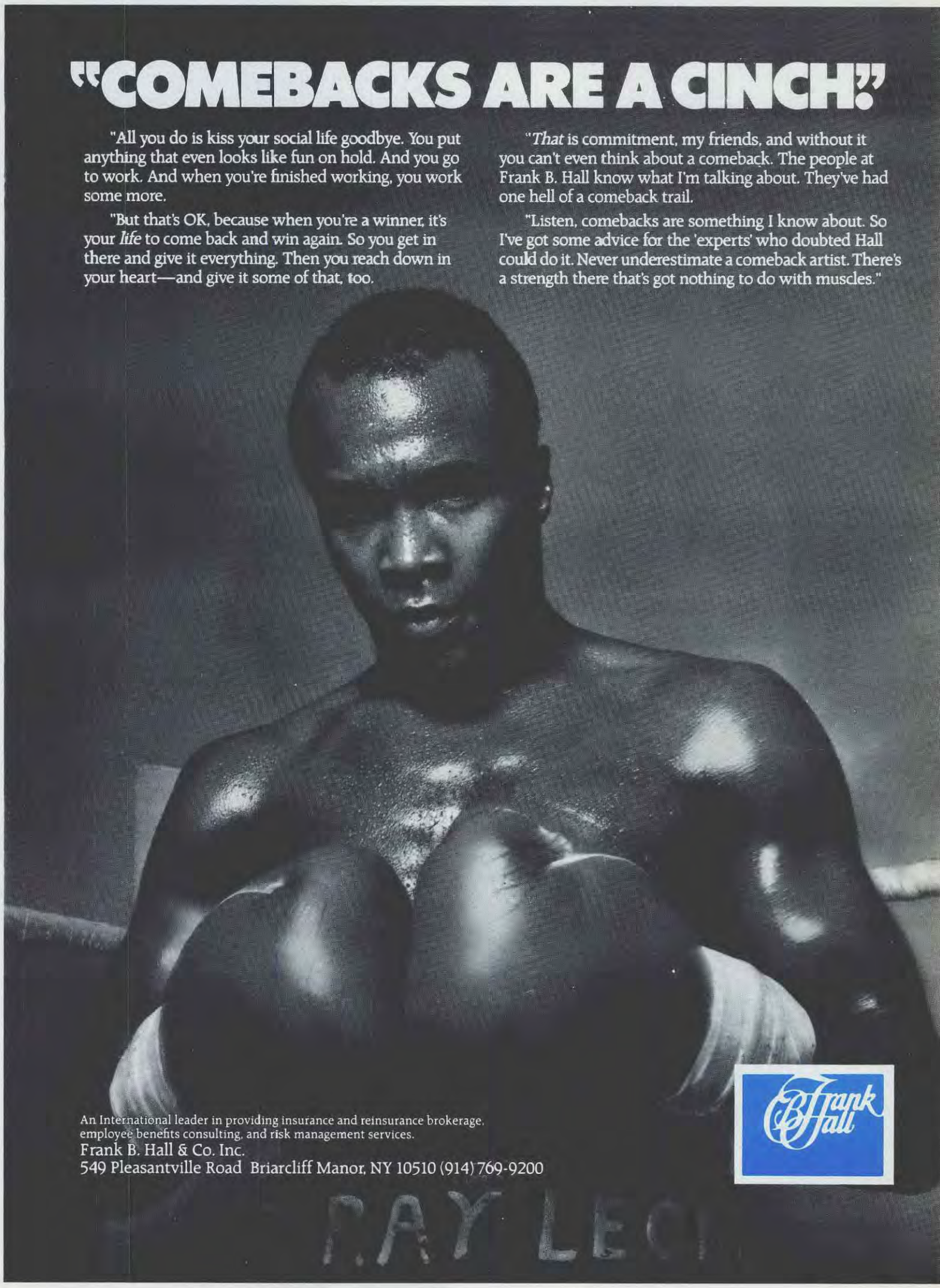

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Dispute resolution can cut trial time

By JERRY GEISEL

WASHINGTON—Alternative dispute resolution procedures, such as mediation and arbitration, often can settle legal controversies more effectively than long, drawn-out trials, a panel of experts says.

"Alternative dispute resolution is a better way of trying to reconcile competing interests and viewpoints," said Jonathan B. Marks, president of ENDISPUTE Inc., a Washington, D.C.-based firm that specializes in assisting opposing parties settle disputes outside of the courtroom.

"Companies often don't consider alternatives (to trials) which can yield better results in a more cost-effective manner," Mr. Marks said at the 26th annual Risk & Insurance Management Society conference last week.

Alternative dispute resolution, or ADR, consists of a wide range of tools that help resolve disputes in a cost-effective way.

In nearly every instance, the parties in dispute select a neutral third party, such as a retired judge, to help resolve the dispute.

"Only your imagination limits the use of ADR," said Daniel J. Kelly, an attorney with law firm Walkup, Shelby, Bastian, Melodia, Kelly, Encheverria & Link in San Francisco.

According to Mr. Kelly, ADR may be appropriate when, for example:

- There is a wide difference in settlement offers between a claimant and a defendant.
- Both parties know that transaction costs, which include legal charges and fees for expert witnesses, are going to be substantial.

"ADR can avoid situations where depositions are taken right and left, a cost you ultimately pay for," Mr. Kelly said.

- There is a neutral third party that both sides can agree upon to help resolve the dispute.

In the case where both a claimant and a defendant favor a settlement but they are far apart on terms, a third party could decide the amount of settlement through a procedure known as a "high and low" conference.

For example, a claimant may seek $25,000 for an injury caused by a defective product, while the defendant may be willing to pay only $10,000.

Prior to the conference with the neutral third party, both the claimant and the defendant agree that the third party can award no less than $10,000 and no more than $25,000.

Both sides then present their cases, and the outside party selects a figure that is closest to his or her value of the case.

The advantage to the defendant of such a procedure is knowing that its liability will be capped, Mr. Kelly said.

In some cases, ADR can expedite a settlement when a defendant is having internal battles deciding how much it should offer to settle a case.

In illustrating how ADR can resolve such internal battles, Mr. Kelly cites the case of an individual who lost his arm in a railroad accident.

The worker was willing to settle the case out of court for $600,000, but the railroad president refused, stating that no arm was worth that much money.

Ultimately, when the case went to trial, a jury awarded the accident victim $1 million.

Perhaps if ADR had been used and an independent third party placed a value on the injury, the railroad president would have been more inclined to settle the case, Mr. Kelly observed.

"ADR can be effective as an educational tool. In the railroad case, the president thought he knew more than the attorneys," Mr. Kelly said.

ADR techniques can be either voluntary or binding.

One voluntary technique is known as "shuttle diplomacy." This technique is named after the style of diplomacy of former Secretary of State Henry Kissinger, who shuttled between Israel, Syria and Egypt to reach a truce after the 1973 Yom Kippur War.

As an ADR technique, shuttle diplomacy is used when all parties want to reach a settlement but do not trust each other.

The opposing parties tend to be much more honest with the outside expert.

Similarly, non-binding arbitration can be used when the plaintiff gives one estimate of what it will accept to settle, and the defendant provides a much lower estimate of the amount it will offer to settle.

The third party can give his or her estimate of the "value" of the case if it went to trial.

The third party might say: " 'This is my estimate.' It provides non-binding input to get the parties moving again," Mr. Kelly said.

Another form of a non-binding ADR technique that is intended to get two parties talking to one another is mediation.

"A third party helps the opposing sides to communicate to each other. It is intended to open up the lines of communication," said Donald Farbstein, an attorney with Farbstein Law Corp. in San Mateo, Calif.

Mr. Farbstein cautioned, though, that mediation, being voluntary, should not be used as a "head-banger." He said there should be some goodwill between the two opposing parties at the start.

ADR also can be binding, such as through binding arbitration, the speakers noted.

For example, to avoid potentially long drawn-out legal battles, a contract may stipulate that in the event of a dispute, binding arbitration must be used to resolve the conflict.

"In binding arbitration, both sides agree that they will abide by a settlement proposal by a third party," Mr. Kelly said.

However, Mr. Kelly advised that both parties agree in writing ahead of time that any dispute be decided through binding arbitration.

Failure to obtain a written agreement can result in courts throwing out a settlement if one party later objects to the arbitrator's decision, according to Mr. Kelly.

Binding arbitration is helping to keep personnel disputes out of the courtroom.

Mr. Kelly noted that some major employers are requiring employees to sign statements that require binding arbitration in the event of a dispute.

The session was moderated by Carol Harrington, risk manager at Raychem Corp. in Menlo Park, Calif. ■

SHIFTING INTO OVERDRIVE.

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Continued from previous page
the project," Mr. Driscoll said.

The manual also should discuss the contractors' responsibilities for in the event that an insurer or policyholder decides to sever the relationship, according to Mr. Driscoll.

Impartial workplace drug testing urged

By JAMES M. BURCKE

WASHINGTON—Employers must adopt fair and equitable drug testing programs because no company's workers are drug-free, a risk manager says.

"One of five employees abuses drugs or alcohol on the job. Drug abuse is in your company," warned James E. Crockett, manager of risk and benefits for the Denver Board of Water Commissioners.

Drug abuse costs American industry $50 billion annually, pointed out John C. Cruden, special counsel to the U.S. Justice Department's Civil Division in Washington, D.C., according to National Institute on Drug Abuse figures.

However, legal challenges to drug testing programs have hindered employers' efforts to weed out and rehabilitate drug users, Mr. Crockett explained at a seminar during the 26th annual Risk & Insurance Management Society conference last week.

"The issue has changed from trying to stop drug abuse to trying to stop drug testing," he said.

Opponents have likened workplace drug testing to "chemical McCarthyism," he said.

But, employers must act to control the use of drugs, Mr. Crockett emphasized, citing a litany of statistics from NIDA:

- Two-thirds of all people entering the workforce have used illegal drugs at some time.
- Some 44% of those entering the workforce have used illegal drugs within the last year.
- Between 10% and 23% of workers use drugs while on the job.

When the Denver Water Department first started its drug testing program, it "didn't believe these statistics," Mr. Crockett said. But now, he he said, he believes "drugs are everywhere."

Drug use—whether on or off the job—hits employers in the pocketbook, Mr. Crockett said, pointing out that:

- Drug users are absent three times more often than non-drug users.
- Drug users file five times as many workers compensation claims as their non-drug user counterparts.
- Drug users are 3½ times more likely to have an accident on the job.
- Drug users' health care costs are three times as high as other employees'.

In addition, Mr. Crockett said, drug use opens employers to three types of liability:

- Liability for torts committed by the employee who uses drugs.
- Liability for negligent hiring. Mr. Crockett explained that an employer could be sued for negligent hiring if an employee who has a history of drug abuse injures another worker or a client while he or she is under the influence of drugs.
- Liability for negligent supervision.

Following the session, Mr. Crockett offered the following example of negligent supervision: when an employee who has been told to leave the workplace because he is under the influence of drugs is involved in an automobile accident on the way home in which the other driver is killed.

To reduce this exposure, employers should arrange for transportation for any worker sent home because of drug abuse, he advised.

Employers can play an important role in the fight against drug abuse because "a job is the most important thing to a drug user," since a drug user must have a steady source of income to support the habit.

"You have to have a policy if you're going to make any headway" in ridding the workforce of drug users, Mr. Crockett said.

However, he noted that employers must make sure their program is considered fair.

However, he warned employers that even if the program is fair, they should anticipate that the program will be challenged.

"If you go into a program, it will be challenged, and you have to be prepared to pay to defend it," Mr. Crockett said.

He added that a business should give its employees at least six months' warning before a program goes into effect to reduce workers' "reasonable suspicion."

There are many times when drug testing is appropriate, Mr. Crockett said. These include:

- Pre-employment testing to make sure new employees are not drug users.
- Testing employees who have tested positive for drug use previously to make sure they are fit for duty.
- When there is "reasonable suspicion" of drug use, such as staggering, sleeping on the job and glassy eyes.
- Following an on-the-job accident.
- After an employee completes a drug treatment program.

"We have yet to have a successful treatment program with a cocaine user," Mr. Crockett said, referring to the Denver Water Department's testing and rehabilitation program. "There has been a relapse in every case."

Mr. Crockett noted that while some companies believe they have the right to require random drug testing, "that could get you into a lot of problems" because of employee opposition.

In his remarks, Mr. Cruden also explained how the federal government's drug testing program will operate when it is fully implemented. ■

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Photo: Michael Bradford

Despite the efforts of Bob Nason (left), Peter King and Peter Bostwick, Team USA bowed 5-3 to their Canadian counterparts.

Canadian goalie leads assault to seize coveted golden skate

By MICHAEL BRADFORD

WASHINGTON—Strong defense from goalie Steve Patenaude helped Team Canada to a 5-3 win over Team USA in the Risk & Insurance Management Society's "All Star" hockey game.

In the game, played on April 17, the first day of the 26th annual conference, "old-timer" hockey players from the United States and Canada faced off at the Fort Dupont Ice Arena in Washington.

When the game was over, Team Canada possessed the coveted golden skate trophy.

The trophy, a once-discarded hockey skate salvaged from an old-timer's closet and painted gold, had rested with the American squad since the two teams battled to a 5-5 tie at the 1986 RIMS meeting in Toronto (*BI*, April 21, 1986).

In that first game, the American skaters battled back to tie the contest in the final three minutes.

Canadian goalie Steve Patenaude 'was the critical difference,' according to Team USA captain Dick Pierpont, a vp at Johnson & Higgins in Stamford, Conn. 'He made (saves) high and low, sometimes without even looking.'

Although there was no winner in the 1986 game, the visiting Americans were given the trophy as a goodwill gesture. There was no match at the 1987 RIMS conference, held in Las Vegas, Nev., because of a lack of facilities.

Both the 1986 matchup and this year's tilt were held at the opening of the RIMS conference. The event raises funds for the Robert S. Spencer Memorial Foundation, which awards scholarships to students of risk management, insurance and employee benefits.

Mr. Patenaude, the Canadian squad's captain and senior account representative for Arkwright Mutual Insurance Co. in Montreal, drew praise from Team USA after the game for his play in the net.

"He made exceptional saves from all corners of the goal," said Team USA Captain Dick Pierpont, a vp at Johnson & Higgins in Stamford, Conn.

"He made them high and low, sometimes without even looking. He was the critical difference," Mr. Pierpont said.

Mr. Pierpont also said his team's hard work the evening before the game contributed to the loss. "Our training session at the bar proved too extensive," he remarked.

Mr. Patenaude said the Americans "played a tough game. They had us on the ropes in the second period."

It was the Canadians, however, who took an early lead. With about eight minutes remaining in the first period, Doug Bennett of Morris & Mackenzie Ltd. in Toronto missed his first shot at the goal but then slammed in the first goal of the day with an assist from Costa Saviolibis of Grilli Corp. in Montreal.

The Canadian lead lasted until late in the period, when the Americans produced a flurry of scoring.

At the 17:31 mark, David Wagstaff of The Equitable Life Assurance Society of the United States in New York missed a shot when Mr. Patenaude left the net partially unguarded.

But seconds later, Joseph Tarbell of Corroon & Black in Boston took a pass from Mr. Wagstaff and slapped in the tying goal.

The Americans controlled the puck at the ensuing face off and at 17:48 into the period, Felix Kloman of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in Darien, Conn., gave Team USA a 2-1 lead with another assist from Mr. Wagstaff.

However, Team Canada roared back following the face off. Ron Williams of CSP Foods Ltd. in Saskatoon, Saskatchewan, tied the score at 2-2 when he jammed the puck home on an assist from Mr. Bennett.

The Americans battled back in the second period, reclaiming the lead with 13:26 left in the period.

Mr. Kloman scored his second goal of the day with an assist from Terry Higgins of Garlington Insurance Brokers in Mountain View, Calif.

Team USA missed an opportunity to score minutes later in a power play that developed when the penalty box began filling up

Continued on next page

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with Canadian players.

After a penalty-free first period, Mr. Bennett was the first to draw a foul and referees sent him off the ice.

"They called me on interference, but the puck was right there," Mr. Bennett complained.

Although Team Canada's Mr. Saviolibis soon joined Mr. Bennett in the penalty box, Team Canada's defense stiffened, and the Americans could not score a power-play goal.

Just past the halfway mark in the period, the Canadians tied the score at 3-3.

Jean Pichette of Donohue Paper in Quebec City brought Team Canada even when he scored on an assist from Brian Matthews of Domtar Inc. in Montreal.

