

# Business Insurance

## Bain Clarkson to acquire Hogg, raising rank among brokerages

LONDON—Bain Clarkson Ltd.'s parent, Inchcape P.L.C., plans to acquire Hogg Group P.L.C. for 176.6 million pounds (\$263.2 million), ending speculation over who would buy the world's 12th-largest brokerage.

"I've been trying to get (Hogg) for four years," Simon Arnold, chairman of Bain Clarkson, said Friday. "It's long been my ambition to see Bain Clarkson move ahead."

When the deal is completed at the end of May, the firm will be known as Bain Hogg  
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## AIA, unions negotiating work comp reform deal

By MARK A. HOFMANN

WASHINGTON—Several labor unions and the American Insurance Assn. are close to agreeing on a health care reform proposal under which workers compensation medical benefits would still be paid by workers comp insurers but companies could negotiate alternative workers comp benefits with workers.

Modeled on a 1991 Massachusetts reform law, the proposal is designed to replace Title X, the section of President Clinton's Health Security Act that would shift payment of medical care for work-related injuries and illnesses to the group health care system from workers comp programs.

AIA officials discussed the proposal on the condition that their names be kept confidential.

Businesses have actively lobbied

against the president's workers comp proposal, and some argue that workers comp reform should not even be mentioned in a health care reform bill.

"Obviously, we don't like Title X as written," said an AIA source, adding that merging the two medical care systems would be even worse.

The source said that the Clinton plan does not recognize the unique aspects of workers comp, a complaint that has reverberated through the insurance industry since the issue of possibly combining workers comp medical care with group health care first arose last year.

For several months, the source said, the AIA has been negotiating with construction companies and unions, which have a long history of cooperating on safety and workers comp programs.

"It's a recognition that everybody is in this boat together," said Donald Elisburg, a Potomac, Md., labor attorney familiar with the AIA-labor talks.

*Business Insurance* has obtained an outline of the compromise, dated March 31. AIA sources say that the details are unlikely to change significantly if at all.

The compromise would leave state workers comp medical care systems intact. In return, it would permit workers to collectively bargain over arrangements that "specify binding obligations and procedures" in the delivery of medical care to injured workers. Such collectively bargained agreements could then effectively pre-empt state laws that now guarantee workers the right to choose their doctors.

The proposal is modeled on a 1992 pilot project run by the Pioneer Valley Building & Construction Trades Council and Bechtel Construction Co. (BI, May 31, 1993).

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### RIMS takes stage in New Orleans

J.A. "Tony" Bridger, outgoing president of the Risk & Insurance Management Society Inc., toots RIMS' horn during its membership meeting at the 32nd annual conference last week in New Orleans. Coverage begins on page 3.

## Congress springs into action

### Alternate health reform bills emerge

By MARK A. HOFMANN

WASHINGTON—Health care reform proposals are springing up like April flowers on Capitol Hill.

Rep. Pat Williams, D-Mont., last Thursday offered an alternative reform bill that primarily would restructure the alliances that are the centerpiece of President Clinton's reform proposal.

No sooner had Rep. Williams introduced his bill to the House Education and Labor Committee's Subcommittee on Labor-Management Relations, which he chairs, than the panel's ranking Republi-

can—Rep. Marge Roukema of New Jersey—announced that she would soon offer a GOP alternative.

Elsewhere in the House, Rep. John D. Dingell, D-Mich., continued efforts to forge a consensus behind a bill in his Energy and Commerce Committee. To help win the few votes he still needs for a committee majority, Rep. Dingell last week proposed absolving businesses with 10 or fewer employees from having to pay any portion of their employees' health costs, either through a direct mandate or through a payroll tax.

On the Senate side, meanwhile, Majority Leader George Mitchell, D-Maine, began circulating three limited modifications to the president's bill for the perusal of his Democratic Senate colleagues. Each version is designed to cut the cost of the Clinton plan by changing an assumption or two, such as reducing the value of the basic benefits package.

Much of the attention last week was focused on Rep. Williams' subcommittee, which began markup on a health care bill.

Complicating matters, though, Rep. Williams began by proposing that his subcommittee pass judgment on two bills—his measure

and also a single-payer bill. Nearly a dozen of the subcommittee's 16 Democratic members are co-sponsors of a single-payer bill drafted by Rep. Jim McDermott, D-Wash., a fact they made clear during opening remarks last Thursday.

Rep. Williams said that his proposal "builds on the president's principles" but improves on that bill in numerous ways.

Most strikingly, Rep. Williams would change the ground rules for regional health care purchasing alliances, which have been the target of employer ire since the president recommended requiring

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## Minnesota offers lesson for national reform effort

By CHRISTINE WOOLSEY

MINNEAPOLIS—Minnesota's experience with health care reform may offer valuable lessons to federal policymakers crafting national health care reform legislation.

Two years after passing MinnesotaCare, as the state's sweeping health care reform law is commonly known, Minnesota has achieved some of its goals, including small-group insurance market reforms and expanded access to health insurance for the state's uninsured.

But, state lawmakers and interest groups continue to clash over financing for universal coverage, which the state hopes to achieve by 1997.

And, during this year's legislative session—which happens to be an election year for Republican Gov. Arne Carlson and some of the state's key Democratic legislators—partisan politics threatens to halt further progress for reforms in the state.

What's more, many observers say the prospect of increased state oversight of the health care market has spurred Minnesota health care providers into action. Hospi-

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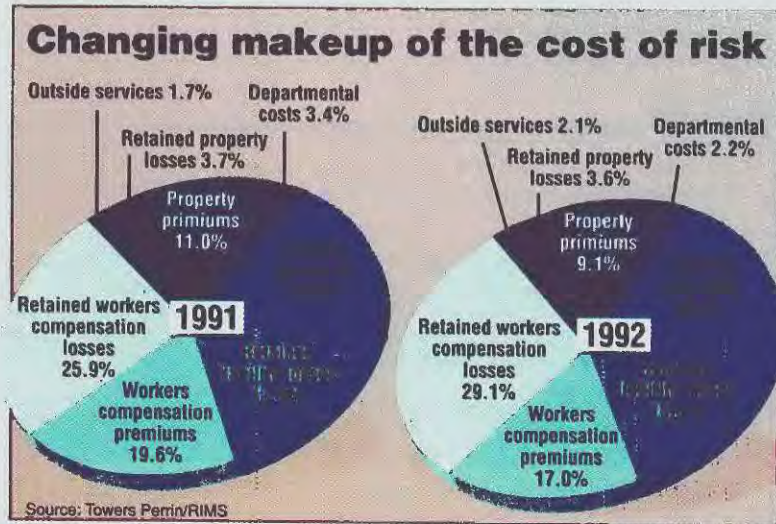
## Cost of risk still on the rise: Study

By SARA MARLEY

NEW ORLEANS—Most risk managers who attended the Risk & Insurance Management Society Inc. annual conference last week are seeing their staffs reduced, their budgets dwindle, and their offices take on greater responsibility.

At the same time, their property/casualty risk financing costs are increasing, with large companies seeing the greatest jump in premiums and retained losses combined.

Those are among the findings of the 1993 Cost of Risk Survey, an annual study of corporate risk management expenses conducted by RIMS and Towers Perrin.



Risk management staff size decreased 11% to 4.9 full-time equivalent employees in 1992, from 5.5 in 1991 (BI, July 5, 1993).

At the same time, risk management department budgets declined 22.2% to 14 cents per \$1,000 of revenue from 18 cents per \$1,000.

Expressed as a percentage of the cost of risk, departmental costs fell to 2.2% in 1992 from 3.4% in 1991. Conversely, the amount paid for outside risk management services increased during the same period to 2.1% of the cost of risk from 1.7%.

"I see more outsourcing rather than less," said Jerry Miccolis, practice leader of risk manage-

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## Updates

### Bain Clarkson to buy Hogg

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Clarkson. Anthony Howland Jackson, now chairman and chief executive of Hogg, will be chairman and Mr. Arnold will be deputy chairman of the combined brokerage firm. Mr. Howland Jackson previously was managing director of Clarkson Puckle Ltd. when it merged with Bain Dawes P.L.C. in 1987, after which he briefly served as managing director of Bain Clarkson before leaving to join Hogg.

Ron Forrest, chief executive of Bain Clarkson, will be chief executive of the merged brokerage. Mr. Forrest left Alexander & Alexander Services Inc.'s U.S. retail operation last year.

Bain Hogg Clarkson will be one of the largest U.K. retail brokers, while Hogg's U.S. subsidiary, Hogg Robinson Inc., will give it a U.S. presence. Hogg Robinson had gross revenues of \$68.6 million in 1992.

Based on 1992 revenues, the combined firm would be the world's seventh-largest broker (*BI*, July 5, 1993).

However, slow growth at both firms, combined with lower average currency exchange rates, could change that position when the 1993 rankings are published July 18. Combined revenues totaled 266.17 million pounds at year-end 1993, up 1.5% from 262.2 million pounds in 1992. But, based on average dollar exchange rates, revenues dropped 1.4% to \$399.3 million from \$462.9 million in 1992.

### Cats hurt P/C quarterly results

OLDWICK, N.J.—Huge catastrophe losses have hammered the property/casualty industry's first-quarter results and will boost the industry's combined ratio for all of 1994, A.M. Best Co. says.

January's earthquake in Los Angeles and brutal winter storms in the East will push the industry's first-quarter combined ratio to 117% from 105.5% in the fourth quarter of 1993, Best estimates. The quarter's heavy losses could also boost the full-year 1994 combined ratio as high as 111% from 106.9% for 1993, the rating agency predicted.

The quake has cost insurers \$5.3 billion, while the winter storm losses could "easily" hit \$2 billion, said Senior Vp John H. Snyder.

While the earthquake isn't likely to drive any insurers into insolvency, the winter storms could cause "financial havoc" for some companies, he added. Because the storms produced hundreds of thousands of small claims over multiple occurrences, reinsurance recoveries for most companies will be limited and net losses will be high, especially for single-state or regional insurers in the Northeast, he said.

### KAL case may be reopened

WASHINGTON—A federal judge will decide whether a liability judgment against Korean Air Lines in 1989 should be reopened in light of recently disclosed evidence from the Russian government about the 1983 downing of Flight 007.

Judge Aubrey E. Robinson Jr. held a hearing last Friday in the U.S. District Court for the District of Columbia to determine whether there should be a new trial based on tapes of Flight 007's cockpit voice recorder and digital flight data recorder, as well as transcripts of Soviet military communications. The KAL Boeing 747 was shot down Sept. 1, 1983, after entering Soviet airspace while en route to Seoul, South Korea. All 269 people aboard were killed (*BI*, Sept. 12, 1983).

A new trial could overturn a jury's 1989 decision—upheld on appeal—that KAL was guilty of "willful misconduct." The Warsaw Convention liability cap of \$75,000 per person does not apply to willful misconduct. Many of the 200 suits originally filed have been settled, but a new trial would affect 61 suits still pending or on appeal.

### Record OSHA fine contested

NASHVILLE, Tenn.—Bridgestone/Firestone Inc. says it will contest a record \$7.5 million in proposed fines for allegedly violating OSHA lockout/tagout rules in the case of a 1993 death at a Dayton Tire plant.

Calling the company's behavior "offensive and unjustifiable," Labor Secretary Robert R. Reich last week hand-delivered citations to the Oklahoma City plant for multiple violations of the rules that require employers to ensure machinery is disconnected from its energy source and inoperative before maintenance or service work begins.

The maximum fines of \$70,000 for each willful violation reflect that 98 other workers also are at risk of serious injury. Robert Julian, 25, died after his head was crushed in a tire-making machine.

OSHA also took the unusual step of obtaining a restraining order from a federal judge ordering the company to adhere to tighter safety standards. The company closed its plant for one day last week, until the judge lifted the order at least until a May 10 hearing.

Bridgestone/Firestone said it will contest the fine, arguing that the lockout/tagout standard does not apply when workers are operating—not servicing—the machinery.

### Lloyd's reserves questioned

LONDON—A new report on Lloyd's of London concludes that the market is underreserved for asbestos and pollution claims by at least 11 billion pounds (\$16.40 billion).

Insurance archeologists R.M. Fields & Co. says that Lloyd's needs 15 billion pounds (\$22.36 billion) in reserves to pay for its portion of billions of dollars in global asbestos and pollution claims. But Lloyd's

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### Notice to Readers

Due to a production error, the Reader Reply Service published in the April 18 issue was inaccurate. The correct Reader Reply Service for the April 18 issue appears on page 46 of this issue. To obtain information from any advertiser in the April 18 issue, use the form printed on page 46.

# Hoffenberg faces charge he diverted insurers' funds

By DOUGLAS McLEOD

CHICAGO—New York financier Steven Hoffenberg is facing federal charges that he siphoned more than \$3 million out of two Illinois insurers before the companies collapsed in 1988.

Mr. Hoffenberg, former head of Towers Financial Corp., a bankrupt New York debt collection firm, was indicted last week for allegedly diverting funds from now-defunct Associated Life Insurance Co. and United Fire In-

surance Co. of Des Plaines, Ill.

A 13-count fraud indictment charges that he illegally used the insurers' assets to support Towers' failed attempts to take over Pan American World Airways Inc. and Emery Air Freight Inc. He also diverted the insurers' money to pay personal expenses, including college tuition for his stepdaughter, prosecutors allege.

This is only the latest legal problem for Mr. Hoffenberg, who made a widely publicized attempt to acquire The New York Post in

January 1993.

The Securities and Exchange Commission sued him last year for allegedly defrauding investors of \$450 million in the sale of Towers promissory notes and bonds.

Towers filed for bankruptcy protection soon afterward. Mr. Hoffenberg was arrested in New York in February and has since been charged with securities fraud and obstruction of the SEC investigation, in what prosecutors have described as one of the larg-

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# IRI hit with large fire loss

Extent of damage to steel plant unknown, estimates vary

By DOUGLAS McLEOD

WEIRTON, W.Va.—A devastating fire at a Weirton Steel Corp. plant earlier this month could produce a loss in the tens of millions of dollars for Industrial Risk Insurers, industry sources say.

Weirton Steel was still trying to assess its damages last week after a fire swept through a rolling mill that supplies steel coils for the company's tin mill operations. The April 6 fire injured 13 people

and caused "extensive structural damage" that could affect about 20% of Weirton's production, the company said.