And, three minutes later, Team Canada went out front to stay.

The go-ahead goal came on a shot by Mr. Matthews, who scored with an assist from teammate and co-worker Daniel Desjardins of Domtar.

The Canadians hung on to the 4-3 lead through the period.

As the players left the ice for intermission, Mr. Patenaude offered insight into the tenacity of the American squad and the rigors of old-timers hockey: "I'm dead-tired," the goalie confessed.

The opening minutes of the third period saw the Canadians and Americans swap the puck several times, but neither side scored.

Team Canada, however, added a goal with around 11:00 left in the final period. Mr. Desjardins scored on assists from Mr. Saviolibis and Joe Hardy of the Oshawa Group in Toronto.

Mr. Patenaude and the Canadians kept the Americans from scoring to preserve the 5-3 win and gain the right to take home the golden skate.

After the loss, Mr. Pierpont displayed a sense of sportsmanship. "It was a great game," he said. "A lot of fun was had by all," although the scoreboard did reflect "disappointing results." ■

Team Canada goalie Steve Patenaude, surrounded by his teammates, holds the Golden Skate award following their win over Team USA. (Photo: Michael Bradford)

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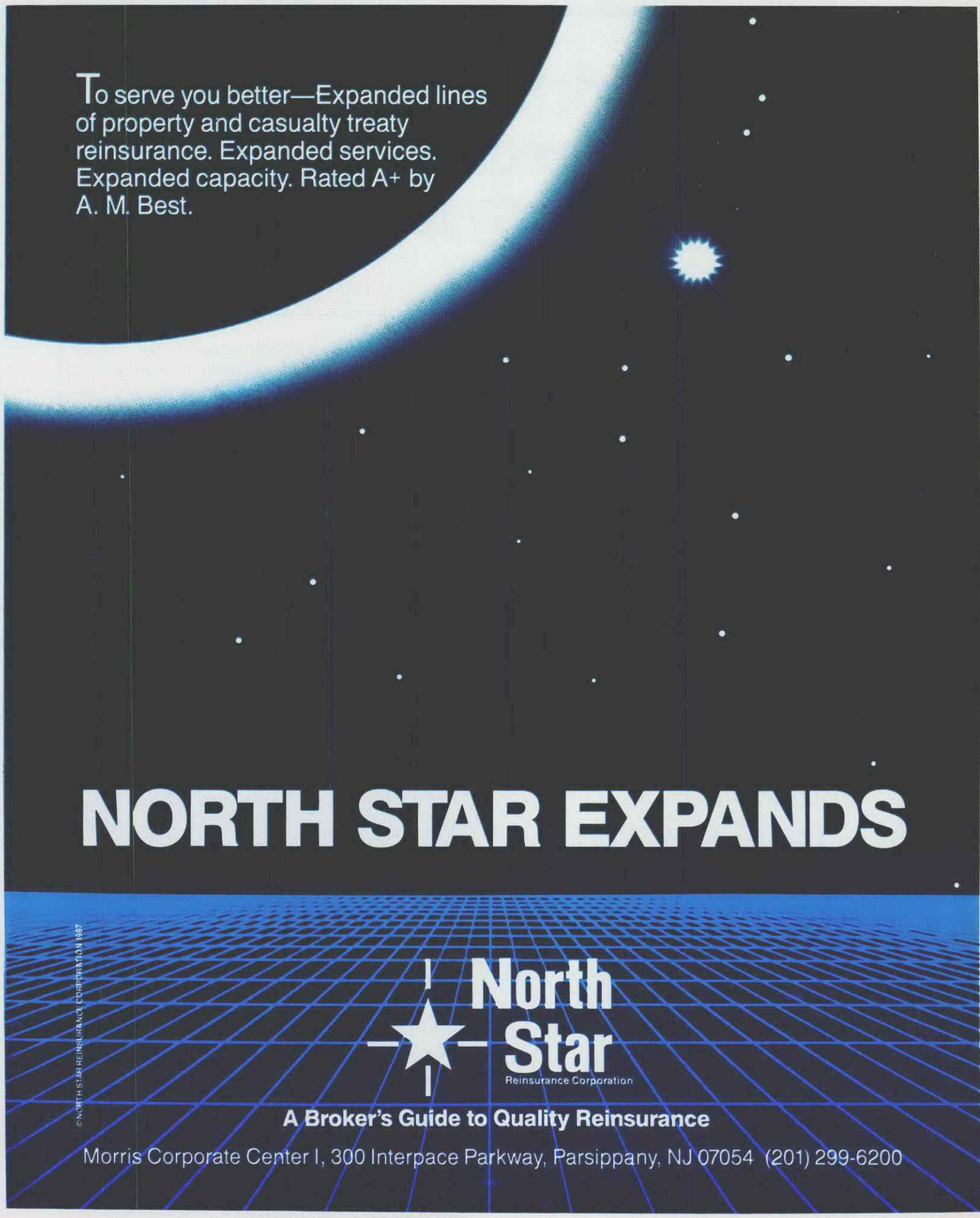

Carey named chairman at Allendale Mutual

John J. Carey has been elected chairman of Allendale Mutual Insurance Co. in Johnston, R.I., and its subsidiaries.


Mr. Carey

Mr. Carey, who remains president and chief executive officer, succeeds **George R. West**, who retired as chairman but continues as a director of Allendale, a member of the Factory Mutual System.

Mr. Carey, 59, joined Allendale in 1979 as senior vp-administration. In 1981 he was promoted to executive vp, and in 1982, he was named president and chief operating officer. In 1985, he also was named CEO.

Comings & goings: industry

In other insurer changes:

E.F. (Ted) Belton named vice chairman and chief executive officer of Symons General Insurance Co. and Pafco Insurance Co. Ltd. of Toronto and Pafco General Insurance Co. of Indianapolis, all units of Toronto-based Pafco Financial Holdings Ltd.

In addition, Mr. Belton was named executive vp of insurance operations for Pafco Financial Holdings.

Mr. Belton previously was president and chief executive officer of the Canadian Insurance Exchange, which folded after government funding was cut off before it began operations (*BI*, Nov. 30, 1987).

Edmond A.B. Garesche III named president, chief executive officer and assistant treasurer of Safety Mutual Casualty Corp. in St. Louis. Mr. Garesche, who joined the insurer in 1971 as corporate vp, previously was senior vp.

Also at Safety Mutual, **C. Donald Ainsworth** named executive vp and chief operating officer. Mr. Ainsworth joined the company in 1985 after serving as commissioner of insurance for the state of Missouri.

Dina W. Kennedy appointed vp/director of portfolio surveillance in the risk underwriting area at Bond Investors Guaranty in New York. Previously, Ms. Kennedy was manager of general surveillance and assistant vp at Municipal Bond Investors Assurance Corp.

The Credit Life Cos. Inc. in Springfield, Ohio, promoted **James E. Hall** to executive vp and chief financial officer; **Brian A. Silva** to executive vp for marketing and planning; and **Gary T. Fagg** to executive vp and actuary. Previously, all three were senior vps.

Agents/brokers

Rodney D. Day III named president of the New York division of Johnson & Higgins. Mr. Day is a senior vp of the parent corporation and a member of its board of directors.

Also at J&H: **L. Edwin Graziano Jr.**, currently senior vp of the casualty department, named executive vp of J&H of Virginia Inc.; and **F. Michael Crowley**, currently vp and manager of the property and sales departments, named deputy branch manager of the Richmond, Va., office.

Thomas F. O'Connell appointed executive vp of Rollins Burdick Hunter of Illinois Inc. in Chicago, a unit of Rollins Burdick Hunter Co. Previously, Mr. O'Connell was head of RBH of Illinois' risk management division.

Richard Bowers promoted to senior vp at L.K. Lloyd & Associates in San Francisco, a subsidiary of ABI Management Inc. Mr. Bowers previously was vp of ABI Management.

Raymond E. Carver named senior vp and profit center manager of Fred S. James & Co. Inc. in West Palm Beach, Fla. Mr. Carver previously was vp of the West Palm Beach office.

Reinsurers

David J. Vermeulen appointed president and chief executive officer of Security Reinsurance Co. in New York, a subsidiary of Orion Capital Corp. Mr. Vermeulen will continue as president of Security Reinsurance Underwriters, the facultative insurance arm of the corporation.

Also, **Lawrence D. Nolen** promoted to president of Massachusetts Reinsurance Corp., Orion's Boston-based treaty reinsurance operation. Mr. Nolen will report to Mr. Vermeulen.

Mr. Nolen replace **Donald A. Hoyt**, who was promoted to vice chairman for Security Reinsurance Co. He will continue to be based in Boston.

HMO/PPO

Dr. Michael R. Soper named as senior vp and corporate medical director of CIGNA Healthplan Inc. in Hartford, Conn. Dr. Soper had been chief operating officer of AV-MED Health Plan in Miami.

Excess/surplus

Steve S. Zeitman, promoted to senior vp of the excess casualty and specialty lines division of United Capitol Insurance Co. in Atlanta. Mr. Zeitman was vp of the excess casualty division.

Robert J. Leggio named vp for Stewart Smith West Inc., a brokering and underwriting firm in Los Angeles. Mr. Leggio will serve as a wholesale producer/broker in the casualty department. He previously was an account executive/producer with American Marketing Center in New York.

Elizabeth A. Marston named president of RISCO Inc. in Providence, R.I., which writes property, casualty and special risk insurance. Ms. Marston was formerly the senior vp of Surplus Line Manager Inc. in Nashua, N.H.

Other suppliers

Robert O. McLaughlin named president of Northamerican Pharmaceutical Services Inc. in Phoenix, Ariz., a wholly owned subsidiary of National Vision Services Inc. Mr. McLaughlin previously was vp of marketing.

At Booke & Co. in Winston-Salem, N.C.: **Roy K. Sinclair** and **James A. Swain** promoted to senior vps of the employee benefits division. Mr. Sinclair is a retirement consultant specializing in the design and administration of defined benefit and contribution plans. Mr. Swain is currently manager of the data processing division. ■

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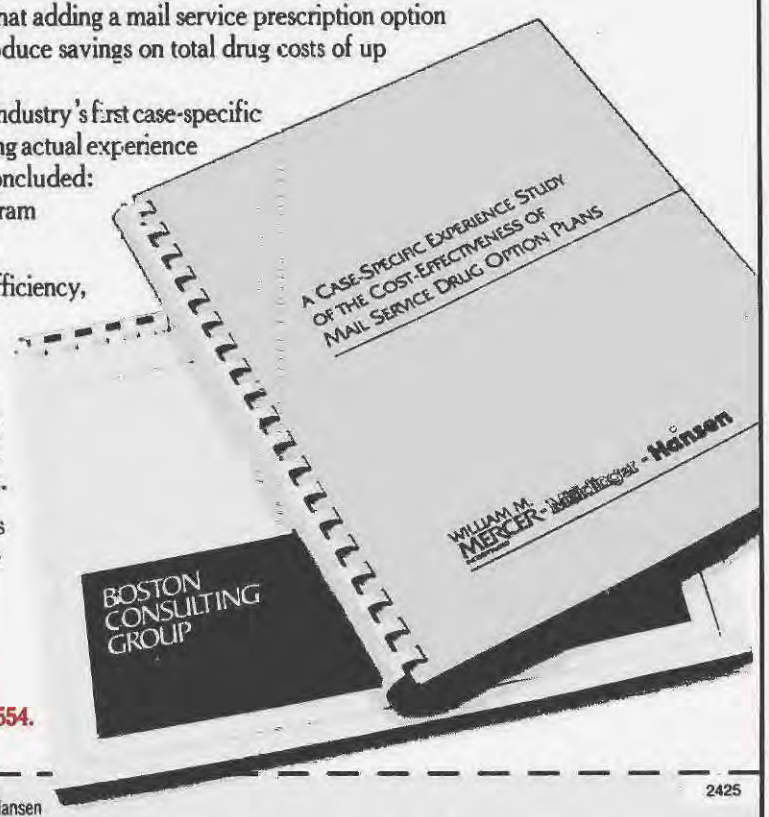

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Managed care

Continued from page 12

its UR program—to control both the cost and utilization of health care services, said Mr. Motz.

"With the right data and analysis, benefit managers can pinpoint areas for further managed care programs," said Mr. Motz.

Mr. Mahoney said that even after a company has determined what form of managed care it needs, the selection of a managed care provider is critical.

He advised benefit managers to determine the goals of their managed care program, find a provider that will meet those goals and then carefully monitor that program.

Employers today have "an alphabet soup of approaches"—including health maintenance organizations and PPOs—from which they can choose to solve their health care problems, he said.

"HMOs are like the magic black box," said Mr. Mahoney. "You put money in one end and hope you get health care on the other."

He also was critical of PPOs, saying they control only the cost of care, not utilization.

Mr. Mahoney did have some suggestions to guide benefit managers when purchasing these programs.

First, benefit managers must look at the scope of services provided, he said. Make sure the plan meets the goals and does not force the company to buy services it doesn't need, he advised.

It also is important to carefully examine the management of HMOs, PPOs and other managed care programs, said Mr. Mahoney. He advised benefit managers to look at treatment protocols; make sure there is an internal peer review system in place; and make sure the management has experience in the particular industry of the benefit manager's company.

As in all purchasing decisions, cost is an important factor, said Mr. Mahoney. He stressed that benefit managers should buy only those services they need and avoid getting stuck with package deals.

Employee access to the managed care program also is important, Mr. Mahoney said. He warned benefit managers to beware when a HMO or PPO says it is affiliated with a large number of hospitals, because often that simply means the hospitals operate on a rotating basis in which only a few hospitals are available on a given day.

"It depends on what night the employee gets sick as to how far he has to drive," he said.

Once a benefit manager has identified his needs and purchased a managed care program, he must continue to evaluate the program, Mr. Mahoney said, adding, "Health care is an active, fluid, ever-changing environment. You have to constantly measure it."

In addition to studying the cost and utilization of the managed care services, Mr. Mahoney advised benefit managers also to look at employee satisfaction.

Benefit managers must hold the vendors of managed care products accountable, he said; thorough reports of employee utilization from the vendor are critical.

And, benefit managers should seek similar employee utilization data from other sources, such as the claims payer, he advised.

C. Ray Gould, employee relations manager for American Moulding & Millwork Co. in Prineville, Ore., said he judges a managed care program by five criteria:

- Does it have a toll-free number for employees to call for advice about treatment plans?
- Are doctors available to answer employees' health questions?
- Does it offer third and fourth surgical opinions in addition to second surgical opinions. Mr. Gould said these medical reviews can produce additional savings.
- Does it offer cost control during and after treatment?
- Is it relatively easy for employees to access?

The speakers stressed the importance of communicating a managed care plan to employees.

Mr. Gould said benefit managers should consider: employee meetings; supervisor meetings, to make sure they understand the plan; and preparing a pocket-size employee handbook. He also suggested the use of bulletin boards, newspapers and letters to employees' homes to further communicate the managed care program.

"Managed care is an active process," said Mr. Mahoney. "To the extent you work at it, it will work for you."

The program was moderated by Linda G. Hellman, compensation and benefits manager for Liebert Corp. in Columbus, Ohio, and coordinated by Donna C. Rozelle, communications supervisor in the group insurance division of Great-West Life. ■

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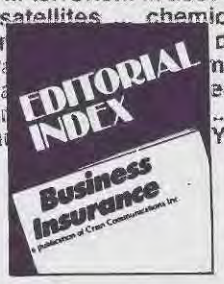

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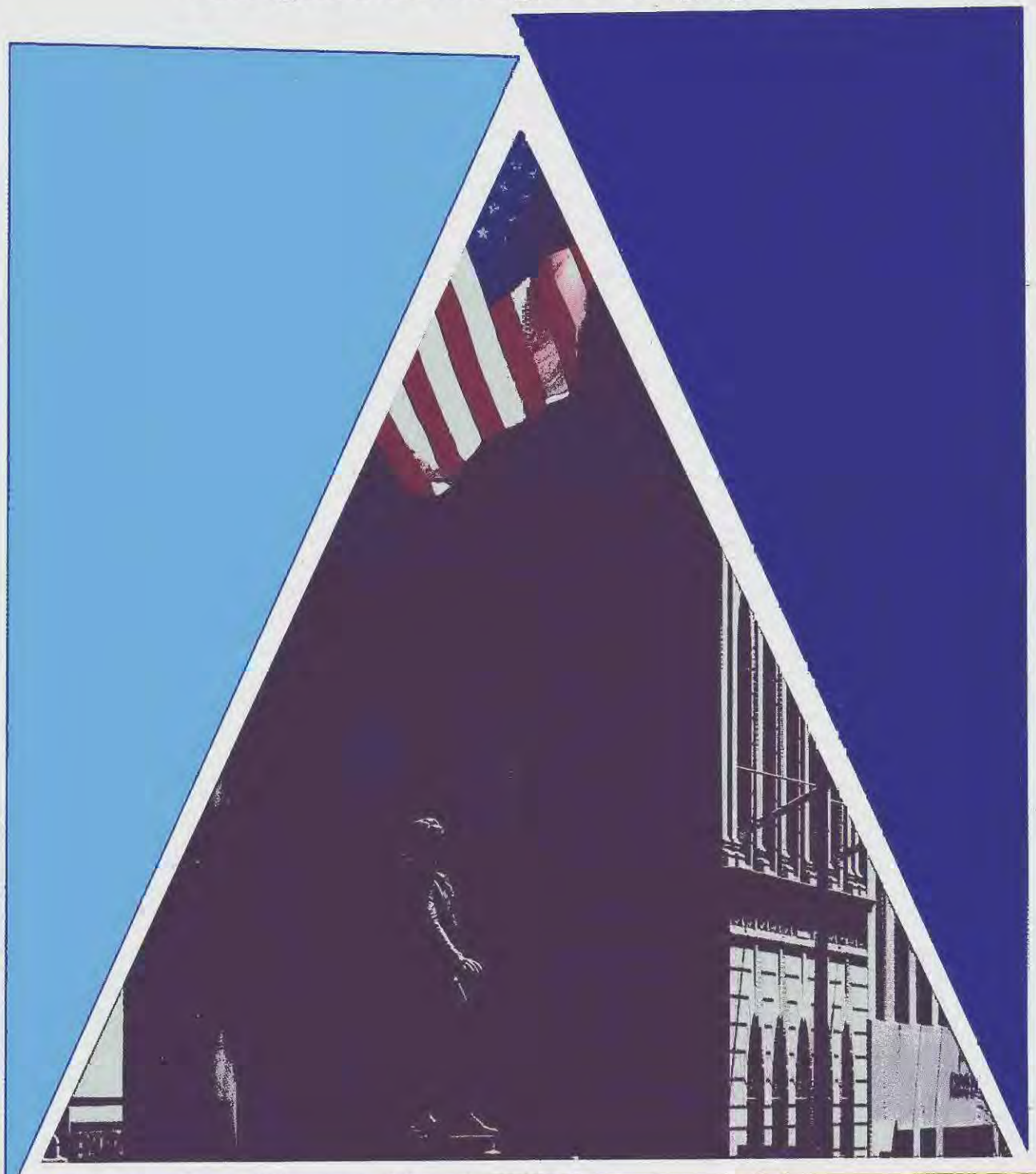

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Mandated benefits

Continued from page 3

Committee Chairman Edward Kennedy, D-Mass., mandating that employers offer a so-called minimum health care plan.

Under that plan, which would have to be offered to all employees working at least 17.5 hours a week, the employer generally would have to pay 80% of the premiums, while annual individual and family deductibles could not exceed $250 and $500, respectively. The maximum annual out-of-pocket expense would be limited to $3,000 a year (*BI,* Feb. 22).

In addition, a congressional conference committee is trying to iron out differences in House- and Senate-passed bills that would expand the federal Medicare program to give the elderly more protection from catastrophic acute care medical bills.

Medicare conferees also are expected to consider a proposal Rep. Stark advanced that would allow states to set up employer-subsidized pools to provide health care coverage to high-risk uninsured individuals.

As the ranking minority member of the Labor and Human Resources Committee, Sen. Hatch has made clear his intense dislike of any legislation that forces employers to provide health care coverage.

For example, in February, as the Labor and Human Resources Committee was preparing to vote on Sen. Kennedy's bill, Sen. Hatch described the legislation as "socialism, pure and simple."

He warned then that enactment of the Kennedy bill would force employers that could not afford a federal health care mandate to lay off workers or shut down.

Sen. Hatch continues to lead the charge against a federal health care mandate in general and Sen. Kennedy's bill in particular.

At the RIMS conference, Sen. Hatch noted that the price tag of the "minimum plan" Sen. Kennedy wants employers to offer is far higher than what the Massachusetts Democrat has estimated.

Sen. Hatch estimated individual coverage would cost $1,700 per year and family coverage would cost $2,600 a year; an actuarial study conducted for Sen. Kennedy has put the cost at $708 per year for individual coverage and $1,798 for family coverage.

And while Sen. Kennedy says the annual cost of his health care mandate to employers would be $15 billion, Sen. Hatch estimates those costs actually could range between $39 billion and $100 billion a year.

The Institute for Research on the Economics of Taxation in Washington has estimated the Kennedy plan would cost employees and employers $100 billion (*BI,* Nov. 16, 1987).

Sen. Hatch acknowledges that something must be done to reduce the problem of hospitals shifting the cost of the uninsured's health care expenses to insured patients.

But the solution to an estimated uncompensated care bill of $8 billion should not be a federal health care mandate that could boost employers' expenses by more than $30 billion, he said.

"I cannot support a bill that is a $39 billion solution to an $8 billion problem," Sen. Hatch said.

There are several far less costly steps that can be taken to improve access to health care and cut the cost of coverage, said the senator.

For example, Congress should examine ways to expand the Medicaid program to increase coverage to the poor, he said.

In addition, legislators should consider a series of tort reforms to cut the high cost of medical malpractice insurance, a factor boosting health care bills, he said.

Needed tort reforms, according to Sen. Hatch, include:

- Placing a cap on awards for non-economic damages.
- Placing caps on attorneys' fees.
- Eliminating the collateral source rule so damage awards would be reduced automatically by the amount of other benefits received.
- Requiring periodic payments for large damage awards.

But Rep. Stark wants to go much further to increase access to health care coverage.

He has backed a proposal—twice rejected by Congress—to allow states to set up employer-subsidized health care pools.

Rep. Stark continues to support the pool concept, describing it as a fair way to spread the cost of the uninsured.

While Rep. Stark believes Sen. Kennedy's bill is too complicated, he endorses the concept of mandatory employer-provided health care coverage.

"I would prefer a simpler approach. If 'Mom' can't understand it, we're in trouble. Sen. Kennedy's bill is more complicated than I'd like. The simpler we keep it, the better it would be," Rep. Stark said.

One approach to mandating benefit coverage could be to place a cap—perhaps $2,000 a year—on an employee's annual out-of-pocket health care expenses, with the employer picking up the rest, Rep. Stark said.

And, while Rep. Stark did not discuss it at the RIMS session, he has been circulating a copy of draft legislation that would require employers to offer health care plans that would pay expenses after a $1,500 deductible. Employers would have to pay 80% of the premium.

In addition, under a second part of the proposal, known as the Employee Health Benefit Improvement Act of 1988, state pools would be established to cover those not covered by employer plans.

If premiums paid by pool participants do not cover claims, the pools could make up the difference by charging employers special assessments. The special assessment would be in proportion to the employer's wages paid in the state.

Rep. Stark also urged Congress to pass legislation now pending before a House-Senate conference committee that would limit Medicare beneficiaries' annual out-of-pocket expenses for acute care to less than $2,000.

Currently, because of the high coinsurance and deductible requirements under Medicare, beneficiaries can be liable for tens of thousands of dollars in bills (*BI,* March, 21; Nov. 16, 1987).

Rep. Stark described the Medicare expansion legislation as a "damn good program. It seems simple; it seems fair."

He said Medicare is an example of a federal program at its best: using 98% of the program's revenue to pay benefits.

However, Medicare does need some fine-tuning, Rep. Stark said.

The program has to do a better job of controlling physician costs, according to Rep. Stark. One possible way to do that would be to set doctors fees in advance, just as Medicare sets fixed rates for hospital procedures based on diagnosis, Rep. Stark suggested.

Rep. Stark also noted that one of the next benefit issues Congress may address is giving employers tax incentives to fund retiree health care benefits. But in return for tax breaks, Congress may insist that employers do more to pay for coverage for the uninsured.

"I will extract my pound of flesh. That is the Stark prediction," he said.

Rep. Stark, who played a key role in the passage of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, came under fire at the session for the way in which legislators enacted COBRA.

The health care provisions never received a public hearing and were later tacked onto an unrelated budget bill.

A member of the audience complained that it was "sneaky" for Congress to attach the health care provisions to a budget bill.

Rep. Stark responded that there was long-time public pressure for a bill like COBRA to fill gaps in coverage and that legislators responded to that pressure.

However, Rep. Stark conceded that COBRA could have been better-drafted and apologized for the drafting glitches.

He also advised employers to take a more active role in the legislative arena. Indeed, many companies were not even aware of COBRA's ramifications for health care plans until it was enacted.

"Get into the tent with your enemies. Generally, you will get better legislation," he said.

The session was moderated by Galt Grant, director of risk management at Polaroid Corp. in Boston. ■

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Improved market conditions favor non-specialized lines

By JUDY GREENWALD

NEW YORK—Primary and excess insurance market conditions improved overall in 1987, but "non-specialized coverages" improved more than "specialized coverages," according to a survey sponsored by the Risk & Insurance Management Society Inc.

The survey of 1,178 risk managers reveals, for example, that the improvement in market conditions was better for umbrella/excess liability and property coverages than for environmental impairment, directors and officers and product liability coverages.

"Notably, there were no lines surveyed that reflected a demonstrable deterioration of availability or cost," the survey says.

However, it adds: "It appeared that 'non-specialized' lines are benefiting from a competitive environment, while insurers have not competed as fiercely in other, more 'specialized' lines."

For instance, 64% of the respondents reported premium decreases for property insurance, 65% reported decreases for umbrella/excess liability insurance and 49% reported decreases for primary general liability coverages.

Among the specialty lines, 43% of the risk managers buying product liability coverage and D&O liability insurance said they paid less in 1987 while only 10% of surety bond buyers did so.

The EIL insurance market remained tight in 1987, the survey said. Some 55% of the risk managers reported the coverage was unavailable in 1987, and only 26% who found the coverage reported premium decreases. However, those results are still an improvement from 1986, when 70% of that year's survey respondents reported the coverage was unavailable.

Respondents to the 1988 Insurance Availability Survey, which was conducted with the assistance of Tillinghast, a division of Towers, Perrin, Forster & Crosby, reflect a wide range of industry groups from 49 states, the District of Columbia and several Canadian provinces. Some 84%, or about 990, of the respondents had revenues of between $100 million and $10 billion.

The survey solicited information about 10 lines of commercial insurance, focusing on availability, premiums, coverage conditions, limits and deductibles.

Survey highlights by line of coverage include:

- Primary general liability. Some 65% of the 989 respondents who bought the coverage reported it was "easy to purchase," compared with 44% in 1986.

A total of 65% said there was no change in coverage conditions, while 20% of the respondents said that coverage conditions had improved. Only 15% said the coverage was either somewhat or highly restricted, compared with 40% in 1986.

- Umbrella/excess liability. Only 8% of the 1,034 respondents who bought this coverage said they either had "much difficulty" finding this coverage or were unable to find it, compared with 45% in the 1986 survey.

Some 19% reported conditions were either somewhat or highly restricted, down from 54% in 1986. Some 37% reported the limits of their coverage had been increased. And, 65% reported premium decreases, compared with 11% in the previous survey.

- Property damage. Sixty-four percent of the 1,080 respondents reported premium decreases, compared with 15% in the 1986 survey.

Some 34% reported improved coverage conditions, compared with 13% in 1986. And, 37% reported higher limits in 1987.

- Product liability. Of the 82 respondents, 34% said they found the coverage easy to purchase. But, 37% said they had some difficulty finding the coverage, 20% said they had "much difficulty,' and 7% said the the coverage was unavailable.

A total of 18% reported coverage conditions were somewhat or highly restricted, compared with 36% in 1986. Only 15% reported premium increases of more than 10%, compared with 47% in the previous survey.

- Professional liability. A total of 37% of the 225 respondents reported premium increases of more than 10%, compared with 67% of the respondents who reported similar premium increases in the 1986 survey. And, 12% reported deductible increases of more than 50%, compared with 24% who reported similar deductible increases in the previous survey.

- D&O liability. Only 16% of the 834 respondents said they had "much difficulty" finding D&O coverage or could not get coverage at all, compared with 42% in 1986. A total of 28% reported improved conditions.

While 31% of the respondents reported premium increases of more

Continued on next page

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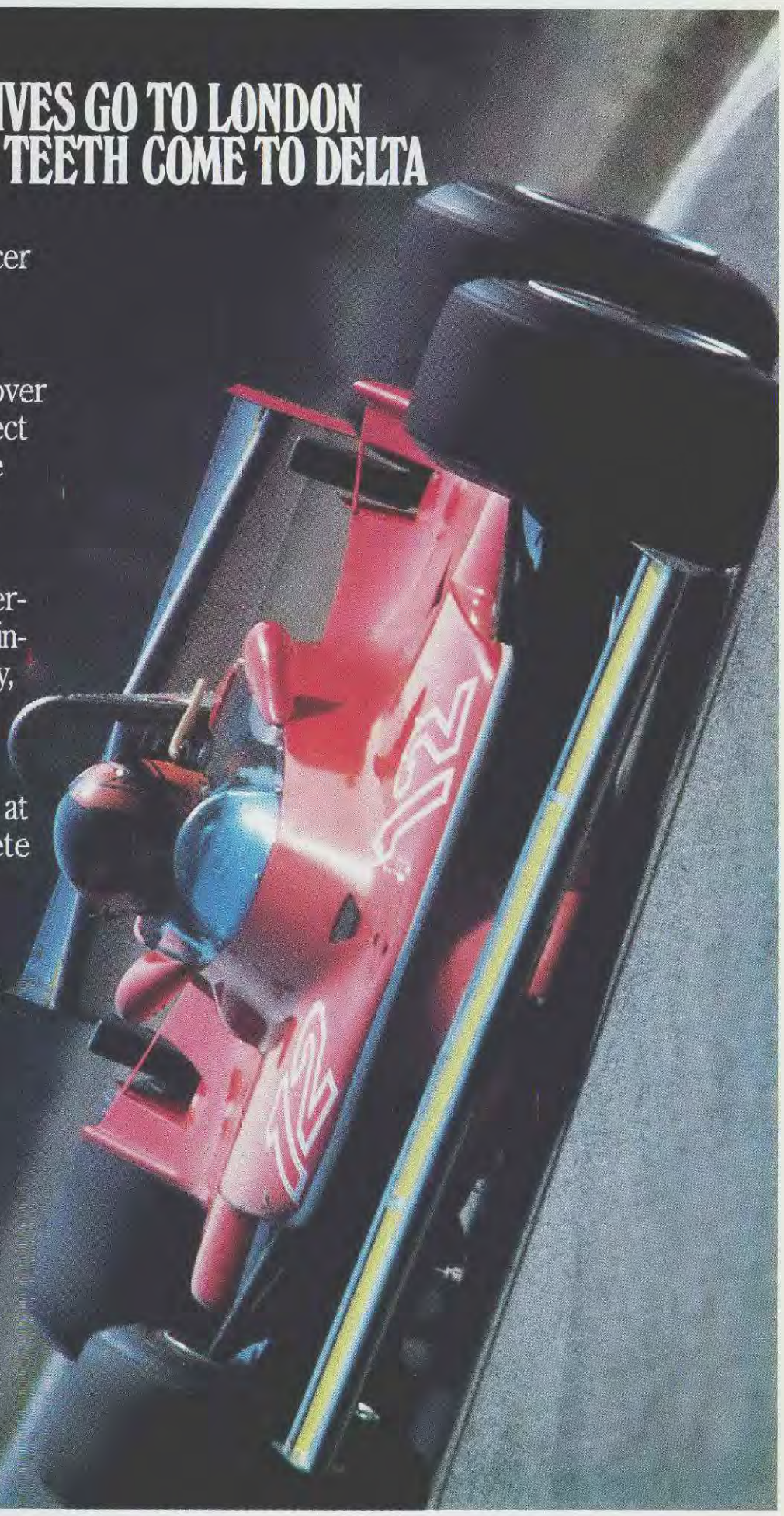

RIMS survey

Continued from previous page

than 10%, 78% had reported similar increases in the 1986 survey. And, 43% reported premium decreases in 1987, compared with just 7% in the 1986. A total of 26% reported higher limits.