Weirton has not determined the cause of the fire, according to a spokesman. The steelmaker also has not estimated its damages or how long the mill will be closed. Though parts of the Weirton complex are up to 80 years old, the mill where the fire occurred was built in 1976 and was fully automated.

In a statement issued with its first-quarter results, Weirton said that it will rebuild the mill as soon as possible, but that the company is entering a peak season for its products and that its production and shipments will be hurt in the second quarter.

Insurance industry sources say they have heard damage estimates ranging from about \$50 million to more than \$100 million. Weirton could not confirm any estimate.

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## Ways and Means panel hears call for pension reform

# Economy ripe to boost funding: Reich

By MARK A. HOFMANN

WASHINGTON—The recovering economy makes now the best time to solve the problems of underfunded defined benefit pension plans, a Clinton administration official says.

Labor Secretary Robert Reich kept reiterating that message as he promoted H.R. 3396, the Clinton administration's pension funding reform bill, before the House Ways and Means Commit-

tee last week. During questioning by committee members, Mr. Reich added that he has been in contact with the leadership of other congressional committees that will pass judgment on the bill.

Committee members said the time to act is now.

"Failure to act will present us with greater problems in the future," said Ways and Means Chairman Dan Rostenkowski, D-Ill., before turning to the first panel of witnesses, which in-

cluded Mr. Reich, Pension Benefit Guaranty Corp. Executive Director Martin Slate and Assistant Treasury Secretary Leslie B. Samuels.

Rep. J.J. Pickle, D-Texas, and chairman of the Ways and Means Oversight Subcommittee, said that while the "PBGC does not face immediate collapse," the problem of pension underfunding could ultimately require a "congressional bailout" if steps to

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# New workers comp programs

By DAVE LENCKUS and GAVIN SOUTER

NEW ORLEANS—An insurer and a broker are touting two new workers compensation insurance programs that emphasize cost containment and offer employers premium savings.

American Home Assurance Co.'s new "Gain Share" retroactively rated workers comp program stresses cost-containment services designed to reduce policyholders' losses and, there-

fore, their total premiums. And, if a policyholder's actual losses exceed expectations, the American International Group Inc. subsidiary will pay a portion of the additional losses under the retro program.

Several other insurers, meanwhile, have agreed to negotiate reduced workers comp premiums upfront for large clients of Marsh & McLennan Cos. Inc. if the employers agree to implement the in-

surers' suggested cost-containment strategies.

Both American Home and M&M unveiled their programs last week.

"The theme song is we are putting our money where our mouth is," said American Home President B. Michael Schlenke at the Risk & Insurance Management Insurance Society Inc. conference in New Orleans.

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## Inside

• Benefit managers must stay in the thick of the health care reform debate, this week's editorial says. **PAGE 8**

• Haggard Apparel Co. has cut health costs through education, attendees heard at the National Managed Health Care Congress. Coverage begins on **PAGE 32**

• Some Lloyd's managing agents are canceling members' participation for 1995. **PAGE 39**

• The insurance industry is gearing up for China's first insurance law. **PAGE 39**

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# Employer input can shape reforms

*Employers are at risk of losing role in benefits*

By CHRISTINE WOOLSEY

NEW ORLEANS—Now more than ever employers need to get involved in lobbying efforts to help shape the outcome of federal health care reform, two corporate benefit executives say.

The biggest mistake employers—and employee benefit professionals—can make is to sit back and accept the inevitability of massive changes to the national health care system.

Rather, they should do whatever they can now to protect their role in planning and designing employee health care plans, the executives say.

Even more importantly, employers should guard against federal or state reforms that could erode the progress benefit managers have made in creating innovative employee health care plans to control rising health care costs.

So many employers are getting caught up in the almost daily ritual of determining how the latest reform proposal will impact their health plans, they are losing sight of the bigger picture, said Allen DeNiro, corporate vp of human resources for Turner Broadcasting System Inc. in Atlanta.

"I am angry by what I sense as an inappropriate response to health care reform by vendors, brokers and my peers. I sense there has been a complete acceptance to the inevitability of this happening. That's a premise I'd like to challenge," said Mr. DeNiro, who oversees the design and administration of benefits for Turner's 7,000 employees.

"Every newspaper in the country is dwelling on what health care reform will look like and the inevitability of it. I'm upset and disturbed our industry has given up" by accepting the premise that significant federal reforms are

Urging employers to get involved in reform efforts are, from left: Margaret Spyers, Stuart Weston, Allan DeNiro and Michael Murphy.



bound to occur, he said during a panel discussion on the impact of health care reform at the 32nd annual Risk & Insurance Management Society Inc. conference, held last week in New Orleans.

Mr. DeNiro also said he is tired of receiving calls from vendors who want to explain how the latest reform bill will affect his benefit plan. "I would like just once to get a call from someone who says, 'We are going to Washington, do you want to come with us? I'm very, very upset that hasn't happened so far.'"

Many large employers worry that federal health care reform will undo the positive changes they've made to their employee benefit plans, said Stuart Weston, director of risk management for the Pinellas County School Board in Largo, Fla.

Mr. Weston, who moderated the session, oversees the administra-

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tion of the school board's \$25 million employee benefit plan, which covers about 30,000 employees, retirees and dependents.

"A lot of us believe we shouldn't throw the baby out with the bath water," he said. While some health system reform is necessary, 80% to 90% of individuals are happy with the health care coverage they now receive. As a result, many large employers favor moderate, step-by-step intervention over wide-scale national reform, he said.

Massive federal health care reform "is going to cause those em-

ployers that have acted responsibly to suffer, and there is something about that that just doesn't make sense," Mr. DeNiro said.

"I know there are social reasons for health care reform. But I would submit that employees who work for organizations that have acted responsibly up to this point in terms of their benefit plan design will scream bloody murder when (federal reform) is imposed upon them. And, they are going to be very rightfully angry at people like you and me."

If Congress passes national health care reform this October or November, "Employees will say to us, 'Why didn't you do something? Why did you let my benefits plan change?'" Mr. DeNiro predicted.

What's worse, if the government imposes federal reforms like those described in President Clinton's proposals, benefit managers will

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## Proportional liability among changes to Superfund RIMS will seek

By SARA MARLEY

NEW ORLEANS—The Risk & Insurance Management Society Inc. is publicly opposing the Clinton administration's proposed Superfund reauthorization bill.

The position was approved by RIMS' board of directors and announced at the society's 32nd annual conference held in New Orleans last week.

Even though the announcement follows the tabling of the reform bill by a House subcommittee (BI, April 18), RIMS' position is still timely, said David R. Haight, RIMS vp-environmental. While the bill is stalled in the House, the Senate version has not been tabled, he pointed out.

Congress will likely make changes to Superfund, formally known as the Comprehensive Environmental Response, Compensation and Liability Act. "We can't afford to have Superfund continue as it is," said Mr. Haight, who is also director-risk management for CF Industries Inc. in Long Grove, Ill.

The worst-case scenario is for Congress to reauthorize Superfund without making major changes, as happened in 1986 when the law was last reauthorized, he said.

RIMS' position, drafted by the group's year-old environmental committee and approved unanimously by the more than 60 board members present last Sunday, will serve as the basis for RIMS' lobbying efforts, Mr. Haight said. The society's government and public affairs committee now is working to promote RIMS' position.

"We are already getting interest and support from members and other groups," he said.

Specifically, the five-page position paper recommends:

- Protecting policyholders that clean up sites voluntarily.

Currently, policyholders have to wait until "the EPA hits them with a club" to avoid jeopardizing liability insurance coverage, Mr. Haight said, since insurers maintain that voluntary cleanups are not covered under existing insurance policies.

- Replacing joint and several liability for potentially responsible parties with proportional liability shared by identified and viable parties. The law should draw a line on a specific date for historic waste disposal liabilities. Unallocated liability should be paid by a broadly based tax mechanism like, for example, a premium tax.

- Rejecting the proposed Environmental Insurance Resolution Fund outlined in the Clinton proposal. That fund, which would be financed by a new tax on insurers, would be used to clean up sites so long as a potentially responsible party agreed not to litigate with its liability insurers (BI, Feb. 7).

Recovery from the fund would be based on case law in the policyholder's home state. PRPs would receive from the fund 20%, 40% or 60% of cleanup costs, depending on whether the law in the state in which a cleanup coverage suit was filed favors the insurer, the PRP

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# A mandate to enact health care reform

*Congress likely will omit contentious provisions, lobbyist predicts*

By JERRY GEISEL

NEW ORLEANS—Despite deep divisions among members, Congress is almost certain to pass health care reform legislation this year, a business lobbyist predicts.

But the bill will be much more modest than a sweeping reform measure passed by the House Ways and Means Health Subcommittee in March or an earlier measure proposed by President Clinton.

Speaking last week at the Risk & Insurance Management Society Inc.'s 32nd annual conference in New Orleans, Sharon Canner, assistant vp of industrial relations at the National Assn. of Manufacturers, said legislators feel pressured—after months of hearings and national discussion—to pass a reform measure. "They feel they have to do something."

But, she added, the final reform bill is unlikely to include such contentious provisions as an em-

ployer mandate or caps on health care cost increases, elements of both the Clinton and the Ways and Means Health Subcommittee bills.

Instead, the measure will be more limited and far less controversial and will include such provisions as curbs on the ability of employers and insurers to deny health care coverage on the basis of pre-existing medical conditions, making it easier for employers to buy coverage through purchasing alliances and offering subsidies to help offset the cost to individuals to buy policies.

And, instead of an employer mandate, legislators might include a so-called trigger mechanism. Under that concept, Congress would set a target for reducing the number of individuals without health insurance, Ms. Canner said.

If that target was not met—perhaps within five or six years—then an employer mandate would

kick in, Ms. Canner said.

It also is possible that the final bill will include medical malpractice reforms, but those reforms probably wouldn't go as far as a measure approved by the Ways and Means Health Subcommittee, which would cap malpractice awards for non-economic damages at \$350,000.

Senate Majority Leader George Mitchell, D-Maine, who is likely to play a crucial role in trying to win approval of a reform bill on the Senate floor, opposes a cap on damages, she said.

Sen. Mitchell, whom Ms. Canner described as "helpful," recently outlined three alternative reform proposals, while House Energy and Commerce Committee Chairman John Dingell, D-Mich., has been drafting and floating proposals to see which one can win a majority of votes on his committee (see story, page 1).

Another sign of optimism, Ms. Canner noted, recently came from

Senate Minority Leader Robert Dole, R-Kan. During a meeting with NAM officials, Sen. Dole predicted that a bipartisan reform bill will pass this year.

One of the toughest issues that legislators are grappling with is whether employers should be required to pay for most of the cost of employees' health care coverage, Ms. Canner said.

Many legislators, even those who favor sweeping reforms, are worried about the impact an employer mandate would have on the smallest firms, she said.

Seeking to defuse opposition from the small business lobby, some legislators, most recently Rep. Dingell, are offering proposals that would either exempt very small firms—generally those with fewer than 10 employees—from a mandate or have them pay a small additional payroll tax.

The employer mandate is just as controversial in the business com-

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# POS plan may not be the bargain it appears

## MCA opts for own managed care plan

By CHRISTINE WOOLSEY

NEW ORLEANS—Employers getting a hard sell from insurers promoting point-of-service plans should take a careful look at what may be just marketing glitz, a risk manager and a benefit consultant advise.

Employers may achieve better control over plan costs and improve employee satisfaction by forging their own managed care plans.

MCA Inc., the Universal City, Calif.-based entertainment conglomerate, did just that in 1993. It developed an innovative flexible benefits program after rejecting an insurer's advice to implement a POS plan, which basically is a health mainte-

nance organization with an option to use non-network providers at higher cost.

"We've been able to get long-term solutions to benefit plan design problems, create leading-edge benefits and achieve finite cost control," said Susan Goodwin, MCA's corporate manager of group benefits. Ms. Goodwin moderated a session on achieving leading-edge benefits during the Risk & Insurance Management Society Inc. conference.

"MCA custom-designed a non-traditional flexible benefits plan that broke new ground in the way it is designed and operates," said Doyal Boring, managing director for William M. Mercer Inc. in Los Angeles, who helped MCA create its plan.

The self-insured company decided to offer four medical plan and three dental plan options with the goal of steering employees into the most cost-effective plans.

One of the reasons MCA rejected the POS plan was its cost-effective experience with its current HMOs, said John Surabian Jr., vp of risk management for MCA and coordinator of the session.

Traditional POS plans "attempt to move all employees into the POS product and get rid of all other HMOs," Mr. Boring said. But doing so may eliminate HMOs that are effectively containing costs.

"If you move all your employees from a traditional HMO into a POS program, all your experience moves into plans an insurer can follow and rate," Mr. Surabian pointed out.

"It's really a cloaked indemnity plan with a managed care design."

In addition, insurers often fail to fully explain the guarantees they make on claims experience in multi-year POS contracts, Mr. Surabian said. For example, an insurer may quote projected claims experience under a POS plan for the first year and promise to absorb all or part of the cost if claims exceed its projections. Then, in years two and three, insurers typically promise claims will rise no more than a certain percentage over the Consumer Price Index or some other inflationary measure.

Insurers don't explain that the base they will use to calculate the inflation component in years two and three will be an employer's actual claims experience under the

plan, not the insurer's projection of POS claims experience, Mr. Surabian noted. As more employees move into the plan, actual claims experience is likely to be worse than the insurer's projection, he explained.

Rather than adopt a POS plan, MCA decided to analyze its own health plan data and create several options. The company offers four medical plan options with basic and high-option coverage. Employees can choose a standard indemnity plan, a preferred provider option with basic or enhanced benefits, or an HMO.

The deductibles for indemnity and preferred provider plans range from \$200 to \$1,500 for individuals and from \$400 to \$3,000 for families. The firm designed the deductibles and out-of-pocket limits so that employees would have to pay higher costs for richer coverage.

Both indemnity and PPO plans also follow a gatekeeper model, Mr. Boring explained. Like in an HMO, the gatekeepers are primary care physicians that coordinate and approve all of the specialty care for patients.

But, MCA put a new twist on the gatekeeper concept by expanding the definition of primary care doctor. Among the physicians considered as primary care doctors are general and family practice doctors, as well as psychiatrists, chiropractors, podiatrists, acupuncturists, physical therapists, ophthalmologists and other mental health providers like social workers.