- EIL. Some 55% of the 207 respondents said this line of coverage was unavailable, while 15% said it was easy to purchase.
- Bankers blanket bond. Of the 251 respondents purchasing this coverage, 15% reported premium increases of more than 50%, compared with 36% in the 1986 survey. Some 22% reported higher limits.
- Surety. Of the 593 respondents, 22% reported premium increases of more than 10%, compared with 31% in 1986.
- Flood/earthquake. Only 10% Of the 403 respondents, 10% either had difficulty in obtaining coverage, compared with 29% in 1986.

Similarly, 12% said coverage conditions were somewhat or highly restricted, down from 29% in 1986. A total of 44% reported premium decreases, compared with 9% in the 1986 survey.

The survey also found that the percentage of companies that decided to join risk financing alternatives such as A.C.E. Insurance Co. Ltd. or X.L. Insurance Co. last year fell to 13% from 18% in 1987.

And, some industry segments were much more likely to join alternative risk financing facilities, the survey found. For instance, 32% of the electric utilities, 28% of the water, gas and other utilities, and 26% of the food and tobacco manufacturers said they joined such facilities in 1987. But, o textiles and clothing or machinery manufacturing firms did so.

A total of 6% of the respondents overall said they either joined a risk retention group for general liability coverage in 1987, or were considering joining or forming one in 1988. But, 16% of government entities said they had joined or were considering joining a risk retention group.

And while only 5% of the overall respondents joined a risk retention group for D&O liability, 29% of engineering, accounting and professional services firms and 22% of health care services firms did so.

'Notably, there were no lines surveyed that reflected a demonstrable deterioration of availability or cost,' the RIMS survey says.

A total of 8% said they joined or were considering joining a risk purchasing group for general liability coverage. But this included 29% of agriculture and forestry firms, 23% of mining, oil and gas exploration firms and 22% of health care services firms.

A total of 10% of the respondents reported they had implemented formal self-insurance programs in 1987 to cover their general liability exposures, including 42% of government entities and 20% of health care services firms.

In addition, 8% of the respondents said they created formal self-insurance programs for their environmental impairment exposures, including 38% of government entities.

And while only 7% of all respondents created formal self-insurance programs for professional liability risks, 24% of the machinery manufacturing firms and 22% the of government entities did so.

A total of 37% of government entities also formed a formal self-insurance program for property coverages, although only 6% of the respondents overall did.

In addition, 10% of the respondents formed single-parent captives that write directors and officers liability insurance, including 36% of government entities and 20% of health care services firms.

A total of 7% of the respondents overall formed single-parent captives to write product liability insurance, including 30% of the government entities.

●

Copies of the survey can be obtained for $25 from the Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017.

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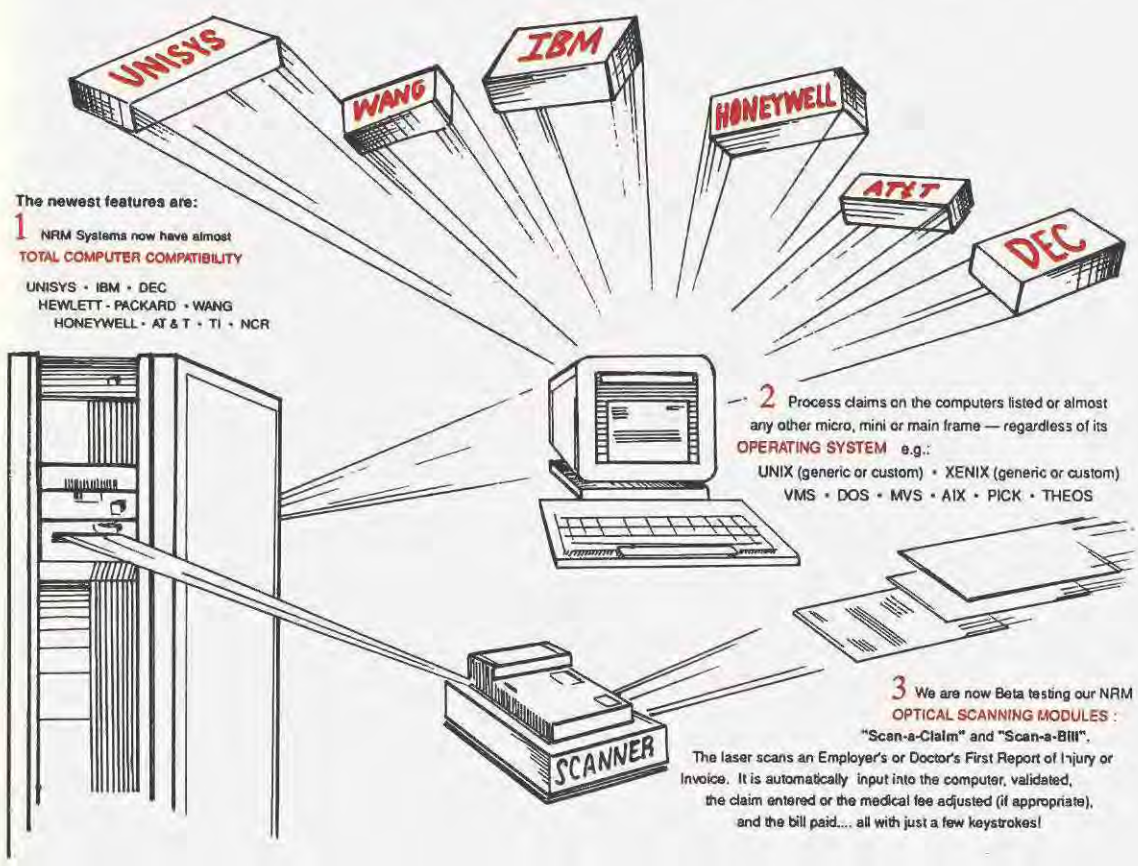

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Illinois acts to halt 2 offshore insurers

By DOUGLAS McLEOD

CHICAGO—The Illinois Insurance Department is moving to liquidate two unauthorized offshore insurers that have issued about 200 policies and bonds on risks in Illinois and several other states.

The Insurance Department last week filed a petition in Cook County Circuit Court to liquidate Commercial Inland & Marine Indemnity Co. Ltd. and North American Fire & Casualty Co. Ltd.

Both companies purportedly are domiciled in St. Kitts, British West Indies, and are controlled by Jonathan P. Saunders, an Englewood, Colo., businessman.

However, a regulatory official in St. Kitts said that Commercial Inland is not registered as an insurance company on the island and would not comment on the status of North American.

Neither insurer is admitted or eligible as a surplus lines insurer anywhere in the country, said Tris Schnepper, supervising deputy with the Illinois department.

A Cook County circuit judge earlier this month placed the two insurers in conservatorship and ordered cancellation of all the insurers' policies and bid and performance bonds after Illinois department officials seized records from the office of a Chicago-area surplus lines agent representing the companies.

The Insurance Department currently is mailing cancellation notices to Commercial Inland and North American Fire & Casualty policyholders and bondholders.

Mr. Saunders, chairman and chief executive of Saunders Financial Group Inc. in Englewood, called the Illinois action a "political maneuver" and said the Insurance Department has no authority over the two insurers.

"We are getting tired of people picking on us," Mr. Saunders said.

The Illinois department discovered that North American and Commercial Inland were operating in the state after it was contacted by Pennsylvania Insurance Department officials about a Commercial Inland binder that had been issued by Peter Dietl, a licensed surplus lines agent based in Brookfield, a Chicago suburb.

After seizing the records from Mr. Dietl, Illinois department officials found that North American and Commercial Inland had written about 200 general liability policies and bid and performance bonds.

North American Fire & Casualty wrote about 125 risks before last July, when the state surplus lines association warned agents not to use the insurer, Mr. Schnepper said.

Subsequently, Commercial Inland started issuing bonds, writing about 75 risks before the insurance department shut the operation down, he said.

The Illinois department has not taken any action against Mr. Dietl, who expressed surprise at the trouble North American Fire & Casualty and Commercial Inland have encountered.

Mr. Dietl said he placed business with Commercial Inland after reviewing a financial statement that showed substantial assets and that "looked good."

A financial statement prepared by Commercial Inland showed policyholder surplus of $32.6 million as of Dec. 31, 1987, according to Robert M. Howard, assistant attorney general in Colorado.

Most of the coverage was written for Illinois policyholders, though policies or bonds also were issued on risks in Florida, New Jersey, Utah, Missouri and Indiana, according to the Illinois department.

Some of the performance bonds were issued to Illinois contractors and protected the city of Chicago on various municipal construction projects, Mr. Schnepper said.

The two insurers wrote a total of about $250,000 in premiums in the state, some of which went to Mr. Saunders, Mr. Schnepper said. The insurers also have some assets in Chicago-area banks, he added.

About $150,000 of the premiums are still unaccounted for, and Illinois department officials are trying to reconstruct records of the companies' transactions, Mr. Schnepper said.

After seizing books and records of the two insurers, the Illinois department on April 11 obtained a court conservation order allowing it to take control of the companies' affairs and to cancel its policies and bonds.

Last Monday, the department asked the Cook County court to order the liquidation of North American Fire & Casualty and Commercial Inland on the grounds that they have operated without authorization in the state and that their continued operation would be hazardous to policyholders and other creditors.

Meanwhile, a Denver District Court judge issued a preliminary injunction April 11 against Commercial Inland and Mr. Saunders, according to Colorado's Mr. Howard.

The injunction bars Commercial Inland and Mr. Saunders from unlawfully engaging in the insurance business in Colorado and from doing business in any other state without a license or other authorization, Mr. Howard said.

The Colorado Insurance Department recently denied an application by Mr. Saunders to form an admitted subsidiary of Commercial Inland in the state, Mr. Howard said.

The license application was denied in part because of false statements by Mr. Saunders in a biographical affidavit, he said. In the affidavit, Mr. Saunders said that he "had never been convicted of a felony when in fact he had," according to the Insurance Department's petition for an injunction, which does not describe the felony conviction. In an interview, Mr. Saunders denied that he is a convicted felon.

The actions by the Illinois and Colorado regulators are not the first brushes Mr. Saunders and North American Fire & Casualty have had with regulators: Both were hit with a civil fraud lawsuit by the Texas attorney general last fall (*BI*, Sept. 7, 1987).

The suit, filed in District Court of Travis County in Austin, charged that Mr. Saunders misrepresented North American's financial condition and falsely claimed that it was an authorized insurer.

In a default judgment entered last September, North American and Mr. Saunders were permanently enjoined from conducting insurance business in Texas, and Mr. Saunders was ordered to pay $1 million in fines and penalties, according to Frank W. Stenger, assistant attorney general.

Mr. Saunders has not paid the fines and penalties, he added.

Separately, Mr. Saunders was ordered to serve jail time on seven counts of contempt of court after he continued to operate the insurer after being enjoined from doing so, Mr. Stenger said.

Mr. Saunders said he has not served the jail time. ■

Insurers told to back safety, cost control

By MEG FLETCHER

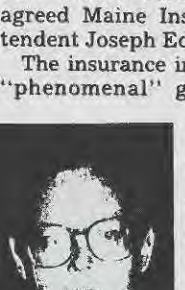
Frank Nutter, president of the Alliance of American Insurers, argues that many states have regulations that inhibit insurers' cost containment efforts and make workers compensation 'the last bastion of the medical blank check.'

NEW YORK—Workers compensation insurers should provide leadership in promoting workplace safety and containing medical costs, instead of merely reacting to these issues, state regulators urge.

"The industry must come forward with accident prevention programs," said Theodore Kulongoski, Oregon insurance commissioner.

Insurers should promote safety and health issues nationwide, agreed Maine Insurance Superintendent Joseph Edwards.

The insurance industry can make "phenomenal" gains by moving from a reactive position to a proactive one, said William Hager, Iowa insurance commissioner.



Mr. Hager

The three were among regulators who participated in panel discussions at the annual issues symposium sponsored by the National Council on Compensation Insurance in New York earlier this month (*BI*, April 11).

Most of the panelists agreed that during recent years, insurers have not played an active role in backing legislation and devising incentives to get employers interested in workplace safety.

For example, although work comp insurers in Oregon are required to provide loss control services, that generally is not being done, said Oregon state Rep. Robert Shiprack, D-Beaver Creek.

The lack of adequate loss control services contributes to high work comp rates, because it drives up the costs of claims, he said. And, many employers in the state are reeling from high work comp costs, Rep. Shiprack said.

"I would like your industry to be part of the solution," Rep. Shiprack told the insurers present.

U.S. Rep. James Florio, D-N.J., said insurers can play a "self-interest and public interest role" by promoting safety.

For example, insurers can refuse to insure employers that do not implement proper safety procedures. And, insurers can lobby for legislation that would promote workplace safety among employers, Rep. Florio said.

"Safety is clearly in our own best interest," agreed Robert Vagley, president of the American Insurance Assn. "We (insurers) need to align ourselves with legitimate consumer groups."

And, insurer representatives said insurers for years have promoted safety in the workplace by providing employers with loss control information and performing safety inspections.

But safety inspections can also create a liability problem for insurers, said Grover Czech, AIA vp for the mid-Atlantic region. An insurance company inspector who overlooks a significant hazard could later be sued in most states for that omission, he said.

Also, when employers purchase their workers comp insurance through an assigned risk plan, there is a "disincentive" for individual insurers to fund safety programs, because their responsibility for a risk is limited to their share of the pool, Mr. Vagley said.

In addition to promoting workplace safety, the regulators urged insurers to do more to control rising medical costs.

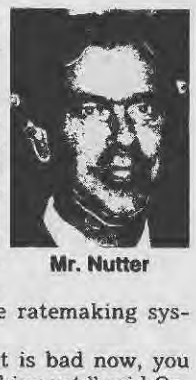
Oregon's Rep. Shiprack said insurers should take steps, including curbing excessively expensive vocational rehabilitation programs and inadequate auditing of medical services and costs.

Oregon's Mr. Kulongoski agreed that insurers should control rehabilitation costs and should couple that with support of more-aggressive return-to-work programs.

Iowa Commissioner Hager said he is disappointed by insurers' "zero" interest in information available from his division on physician practice patterns and hospital charges.

But Frank Nutter, president of the Alliance of American Insurers, countered that many states have regulations that inhibit insurers' cost containment efforts and make work comp "the last bastion of the medical blank check."

Regulators could help insurers manage work comp benefit costs by approving mechanisms like copayment and deductible requirements, the AIA's Mr. Vagley said.



Mr. Nutter

Many regulators agreed that it is important for insurers to take a positive approach now, especially in light of the increasingly political nature of the ratemaking system.

"If you think it is bad now, you haven't seen anything yet," said Oregon's Rep. Shiprack.

Insurance regulation has become more politicized in part because of insurers' efforts to promote tort reform at the state level.

In addition, adoption of insurer-promoted tort reform measures built up expectations, especially on the part of small businesses, that insurers would reduce rates in return, Rep. Florio said.

But many insurers adopted a wait-and-see attitude, which legislators and many others perceived as "duplicitous," according to Rep. Florio.

In defense of the industry, Mr. Vagley emphasized that some of the tort reform legislation included sunset provisions that limited the duration of the reforms.

And, Mr. Nutter pointed out that insurance companies did participate in joint underwriting authorities for difficult lines of coverage in some states.

The industry had hoped to avoid similar problems over proposed federal product liability legislation by clearly stating that the legislation will not lead to reduced rates, Mr. Vagley said.

But, the bill has been stalled in Congress and further action is unlikely unless the industry promises rates will go down if it is approved, he said. ■

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NOTICES

SILLS CUMMIS ZUCKERMAN RADIN TISCHMAN ESPSTEIN & GROSS, P.A.
33 Washington Street, Newark, New Jersey 07102, (201) 643-3232, Attorneys for Kenneth D. Merin Commissioner of Insurance of The State of New Jersey, in his capacity as Liquidator of Integrity Insurance Company, and Michael Miron, as Deputy Liquidator of Integrity Insurance Company
SUPERIOR COURT OF NEW JERSEY, CHANCERY DIVISION: BERGEN COUNTY, GENERAL EQUITY PART, Docket No.: C-7022-86
IN THE MATTER OF THE LIQUIDATION OF INTEGRITY INSURANCE COMPANY
Civil Action
ORDER TO SHOW CAUSE

The Honorable Kenneth D. Merin in his capacity as Liquidator of Integrity Insurance Company and Michael Miron, in his capacity as Deputy Liquidator of Integrity Insurance Company, having submitted the Certification of Special Counsel, Steven S. Radin, Esq., and it appearing from the papers filed herein that numerous proofs of claim havew been filed in the offices of the Deputy Liquidator, Guaranty Associates, or Ancillary Receivers and that notification to policyholders, claimants and other interested parties of fugure proceedings in the liquidation of Integrity Insurance Company is to be made as set forth herein, And, it also appearing from the papers filed herein, that an Application for Ex Parte Orders has been filed with this Court, IT IS on this 15th day of April, 1988, ORDERED, that all persons or entities who have filed proofs of claim on or before March 25, 1988 in the offices of the Deputy Liquidator, Guaranty Associations or Ancillary Receivers and all other interested parties show cause before the Superior Court of New Jersey, Chancery Division, Bergen County Courthouse, Hackensack, New Jersey on the 6rh day of May 1988 at 9:00 a.m. in the forenoon or as soon thereafter as counsel may be heard, (a) why an Order should not be entered providing that notice of future proceedings in this Liquidation be duly served only upon those persons or entities who either appear before this Court to be heard on such return date or submit a written statement requesting such notice of future proceedings with the office of Special Counsel representing the Liquidator and Deputy Liquidator, Sills Cummis Zuckerman Radin Tischman Epstein & Gross, P.A., 33 Washington Street, Newark, New Jersey 07102 (Attn: Steven S. Radin, Esq.) on or before the 2nd day of May 1988 and (b) why an Order should not be entered providing for Ex Parte Applications and Orders as provided for in the accompanying moving papers, and IT IS FURTHER ORDERED, that all persons or entities who appear on the return date may petition this Court to form a committee of creditors to facilitate the administration of the estate of Integrity Insurance Company in Liquidation, and IT IS FURTHER ORDERED, that service by mail on or before April 26, 1988 of this Order to Sho9w Cause and all supporting papers be made upon all Guaranty Associations, Ancillary RE-ceivers, State Departments of Insurance, and all creditors who previously appeared herein on March 24, 1987 in regard to the Liquidation Order, and all persons or entities who have filed proofs of claim alleging an amount in excess of $100,000.00, and that service to all other persons or entities who have filed proofs of claim be made by publication of this order to Show Cause in the New Jersey Law Journal, Newark Star-Ledger, New York Times, New York Law Journal, Wall Street Journal, Business Insurance, National Underwriters and Lloyd's List on or before April 29, 1988 and that such service be deemed good and sufficient.

WILLIAM C. MEEHAN, J.S.C.
Dated: April 15, 1988

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Demographics changing industry

By MICHAEL BRADFORD

PALM BEACH, Fla.—Insurers have to consider the impact of shifting demographics in their long-range business plans, according to a group of experts who gathered to discuss social change and its effects on the insurance industry.

Social scientists, economists and insurers gathered for an all-day meeting at The Breakers in Palm Beach, Fla., to discuss how aging baby boomers, population trends, politics and other factors will shape the insurance industry and society as a whole in the coming years.

The session was part of the annual meeting of the Alliance of American Insurers held April 12-13 at the Florida resort. At the meeting, an afternoon panel of insurance industry experts reacted to a morning program that featured scholars from the American Enterprise Institute for Public Policy Research in Washington, D.C.

And, insurance industry experts agreed that the demographic figures they heard will shape future business decisions—particularly with regard to hiring.

Insurance companies, the experts agreed, will have to work harder to attract quality personnel from a shrinking pool of candidates.

Lawrence G. Brandon, executive vp of The American Institute for Property & Liability Underwriters in Malvern, Pa., said the challenge for insurers to hire capable employees is "the single most critical item facing the industry in the next 10 years."

Mr. Brandon said demographics presented earlier in the day "make it very, very clear that we're going to be having a much lower number of people coming into the labor force. And the competition for those young people is going to be very strong from other industries.

"So I think the insurance industry is perhaps going to have to abandon a policy we may have gotten away with—and that's just hiring average people and paying them average wages. I think now we're at the point in time where we can't afford to do anything other than hire the best that we can and train them early and educate them continuously."

Mr. Brandon mentioned figures presented in the morning session by Benjamin Wattenberg, a senior fellow at the AEI and author of the recently published book "The Birth Dearth."

Mr. Wattenberg told the group his research shows that between 1990 and 2000, "the actual number of young adults between age 25 and 34 will go down by about 18% . . . .Now this has enormous ripples throughout the economy."

Those ripples will cause a labor shortage for some areas of business and industry in some parts of the country, he noted.

Other insurance industry experts agreed with Mr. Brandon that there is a need for insurers to carefully select and train personnel in coming years.

Peter F. Frenzer, executive vp of Nationwide Insurance Cos. in Columbus, Ohio, said, "Companies that don't hire excellent people will be the ones that are consolidated. They won't be in business anymore."

"I agree that as an industry we haven't done a very good job in recent times of training and developing underwriters, marketers, claims people and the like," added James C. Lett, vp/underwriting at Unigard Security Insurance Co. in Bellevue, Wash.

Sean Mooney, senior vp and economist with the Insurance Information Institute in New York, noted that "we definitely need to attract young people because of this decreasing pool based on demographics."

Mr. Wattenberg said the diminishing number of young workers and the slowing of population growth overall will have both good and bad effects on the insurance industry.

On the negative side, he predicted:

- Fewer homes will be built as the population shrinks, meaning fewer homeowner policies will be needed.
- There will be fewer first-time car buyers that get on the automobile and insurance purchasing "treadmill" for life.
- Smaller families will mean less life insurance will be needed.
- Workers compensation writings will decrease because there will be fewer workers.

On a more positive note for insurers, Mr. Wattenberg predicted that:

- Insurance companies will have to write coverage for exposures that are now insured by federal programs like Medicare. Those programs will be underfunded because of the shortage of workers paying into the plans, he noted. There will be shortfalls in the Social Security program that "one way or the other, insurance companies on the private side will have to pick up," he remarked.
- Fewer people means a higher per-capita income. Those people will be able to purchase more possessions that they will insure, said Mr. Wattenberg.

Mr. Lett of Unigard said the demographics presented by the AEI scholars show that insurers have to be careful when putting together marketing strategies.

For example, he pointed to a recent study that shows Orange County, Calif., and neighboring counties are expected to continue their booming growth patterns over the next six years.

"Now that's not all that significant until you have something to compare it to," said Mr. Lett. He pointed out that, "there are more people in Orange County right now than there are in the entire state of Idaho."

Such a densely populated area "spawns competition," he said. "You can write more business in the three blocks from your office than you can in the entire state of Idaho. Competition is ferocious right now."

Mr. Brandon told the group that although insurers have come a long way in terms of business planning since the late 1960s, the industry is still "too short-term oriented."

He said insurers need to establish "a vision" of the future to work toward.

Mr. Brandon told chief executive officers the most important piece of planning is to "get a good vision of where you want the company to go. And then communicate that vision to the best people you can possibly surround yourself with and let them carry out that vision."

Mr. Lett agreed, adding that computerization should be an integral part of the chief executive officer's vision.

Mr. Lett asked the audience to "just consider what has taken place in the last decade" in terms of technological breakthroughs. "There's more on the way. A lot more."

He mentioned such advancements in automation as compact discs that store great quantities of information, speech recognition equipment that allows humans to talk with computers and video programs being used to train workers.

"I think companies that have this vision and stay abreast, continuously using it, will be those that have a better-than-average chance of succeeding in the next decade," said Mr. Lett.

Mr. Mooney of the III said he thinks computerization could be used as a drawing card for insurers that need to attract young workers.

"We definitely do need to attract young people because of this decreasing pool based on demographics," said Mr. Mooney.

He said the insurance industry doesn't realize it is way ahead of most businesses in terms of being highly automated. And it should promote that feature of the business in its recruiting, he noted.

"We should be conscious of this, that we do have something to sell to young people who are interested in an industry that is involved with high-tech and uses high-tech in its business. And we could look a lot more attractive to them rather than just saying, 'We sell insurance.' "

F. David Rolwing, president of The Montgomery Mutual Insurance Co. in Sandy Spring, Md., moderated a panel discussion among the AEI speakers that followed their formal presentations.

Norman J. Ornstein, a resident fellow of the AEI, and AEI senior fellow Irving Kristol also spoke at the meeting.

The afternoon session also featured John B. Conners, executive vp of Liberty Mutual Insurance Co. in Boston. That program was moderated by J. John Wortman, president and chief executive officer of the American Mutual Liability Group in Wakefield, Mass. ■

P/C industry takes on new role says Whitcomb

By MICHAEL BRADFORD

PALM BEACH, Fla.—The property/casualty insurance industry has outgrown its role as just a "protector" of people and property and today is regarded as an important element of the U.S. economy and society, says an insurance company chief executive.

"The industry's role as a protector is only part of its function in today's society. . . .The insurance industry has a tremendous economic impact on the country in other areas as well," says Clifford H. Whitcomb, chairman of the Alliance of American Insurers and president and chief executive officer of Prudential Property & Casualty Insurance Co. in Holmdel, N.J.

Mr. Whitcomb, in opening remarks at the Alliance's annual meeting held earlier this month at The Breakers in Palm Beach, Fla., said: "Since Ben Franklin organized the first American insurance company in 1752, the property and casualty industry has expanded to a $200 billion a year business which touches the life of virtually every American."

As an example of how much the industry has changed since the days of Ben Franklin and to show the industry's current impact on the U.S. economy, Mr. Whitcomb pointed out that the entire insurance industry:

- Contributed $79.3 billion to the U.S. gross national product in 1986.
- Employs 2.2 million Americans and contributes nearly $57 billion to U.S. payrolls annually.
- Will create more than 35% of the new jobs in financial services between 1984 and 1990.

Mr. Whitcomb also said property/casualty insurers will pay an estimated $2 billion in 1987 federal income taxes and provided around $4 billion to state governments in the form of premium taxes and various fees.

"So, besides providing financial stability," Mr. Whitcomb remarked, "the insurance industry also participates in the economic and social processes vital to the nation's well-being in its role as an employer, a source of capital and a distributor of funds."

With such an integral role in the U.S. social and economic process, the insurance industry has certain obligations, Mr. Whitcomb said.

For example, he noted, the industry's involvement in civil justice reform "and the changes we advocate will provide a fairer system of compensation for everyone. Uncontrolled costs, widespread abuses, long delays and unpredictable outcomes add unnecessary trauma to the courtroom ordeal, and have a devastating impact on the cost and availability of many goods and services."

"Insurers are key players in the legal, social and economic developments that are continually shaping our society. Logic dictates that we take an active role in the debates and the problem-solving process," he said.

The Alliance also elected 1988-89 officers at its annual meeting: Dieter H. Nickel, chairman and president of Church Mutual Insurance Co. of Merrill, Wis., was elected chairman of the Alliance.

Elected vice chairmen were: Gordon A. Ennis, president of Merchants & Business Men's Mutual Insurance Co.; Fred W. Green, chairman and CEO of Abington Mutual Fire Insurance Co.; Ronald R. Harder, president of Jewelers Mutual Insurance Co.; and Morris Lloyd Jr., president, treasurer and CEO of the Philadelphia Contributorship Insurance Co.

HMO costs

Continued from page 1

the utilization patterns of those employees," who typically are the younger, healthier employees, said Glenn Meister, a vp in the Los Angeles office of A. Foster Higgins Health-Group.

"While employers were somewhat concerned about this three years or so ago, the impact on their overall health costs then was not that great," since most employers had small numbers of employees enrolled in HMOs, Mr. Meister added.

Indeed, during the last several years of escalating health care inflation, employers directed their health care cost-containment efforts toward their indemnity plans, since these plans typically covered the health care of most of their employees.

Employers also figured that HMOs could manage the health care costs of the small percentage of their employees that enrolled in the prepaid plans.

And, most employers assumed they had little or no control over HMO premiums because of federal regulations governing rate-setting by HMOs.

However, the cost impact of HMO premiums—as well as adverse selection against indemnity plans—certainly is too great for most employers to ignore today, benefit experts say.

Actions by employers to understand and manage their HMO costs "have pretty rapidly increased in the last year, and we will see more of it, particularly as employers see greater increases in their indemnity plan costs" as a result of inflation and adverse selection against those plans, predicted Pat Richter, a consultant in the Lincolnshire, Ill., office of Hewitt Associates.

"HMOs have in the past been a one-way delivery system," asserted Neil Austin, staff manager-health care cost containment for San Francisco-based Pacific Telesis Group, a telecommunications concern. "But, we need to start purchasing HMO services like we purchase other business services," he said.

"We're going to spend $100 million on HMO services in 1988, and if we're going to spend that much, we need to know exactly what we are purchasing," he said, noting that the company estimates it will spend a total of $250 million on health care costs in 1988.

Some 65%—or about 45,500—of Pacific Telesis' 70,000 employees in California and Nevada are enrolled in 20 HMOs.

"We are currently reviewing all of our employees enrolled in HMOs. We are trying to look specifically at the ones that meet the needs of the company as well as those that meet the needs of our employees," Mr. Austin explained.

To accomplish this goal, Pacific Telesis intends to reduce the total number of HMOs it contracts with and is establishing certain requirements that HMOs must meet if they wish to contract with the company, Mr. Austin explained.

For example, Mr. Austin said, "In 1989, we will require some form of experience-rating from the HMOs we deal with."

In an effort to determine which of its current HMOs would be the most cost effective, Pacific Telesis, along with Foster Higgins, developed a detailed questionnaire for the HMOs that sought information about their data reporting capabilities, quality assurance mechanisms, flexibility in designing benefit plans and rating flexibility.

All HMOs the company currently contracts with are federally qualified. Federally qualified HMOs are permitted by the federal HMO Act of 1973 to require any employer with 25 or more employees to offer the HMO if the employer does not currently offer a federally qualified HMO.

The law specifies that employers with 25 or more employees can be required to offer at least one group model HMO and at least one individual practice association model HMO.

When a federally qualified HMO mandates an employer, the HMO is required to offer the employer a community rating—a rate based on the health care utilization and cost experience of the HMO's entire enrollment.

However, Mr. Austin explained that since Pacific Telesis has never been mandated by any of its 20 federally qualified HMOs, the company is able to negotiate rates with the HMOs, instead of having to accept the community rate.

Continued on next page

HMO costs

Continued from previous page

"In a non-mandated situation, the federal regulations permit an employer and an HMO to negotiate whatever rate is mutually acceptable," explained David W. Brown, a consultant with Foster Higgins in San Francisco who assisted Pacific Telesis.

"Because community rating has not served Pacific Telesis well, they would like to enter into some kind of experience rating or risk sharing arrangement" with HMOs, he added.

Meanwhile, under a proposed amendment to the HMO Act, federally qualified HMOs that mandate an employer to offer the HMO would, among other things, be allowed to charge employers mutually acceptable premiums. Many benefit experts interpret the bill, H.R. 3235, introduced by Rep. Henry Waxman, D-Calif., as allowing experience-rated premiums. The bill is awaiting action in the U.S. Senate.

Many employers, including Pacific Telesis also are requiring their HMOs to provide utilization data on HMO enrollees so the employers can negotiate and substantiate rates.

And, many more are requiring that HMOs provide the data as a condition of contracting with the employer.

"One of the things we're really looking for is for HMOs to provide Pacific Telesis with monthly utilization statistics on our HMO enrollees. This will be one of the requirements for an HMO to contract with Pacific Telesis," Mr. Austin said.

The company already has an extensive health care data base built on information from its indemnity plans. "But, the data base represents claims information from only 35% of our employees. So, it's hard to design benefit plans and programs to control costs when we don't have health information on 65% of our population," he said.

Some employers also are closely studying the cost and utilization experience of their employees both in indemnity plans and HMOs so they can accurately adjust their contributions to HMO premiums.

For example, Chicago-based Morton Thiokol Inc. decided it needed such a strategy to better control its health care costs. Of the roughly $50 million the company spends annually on health care for its 18,000 employees nationwide, approximately $6 million goes toward HMO premiums, according to Keith Carlson, manager of group benefits.

"We have offered HMOs for a number of years and, as part of our annual review of health care expenses, we looked at the HMO enrollment statistics of several of our plants," Mr. Carlson said. "As part of our overall strategy to manage our benefit plan, we felt we could not ignore this sizable portion of our health care costs."