By expanding the definition of primary care physician, MCA was able to cut down on specialty referrals, Mr. Boring explained.

MCA also reduced costs by requiring employees to call its utilization firm to obtain permission for any non-emergency surgery, hospitalization or diagnostic tests.

The firm also contracted with a case management firm for its high-cost cases. "We didn't feel we could influence the number of cancer or heart cases through wellness programs, but we felt we could influence premature births and HIV/AIDS claims," said Mr. Surabian.

The company has had an overwhelming decrease in premature birth claims since instituting the case management program. In 1990, MCA spent \$1 million on such claims, and in 1991 it spent \$850,000. It had no premature birth claims in 1992 and only one in 1993, from a division that had not yet instituted the program.

The company's targeted case management program for employees with the human immunodeficiency virus, which causes AIDS, has been equally successful. Patients are targeted for early intervention and prevention and can get care for alternative treatments and care like nutritional counseling. In 1990, the firm paid more than \$800,000 in AIDS claims and in 1991 it paid \$700,000. No claims were reported in 1992 and in 1993 there was only one case, which cost less than \$25,000.

MCA made most of its plan design changes in April 1993 for its core group of companies and phased in components of the plans to other divisions in April 1994.

Thirty-seven percent of eligible employees are currently enrolled in the indemnity plan, compared with 51% before the plan changes. And, the remaining 63% of eligible employees are enrolled in HMOs or the PPO option.

MCA Group spent about \$3,500 per employee, excluding employee contributions, for all benefits in 1992, Ms. Goodwin said. In 1993, its per employee cost was \$2,900. After implementing the program changes, "We reduced our medical cost by \$400 per participant." **BI**



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# Flex plan offers retirees benefit choices

## Dow Corning retirees pick their own health plan

By JERRY GEISEL

NEW ORLEANS—At Dow Corning Corp., newly retired workers now have a choice.



Retirees receive flexible benefit "credits" to apply toward the cost of purchasing different

employee benefits.

They can use the credits to receive coverage through a rich medical plan that pays for 90% of health care bills. Retirees choosing this plan not only will use up all their credits but will have to make additional contributions to cover part of the premium.

Or, they can opt for a lower-cost plan—one that covers 80% of the expenses—and not share in paying the cost of the premium. But, retirees choosing this option will not have any credits left over to purchase other benefit coverages.

Retirees have a third choice: They can use their flexible benefit plan credits to select a plan with the highest coinsurance requirement—one in which retirees pay 30% of medical bills. Retirees choosing this plan will have credits left over to apply toward coverage in Dow Corning's dental, vision and life insurance programs.

With this new program—launched Jan. 1—Dow Corning joins the ranks of a still very small but growing number of employers that offer flexible benefit plans to retirees. The program applies to Dow Corning employees who retire after June 30, 1993. Employees who retired before then are covered under a traditional benefits program.

Retirees also are shifted into a more traditional health plan after they turn 65 and are eligible for benefits under the federal Medicare program.

With its new program, Dow Corning hopes to give retirees more benefit choices and better control over corporate health care costs, explained Larry Muzzy, benefits manager at the Midland, Mich.-based company.

The plan provides "affordable benefit choices," he said, adding that dental and vision benefits were not previously offered to retirees.

Like other employers, Dow Corning opted for a flex plan to better control and manage health care costs, which have been rising in recent years by double digits.

"We have had a strong incline in health care costs. It is not something I'm proud of," Mr. Muzzy said during a session at the Risk & Insurance Management Society Inc. conference.

Under a new cost control feature, Dow Corning only will cover the first 8% increase in medical plan costs each year with retirees responsible for increases over 8%.

"We want to bring down inflation in our health plans to single digits. We felt that is one of our long-term objectives."

But, Mr. Muzzy emphasizes that the program is not intended to reduce benefits but to control costs.

Indeed, Dow Corning designed the program and priced benefit options so that its benefit program would continue to be in the top third of benefit plans offered by chemical companies.

"That was important to help keep us competitive," he said.

Dow Corning, like other companies overhauling their retiree

health plans, now links the amount of benefits—in this case flexible benefit plan credits—with the number of years an employee works before retiring.

Under this feature linking benefits with service, the credit base is 30 years of service. For example, an individual retiring after 20 years of service would receive two-thirds of the credits that a 30-year employee would receive.

Without such a service-related feature, employees who retired with relatively short periods of service could collect more in health care than pension benefits, Mr. Muzzy noted.

The company listened to suggestions from employees and retirees

in designing the program, he said. For example, to make the plan more affordable, the dental plan does not offer orthodontia benefits.

"Retirees wanted a plan that offers more preventive services," he said.

In an unusual feature, Dow Corning offers retirees a "personal management account." Under this feature, the company kicks in between \$100 and \$300 per retiree annually—the amount varies depending on which health care plan a retiree chooses—to pay for health care-related costs, like wellness benefits, not covered in the regular plan.

"We want retirees to stay healthy just like employees," Mr. Muzzy

said.

Currently, the flex plan ceases when retirees turn 65. Dow Corning thought a flexible benefit plan, with features like benefit credits, would be too complicated for elderly retirees.

While it is not known how many employers are offering flexible benefit plans to retired workers, more employers are exploring flex as a way of controlling health care costs, said Juliann Bannon, a senior consultant with Alexander & Alexander Consulting Group Inc. in Philadelphia.

By setting the amount of benefit credits it will provide to retirees, an employer can limit its costs.

The employer agrees to make a specific financial commitment rather than "writing a blank

check," Ms. Bannon said.

In addition, employers offering flex plans to employees will have a consistent benefit program when they extend flex to retirees.

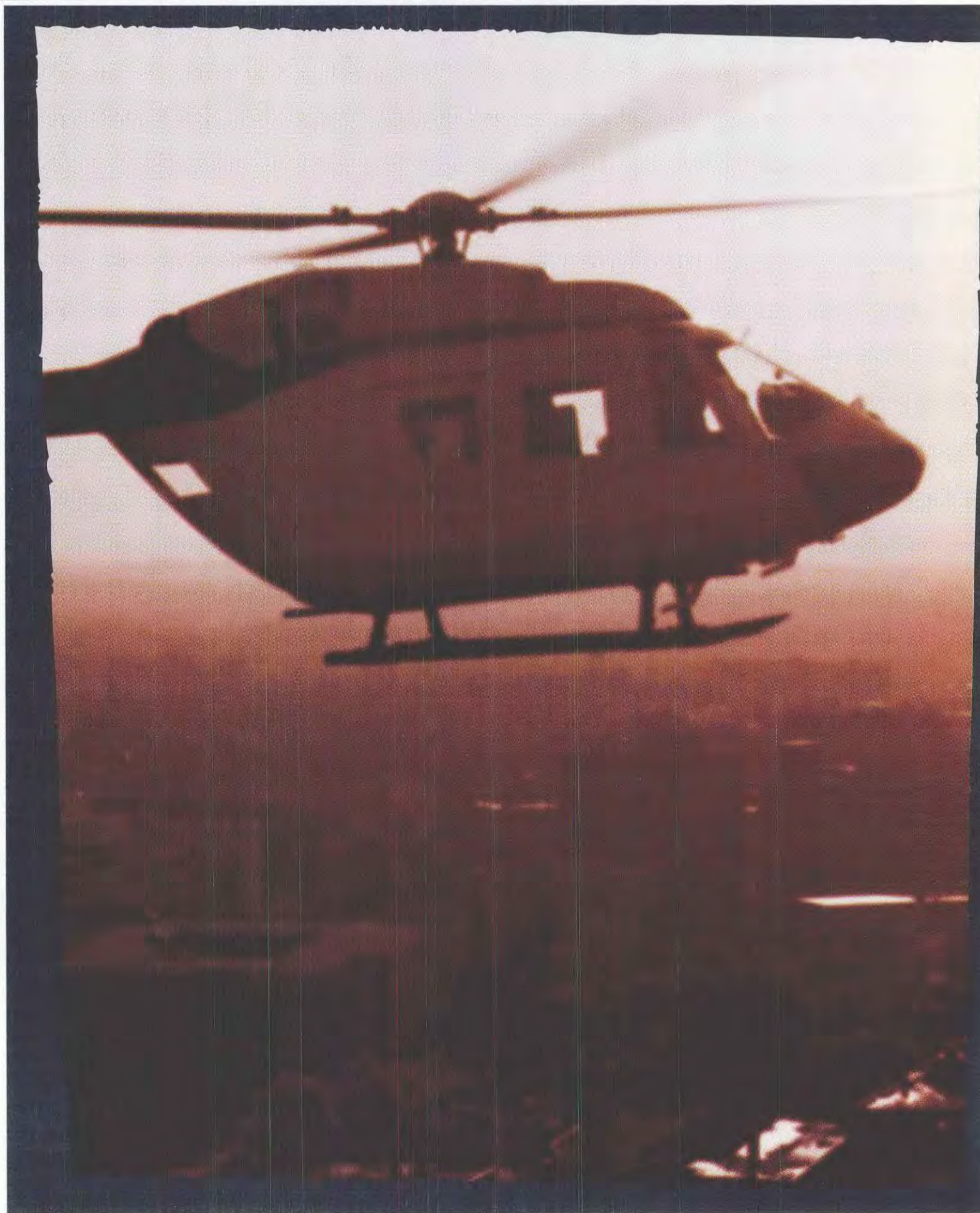
Still, employers need to be aware of the complications that come along with establishing a flexible benefit plan, Ms. Bannon noted.

For example, providing enrollment material and communicating the plan can be difficult because retirees often live throughout the country.

"Enrollment is a big process," she said, adding that a program's first year is much harder than succeeding years.

But, through the new choices offered through a flex plan, "I think your retirees also will be happy," she said.

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



# Captives may yet fund benefits: Expert

## CSX rejection is not end of story

By JERRY GEISEL

NEW ORLEANS—The door isn't closed on using captive insurers to fund employee benefit risks despite a recent setback, a captive expert maintains.

"The next major wave of captives will be for employee benefits. It is coming. I'm just not sure when," said Arthur Koritzinsky, a senior vp with Johnson & Higgins in New York.

Despite a Labor Department ruling rejecting CSX Corp.'s bid to reinsure its group term life insurance benefits through its Vermont captive, "there are still a lot of opportu-

nities" for captives to fund benefits, Mr. Koritzinsky said during a session at the Risk & Insurance Management Society Inc. conference.

The Labor Department rejected CSX's proposal because too much business—about 90% of CSX Insurance Co.'s premiums—is derived from CSX-related risks.

That exceeded the Labor Department's so-called 50% test requiring that no more than 50% of a captive's gross premiums be generated by the parent before the captive can fund the parent's employee benefit risks (BI, April 4).

Labor Department approval is needed for such transactions because dealings between related companies are normally considered pro-

hibited under the Employee Retirement Income Security Act of 1974, which the department administers.

The CSX ruling, on the surface, would seem to eliminate captives as a benefit funding option unless a captive wrote a huge amount of third-party business.

But Mr. Koritzinsky says such a conclusion is premature.

The Labor Department ruling does not cover benefit programs provided outside the United States by U.S. multinational companies; the department has no regulatory authority over foreign benefit programs, he noted.

In addition, given a different set of facts, the Labor Department might rule differently, he said.

CSX told the Labor Department that it would "commit" to reducing

employees' life insurance premiums based on savings the company would realize through the reinsurance arrangement. The department, though, said this general commitment was not persuasive.

CSX might have had a better chance of Labor Department approval if it had agreed to share a specific amount—perhaps 10% to 20%—of its savings with plan participants, Mr. Koritzinsky said.

In addition, the department might rule differently if a captive has more outside business.

It isn't clear how much business would satisfy the Labor Department, but Mr. Koritzinsky believes the 50% test is not ironclad.

Just as RIMS and other groups successfully lobbied the National Assn. of Insurance Commissioners

to soften earlier proposed restrictions on the use of fronting for captive programs, "collective action" may be employers' best hope to get the Labor Department to take a second look at the 50% test, he said.

Employers could raise several arguments with the Labor Department. For example, putting more outside business into a captive will not necessarily improve the captive's financial soundness. Taking on third-party business led to the collapse of a number of Bermuda-based captives in the 1970s and '80s, Mr. Koritzinsky noted.

In addition, an arrangement in which the captive is reinsuring licensed insurers writing benefit coverage offers much more protection to participants than self-insuring, which the Labor Department does not restrict, Mr. Koritzinsky said.

In CSX's case, for example, Aetna Life & Casualty Co. and Prudential Insurance Co. of America—two of the largest U.S. insurers—would have written the term life insurance benefits with CSX Insurance Co. reinsuring Aetna and Prudential.

Until recently, the funding of employee benefit programs through captives was not a hot topic in either risk management or employee benefit circles, except among a handful of captive promoters.

But a series of events unfolded in 1992, Mr. Koritzinsky explained, that gave employers a new reason—reaping new tax breaks—to fund benefits in their captives.

Those developments included:

- Several appeals courts ruled that a parent can deduct premiums paid to a captive as long as the captive writes a significant amount—about 30%—of outside business.

- The Internal Revenue Service ruled that employers can deduct group term life insurance premiums paid to their captives because these represent unrelated business.

"The IRS went on record and said it (group term life insurance) was third party business," Mr. Koritzinsky said, adding that the IRS made clear in the ruling that group health insurance also would be considered outside business.

As a result, captive experts concluded, if a captive funds a company's employee benefit coverage, that could be considered a significant amount of outside business. That would increase the chances that a parent could deduct property/casualty premiums it paid to the captive.

"Unfortunately," Mr. Koritzinsky said, "It is not that easy." While CSX never said so directly, captive experts said CSX's attempt to fund benefits through its captive were undoubtedly tax-driven.

While, the ruling is "disappointing, it is no reason to quit" the drive to fund benefits through captives.

And, captives remain viable vehicles to fund a range of other benefits, such as international benefit plans or benefits provided to third country nationals, noted Paul Shimer, a managing consultant with A. Foster Higgins & Co. Inc. in Hartford, Conn.

It is possible that the IRS also would consider international benefit risks written through a captive to be outside business, he said. As a result, if enough international business was funded through the captive, an employer might increase its likelihood of being able to deduct property/casualty premiums paid to the captive.