"The company was suspecting that adverse selection was occurring against their indemnity plan," explained Susan Brown, manager of the actuarial and benefits consulting practice of Touche Ross Inc. in Chicago.

"By tracking the changes in HMO membership, we found that about 33% of the population had moved into HMOs in one of their locations," she said.

Morton Thiokol then decided to concentrate on two of its facilities with the highest penetration of HMOs: its Boston and Salt Lake City plants. About 3,000 of the 8,000 employees working at both plants are enrolled in HMOs, with 30% of the employees in Salt Lake City and 60% of the Boston employees enrolled in HMOs.

With the assistance of Newark, N.J.-based Prudential Insurance Co. of America—which administers claims under the company's self-insured indemnity plan—and Touche Ross, the company "analyzed the claims experience of the HMO enrollees before they went into the HMO," Mr. Carlson explained.

"We found that the enrollees had favorable claims experience under the indemnity plan and thought that our HMO premiums for these employees should be based on this experience," he said.

"We decided to be more aggressive in dealing with our HMOs, and in 1987 we approached them and asked for experience-type rates. We asked the HMOs to develop rates for different age brackets to reflect the lower health care costs of the younger, healthier employees that were enrolled in the HMOs," he said.

However, the HMOs serving the Boston and Salt Lake City locations were hesitant to provide these rates. But, Mr. Carlson said, the company felt it "had room in terms of the federal HMO Act to adjust" its contributions to HMO premiums.

"We based our premium contribution on the demographics of the entire employee group, including the demographics of the HMO enrollees. Then, as in the past, employees are required to contribute to the HMO premium any amount in excess of the company's contribution," Mr. Carlson explained.

This approach to reducing the employer's share of HMO premiums also was employed by New York-based J.C. Penney Co. and other employers a few years ago (*BI*, Dec. 23, 1985).

Computer Sciences Corp. of El Segundo, Calif., implemented several techniques to contain its HMO costs.

For example, CSC decided last year that it wanted to replace all of the approximately 70 HMOs it offered its employees with one nationwide network of HMOs administered by one company.

"We selected PruCare but met with a lot of resistance from our divisions," said Rena McAfee, corporate director of compensation and benefits for CSC, referring to the HMO network owned and operated by Prudential.

CSC has 18,000 employees in 225 locations nationwide, about 40% of which are HMO enrollees. HMO contracting is handled separately by each of the company's 16 divisions across the country, although CSC administers its indemnity plan from its headquarters.

"We determined that because of the $10 million we were spending on HMOs, we needed to consolidate the plans. Employee benefits is the only department that has a $10 million outlay and can't explain it or control it," Ms. McAfee said.

For 1988, CSC has asked each division to phase out one HMO and has restricted divisions from adding any new HMOs. "So, the number of HMOs eventually will be consolidated through these steps," she said.

And, the benefit plan design under PruCare is intended to give employees that select HMOs the incentive to join PruCare, she explained.

The company, for example, instituted an "escape clause" in its HMO plan that gives HMO enrollees the option to receive health care from non-network providers and still receive partial coverage, she pointed out.

If an employee elects to use a non-network provider, he or she pays a $250 deductible and a 30% copayment up to a maximum out-of-pocket expense of $3,000 annually.

Normally under an HMO plan, enrollees must use only network providers to receive any coverage.

CSC's indemnity plan requires a $150 deductible and a 20% copayment, up to an annual maximum of $1,500.

CSC also plans to negotiate or adjust HMO premiums to further control its HMO costs.

Foster Higgins and CSC conducted a demographic study similar to the one Morton Thiokol conducted in which the cost of providing health care for all CSC employees in HMOs and the indemnity plan was determined. CSC plans to use this information to negotiate or adjust HMO premiums.

"This information also serves the purpose of showing senior management that the company must consolidate its HMOs because it's affecting the bottom line," said Mr. Meister of Foster Higgins.

In addition to the study, CSC is requiring its HMOs to begin providing utilization data so that rates can be negotiated and substantiated, Ms. McAfee said.

"This is just the first step in asking HMOs to be accountable. We know everyone needs to make a profit, but we want to make sure it's the right amount of profit," she said.

But, some consultants say it could be a while before employers are able to obtain utilization review data, because most HMOs lack the means to collect and report employer- and employee-specific data.

However, Mr. Meister said he thinks "we're close to getting specific data from HMOs. Some are responding to this demand slowly, especially in the more competitive areas like Phoenix and Los Angeles. Some HMOs are seeing the ability to provide this data as a marketing advantage," he explained.

"How quickly the HMOs respond will depend on how serious employers get in demanding data," he added. ■

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Asbestos coverage

Continued from page 2

Since then, the company has been bombarded with thousands of asbestos bodily injury claims and, more recently, hundreds of claims from the owners of schools and other public buildings seeking billions of dollars for the cost of finding and removing asbestos in their buildings.

UNR speculates in its motion for partial summary judgment that, "the asbestos building cases may even surpass the massive litigation over asbestos-related bodily injuries" in terms of number of claims filed.

In its brief, UNR cites a 1985 study by the U.S. Environmental Protection Agency that estimated asbestos-containing materials can be found in as many as 31,000 school buildings and 733,000 other public and commercial buildings in the country.

While the company denies that asbestos in buildings constitutes a health hazard, it still maintains that its primary insurers—Zurich Insurance Co., Bituminous Casualty Corp., National Surety Corp. and Continental Insurance Co.—and its excess insurers—Northbrook Excess & Surplus Insurance Co., First State Insurance Co., The Home Insurance Co. and Continental Casualty Co.—have a duty to investigate and defend the company against these claims.

The insurers wrote 15 policies for UNR from 1961 to 1970, providing $4.3 million in primary liability coverage for third-party property damage, $9.5 million in primary bodily injury coverage and $60 million in total excess liability coverage with various attachment points.

In addition to alleging that some of the underlying claims are not subject to the policies' aggregate limits, UNR also is asserting that defense costs should not be included within the policy limits.

The insurers argue, in four separate motions, that they do not owe UNR a defense or indemnification.

At the outset, insurers say they have not and will not defend the third-party property damage claims pending against UNR because they are stayed by the bankruptcy hearing.

However, UNR states, "The fact that proofs of claim may remain unlitigated in the bankruptcy court while awaiting the objection of the insured does not relieve the duty of the insurer to defend."

In all four motions, the insurers argue that the claims do not represent property damage, but rather that UNR is seeking recovery for an economic loss incurred in the course of doing business.

But UNR argues that the claims do represent property damage because they allege asbestos damages the buildings, reduces the value of the buildings and its removal reduces the occupants' ability to use the buildings.

"Each of these items is a separate and independent trigger of UNR's insurance carriers' obligations under the 'property damage' provisions of the insurance policies purchased by UNR," according to the asbestos producer.

However, the insurers argue in their brief: "Asbestos in buildings does no injury to the buildings themselves." They assert that UNR is simply looking to shift the cost incurred for "having produced a faulty or undesirable" product.

Similarly, the insurers deny coverage for claims alleging diminution in the value of a building because it contains asbestos or loss of use of a building during asbestos removal where there is no physical property damage.

In a unique twist, UNR argues that the air space within buildings is tangible property and that because the claimants allege the air in their buildings is contaminated by asbestos fibers, there is property damage.

But the primary insurers label this "one of the most bizarre, tortured analyses of the concept of property ever put before the bench."

"It is ridiculous to suggest that the parties clearly intended 'space' to be tangible property covered by the property damage insurance," they say.

The insurers also argue that even if the claims against UNR do represent property damage, the claims do not fall within any of the policy periods because the damage did not occur until the owners of the buildings were aware that asbestos was dangerous—1979 at the earliest.

"It is only upon discovery that any injury occurs," assert the primary insurers in their motion. "Since no such discovery possibly could have occurred before 1979. . .there is no occurrence during the period of the primary policies and hence no duty to defend or indemnify."

According to the insurers, the dangers of asbestos were not widely known prior to 1979 and probably not before 1982, when the EPA issued regulations requiring the testing and identification of friable—or flaking—asbestos.

But, UNR states that since the claims against the company allege continuing damage from the time the asbestos-containing products were installed until they are removed, insurers on the risk from the date of installation must be held accountable.

In developing its definition of when coverage is triggered, UNR relies heavily on court interpretations in bodily injury cases. In many of those cases, the courts have ruled that because asbestosis begins to develop at the moment a person inhales asbestos fibers, coverage should begin at the time of exposure.

But the insurers say it is inappropriate to use a bodily injury definition for the trigger of coverage in a

Continued on next page

Mentor suit

Continued from page 1
under the federal Racketeer Influenced and Corrupt Organizations Act if the case were moved to Bermuda.

"The attorney for the liquidators was hoping to try this case in a forum which did not have a feel for reinsurance. It now looks likely to be tried in an environment where people understand the nature of reinsurance," said David Spector, a lawyer with the Chicago firm of Mayer, Brown & Platt, which represents ODECO.

"This is the most fundamental blow to the liquidator's case," he said.

"One of the reasons ODECO sought trial in Bermuda was because litigation proceeds more promptly there than in the U.S.," he added. "It is not in ODECO's best interests to delay this case."

However, one Bermuda source said the case would likely represent a significant burden to the Bermuda Supreme Court.

Indeed, a provision of Bermuda law could allow the chief justice of the Supreme Court to appoint an associate justice to assist in the trial, the source said.

Liquidator Charles W. Kempe Jr., a partner with Arthur Young & Co. in Bermuda, said he is considering appealing Judge Livaudais' ruling to the 5th U.S. Circuit Court of Appeals in New Orleans.

Mr. Kempe and Mentor co-liquidator Michael J. Arnold, another Arthur Young partner, filed suit against New Orleans-based ODECO and the other defendants in U.S. District Court for the Eastern District of Louisiana in March 1986, seeking to force ODECO and several ODECO and Mentor officers to cover the estimated $500 million Mentor insolvency (*BI*, March 24, 1986).

In addition to ODECO, the defendants are Mentor's immediate parent, Mentor Holding Corp.; Bermuda-based reinsurer Pinnacle Reinsurance Co. Ltd.; and current and former ODECO and Mentor Holding officers William L. Colson, Clovis H. Steib, Ronald W. Herman, Odie F. Vaughan, James L. Kilpatrick, Hugh J. Kelley, Herman S. Kelley and J. Douglas Higley.

The suit alleges that seven of the defendants devised a scheme to defraud Mentor, its policyholders and creditors by arranging excess-of-loss reinsurance contracts to conceal Mentor's true financial condition. The defendants have consistently denied the allegations since the litigation began.

Mentor took credit on its balance sheet for two reinsurance contracts with Pinnacle without disclosing other agreements providing that Pinnacle would not pay any reinsurance claims for 10 years from the inception of each contract, at which time a single lump-sum payment of a predetermined amount would be made, the liquidators allege.

As a result of the contracts, Mentor reported net income of $8.3 million in 1982 instead of a $2.5 million loss, and a net loss of $59,000 in 1983 instead of a $7.7 million loss, the lawsuit alleges.

Charging common law fraud, RICO violations and negligent misrepresentation, the suit seeks recovery of about $700 million in damages.

In their forum non conveniens motion, all 11 defendants argued that the civil case against them represented a transparent exercise in forum shopping.

The defendants claimed that by bringing the suit in New Orleans, the liquidators were ignoring Bermuda's strong ties to the dispute and its economic interests in the resolution of the case.

In addition, the fact that Bermuda law does not allow the triple damages recoverable under the U.S. RICO statute does not make the island an inadequate forum for the suit, the defendants maintained.

ODECO and the other defendants also alleged that Messrs. Kempe and Arnold were trying to prevent testimony by non-party witnesses based in Bermuda and, thus, outside the subpoena powers of an American court.

The motion for dismissal requested that the case be brought in a Bermuda court, that all related legal proceedings in the United States be stayed and that statute of limitations provisions on the case be waived provided the action was begun in Bermuda within a year (*BI*, Nov. 16, 1987; Nov. 9, 1987; Sept. 21, 1987).

Mentor's liquidators, meanwhile, urged Judge Livaudais to dismiss the defendants' motion.

The liquidators argued that Bermuda would be an inadequate forum for their claims, contending that the RICO claims could not be heard in a Bermuda court and that the forum non conveniens doctrine cannot be applied in RICO cases in any event.

In addition, the liquidators pointed out ODECO's view that none of the liquidators' causes of action could be heard in Bermuda. Messrs. Kempe and Arnold argued that if this proved to be correct, they would run the risk of being deprived of all legal remedies.

Making use of the defendants' own arguments, the liquidators said that if the suit is allowed to be brought in Bermuda, they would be unable to compel vital U.S.-based witnesses to appear.

But Judge Livaudais ruled that the first test of a proposed alternative forum is whether it is "available and adequate."

Other factors involved whether the private interests of the litigants or public interest favored trial in a foreign forum, the judge said.

"It is unquestioned that the plaintiffs, appointed by a Bermuda court to wind up the affairs of Mentor, are subject to jurisdiction in Bermuda," Judge Livaudais ruled.

"The court further finds that all defendants. . .have agreed to submit to jurisdiction in Bermuda."

Judge Livaudais described as "unpersuasive" the liquidators' contention that their RICO claim cannot be heard in Bermuda and that their case would be hampered by the island's limited discovery provisions.

"Neither the unavailability of RICO nor any alleged deficiencies in the complaint are sufficient to render Bermuda an inadequate forum. A forum is inadequate only where it would afford a plaintiff no remedy at all. . .as where the forum does not permit litigation of the subject matter of the dispute.

"There is no doubt that Bermuda permits litigation of the subject matter herein, namely common law fraud, negligent misrepresentation, breach of fiduciary duty and piercing the corporate veil. Therefore, for the purposes of forum non conveniens analysis, plaintiffs will not be deprived of all remedies by trial in Bermuda," the judge said.

The judge went on to point out that Bermuda's "allegedly more restrictive discovery practices" will impose no greater burden on plaintiffs than on defendants. He said that unless Bermuda discovery is so unfair as to deny due process, this aspect should receive little, if any, consideration in a forum non conveniens analysis.

"Finally, any possible prejudice to plaintiffs will be all but eliminated by making dismissal subject to a six-month stay to allow the parties to complete discovery in the United States before proceeding to Bermuda," Judge Livaudais ruled.

On the subject of private interest factors to be evaluated in considering the defendants' dismissal motion, Judge Livaudais said that the defendants' "professed" need for documents from third-party witnesses in Bermuda tips this factor in favor of trial in Bermuda.

Judge Livaudais also concluded that "considerably more live trial witnesses will be available in Bermuda than in New Orleans, where it appears that relatively few witnesses reside."

In any case, "the parties will still be able to depose the large number of witnesses residing elsewhere in the United States, since the court will subject its order of dismissal to a six-month stay to allow discovery," the judge said.

"As the overwhelming number of these witnesses reside in and around New York, we further hold that Bermuda is a closer and more convenient forum than New Orleans, should any of them be willing to testify at trial."

The judge said that another private interest factor affecting his decision was the enforceability of a final judgment. But he said that because the U.S. defendants had undertaken to accord "full faith and credit in any U.S. district court in which plaintiffs seek to enforce said judgment," enforceability will not be affected whether a judgment is procured in New Orleans or in Bermuda.

Judge Livaudais also disagreed with the liquidators' argument that the defendant's motion for dismissing the case in New Orleans was untimely and had been produced 18 months after the liquidators' suit was filed.

He said that although timeliness is another private interest factor in a forum non conveniens analysis, the court had considered the magnitude and complexity of the case and determined that the 18-month delay does not demonstrate the defendants were dilatory.

"We also note that this case has not reached the discovery stage, and we infer that dismissal at this juncture will not prejudice the parties' ability to prepare for trial," the judge ruled.

He said that public interest factors in the analysis included congestion in the New Orleans federal court and Bermuda's interest in having "localized controversies resolved at home."

"Bermuda has an interest dwarfing any this forum might have," because the alleged injury occurred to a Bermuda company whose affairs are being wound up under the laws of Bermuda and because the propriety of annual audits of Mentor are at the very heart of the suit, the judge ruled.

"Although we were (and are) prepared to recognize that the Louisiana residence of most of the defendants constitutes a Louisiana interest in the exercise of jurisdiction, we cannot say that the residence of the defendants is nearly enough to make Louisiana the more convenient forum," the judge ruled.

Responding to the liquidators' claim that numerous fraudulent acts had occurred in Louisiana, Judge Livaudais said: "If the defendants have perpetrated the fraudulent and negligent acts averred by the complaint, we are confident that a Bermuda trial court will see to it that defendants make good whatever harm they did, contrary to plaintiffs' repeated representations that defendants will go unpunished if they are not tried here."