But Mr. Shimer advised employers to use the captive as a reinsurer for an international benefits program because of the difficulties of meeting licensing requirements in other countries.

The session moderator was Donald Haufe, insurance director at Waste Management Inc. in Oakbrook, Ill. **BI**

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## Opinions

## Duty calls benefit managers

CAN BENEFIT managers sway the course of health care reform now wending its way through Congress?

Absolutely. But in order to influence legislators on the all-important legislative details, many employee benefit managers will have to change their attitude.

As we reported recently, many employee benefit managers are paying little attention to the legislative proposals now before Congress (*BI*, April 11). Employee benefit managers say, at best, they are skimming the headlines and not getting immersed in the details. Instead, a number of managers say they are content to wait until a final bill emerges before they pay close attention to reform developments in Washington.

In our view, that is a dangerous attitude.

Time and time again, legislators have made terrible decisions on employee benefits legislation. Among the myriad examples are allowing Section 89—with its maze of ridiculously complicated rules—to become law and, more recently, requiring employers to file detailed health care coverage reports on employees and dependents for a Medicare data bank.

Although employee benefit managers complained plenty about Section 89 and the new Medicare data bank filing requirements, most did so only after it was too late and the legislation had been enacted.

We had hoped employee benefit managers would learn from those and other bad experiences with benefits legislation in Congress.

Now is the time to get involved, while health care reform proposals still are being shaped by lawmakers and there is an opportunity to make a difference—not at the 11th hour when most decisions will have been made.

Indeed, as we report on page 3 of this issue, corporate benefit executives at the Risk & Insurance Management Society Inc. conference last week urged their colleagues to quit complaining about the Clinton proposal—which they regard as dead in the water—and start lobbying for health reform changes that protect their role in the health care system.

We have no doubt that employee benefit managers



can influence legislators. But for whatever reason, many employee benefit managers seem content to sit on the sidelines while crucial decisions about the shape of corporate health plans, as well as the nation's health care delivery system, are made on Capitol Hill. Certainly, benefit lobbying groups can carry some of the load. But the day-to-day experience of benefit managers will influence a lot more lawmakers than paid lobbyists.

It is up to employee benefit managers to educate legislators about which health care reform proposals they support and which ones they oppose. We think their views will be given more consideration than they may think because they have a better idea how legislation would affect employer programs than anyone else in the country.

We hope employee benefit managers use their influence now to shape health care reform legislation and don't wait until it is too late.

## Letters

## Industry cannot fail to see need for health care reform

To the editor: Given a golden opportunity to resolve several serious problems that have developed over the years, the insurance industry fails to move to the forefront to seize the opportunity to correct the almost random development of medical and accident coverages.

To say that present health care programs adequately meet the needs of our population requires almost total blindness to reality.

Severe restrictions as to whom coverage attaches, with multiple limitations, exclusions and exceptions—not to mention the 18 to 20 million citizens not covered at all—hardly represent an adequate system, let alone the "best in the world." If even 20% of the national workforce has no health coverage, we surely don't have a level playing field, and the percentage is much worse than that.

Historical and social accident fostered the development of separate medical

and accident insurance programs for workers compensation, automobile, landlord and tenant and homeowners. All are handled separately from health coverage, leading to double payments for the same conditions. Is that a first class system?

With universal health care, all payments for sickness and injury should be made only under that system. This would help eliminate much of the fraud associated with compensation claims, inflated medical damages in automobile and general liability claims and place the burden of expense where it belongs.

The insurance business knows full well that the public pays for all claims in the final analysis. We can reduce administrative costs, reduce opportunities for fraud, reduce liability and workers comp premiums, and continue to manage the liability element of coverages in an appropriate manner by embracing universal health coverage through HMOs or similar facilities.

Business leaders have repeatedly proclaimed their desire for a level playing field for foreign and domestic competition. How level is the field when large numbers of employers provide no health coverage whatsoever? Predictions of growing numbers of temporary employees who will receive no health benefits are rife.

Many major employers, such as the fast food companies, supermarkets,

cut-rate stores, and farm enterprises now provide coverage for "key" employees only, if that. If every employer had to provide health insurance, the field would be level with respect to a major expense factor.

Most, if not all, of the care improvement and cost-saving developments of the past few years have come out of the insurance business. Peer review, utilization management, systems to track prescriptions and procedures have all emanated from the insurance business. Why do we now say we don't know how to make it work?

With the mandate for universal health care clearly coming from the general public, why sponsor scare advertisements and give a golden opportunity to the severe critics of our industry? It is time to assume our proper leadership role in solving a serious social problem.

I congratulate you for the stand taken on your editorial page for universal health care for all citizens.

If we recognize health and accident insurance premiums as a tax—and certainly government-mandated worker comp and automobile premiums are just that—it is difficult to see how some of the analysts can see such a huge jump in costs.

As the younger generation would say, "Why don't we get real?"

Donald E. Reutershan  
Sag Harbor, N.Y.

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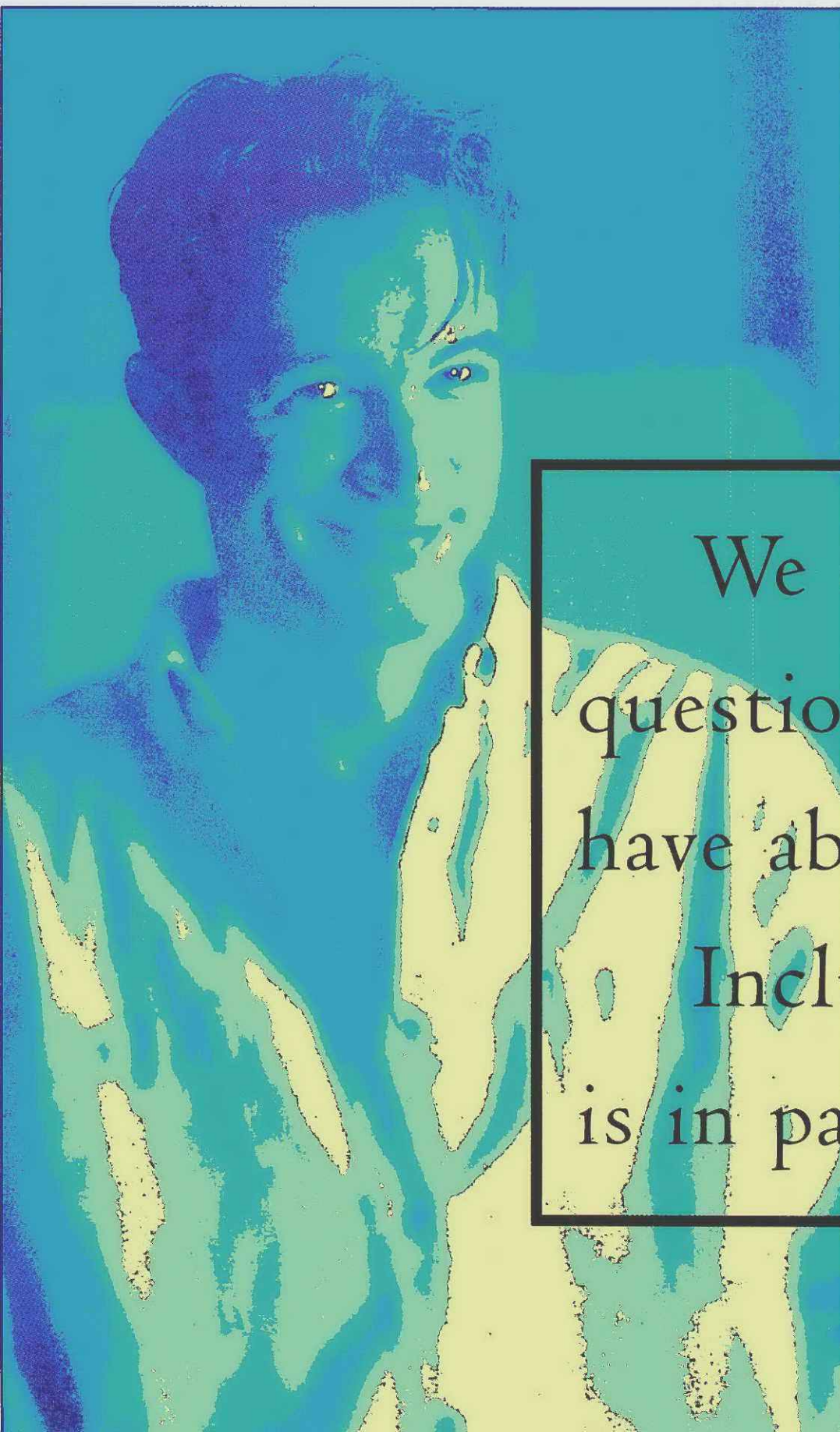
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# Work comp claims deserve special treatment

## Goals differ from group health arena

By JOANNE WOJCIK

NEW ORLEANS—Simply borrowing the managed care techniques used in group health administration is not enough to rein in workers compensation costs, experts say.

Employers will realize greater savings by developing their own occupational health treatment programs that employ medical practice protocols tailored specifically to the treatment of workplace illnesses and injuries, they say.

While managed care has been

successful at capping inpatient hospital costs, isolating hospital bill overcharges, negotiating discounted rates and limiting unnecessary surgery, the targets are different in the workers comp arena.

Besides medical costs, the occupational health delivery system also encompasses "the costs of regulatory compliance and workers comp liability, employee relations, productivity—a whole cadre of programs. And the cost of administering and managing these things is tremendous," said Dr. Howard M. Sandler, president of Sandler Occupational Medicine Associates Inc. in Melville, N.Y., a workers comp medical cost containment consulting firm.

Employers that apply traditional managed care techniques to the treatment of occupational illnesses and injuries "end up in a situation where they're constantly having their third-party administrator or some sort of computer system go over these transaction costs again and again and again," he said.

"Right now, managed care is really discounted care," asserted Dr. Sandler during a session at the Risk & Insurance Management Society Inc. conference. "It has nothing to do with managing true care."

That's why simply purchasing the discounted services of an occupational health PPO is not enough to reduce workers comp medical costs, agreed William M. Cauveren Jr., director of risk management

and safety for Payless Cashways Inc. in Kansas City, Mo.

Discounts "aren't that important, folks, because the most important thing is to get the people back to work, get them productive and get your productivity back," he said. "If you just get a discount, you're going to get multiple treatments" so that the physicians still get their money.

In addition, many of the occupational health PPOs being sold today primarily are composed of group health physicians, "and not all those physicians know how to treat workers comp," Mr. Cauveren asserted. "They're not occupational physicians."

In fact, "there's a shortage of occupational physicians in this country," he said.

Rather than delegating the task of setting up an occupational health delivery system to an insurer or TPA, employers should take the initiative themselves and set up their own occupational health delivery systems that include physicians who have experience with treating work-related illnesses and injuries, Mr. Cauveren suggested.

"You need to set down on paper your specifications, exactly what you want," including provider selection criteria, he advised. "You should make sure that whomever you are working with has treatment guidelines and is willing to share them and you can understand them."

Employers also should identify the particular occupational illnesses and injuries that they want to target, Mr. Cauveren said.

Some employers may even want to take a holistic approach and encourage the occupational physicians treating their employees to help them identify potential workplace hazards in order to prevent illnesses and injuries, he said.

Employers working to develop a focused occupational health delivery system also should solicit the involvement of both human resources and the risk management departments, as well as their insurers and TPAs, Mr. Cauveren said.

"You should even have your legal department involved because they're the ones that are going to defend these cases," he added. "I also highly recommend getting a medical consultant, whether it's an outside consultant or a medical director on staff. You definitely want that person there to evaluate the treatment criteria."

"I'd treat it just like a broker selection. You really need to have oral presentations, go to their site, make sure they have the kind of rehab and physical therapy facilities that you want them to," he said of selecting preferred occupational physicians.

The development of an efficient and cost-effective occupational health delivery system requires a cooperative effort between employers and the treating physicians, both speakers stressed.

Even though medical treatment accounts for just 40% to 50% of the cost of the workers comp system, physicians potentially control as much as 80% by determining which employees can return to work and which should stay on disability, Dr. Sandler said.

While most employees will follow the advice of employer-selected physicians, "you want them to make the right calls," he said.

Unfortunately, today, "half the doctors in the United States don't know how to use the AMA guidelines for disability," and few physicians prescribe the same treatment approach to similar diagnoses, Dr. Sandler observed.

A big step forward in managed care for workers compensation would be to actually develop and adhere to uniform protocols and criteria for diagnosis, treatment, time off, rehabilitation and work-hardening, modified duty restrictions and impairment determination, Mr. Sandler suggested.

"Until employers demand this type of specification, consistency and quality, workers will not receive appropriate care and employers will face ever-increasing workers compensation costs," he asserted.

The session was coordinated by Sally C. Hashem, director of risk management for Fort Lauderdale, Fla.-based Alamo Rent-A-Car Inc. Ms. Hashem also served as moderator. **BI**

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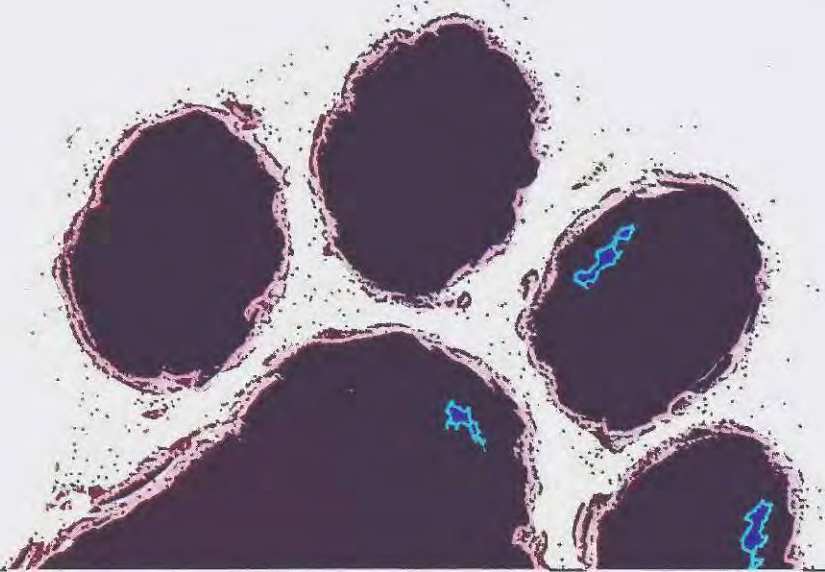
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# Exhibitors tout new products, not gimmicks

## 24-hour-type products steal the show

By LOUISE KERTESZ

NEW ORLEANS—Underscoring a no-nonsense approach to holding down employee benefit costs, most health care-related exhibitors at the Risk & Insurance Management Society Inc. conference did not give out extravagant giveaways, instead offering tokens like pens and T-shirts or simply handing out informational brochures.