He found that "whatever regulatory interests Louisiana may once have had in Mentor is scarcely reflected in this litigation, which arises out of no Louisiana risk insured by Mentor and involves no claims by Louisiana insureds against Mentor.

"Moreover, as defendants note, the proposition that Louisiana has a regulatory interest in this litigation cannot be squared with the fact that the Louisiana Insurance Department has closed its file on Mentor."

The judge further noted that the trial of the Mentor suit in New Orleans would raise problems not only with conflicts of laws but also with the application of Bermuda law, which, he said, would be involved in at least two of the liquidators' charges. ■

Asbestos coverage

Continued from previous page
property damage case.

The insurers also argue that coverage for the third-party asbestos property damage claims is barred by several exclusions in the CGL form:

- The "owned property" exclusion, which precludes coverage for damage to a policyholder's own property or products.

"The Supreme Court of Illinois has made clear that a policy with this exclusion is not intended to cover the costs associated the repairing or replacing an insured's own products," said First State in its motion.

However, UNR says: "The intent and effect of this exclusion is to bar recovery only of the cost of the defective product; it does not exclude coverage for injury to other property caused by UNR's products."

- The "loss of use" or "business risk" exclusions that bar coverage for the failure of UNR's products to perform satisfactorily.

"The only thing that is clear about this exclusion is that it does not apply to loss of use of property that has already been physically injured," UNR says. "Therefore, because the physical injury is alleged in the underlying cases, this exclusion is inapplicable."

UNR says the exclusion only applies when a product fails to perform as warranted, not when a product causes property damage. UNR's products did not fail to keep the building insulated, therefore the exclusion is not valid, according to the manufacturer.

- The "sistership" exclusion, which states there is no coverage when a policyholder withdraws its product from the market because of a known or suspected deficiency.

UNR contends that this exclusion only applies when the insured withdraws a defective product, not when the policyholder is forced to withdraw the product, as is the case with the asbestos claims.

However, insurers argue that "limiting the sistership exclusion to situations in which only the insured initiates withdrawal would not only be directly contrary to the plain policy language, but it would also lead to absurd results."

"Insureds who are in jeopardy because of a known defective product would never mitigate their potential losses by initiating withdrawals of their products," the insurers say. Rather, "they would simply await suits by the aggrieved public and pretend this plain exclusion does not apply—as UNR does here."

- The "pollution exclusion" clause, which bars coverage for claims arising out of the discharge, dispersal, release or escape of contaminants unless such pollution is "sudden and accidental."

Insurers say "neither the claimants nor UNR make any claims that the release of asbestos fibers is sudden and accidental" and, therefore, the pollution exclusion clause bars coverage.

UNR argues that the pollution exclusion clause only applies to pollution into or upon land, air or water—not to claims involving contamination of buildings.

UNR also states that none of the third-party asbestos property damage claims allege pollution and that the courts have said the exclusion only applies to willful industrial polluters.

And, in a joint motion, Continental Casualty and Northbrook say their policies contain an exclusion that states "coverage under this policy shall not apply in the case of any claims arising out of asbestosis."

However, UNR points out that Judge Brown, ruling in the coordinated asbestos coverage litigation in San Francisco, said, "The asbestosis exclusion does not apply to claims concerning property damage."

Therefore, UNR argues that this exclusion is not applicable in its case. The basis of Judge Brown's landmark decision is that asbestosis is a disease that is relevant to bodily injury claims, not property damage claims.

Insurers also vigorously oppose UNR's rationale that many of the claims can be covered under the bodily injury provisions of its CGL policies because many of the claims allege that asbestos is a trespasser and a nuisance since the owners of the buildings do not want it there and it interferes with their right to use and enjoy their property.

The bodily injury provisions insure, among other things, "wrongful eviction or other invasion of the right of private occupancy."

"The claims allege trespass and nuisance, and our insurance covers trespass and nuisance," said UNR attorney Mr. Pasich.

But the primary insurers say: "Even a cursory examination of the package shows that the property damage coverage is intended to cover physical injury to tangible property while the personal injury insurance is intended to cover injury to tangible interests of people. . . .People, not inanimate objects such as buildings, are the focus of the coverage."

But UNR goes one step further and says: "Even when a complaint or claim is not couched in terms of trespass or nuisance, UNR's carriers owe a defense under the personal injury hazard if the claimant alleges a potential health hazard due to the presence of asbestos-containing products in its building. The mere threat of future injury may interfere with the present use and enjoyment of land and thus constitute an actionable and present nuisance."

Insurers also reject UNR's argument that because some of the claims accuse the company of being a generator of dangerous materials under the Superfund Act, the cost of asbestos removal is covered under non-product provisions of UNR's CGL policies and, therefore, are not subject to aggregate limits.

The company says that because these claims do not allege a defect in UNR's products, but rather seek recovery for a statutory duty to remove the asbestos, the claims are covered.

"UNR's transparent attempt to distort this toxic waste legislation fails for two reasons," according to the primary insurers. "CERCLA claims are not covered 'property damage' and do not constitute claims for 'damages' under these policies."

In addition, the Superfund Act does not apply to claims involving asbestos removal, the primary insurers assert.

"UNR's 'personal injury' and 'non-product' coverage assertions are completely without merit and, needless to say do not raise even the potential for coverage," the insurers say. ■

Update

Tobacco maker cover-up eyed

Continued from page 2

Lorillard had failed in their legal duty to warn Mrs. Cipollone of the dangers of smoking. However, he allowed that claim to stand against the Liggett Group because Mrs. Cipollone had smoked that company's cigarettes before 1966, when federal law first required health warnings on cigarette packages.

Judge Sarokin ruled Oct. 27, 1987, that the plaintiff could not recover against the three tobacco manufacturers under the "risk/utility" theory of strict liability, under which the companies would be liable for manufacturing a defective product because the risk to users significantly outweighs the benefits (*BI*, Nov. 2, 1987).

Acne drug tied to birth defects

WASHINGTON—The Food and Drug Administration will hold a hearing Tuesday to consider a range of possible actions—including a ban—on the anti-acne drug Accutane, manufactured by the Roche Laboratories division of Hoffmann-La Roche Inc.

An internal FDA document revealed last week estimated that the drug's use by pregnant women caused severe birth defects in 900 to 1,300 babies born between 1982 and 1986, and caused 700 to 1,000 spontaneous abortions. The FDA estimates that 16,000 to 23,000 pregnant women used the drug during those years.

But, Howard Rofsky, director of clinical marketing for Roche, said that the FDA estimates—based on Michigan Medicaid figures—"grossly overstated" the number of birth defects caused by Accutane, and that only 62 cases have been tied to the drug to date. He also pointed out that since the drug was introduced in 1982, it has included warnings against use by pregnant women.

Mr. Rofsky would not comment on whether any product liability claims have been filed against Roche connected with Accutane, which produces about $40 million to $50 million in annual sales. Hoffmann-La Roche's risk manager could not be reached for comment on the company's insurance coverage.

Briefly noted

Finnish insurance group Kansa Corp. Ltd. today hopes to announce details of its plans to acquire **Clarendon America Insurance Co. and subsidiary Clarendon National Insurance Co.** this week. The Clarendon companies are units of Bermuda-based Clarendon Group Ltd., which is already 30% owned by Kansa. . . .Massachusetts Gov. Michael Dukakis last week signed legislation requiring all employers with more than five employees to provide **health care coverage** valued at $1,680 per employee annually or pay a surcharge on state unemployment insurance that equals $1,680 per employee. The law takes full effect in 1992 (*BI*, April 18).

Reinsurer subsidiaries offer services to risk managers

Markets

Two U.S. reinsurers have formed subsidiaries to help risk managers solve insurance coverage problems.

U.S. risk managers can access the products and services of New York-based American Re-Insurance Co. through a new subsidiary: Am-Re Managers Inc. of Princeton, N.J.

And, Stamford, Conn.-based General Re Corp. is forming a new underwriting management unit to provide insurance and reinsurance services to such alternative risk financing vehicles as captives, risk retention groups and purchasing groups.

The facility, Genesis Underwriting Management Co., will underwrite workers compensation and general and auto liability coverages through two General Re subsidiaries, General Reinsurance Corp. and General Star National Insurance Co., according to Genesis President G. Roger Greiner.

Am-Re Managers "will be in a unique position to form unique solutions to non-traditional problems," said American Re Executive Vp Paul Inderbitzin, who announced the formation of the company last week at the 26th annual Risk & Insurance Management Society Inc. in Washington.

In addition to risk managers, Am-Re target clients include captives and standard insurance companies with unusual problems to solve for policyholders.

Am-Re Managers intends to bring together the client, primary insurer and broker in the initial planning of a program, Mr. Inderbitzin explained. Traditionally, the primary insurer has been the only entity to deal with the reinsurer, he noted.

Am-Re intends to offer working buffer layer coverage, written with and without aggregate caps.

Other Am-Re services offered include claims, actuarial, financial and data processing.

There is no minimum premium required to deal with Am-Re Managers.

The new subsidiary is under the direction of: James Pearce, executive vp, overseeing planning and interfacing with American Re divisions; Stephen Satler, senior vp, in charge of marketing, including client services and interdivisional coordination; and Richard Moser, vp, executing administration.

Mr. Pearce and Mr. Satler also retain their responsibilities in the major accounts department of American Re, which was formed in 1981.

Meanwhile, Genesis will use its parent, General Re, to provide direct excess workers compensation coverage and reinsurance on workers comp, general liability and auto programs, while General Star National will provide primary general and auto liability coverages, Mr. Greiner explained.

The facility will be used in a variety of ways, he noted. For example, General Re may provide excess workers compensation insurance over qualified self-insured or captive programs, or could act as a reinsurer for captive workers comp or general and auto liability programs.

General Star National may provide primary admitted insurance to purchasing groups formed under the federal Risk Retention Act or act as a policy issuing company, ceding business to a captive insurer, he said.

In addition, General Star National could write primary coverages for risk retention groups, which would then reinsure General Star, or provide gap layer excess coverages for the groups below commercial umbrella excess layers, Mr. Greiner explained.

The facility can provide a $10 million limit on excess insurance or reinsurance of workers comp risks and a $5 million excess insurance or reinsurance limit on general and auto liability risks.

The minimum self-insured retention or captive retention on general and auto liability programs is $250,000, he said.

General Re also maintains a rent-a-captive program as an alternative for those who, for various reasons, are not ready to form their own captive or risk retention group, Mr. Greiner noted.

General Re Corp. units have been providing various insurance and reinsurance coverages to alternative risk financing vehicles for some time, but the growth of these programs has prompted the company to form Genesis as a separate group to handle the business.

"The concept itself is not new. It's just a redirection internally," Mr. Greiner explained.

General Re business of the type that will be handled by Genesis generated about $125 million in gross premiums in 1987, and this will grow to about $166 million this year, he predicted.

Between 75% and 80% of the 1987 business represented direct excess workers comp insurance and workers comp reinsurance, while the remainder represented liability coverages written excess of SIRs or excess of coverage written by captives, he said.

Genesis will probably see an increase in the liability programs' share of the business, though this increase will probably come from self-insured and captive programs, because risk retention and purchasing group programs are difficult and time-consuming to establish, he said. ■

OSHA ruling

Continued from page 2

The investigator was following up on an employee's complaint that assembly division workers were getting headaches from smoke and fumes generated by three tractors.

In addition, the worker complained that another machine was unsafe because it spewed dust and broken earthenware, Ms. Beard said.

While at the plant, the OSHA investigator asked to see two records OSHA requires employers to maintain: Form 200, a log and summary of all recordable occupational injuries and illnesses, and Form 101, which contains supplementary information about those injuries and illnesses.

A.B. Chance's manager refused to produce the forms but allowed the OSHA official to inspect machinery, the 4th Circuit's 12-page decision says.

The OSHA investigator repeated his request to see the forms a week later, but an A.B. Chance manager refused access to the forms without a search warrant. On May 3, 1984, the OSHA investigator notified the company that it had violated governmental regulations designed to protect OSHA's ability to inspect the records.

Subsequently, the Labor Department sought to enforce its citation against the company before the Occupational Safety and Health Review Commission, an independent agency. However, no penalty was ever proposed for the citation.

Instead, an administrative law judge found in January 1985 that A.B. Chance "had no reasonable expectation of privacy" because the two forms "were maintained in accordance with OSHA regulations and were not general business records."

The judge also found that the required forms were sufficiently limited in scope to make it "reasonable" for an employer to produce the forms for inspection and that requiring the employer to do so did not violate the company's Fourth Amendment constitutional guarantee of freedom from unreasonable searches and seizures.

But, in March 1987, the review commission reversed the administrative judge's decision, and held that, under the Fourth Amendment, production of the forms "may not be required without a warrant or a subpoena."

The 4th Circuit reversed the review commission and upheld the administrative law judge's decision. The court ruled that "Chance had no reasonable expectation of privacy" regarding the forms and that the OSHA officer's review of the records "was not an unreasonable search in violation of the Fourth Amendment."

The 4th Circuit's decision acknowledges that the U.S. Supreme Court recognizes that businesses may have a legitimate expectation of privacy at their premises and "that, as a general rule, procurement of some type of warrant is required before an administrative search of business premises."

However, businesses' privacy expectations are "diminished" when a governmental agency requires that records be kept up-to-date, available for inspection, summarized annually and posted in a conspicuous place, the court ruled.

In addition, the judges disagreed with A.B. Chance's contention that allowing this type of warrantless search "devolves almost unbridled discretion" upon an OSHA investigator in his field search.

In their opinion, the 4th Circuit judges expressly disagreed with the 11th Circuit's decision, which "does not address the more important inquiry of whether the expectation of privacy is reasonable, and it does not balance the need to search against the invasion, which the search entails."

Ironically, A.B. Chance is related to the company that benefited from the pro-warrant decision in the 11th Circuit case. A.B. Chance was partially spun off last year from Emerson Electric Co. of St. Louis. The 11th Circuit's pro-warrant decision upheld actions by Emerson's Electronic and Space Division, which has operations in Florida, a company spokesman explained.

A.B. Chance's attorney declined to comment on the conflicting court decisions because the rehearing request is pending before the 4th Circuit.

However, a spokeswoman for the National Assn. of Manufacturers said, "The manufacturing community is consistently and deeply concerned about conflicting rules, vague guidelines and the lack of uniform policy." ■

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AIDS case management

Continued from page 3

in the next couple of years," Dr. Strickland warned.

To best manage AIDS cases, "it is important for us to utilize the experience of regions of the country that have had the highest concentration of cases, like San Francisco and Los Angeles."

"Case management of AIDS has been very successful in these areas," in terms of managing costs and making afflicted persons as comfortable as possible, Dr. Strickland said.

For example, in these cities, extensive social service organizations like the Shanti Project and AIDS Project Los Angeles help AIDS victims with meals, laundry, getting to the doctor and, in some cases, insurance benefits counseling.

And, some health care providers are emphasizing more outpatient treatment of AIDS patients whenever possible, Dr. Strickland said.

"We have been able to save considerably by treating things like pneumocystis (an AIDS-related pneumonia) outside the hospital. Through outpatient testing and home health care we can average $150 to $200 per case. Some cases treated in the hospital can run over $20,000 and can put the patient through invasive diagnostic testing," he explained.

Psychiatric and substance abuse cases also pose great health care expenses for employers.

These costs are even greater when the patient is an adolescent dependent covered by the employer's benefit plan, according to Dr. Frederick B. Hebert, director of child and adolescent psychiatric services at the University of Colorado Medical Center in Denver.

A major reason for the high cost of this care is that many cases are treated in the hospital and the lengths of stay can be 30 days or more, he said.

For example, "an inpatient treatment such as detoxification for substance abuse can take 15 days or less. A stay in a crisis unit can be 30 days while a long-term stay can be 60 days or more," Dr. Hebert explained.

Various counseling and treatment programs can be utilized either separately from or following an inpatient treatment, he explained. These include day treatment or partial hospitalization—where the patient spends days at a hospital but goes home at night—and group treatment and counseling homes.

Employers should select coverage for mental health and substance abuse treatment wisely, he said. "Cover the general areas of human functioning, such as social, physical, emotional, cognitive recreational and work."

Employers should require their indemnity plan insurers to cover multiple treatment methods so that the most appropriate and successful treatment can be obtained, he said. For example, treating adolescents often requires family counseling and group therapy.