A major theme running through many of the products and services touted in this year's exhibit hall was integrated management of workers compensation and group health care

costs.

First-time exhibitor American All-Risk Loss Administrators Inc. of San Francisco, for example, handed out brochures describing the third-party administrator's integrated managed care program for workers comp and group health benefits.

According to Vp Monique Knox, AARLA offers "truly integrated" medical management, though employers still need to purchase separate workers comp and group health coverage.

The Travelers Insurance Cos. and its medical and disability cost management subsidiary, Conservco, also heavily emphasized 24-hour coverage developments, which are more sophisticated than ever, said Ken-

neth F. Martino, Travelers vp.

In fact, Hartford, Conn.-based Travelers offers managed care networks to AARLA clients. It chose the TPA as a partner because its "philosophy is the same" when it comes to integrating medical management of both workers comp and group health claims and focusing on return to work, no matter how the worker was injured, he said.

Beech Street of California Inc. currently is "tightening up" its 24-hour products, said George Bregante, vp of marketing and sales. The Irvine-based PPO's new group health and workers comp products "operate like HMOs," he said. Providers in its Comp Partners network agree to follow certain practice guidelines and to follow a fee schedule.

On the group health side, Beech

Street now offers Independent Physician Network, a "model much tighter than a traditional PPO," composed of providers who have had HMO experience, Mr. Bregante said.

"Common providers (for group health and workers comp) are also found" wherever possible, he added.

A model of the Statue of Liberty used in an ad several years ago presided over Liberty Mutual Insurance Co.'s booth.

Liberty Mutual is touting a "brand-new" managed workers comp product called "Ultra" that involves partnerships with HMOs that have occupational injury expertise, said Vp John Ryan.

Liberty Mutual has so far teamed up with PacifiCare Health Systems and Blue Cross & Blue Shield of Massachusetts HMOs to offer "UL-

tra," which combines the insurer's disability management and the HMO's medical management expertise (BI, Feb. 28).

Another integrated product offered by Liberty Mutual covers both occupational and non-occupational disability benefits, so there is no incentive to file a workers comp claim if the worker is injured at home, Mr. Ryan said.

Similarly, ITT Hartford Group Inc. is offering a new product called "Co-ordinated Workers Compensation and Disability," which will apply all the cost management techniques of workers comp, like case management and return-to-work programs, to both workers comp and non-occupational disability claims, said Richard Bulat, segment marketing manager for major accounts.

Disability Claim Services Inc., a division of CIGNA Reinsurance Co. of Hartford, Conn., sees a market niche in providing fee-for-service claims management for self-insured disability plans. "It's not a traditional role for a reinsurer," but self-insured employers are "not getting their money's worth" in their disability plans, said Kenneth J. Lucas, director of reinsurance claim/TPA operations at CIGNA Re. So the reinsurer formed "a new venture."

MedView Services Inc. of Farmington Hills, Mich., has introduced a new gatekeeper product in its PPO networks to designate the best treatment under workers comp, medical and auto liability programs, said Debra Cerre-Ruedisili, senior vp and chief operating officer.

Employers using MedView for all these lines—and "we're a long way from that," she conceded—could achieve true 24-hour integration of medical benefits. "We're getting a lot of requests from employers" for 24-hour-type programs, she said.

Action Healthcare Management Services of Thousand Oaks, Calif., touted its capability for 24-hour medical management of its workers comp and group health networks.

"Many of our same clients use both" networks, said Kathryn E. Estabrook, account executive.

Wayne, Pa.-based GENEX Services Inc.—which became a total managed care company last December with the merger of General Rehabilitation Services Inc. and General Care Review—believes "distinct nuances" in the workers comp market mean that true 24-hour coverage is "a long way off," said Patricia T. Wiener, vp of operations.

GENEX announced last week that it had acquired Unified Care Inc. of Exton, Pa., which provides pre-certification and utilization review services for both group health and workers comp claims.

Mutual of Omaha's booth again featured conference-goers photo opportunities with a booth full of animals, including a python, an 80-year-old alligator snapping turtle, a bear cub and a lizard.

Mutual of Omaha currently is expanding its HMO and PPO networks, and is just "getting into" a 24-hour product, said Bob Blankenship, major account executive.

Intracorp of Berwyn, Pa., stressed early intervention in workers comp and group health claims in an elaborate booth with a swinging pendulum and the theme "Time Is of the Essence." Intracorp, too, is just beginning a pilot 24-hour program, a spokeswoman said.

Other exhibitors touting their cost-containment products included Medical Diagnostic Management Inc. of Hasbrouck Heights, N.J.

MDM is a specialty PPO offering a carve-out for diagnostic services such as laboratory, radiology and imaging procedures. The program offers 40% to 60% discounts on magnetic resonance imaging, for exam-

Continued on next page

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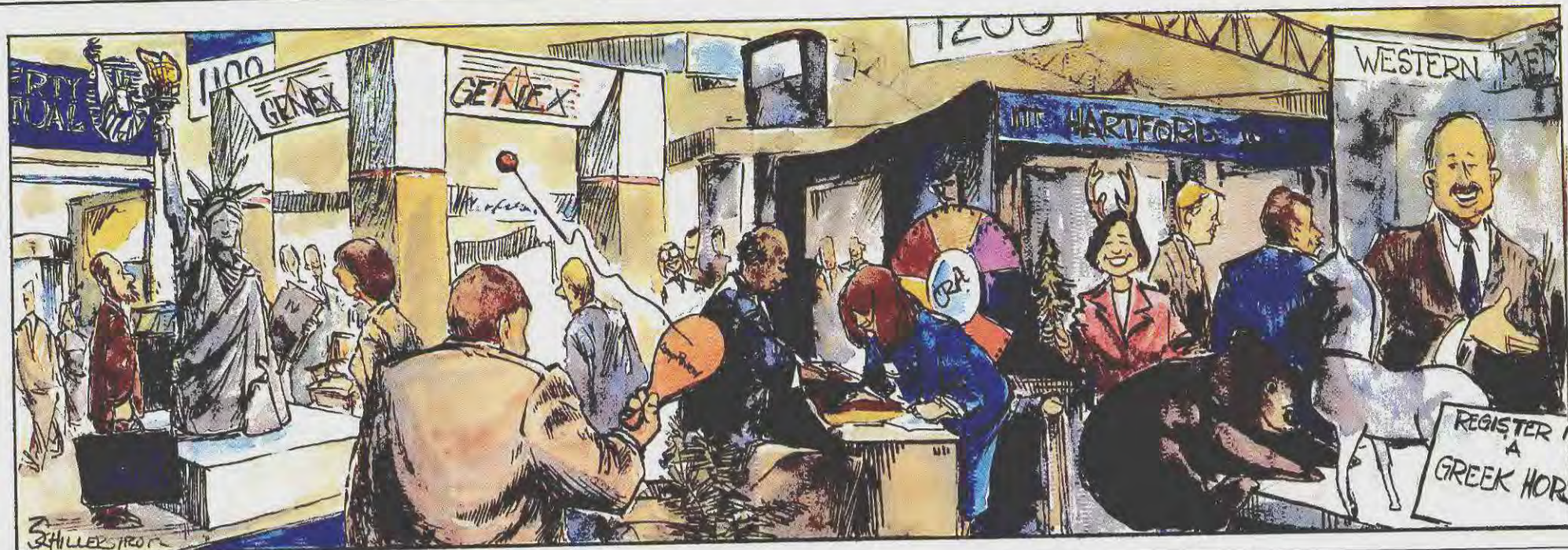
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Continued from previous page  
ple, said Tom Klaas, director of marketing.

Medicode Inc. of Salt Lake City offers data bases of current provider fees to help price health care services and adjudicate claims.

Medicode also offers a claims editing software package that screens claims for accuracy and errors like duplicate billing.

Rick Mandahl, director of marketing and corporate communications, was excited about Medicode's newest product, now being rolled out with selected customers. "Care-Trends" provides national and regional benchmarks that can measure the performance of providers, among other evaluations.

Embassy Group of Burr Ridge, Ill., showed its Claims Analyzer software for the first time. The software can receive a scanned medical bill and screen it for appropriateness according to several criteria, including whether the payer's benefit plan covers billed services.

The program can also fax the bill automatically to a designated UR firm, with medical records appended to it.

Medirisk Inc. of Atlanta offers clients "raw data" showing what physicians are accepting as fees in a particular market area.

"We're not in the software business," observed MariJane Selvaggio, senior account executive. "We want to be the source for health care pricing information. It's a full-time job."

Total medical costs are determined by price and frequency of services as well as by administrative costs, she said, noting that unless more attention is paid to price, total costs will continue to rise.

Express Scripts, which provides pharmacy management services to both the group health and workers comp market, by late Monday afternoon had run out of the pill-shaped pens it was handing out, much to the chagrin of Larry Robbins, workers compensation product manager. But the Maryland Heights, Mo., drug utilization review and PPO firm is upbeat about providing integrated services should true 24-hour coverage become a reality, he said.

Wayne-Oakland Medical Centers Inc. of Troy, Mich., a first-time exhibitor, provides independent medical evaluations, drawing on physicians in private practice. It provides services internationally, said Frank T. Mireles, account representative.

"We do all the legwork" for clients, such as insurance adjusters, TPAs and employers, he said.

Cathy A. McComas, formerly head of the often-cited wellness program at Texas Instruments Corp., was talking up her new firm, Great Performance of Dallas, which produces customized health promotion training packages for employers. **BI**



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## Canadian-style system may offer best shot at universal coverage

By JERRY GEISEL

NEW ORLEANS—A single-payer, tax-financed health care system is the most cost-effective



way of assuring universal coverage, a Canadian health care expert says.

"Insurance through taxation works and it is cheap to run and the money gets to where the people need it. Everyone is covered for basic services," said Jane Fulton, the author of two books on the Canadian health care system and an associate professor of strategic management and ethics at the University of Ottawa.

Delivering the keynote address at the Risk & Insurance Management Society Inc. conference, Ms. Fulton said about 98 cents of every health care dollar in Canada goes to medical providers.

By contrast, in the United States, insurer overhead like administrative and marketing costs amounts to between 25 and 40 cents of every dollar spent on providing coverage.

"There is no (other) nation on earth that allows that kind of inefficiency" in its health care delivery system, Ms. Fulton said.

While a single-payer Canadian-style national health care system is considered too radical for the United States, it is the United States that is going against the stream, she said.

Single-payer systems are in place throughout the world in what Ms. Fulton described as "competitive industrialized nations."

Many people in the United States oppose a single-payer system because they fear it would lead to enormous taxes and a rationing of care. The Canadian experience suggests that such fears are unfounded, she said.

Taxes would have to be raised to fund a single-payer system, though the net out-of-pocket cost would be a lot less than what individuals and employers now pay for health care, Ms. Fulton said. Health care costs comprise about 10% of the Canadian Gross Domestic Product, compared with more than 14% in the United States.

While U.S. critics say care is rationed in Canada, Ms. Fulton said the facts indicate otherwise. Many complex, costly medical procedures are performed at about the same rates in the United States and Canada, she said.

It is true that the United States has a greater quantity of high-tech medical equipment, but the proliferation of expensive devices may have little to do with improving the quality of care.

"The more MRIs you have, the more opportunities you have for orthopedic surgeons" to rack up fees, she said.

But economic issues aside, the Canadian health care system delivers something else that many feel is missing in the United States: peace of mind about always having comprehensive coverage and never being exposed to massive medical bills.

"In Canada, there is no fear of insurance loss. My employer won't throw me out because I am a high-cost worker," she said.

Still, Ms. Fulton said, the United States is a leader in some health care areas.

The United States is the "research engine of the world" for medical care, and health maintenance organizations here "are outstanding," she said.

If the United States does move to a single-payer system, Ms. Fulton offers this advice to policymakers: give the states a major role in administering the program.

"Two hundred sixty million people is too many people to manage" in a federal program, she said. "I think it is marvelous that Washington wants to do it, but it is not rational."

While the federal government is a major source of funding for the Canadian health care system, the country's provinces administer the program. **E1**

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# A survival guide to benefit plan scrutiny

## Directness, good documentation can ease IRS audits

By JERRY GEISEL

NEW ORLEANS—When Internal Revenue Service field agents turn up on your doorstep to audit your employee benefit plans, the best policy often is to quickly admit your mistakes, a consultant advises.

"Own up," says Barbara Tilghman, director of legal and government compliance in the Baltimore office of Alexander & Alexander Consulting Group Inc.

An employer, could, for example, tell federal auditors, "We know we have a problem and this is what we are doing to fix it up," Ms. Tilghman said.

With such a direct and open approach, the IRS might not propose any penalties, she said.

Speaking at the Risk & Insurance Management Society Inc. conference, Ms. Tilghman said company attorneys should be advised when the IRS notifies an employer that it intends to audit the company's benefit plans.

If the IRS calls, "Let your legal counsel know. Ask them if they have any specific advice. But I don't recommend having legal counsel on the scene," she said.

If attorneys are present, IRS auditors may be even more rigorous in scouring plan documents.

"They may say, 'Let's really go over this with a fine tooth comb,'" she said.

Penalties for not complying with various employee benefit plan reporting and disclosure rules, which are laid out in the Internal Revenue Code and the Employee Retirement Income Security Act, can be stiff.

For example, the Labor Department can slap employers with a fine of \$1,000 per day for each day its Form 5500 is overdue. Form 5500, which is filed annually with the IRS and then forwarded by the IRS to the Labor Department, is a detailed financial report for a benefit plan.

The ultimate sanction, which could be used for a variety of infractions, like a pension plan that discriminates in favor of highly compensated employees, is disqualification of the plan. While the potential is there, Ms. Tilghman said she didn't know of any situations where federal regulators have proposed that a plan be disqualified, which would have severe tax consequences on both employers and employees.

While the penalties for breaking various IRS and ERISA rules are significant, many employers still aren't aware of all the rules they must follow.

Generally, employers must maintain written plan documents for all their employee benefit programs and describe those programs in easy-to-understand language in summary plan descriptions, which are provided to employees.

Many employers believe, incorrectly, that some benefit plans are not covered by ERISA reporting rules and that they don't have to maintain plan documents or describe the plans in their SPDs.

For example, a big chunk of employers aren't aware that most severance pay and employee assistance plans are considered employee benefit plans under ERISA, Ms. Tilghman said. "This is a big source of confusion out there."

Labor Department regulations detail the kind of information that

must be included in SPDs: the name and address of the employer, the type of a plan it is, like a defined benefit pension plan, and a description of benefits and eligibility for benefits in language that the average participant can understand.

Ms. Tilghman recommends also including a clause informing participants that the employer has the right to amend or terminate a benefit plan at any time.

This clause is viewed as vital to win court approval for overhauling or eliminating retiree medical programs.

Generally, courts have ruled against retirees seeking to stop their employers from cutting back

or eliminating medical programs—if the employer included a right to amend or terminate the plans provision in their SPDs, she said.

In one recent case, though, an employer's reservation to amend or terminate clause wasn't enough to pass court muster. In a case involving Curtiss-Wright Corp., the 3rd U.S. Circuit Court of Appeals in Philadelphia said an employer also has to specify who, such as a company's board of directors, has the right to amend or terminate the plan (*BI*, Jan. 10).

Very few SPDs include this information, but Ms. Tilghman said employers may wait to overhaul their SPDs to include the addi-

tional language, noting that other courts have yet to adopt the 3rd Circuit ruling.

As an added protection, some employers also include language in plan documents, like their SPDs, that the documents shall be the official and exclusive source of information on how their employee benefit programs operate.

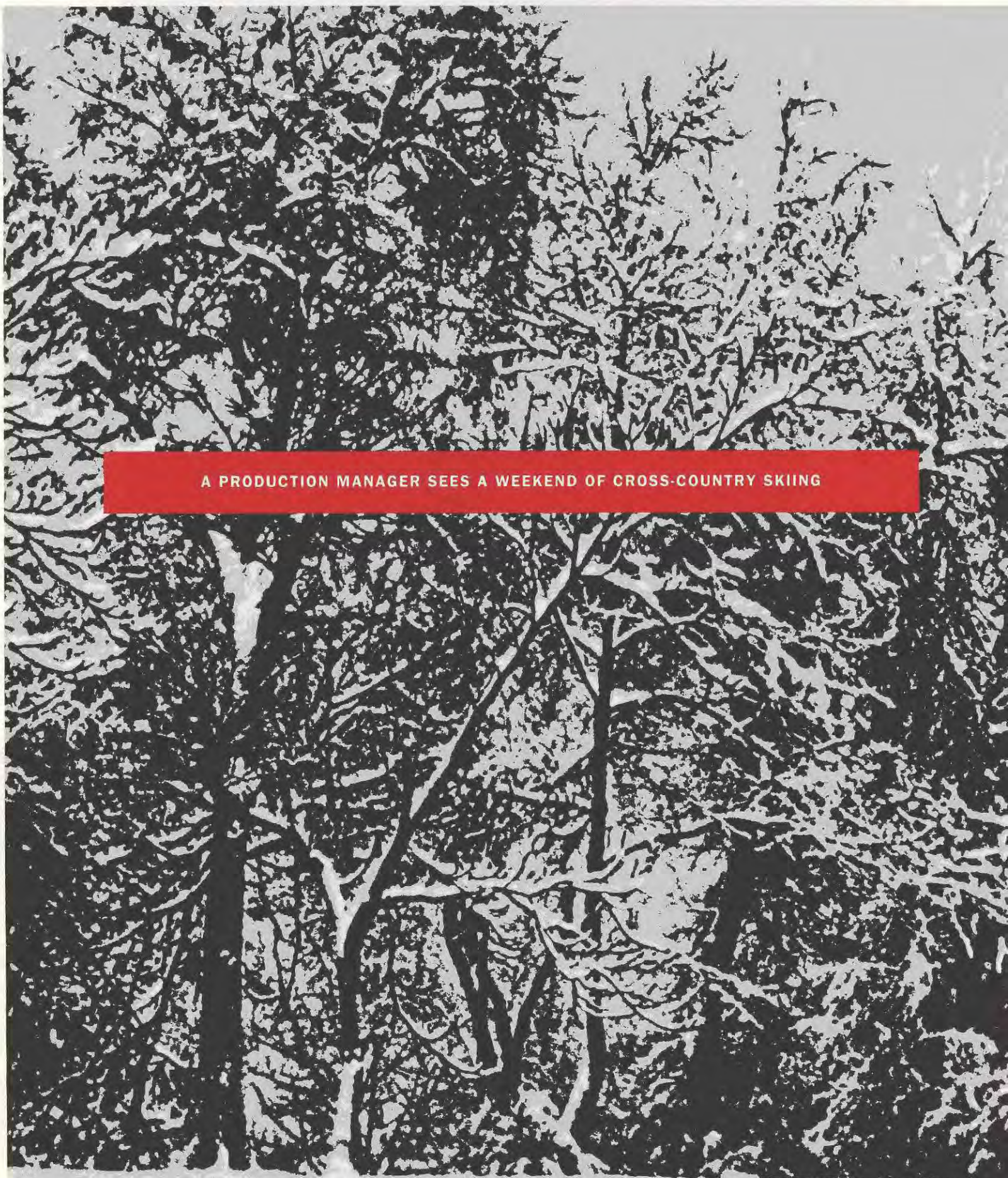
That qualifier is intended to bolster employer rights in court if a plan participant contends that he or she received different information orally. Generally courts have said rules laid out in plan documents pre-empt oral statements.

Employers often wonder whether employees really read all these plan documents. But another panel speaker, somewhat to his surprise, found out that employees do read

at least one plan document: the summary annual report, which details changes in pension plan assets and liabilities.

Several years ago when the funding level of a pension plan sponsored by The Rouse Co. temporarily slipped, employees asked, "What happened to plan assets?" recalled William Boden, vp and director of personnel and administrative services for the Columbia, Md.-based mall and shopping center developer. "I didn't think people read them" but they obviously do, Mr. Boden said, referring to the annual reports.

The session was moderated by Susan Welch, vp of risk management at Carter Hawley Hale Stores Inc. in Los Angeles. Session coordinator was Melanie Gilmore, a communications specialist in the research and development office of Alexander & Alexander Inc. in Dallas. **BI**



A PRODUCTION MANAGER SEES A WEEKEND OF CROSS-COUNTRY SKIING

# California stress claims fall

## Stricter injury standards cut employers' comp costs

By MICHAEL SCHACHNER

NEW ORLEANS—Until last year, California employees who believed they were stressed out on the job were cashing in left and right via the state's workers compensation system. But no more.



Since last July, when the California Legislature enacted workers comp reforms that require a claimant to prove that 51% of an alleged disability has been caused by actual events of employment, the number of compensable psychiatric claims has been falling dramatically, says Michael Dunham, corporate claims

manager with Atlantic Richfield Co. in Los Angeles.

California lawmakers' decision to place a significantly stiffer burden of proof on employees claiming workplace injuries has been of great benefit to employers in the state, especially because of a reduction in stress-related claims, Mr. Dunham said during a session at the Risk & Insurance Management Society Inc. conference.

Prior to the new law, California workers had been able to collect damages under workers comp if they could substantiate that only 10% of their condition was brought on due to a worksite event. This was a rather easy barrier to clear, even in stress cases, Mr. Dunham conceded.

ARCO, for example, was paying out nearly 100 stress claims per year that ranged from \$10,000 to \$50,000 in value. In addition, many of these claims were being filed after a claimant had been terminated, he noted.

However, under the new law, ARCO is facing only four stress-related claims so far this year and virtually all of the 22 compensable claims it had last year were filed before the law was overhauled.

"With the new requirements, attorneys do not appear to be taking these cases as readily. Getting past the 51% threshold is difficult. The cases are clearly less worthwhile to pursue" from the attorneys' point of view, he said.

"Today, it's hard to find a psycho-

therapist who will say that more than 50% of somebody's stress is work-related," Mr. Dunham added.

In addition, the so-called "stress claim mills" that thrived throughout California as recently as early last year by recruiting claimants and diagnosing them as suffering from workplace stress "have either shut down or have moved to other states," he said.

This is all very good news to California employers, many of which thought that even a 51% threshold was too low when it became effective July 16, 1993.

"While stress claims represent only about 2% of volume under workers comp, their estimated costs represent about 7%. The average cost of a stress claim is \$13,200, or about 17% higher than other disability claims. And, the litigation rate on a stress claim has averaged 99% over the last five years," Mr. Dunham said.

With this in mind and with the

number of compensable stress claims taking a nosedive, California employers are now quite satisfied with the new burden of proof, he said.

What had made stress such a pitfall under the old law for employers is that it's very difficult to define and quite costly to defend against, Mr. Dunham said.

"Allegations of work-related psychiatric stress conditions have created havoc for risk management and human resources professionals for years," said Mr. Dunham, who said employers focus on these types of claims for the following reasons:

- Medical treatment is expensive, and can continue for a long time, costs and involve psychiatric specialists.

- Medical diagnosis and opinion is subjective and often involves a protracted process, including costly "doctor shopping."

- Litigation is frequent and expensive.

- Immediate investigation is almost always required, which drives up associated costs.

- Because stress is a sensitive matter, employers tend to defend themselves against stress allegations at all costs.

Mr. Dunham also defined three types of stress-related claims that can lead to a settlement or judgment.

The first and most widely accepted type of claim is a physical injury that leads to a stress condition. An example: physical trauma arising from a severe burn or a worksite accident that produces stress.

The second would be a physical condition that leads to mental impairment. For example, a heart attack or high blood pressure can result in work-related stress, Mr. Dunham said. "The major difficulty with this type of claim is determining whether or not the mental stress is principally work-related or a function of the employee's overall lifestyle."

He said the third, "and perhaps the most controversial" category of workplace stress involves a "mental/mental" claim, in which a psychiatric injury or condition arises with no related physical injury at all.

Mr. Dunham noted that some states allow mental/mental claims to be compensable, while others don't. Some states complicate the situation by having their own standards for compensable mental/mental claims.

In California, the mental/mental claims are compensable and were being filed regularly prior to the change in the state's workers compensation laws.

"The typical mental/mental psychiatric claim involves an employee with poor job performance resulting in termination. The employee then files a highly questionable post-termination claim," and the whole claim defense and litigation process begins, Mr. Dunham explained.

Jack Sahl, a senior research scientist with Southern California Edison Co. in Rosemead, agreed that it is a worker in a job that provides little stimulation and virtually no freedom to manage one's own time that is a prime candidate for stress.

At SoCal Edison, the highest prevalence of stress is among meter readers and field maintenance people, because their jobs are repetitive, overseen by foremen and are not overly stimulating, he said.

"If I want to work until 10:00 p.m. one night and then leave at noon the next day to play golf, I can, because of my position in the company," said Mr. Sahl. "But a meter reader doesn't have this type of freedom."

The session was moderated by John D. Pinner, assistant treasurer with Mattel Inc. in El Segundo, Calif. The session was coordinated by Catherine D. Bennett, vp with Johnson & Higgins in Nashville, Tenn.

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## Wellness

*Continued from previous page*  
timate responsibility to maintain a healthy lifestyle. "But employers have tremendous opportunity to provide a work environment in which employees and dependents can make investments in improving their health."

One of the first things a company must address is the way it views its employees. Employers should examine their human resource policies to make sure that people are considered assets of the firm, not simply investments.

"In West Virginia, businesses are beginning to recognize the importance of healthy and well employees. Over the years, people in our state have adopted unhealthy lifestyles," like smoking, eating high fat foods and not exercising, Mr. Steurer said. "To change that, we

organized the Wellness Council of West Virginia," a statewide public/private organization with more than 175 employer members, as well as representatives from insurance, medical and other groups.

Health is not the only factor affecting productivity levels, Mr. Steurer said. Family demands, like caring for young children or elderly parents, can increase stress or cause employees to miss work. That is something employers need to keep in mind when designing a worksite wellness plan, he said.

"These things are important because not everyone is concerned about their fitness program or nutrition every day," he noted. "A successful program will deal with a broad range of issues vs. having a narrow focus."

The Wellness Council of West Virginia tries to keep information about health and wellness before the employer community and acts as a catalyst to keep employers interested in employee health. The council also attempts to teach employee benefits professionals and others in charge of the area to be better managers of the health and wellness programs they have in place.

"Healthy companies enable employees to learn why they need a wellness program, to provide assistance to achieve wellness and to enable them to maintain healthy lifestyles," Mr. Steurer explained.

On a national level, the Wellness Council of America has recognized the effective wellness programs of dozens of employers by awarding them Well Workplace honors. Companies that are thinking about establishing their own program can learn much from firms that have proven worksite wellness works.

Among other things, executives at companies that have won Well Workplace awards say commitment from senior management and involvement at the employee level is crucial. Wellness can't be dictated; it has to be built into the company's culture.

Recognizing the contributions employees make toward their own health and the ultimate health of the company also is an important motivation, Messrs. Keener and Steurer agreed. Whether rewards are monetary or involve give-aways like T-shirts, they play a big part in changing workplace attitudes.

Employers have to measure the demographics of their employee and dependent populations before designing a workplace wellness program. Companies have different wellness program needs based on their employees' particular health risks, age and sex.

Fortunately, data on risk factors and risk modification is readily available to employers from their insurer or third party administrator, Mr. Steurer said. Employers also can gather data directly from employees concerning other issues, like work and family problems.

After assessing employees' needs, companies should develop a written plan of action with specific goals and objectives. Then a program should be initiated that achieves the goals of increased employee awareness and education, as well as some type of behavioral changes.

Employers should evaluate their wellness programs' impact by measuring baseline data against aggregate health care utilization data in the future. "If you don't measure the results, the plan will die because you'll never understand what happened," Mr. Steurer said.