To best manage AIDS cases, 'it is important for us to utilize the experience of regions of the country that have had the highest concentration of cases, like San Francisco and Los Angeles,' says Dr. Scott R. Strickland, noting that case management of AIDS has been 'very successful in these areas.'

In addition, covering medication therapy for mental illness "can make the difference between having a child in the hospital and being treated as an outpatient," he explained.

Both AIDS cases and psychiatric and substance abuse cases can be effectively managed through case management programs, the experts said.

"The key components to successful case management are early identification of the case, the use of specialized health care professionals, on-site involvement of the case manager and the ability of the case manager to implement cost-effective alternatives," explained Jackie Mazoway, a registered nurse and national product manager for case management for Wayne, Pa.-based Intracorp.

"The phases of the case management process are assessing the patient, coordinating care and evaluating the care under the alternative plan once implemented," Ms. Mazoway said.

The case manager must assess the medical status of the patient, such as evaluating the current treatment plan. And, in AIDS cases, the case manager should assess the patient's understanding of the medical issues of the disease, she said.

In addition, when addressing AIDS cases, "the case manager also must assess the presence of opportunistic infections and the patient's ability to perform the activities of daily living, such as eating and bathing," she said.

In developing an alternative treatment plan, the case manager must consider the level and degree of care the patient needs and the cost-effectiveness of the alternatives.

The manager also must identify the available community-based support groups and what role the patient's family or significant other will play in the care, Ms. Mazoway explained.

In coordinating care, "the case manager must first get the alternative plan approved by the payer or employer. The patient's attending physician also must approve the plan and the patient must agree to the plan," she said.

Then, the case manager coordinates the resources necessary to implement the plan, she said.

These resources can include support groups such as APLA, a visiting nurse or physician to deliver medication and a custodial care giver who assists the patient with daily activities, she said.

Once the plan is implemented, the case manager must evaluate its effectiveness to identify any shortcomings as well as any changes in the medical, psychosocial or financial status of the patient, Ms. Mazoway said.

"The manager also should assess the effectiveness of the alternative plan as well as identify any further alternatives," she said.

If effectively performed, case management has significant advantages for the employer and the patient, said John R. McCartie, benefits manager for New York-based Westvaco Corp.

"Case management should enable the employer to lower claims costs as well as save on long-term disability because employees often can get back to work sooner. You should be able to return the employee to a productive capacity and let the employee know you care," explained Mr. McCartie.

Westvaco is a paper manufacturer with about 7,000 employees covered by its indemnity plan, which is underwritten by Hartford, Conn.-based CIGNA Corp.

The company implemented a case management program six months ago as part of its utilization review program, which is administered by Intracorp, a CIGNA subsidiary.

Westvaco decided to implement the case management program after discovering that 263 claimants had generated more than $6 million of the $14 million in total claims incurred by the company, he said.

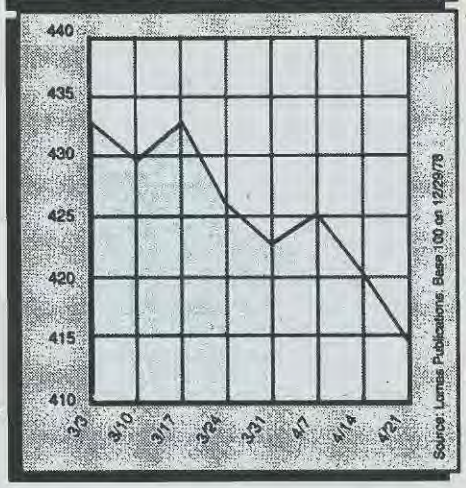
"So, just 2.6% of our claimants accounted for 43% of our claims dollars," Mr. McCartie said. While the company can't estimate the savings under the 6-month-old program, Westvaco expects the program to help it control high-cost cases, he said.

To achieve the best results from case management, employers implementing case management should be sure their benefit plan will support the program, he said.

"The broader the basic plan coverage, the more flexibility the case manager will have. And, this prevents you from having to break ground every time a catastrophic case occurs. Also, exceeding plan limits could set precedents and may cause problems with your bargaining units," because unions may demand for all cases the same unique treatment delivered in catastrophic cases, he said.

Mr. McCartie moderated the panel. ■

BI Insurance Index



Insurance industry stocks continued their downward trend last week, as the *Business Insurance Index* plunged 5.5 points to 415.0 on April 21, from 420.5 on April 14. Advancing issues were led by: SCOR US Corp., up 12.5%; Lawrence Insurance Group, up 8.5%; Zenith National Insurance Corp., up 8.1%; Poe & Associates Inc., up 5.7%; Argonaut Group, up 4.7%; Arthur J. Gallagher & Co., up 4.3%; and Seibels Bruce Group Inc., up 4.3%. Declining issues were led by: Frank B. Hall & Co., down 11.1%; Aneco Reinsurance Ltd., down 9.9%; St. Paul Cos. Inc., down 9.4%; Hanover Insurance Co., down 7.9%; Chubb Corp., down 6.4%; Phoenix Re Corp., down 6.3%; and Hilb, Rogal & Hamilton, down 6.3%. Issues showing the most activity during the period were: Sears, Roebuck & Co. (Allstate), 3.8 million shares traded; Farmers Group Inc., 2.6 million shares traded; and St. Paul Cos. Inc., 2.4 million shares traded. The *Business Insurance Index* sagged 1.3% for the period, on par with the leading market indicators: the Standard & Poor's 500 also fell 1.3%, as did the New York Stock Exchange Composite; the Dow Jones 30 Industrials slipped 0.9%.

British Issues

April 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	332	12.6	21.9	6.4	335—	330
Genl Accident	920	10.7	47.9	5.1	920—	918
Gdn Royal Exch	900	13.4	55.2	6.1	907—	883
Royal	415	11.0	26.4	6.2	418—	410
Sun Alliance	948	15.5	43.1	4.4	949—	942
Brokers						
Bradstock	220	12.4	6.8	3.0	220—	219
CE Health	382	14.1	34.5	8.7	385—	372
Hogg Robinson	140	11.2	9.6	6.7	140—	138
Lloyd Thompson	167	14.5	6.8	4.0	167—	165
PWS Holdings	184	7.7	14.4	7.6	184—	179
Sedgwick Grp	213	13.2	16.4	7.5	218—	213
Steel Brrl Jones	184	11.4	13.7	7.2	186—	175
Willis Faber	226	11.9	15.4	6.7	230—	223

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

APRIL 21, 1988 **4/15/88 THRU 4/21/88**

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	22.13	1.1	24.7	24.50	17.75	549	1.00	4.5	14.5	3.40	6.51
Baldwin & Lyons Inc.	OTC	13.50	0.0	12.5	15.50	12.00	1	0.20	1.5	5.1	18.66	0.72
Corroon & Black Corp.	NYSE	32.13	0.4	13.7	34.75	28.00	134	1.08	3.4	15.2	5.43	5.92
Gallagher Arthur J. & Co.	NYSE	15.00	4.3	-6.3	18.00	13.88	61	0.48	3.2	9.9	4.81	3.12
Hall Frank B. & Co.	NYSE	4.00	-11.1	38.9	5.50	2.88	189	0.00	0.0	9.9	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.25	-6.3	15.4	12.75	9.75	15	0.00	0.0	9.9	0.00	N/A
Lawrence Ins. Group	AMEX	14.25	8.5	111.1	14.00	6.88	16	0.32	2.2	14.5	4.10	3.48
Marsh & McLennan Cos. Inc.	NYSE	48.75	-1.3	-1.5	55.63	45.25	539	2.40	4.9	11.9	6.74	7.23
Poe & Assoc. Inc.	OTC	9.25	5.7	32.1	9.25	6.75	0	0.40	4.3	9.0	0.57	16.23
BROKERS	AVERAGE		0.1	26.7					2.7	11.4		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	24.00	-1.0	0.0	29.00	23.50	234	0.36	1.5	5.9	17.63	1.36
Berkshire Hathaway Inc. DEL	OTC	3650.00	3.5	23.7	3725.00	3000.00	153	0.00	0.0	19.5	69.38	9.88
CIGNA Corp.	NYSE	44.38	0.9	1.1	51.88	43.50	844	2.96	6.7	5.5	50.12	0.89
CNA Fin'l Corp.	NYSE	57.63	-0.6	3.6	64.25	51.00	171	0.00	0.0	8.9	42.71	1.35
General Re Corp.	NYSE	48.50	-3.0	-13.2	56.38	45.50	1586	1.20	2.5	10.1	26.60	1.82
ITT (Hartford Group)	NYSE	45.50	-1.6	1.1	49.25	43.25	1893	1.25	2.7	6.3	52.23	0.87
Sears Roebuck & Co. (Allstate)	NYSE	35.00	2.2	4.1	39.88	32.25	3846	2.00	5.7	8.6	32.94	1.06
Transamerica Corp.	NYSE	31.63	-1.9	6.3	36.75	29.75	511	1.84	5.8	5.8	24.95	1.27
CONGLOMERATES	AVERAGE		-0.2	3.3					3.1	8.8		
INSURERS												
Aetna Life & Cas Co.	NYSE	42.38	-2.3	-6.3	49.88	42.38	1036	2.76	6.5	5.7	53.56	0.79
American General Corp.	NYSE	29.63	-3.6	-6.7	36.38	29.63	1547	1.40	4.7	7.8	27.99	1.06
Amer Heritage Life Invt	NYSE	24.75	-2.0	2.1	26.00	24.00	1	0.96	3.9	11.6	21.70	1.14
Amer Indty Fin'l Corp.	OTC	9.25	2.8	2.8	9.75	8.25	8	0.56	6.1	11.6	20.30	0.46
American Int'l Group	NYSE	50.50	-5.2	-15.8	65.38	50.63	1856	0.30	0.6	8.8	34.54	1.46
Aneco Reins Ltd.	OTC	3.38	-9.9	0.0	4.00	3.13	4	0.00	0.0	4.6	2.51	1.35
Aon Corp.	NYSE	24.38	-2.0	6.6	27.00	21.88	257	1.28	5.3	8.7	15.13	1.61
Argonaut Group	OTC	44.25	4.7	48.7	49.00	29.50	309	0.00	0.0	7.2	29.19	1.52
AVEMCO Corp.	NYSE	24.00	0.0	22.3	25.25	17.88	13	0.28	1.2	11.7	7.74	3.10
Belvedere Corp.	AMEX	4.75	-2.7	8.4	6.00	4.38	7	0.04	0.8	11.3	7.87	0.60
Business Mens Assurn Co.	OTC	32.00	-3.0	19.6	36.00	25.50	31	1.20	3.8	86.5	27.39	1.17
Chubb Corp.	NYSE	51.50	-6.4	-7.8	63.38	51.50	912	2.16	4.2	6.2	46.13	1.12
Continental Corp.	NYSE	35.88	-4.0	-7.4	41.63	35.25	1018	2.60	7.2	6.7	42.10	0.85
Durham Corp.	OTC	26.25	0.0	22.1	28.00	21.50	7	0.92	3.5	22.4	26.00	1.01
Farmers Group Inc.	OTC	63.00	-0.2	56.5	65.75	40.50	2638	1.44	2.3	16.2	22.15	2.84
Fireman's Fund Corp.	NYSE	27.38	-2.7	5.3	31.00	25.75	175	0.50	1.8	30.1	26.17	1.05
Fremont Gen Corp.	OTC	10.50	-1.2	9.0	13.50	9.25	84	0.60	5.7	30.1	16.75	0.63
Home Group Inc.	NYSE	12.00	0.0	1.0	14.38	11.50	273	0.20	1.7	2.5	17.65	0.68
Hanover Ins Co.	OTC	22.00	-7.9	-5.4	26.25	22.38	61	0.36	1.6	4.8	25.10	0.88
Harleysville Group Inc.	OTC	15.25	-1.6	16.2	16.38	13.38	18	0.40	2.6	7.5	16.18	0.94
Hartford Steam Boiler Insp	OTC	27.25	-1.8	18.5	29.25	22.50	84	1.20	4.4	10.1	10.65	2.56
Kans City Life Ins	OTC	29.50	0.0	12.4	29.50	25.25	0	0.00	0.0	10.1	0.00	N/A
Kemper Corp.	OTC	21.75	-2.2	6.1	25.25	20.75	637	0.72	3.3	6.8	27.11	0.80
Liberty Corp. S.C.	NYSE	45.25	0.6	27.5	47.25	34.50	18	0.80	1.8	17.3	17.40	2.60
Lincoln Nat'l Corp.	NYSE	43.13	-4.2	7.5	48.75	40.25	195	2.36	5.5	8.3	36.62	1.18
NAC Re Corp.	OTC	22.25	3.5	25.4	24.50	18.50	18	0.00	0.0	15.3	19.92	1.12
Nobel Ins Ltd.	OTC	4.75	-5.0	-45.7	9.50	4.50	66	0.40	8.4	22.6	9.37	0.51
Northwestern Nat'l Life	OTC	25.50	-1.9	11.5	29.25	22.63	166	1.12	4.4	6.9	35.05	0.73
Ohio Cas Corp.	OTC	35.00	-0.7	-3.4	38.25	33.25	125	1.88	5.4	8.1	27.86	1.26
Old Rep Int'l Corp.	OTC	21.75	-2.8	8.8	24.63	19.13	142	0.74	3.4	5.0	27.82	0.78
Orion Cap Corp.	NYSE	15.38	-3.1	13.9	17.25	13.13	15	0.76	4.9	15.2	11.55	1.33
Phoenix Re Corp.	OTC	7.50	-6.3	15.4	8.75	6.75	52	0.00	0.0	4.7	10.15	0.74
Protective Corp.	OTC	14.38	-1.7	17.4	15.13	12.25	122	0.70	4.9	14.1	16.98	0.85
Provident Life & Acc Ins Co.	OTC	19.38	0.0	24.0	21.88	15.63	124	0.84	4.3	48.5	27.00	0.72
St. Paul Cos. Inc.	OTC	38.50	-9.4	-16.3	51.00	39.50	2407	2.00	5.2	5.7	36.34	1.06
SAFECO Corp.	OTC	23.50	1.1	-15.3	30.00	23.00	574	0.96	4.1	7.5	21.39	1.10
SCOR US Corp.	OTC	9.00	12.5	-2.7	9.25	7.25	98	0.00	0.0	6.9	9.20	0.98
Seibels Bruce Group Inc.	OTC	12.25	4.3	8.9	14.25	11.00	86	0.80	6.5	8.2	12.88	0.95
Selective Ins Group Inc.	OTC	23.00	0.0	21.1	23.25	19.25	124	1.08	4.7	6.1	19.47	1.18
Statesman Group Inc.	OTC	4.06	-4.5	-13.4	2.75	1.88	86	0.05	1.2	6.1	5.43	0.75
Tokio Marine & Fire Ins	OTC	85.13	1.6	29.2	85.88	63.25	39	0.19	0.2	76.0	0.00	N/A
Torchmark Corp.	NYSE	29.63	-1.7	20.9	31.25	24.50	234	1.00	3.4	9.5	12.24	2.42
Travelers Corp.	NYSE	34.00	0.4	-3.2	40.00	33.25	725	2.40	7.1	8.3	45.28	0.75
Trenwick Group Inc.	OTC	11.50	-2.1	12.2	11.88	9.75	19	0.16	1.4	11.0	14.65	0.78
United Fire & Cas Co.	OTC	25.00	0.0	-3.8	27.00	24.00	5	0.96	3.8	4.8	21.64	1.16
United States Fid & Gty	NYSE	29.63	-3.3	4.0	34.38	28.88	782	2.64	8.9	6.0	19.53	1.52
UNUM Corp.	NYSE	20.50	-4.7	10.8	22.75	17.88	388	0.48	2.3	11.8	28.53	0.72
USLIFE Corp.	NYSE	36.25	-3.0	27.2	39.00	28.00	195	1.28	3.5	9.2	46.70	0.78
Washington Nat'l Corp.	NYSE	26.50	-3.2	11.0	28.50	24.00	36	1.08	4.1	20.9	34.12	0.78
Zenith Nat'l Ins Corp.	NYSE	20.13	8.1	34.2	21.25	15.00	333	0.80	4.0	9.7	12.26	1.64
INSURERS	AVERAGE		-1.5	8.7					3.5	14.0		
ALL COMPANIES	AVERAGE		-1.1	10.5					3.3	13.0		

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