Becki Adair, risk manager for Iowa State University in Ames, moderated the session. Ronald Graves, senior vp of loss control for Hewitt Coleman & Associates Inc. in Greenville, S.C., was the coordinator. **BI**

# High Tech Workers' Comp

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# Members get back what they give RIMS

## Society can help managers cut costs

By SARA MARLEY

NEW ORLEANS—It's risk managers' business to stick their noses into other people's business.

That's the advice Lucille A. Gallagher, president-elect of the Risk & Insurance Management Society Inc., offered at the annual membership meeting during the RIMS conference last week.

"Safety, environmental, ergonomics, wellness, anti-smoking programs, stress management, domestic violence—issues affecting employees in any denomination—also affect our bottom-line financial results," said Ms. Gallagher, who is vp of risk management for the ConAgra Red Meat Cos. and subsidiary Monfort Inc. in Greeley, Colo.

"Broaden your vision of risk management," she encouraged. "Seize the opportunities to grow in impact and stature by taking the initiative. Anybody can buy insurance—in fact, many friendly brokers already volunteer to do that for companies."

Risk managers can add value to their organizations by becoming more involved in RIMS, Ms. Gallagher said. Member participation results in stronger chapters, which in turn improve RIMS' committees, board of directors, executive council and the group as a whole.

"We want to see the chapters much more involved in submitting program suggestions and in reaching out to communicate productively

with member organizations at the local level, as well as recruiting new members."

As the chapters, the board and committees become more vocal, Ms. Gallagher would like to see executive council members less involved in the day-to-day operations of the committees that fall under their areas of responsibility. She calls this the "evolution of governance, with the executive council responsible for policymaking and keeping RIMS financially sound and growing."

Executive council members will function as liaisons with the committees in their designated areas," she continued. "At the same time, they will have working knowledge of all committee functions and activities."

Ms. Gallagher's theme of "Involvement, Value and Vision" builds on the example set by outgoing RIMS President J.A. "Tony" Bridger and previous presidents.

During his tenure, Mr. Bridger improved communications, eliminated RIMS' budget deficit, encouraged member participation and implemented the long-range strategic plan approved a year ago.

"These objectives have entailed a rather massive effort to adapt to changing times and new priorities," said Mr. Bridger, who is risk manager for the Bank of Montreal in Toronto. It has required "a re-engineering of RIMS to do more with less, to identify and focus upon the key elements in serving our members' interests and to prioritize and eliminate activities that may not directly relate to the achievement of

our primary objectives."

He added two positions to the executive council, and established environmental and health/safety committees.

He said he also sought "to reposition the role of the executive council into something more like a corporate executive committee and less like an operating committee."

While Ms. Gallagher plans to have executive council members attend more local meetings, overall RIMS is attempting to lessen the time commitment involved in serving on the council to broaden the base of risk managers who can participate.

Another achievement Mr. Bridger cites is RIMS' continued involvement in international issues and with risk management organizations worldwide. During his year as president, he spoke at meetings in: Halifax, Nova Scotia; Monte Carlo; Australia; and the United Kingdom.

In the United Kingdom, RIMS supported the Assn. of Insurance & Risk Managers in Industry & Commerce in challenging the British government's approach to dealing with property insurance related to terrorism.

"This is an important precedent in international cooperation among risk management societies, and quite apt, as well, given the proliferation of global interests among our members," Mr. Bridger said. "It is the

source of great pride to me—and I hope to all of you—that RIMS is respected worldwide for setting the standard in the advancement of the risk management discipline."

He said he carried a message of opportunity to risk managers around the globe.

"In an environment where all organizations are required to become more efficient, we as risk managers have an unprecedented opportunity to establish ourselves and our functions as being vital to effective financial management during turbulent times," Mr. Bridger said. "Getting the point across to the right people in the right places remains the overriding challenge, to RIMS and to every one of us as individual risk managers." (B)

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# Managing work comp, group health costs

By JOANNE WOJCIK

*Even without 24-hour cover, plans can be coordinated*

NEW ORLEANS—While 24-hour coverage is unlikely to become a reality in the near future, employers still can implement round-the-clock management of group health and workers compensation medical costs, experts say.

And, employers that institute a program to manage both types of medical costs will be a step ahead of any health care reforms that are finally implemented, workers comp cost control experts say.

A coordinated approach to managing medical costs will be far more effective than merging the medical components of workers comp with group health care, as President Clinton's reforms propose, said Dennis L. Huffman, principal of HJH Consulting Inc. in Tampa, Fla.

"If you indiscriminately throw workers compensation into health reform, it opens up a whole new can of worms for those on the comp side," he said during a session at the Risk & Insurance Management Society Inc. conference last week.

For example, while the focus of group health plan benefits is to manage medical treatment, the workers comp system is a disability management system that provides incentives to return injured workers to their jobs as soon as possible.

Under workers comp, "the primary goal is to achieve a timely medical recovery sufficient to return the worker to productivity and on the job as quickly as possible."

But, "that return-to-work goal can only be accomplished if the organization responsible for paying the workers compensation lost-wage benefits has a significant influence over the medical management of the case."

Splitting the medical component from the rest of the workers comp system strips the claims payer of the authority to manage the medical treatment, he said.

Under the Clinton administration's proposal, health insurers would not have the same incentive as workers comp insurers of returning employees to work because, unlike workers comp insurance, "health plans are not responsible for paying lost wages," Mr. Huffman said.

Each day of delay in returning injured workers to productivity costs the workers comp system \$10 billion per year, according to a study by the Alliance of American Insurers cited by Mr. Huffman.

In contrast, an employer-directed disability management system that coordinates health benefits with workers comp payments would minimize lost time, regardless of whether the illness or injury is work-related, suggested Glenn Simpson, director of risk management for St. Joseph's Hospital in Tampa.

Since St. Joseph's integrated the medical management for both workers comp and group health benefits in 1988, the hospital's workers comp expenses have dropped from 8.7% of payroll to 3.8% of payroll, he said.

As risk manager, Mr. Simpson manages the workers comp program,

the short- and long-term disability programs, in-house legal services, regulatory compliance with state and federal laws, workplace safety and loss prevention programs as well as the group health plan. As a result, he has close working relationships with the hospital's human resources executive, the health claims administrator, the employee assistance program director and in-house occupational health physicians.

Since the hospital—like most employers—will end up paying for employee health care regardless of whether it is related to an occupational injury, it makes sense to coordinate treatment around the clock, Mr. Simpson said.

He cited as an example the use of an occupational health nurse to monitor the blood pressure of a 45-year-old maintenance worker suffering from hypertension. "He can go to the health office daily to have his blood pressure monitored and to check his medication."

The employer not only is keeping the worker healthy and reducing its group health plan costs but is preventing a workplace injury that could occur if the maintenance worker suffers a stroke while on the job. "It's a more humanistic approach," Mr. Simpson explained.

Coordinating disability management for both group health benefits and workers comp also makes it easier for employers to comply with the Americans with Disabilities Act, he said. "If I were to make a Top 10 list for the reasons to integrate the two programs, all 10 reasons would be

the ADA."

A separate component of the president's health care reform proposal would implement widespread community rating. That would remove the monetary incentives for individual employers to maintain a safe workplace created by experience rating, according to Mark A. DeLillo, vp of risk management services for Jim Walter Corp. in Tampa.

"In my company, we spend a lot of money on safety programs to contain costs. Safety is the only way to prevent injuries from occurring on the job and to contain costs associated with medical treatment and indemnity payments."

Any employer who opts for community rating and drops its safety program "is committing suicide," Mr. DeLillo said.

If health plans are community rated without taking into account the number of work-related injuries or the prevalence of safety programs, "there will not be any monetary incentives to create a safe work environment," HJH Consulting's Mr. Huffman said.

Still, some experts say "it would be worse if workers compensation is left out of the health reform process altogether," he said. "People in the workers comp field feel that health providers would have an incentive to classify medical problems as work-related" if a global budget is imposed to cap the nation's health care expenditures.

Workers without group health benefits already have an incentive to ask their doctors to classify their in-

juries and illnesses as work-related to obtain coverage under the workers comp system, Mr. Huffman said.

Because there are no employee-paid copayments or deductibles, overutilization is prevalent in the current workers comp system, he added, pointing to a recent study by the National Council on Compensation Insurance.

The study of 1,300 closed workers comp cases filed over a six-year period ending in 1993 with the 13 largest workers comp insurers in four states—Florida, Illinois, Oregon and Pennsylvania—found that workers comp cases are more expensive than group health because of overutilization of health care services.

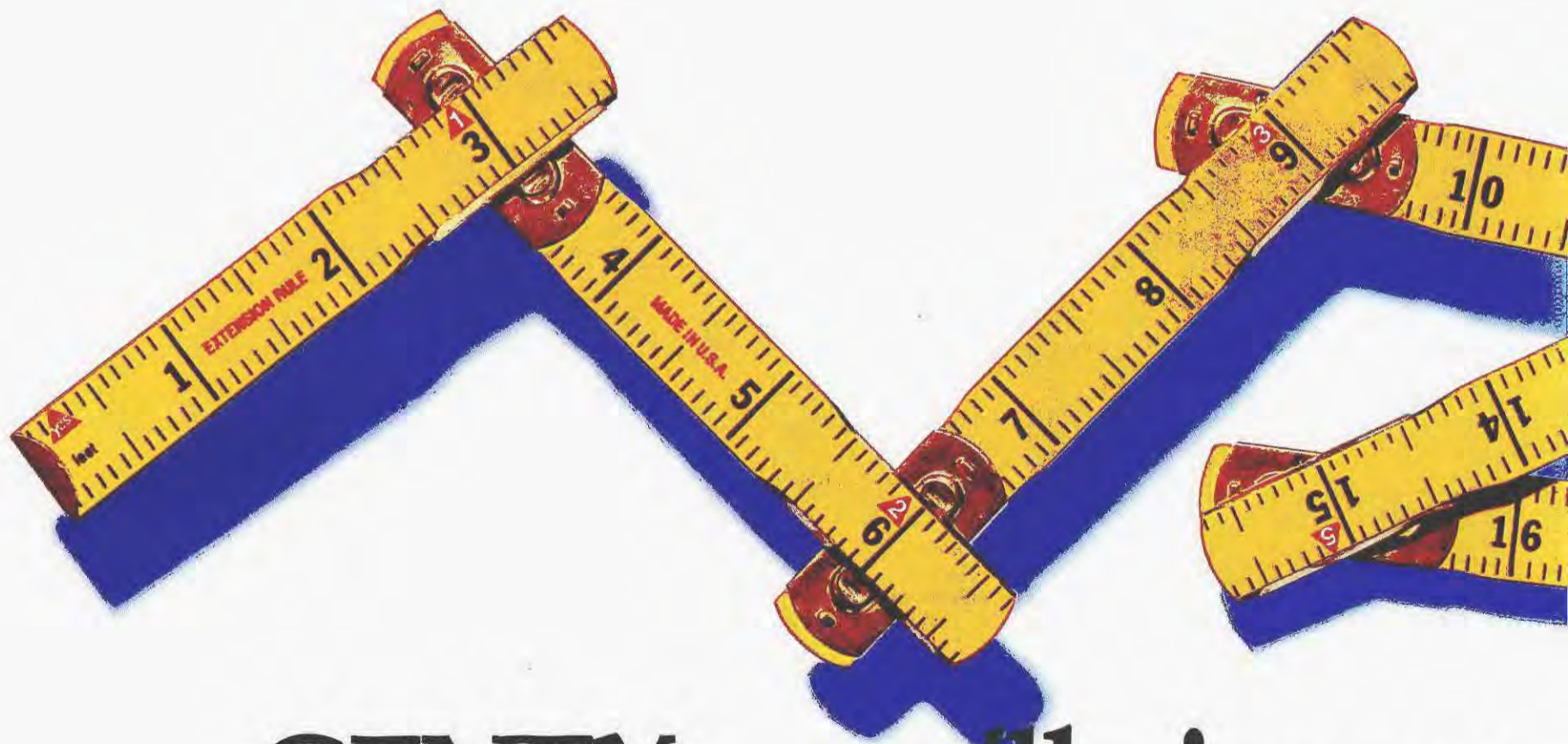
A 1990 Minnesota study had suggested that health care providers were charging more to treat occupational injuries than to treat non-work-related injuries, but "now the NCCI study has brought home the possibility that it was overutilization of services rather than overcharging" that has contributed to the explosion in workers comp medical costs, Mr. Huffman said.

He also criticized the Clinton proposal's provision that would let employees select their own health plan, which would ultimately allow them to choose their own providers.

Few group health care providers currently have the expertise needed to treat occupational illnesses and injuries, Mr. Huffman said. "Costs are undoubtedly going to increase if medical providers are used that are unfamiliar with comp, including knowledge of the workplace and job accommodation."

In contrast, "when the employer has the choice, there is more control over the medical expenditure."

Jim Walter Corp.'s Mr. DeLillo moderated the session. ■



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# Reducing comp costs requires a team approach

By MICHAEL SCHACHNER

NEW ORLEANS—Risk managers can control workers compensation costs if they attack the problem on many fronts, but that approach requires cooperation from upper management, plant supervisors, employees and physicians, two corporate risk managers say.

First, management must have an ongoing commitment to reducing losses from workplace injuries.

"Ongoing is the key word. You can't have six to 12 months of commitment from management and then have them lose interest. When at least two-thirds, and maybe 75%, of your property/casualty losses stem from workers compensation, it's one of the most important things we can work on," said Thomas J. Hassett, director of corporate risk management with Philips Electronics North America Corp. in New York.

While risk managers in recent years have achieved some success in reducing administrative costs, they haven't done nearly as well in managing the claims side, Mr. Hassett and John F. Riley, director of corporate risk management at The Dun & Bradstreet Corp. in New York, concurred.

"Claims costs are 75% of all costs for us. In the words of the famous bank robber, Willie Sutton, 'This is where the money is,'" Mr. Riley said last week at a Risk & Insurance Management Society Inc. conference session.

"For a company like Dun & Bradstreet, you're paying a lot in workers comp costs regardless of whether you have a retrospective plan or some high-deductible program," he said. "But there are probably 100 things you can still do to reduce costs, and you have to do a lot of them to have any success."

Safety and early claim intervention are the keys to controlling workers comp costs, he emphasized.

Early intervention, Mr. Riley said, puts the claim into able hands, shows the injured worker that his or her case is being handled and, most importantly, keeps personal injury attorneys out of the loop.

Mr. Hassett agreed. "The earlier you can get a claim into the system, the better you can manage it. And I can't stress enough the fact that early intervention means no attorney involvement." That strategy has reduced Philips' lost-time costs by thousands of dollars per claim, he said.

Another step that helps eliminate attorney involvement, Mr. Hassett said, is to educate employees about the claims-handling process before they actually file claims. "People unaware of the claims process are much more likely to fall into the hands of an attorney," he said.

Mr. Riley also urged risk managers not to overlook the value a clean shop is a safe place. Productivity without safety is no good at all, and supervisors need to be made aware of this," he said.

One way to get supervisors and foremen more tuned into workers comp cost control efforts is to tie

their economic incentives directly to safety performance, Mr. Hassett said. "Local people need to be part of the teamwork. At one Philips plant, bonuses are directly tied to loss costs and safety, and there should be more plants doing this. Everyone needs to be trained in what is happening at their facility."

Mr. Hassett also urged risk managers not to delegate communication duties: "Don't delegate this very important responsibility to your TPA. Check periodically into what each plant is doing and make contact with supervisors and regional managers. If you give people up to the system, the next person you're going to be hearing from is an attorney."

As an example of aggressive claims management, Mr. Riley explained how several loss prevention and claims control standards that Dun & Bradstreet implemented at its Neodata Inc. subsidiary in Boulder, Colo., in 1989 cut claims to 42 last year from 105 four years earlier.

"Neodata is a magazine subscription clearing house where there are tons of paper and boxes. Back and hand and wrist strains were accounting for 70% of our claims. We were having worse experience than the meatpacking industry and logging companies," he explained.

The company realized that employees wearing headphones to listen to music while working was a major risk factor. "(They) can't hear danger signals and are unaware of normal plant activities. And they were damaging their hearing, which could have been a claims nightmare down the road," Mr. Riley said.

Headphones were prohibited.

D&B also implemented a policy of having every claim investigated by a safety committee that could not simply report that employee error was the cause of the injury. "It's unacceptable to say it was an employee's fault that he slipped on water. Why was the water there to begin with?"

In the area of claims control, D&B began to demand quality claims adjustment, including requiring investigators to write up a claims-handling strategy on each claim the minute they finished viewing the file for the first time.

"You need an expected course for every claim. Without it, the chances of having the claim adjusted properly are very slim," Mr. Riley said.

Finally, he said bringing physicians on site is tremendously beneficial to the return-to-work part of claims management. Doctors who have seen how a plant operates and what employees actually do better understand when employees can resume work and at what position.

"Doctors love this, and it makes a very big difference. How can they possibly know what goes on at a plant if they've never seen it? It cuts down on lost time tremendously," Mr. Riley said.

Mr. Hassett said the greater proficiency offered by physicians who specialize in workers comp care can also help companies control costs. "I think we should always seek specialized providers. Occupational injury specialists, whether they're physical therapists, physicians or what have you, tend to do the best job with workers comp injuries."

With Messrs. Riley and Hassett

both expounding the virtues of early claims intervention, Mr. Hassett said electronic and telephone claims filing has proved to be very helpful and cost-effective at Philips.

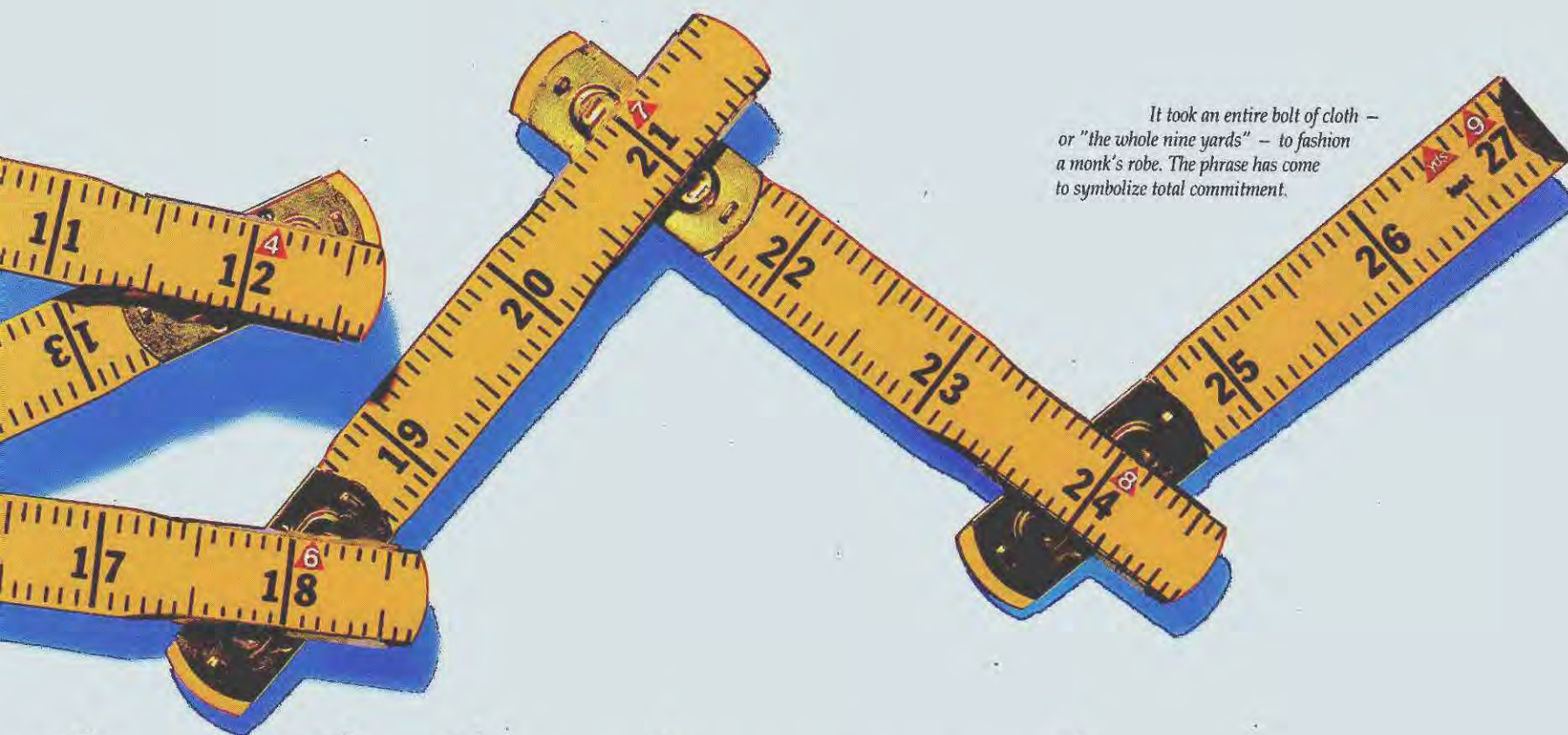
"Nearly 96% of our claims last year were filed by phone, most within six minutes of the injury. This way the claim is in the system by the next day, and you can begin managing it," he said.

Both speakers said that workers comp claims control and loss prevention are tough chores during a time when corporate downsizing has stripped risk management and safety staffs to the bone.

Currently at Philips, there are only two full-time safety professionals among a 38,000-person workforce. Contrast that with the 12 safety people Philips had in 1988, and "it makes you wonder about the commitment major companies have toward safety these days," said Mr. Hassett. "When times get tough, safety and health are always the first to get cut."

"None of this is easy, but it's worth it," Mr. Riley concluded. "It's where the money is in corporate insurance today. You just have to believe that a safe workplace is possible, that you can obtain 100% management commitment, that you can institute various loss prevention measures, and that you can oversee the loss adjustment process. If you do all this, you'll reduce claims frequency and costs."

Jeanne H. Pores, vp-hospital affairs with Physicians Reciprocal Insurers in Manhasset, N.Y., both coordinated and moderated the session. **B**



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# ASK A RISK MANAGER

## Solid safety programs often offer incentives

**Q**

**Successful safety programs require that all employees recognize the role they play in the process. What incentives do you believe are the most effective in administering a safety program?**

**A**

Without a doubt, it is extremely important for all employees to understand and believe they are the single most important factor in a successful safety program. After all, the concept of safety exists to protect their welfare, since the majority of what we call "accidents"

result from a failure to act in a safe manner.

Too many safety programs, though well-intended, suffer a loss of momentum because they lose focus and do not contain the dynamics to sustain the original objectives. We should recognize that a good safety program, like a good marriage, requires constant nurturing. And, since human beings respond best to a praise/reward system, incentives are a vital part of any program. We risk managers learn early on that evaluating exposures, formulating a plan to deal with these exposures and monitoring the results are cornerstones of the risk management process. So it is with safety.

The initial step is to evaluate the organization's culture and design an incentive program to suit that culture. A

constant monitoring of results will allow the program to remain on track. And, when we say *all* employees must commit to safety, we include senior executives, who must unconditionally embrace the safety objectives. If executive management demonstrates that "safety counts," employees will soon understand that *how* they perform their jobs is extremely important.

It would be accurate to state that successful safety incentive programs rely on a reward system to deliver good results. Studies conducted over the years reveal employees view some form of monetary reward as the most desirable form of positive reinforcement. It has also been demonstrated that the amount of the reward does not have to be great. A few dollars spent wisely, for the right purpose, can have a tremendous impact on safety performance.

In recent years an entire industry has been created for the purpose of designing and marketing safety program incentives. There is no limit to the type of creativity used to offer incentives. I know of one company that offers free movie passes to employees who are "accident-free" for a specified period of time. Again, the intent is to obtain interest in the program and keep the interest alive on a daily basis. Perhaps the best approach is to ask employees what type of reward is most meaningful to them. Remember the earlier comment about corporate culture? Soliciting input from employees is a foolproof way of blending the incentive program with the business culture.

Management's recognition of good performers is also a must. How about lauding the best employees in a company newsletter or a personal letter from the most senior executive? I also like the idea of a plaque, since it stands as a permanent reminder that safety goals have been achieved. Several companies recognize their top

performers with an "employee of the month (or year)" distinction. Why not consider offering a choice parking space to the employee with the best safety record? Sounds simple enough, and it doesn't cost any money.

Not surprisingly, I'm certain you will find that these simple incentives create a positive atmosphere throughout the organization. When employees perceive that a company is taking care of them, good will translates into optimum job performance. When the work environment is pleasant, everyone wins. **BI**

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**Ms. Werner**

# ASK A BENEFIT ACTUARY

## Good planning maximizes qualified plan benefits

**Q**

**How can qualified plan benefits be maximized with the \$150,000 compensation cap?**

**A**

This question has come to me from several senior executives. In general, they are concerned about the reduction in future qualified defined benefit plan accruals due to the reduction in the compensation limit for calculating qualified plan benefits. Effective Jan. 1, 1994, a

qualified retirement plan may only take into account compensation up to \$150,000. This may result in a period of years when the executive accrues no benefit under the qualified defined benefit plan.

For many senior executives, this cessation of qualified plan benefit accruals is offset by increased accruals under a non-qualified supplemental executive retirement plan. However, most executives with SERPs would prefer to have their accruals under the qualified plan rather than the SERP, because a qualified plan is funded and generally provides greater benefit security for the executive than an unfunded SERP.

The IRS has issued guidance regarding how a qualified defined plan makes the transition to the \$150,000 cap. Through a prudent selection of the transition options provided by the IRS, a plan sponsor can maximize benefits for its executives from the qualified plan, while minimally increasing the plan administration.

The IRS guidance provides for three transition options:

- Apply the regular plan formula to an employee's compensation with the compensation limited to \$150,000 in each prior year and provide that the resulting accrued benefit cannot be less than the benefit accrued as of Dec. 31, 1993 (when a \$235,840 compensation limit was in effect). This option is being adopted by many plan sponsors and has the effect for many senior executives of cutting off benefit accruals under the qualified plan for a period of years.

- Freeze the accrued benefit for each employee at its Dec. 31, 1993, level and add a future service accrual under the plan's regular formula, counting only pay up to \$150,000. This approach provides that each participant will continue to receive some benefit accruals. However, for a final average pay defined benefit plan, it has the disadvantage that benefits accrued for service before 1994 will not be based on final average pay at separation from service; they will be based on the final average pay level at the end of 1993. This can significantly reduce benefits for individuals retiring more than a few years after 1993.

- Use a combination of the above options, in which the employee gets the greater of the two amounts. This approach maximizes benefits but can create a significant administrative burden because it effectively doubles the number of benefit calculations that must be done.

IRS guidance does provide for some relief from the administrative burden created by the third option. Essentially, the IRS will permit plan sponsors to adopt Option 3 for any employee with pay in excess of \$150,000 per year prior to 1994 and Option 1 for all other employees. This approach can maximize the qualified plan benefits for senior executives while limiting the additional benefit calculations needed for the group of employees who earned more than \$150,000 before 1994.

Before adopting any of these options, a plan sponsor should consider many factors, including: the impact on plan funding requirements as provided in the Internal Revenue Code and ERISA; the impact on the plan's net

periodic pension cost as provided under FAS 87; whether any benefits lost under the qualified plan through the imposition of a \$150,000 cap will be replaced by a SERP; and the impact of any increased SERP benefits upon Federal Insurance Contributions Act taxes that will be paid by both the employer and the executives. In general, vested accruals under a SERP are subject to the Medicare tax of 1.45%. Both the executive and the employer must pay 1.45% of the value of any vested accruals under a SERP during the year.

The IRS guidance does provide some relief for executives whose benefits will be limited due to the \$150,000 pay cap. Carefully planning the transition approach can minimize some of the negative effects. **BI**

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**Mr. Miner**

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

# Large-deductible plans don't fit everyone

By GAVIN SOUTER

*But in right situations, plans can lead to savings*

NEW ORLEANS—Large-deductible programs and self-insurance can lead to significant savings in workers compensation programs, but they should be handled with care.

Not all companies are of sufficient size or have risk management systems sophisticated enough to cope with large deductibles or self-insurance, two risk managers suggested last week at the Risk & Insurance Management Society Inc. conference.

And, large-deductible programs could soon become less attractive as insurance regulators review

their tax status, the risk managers said.

Self-insuring workers comp risks is pointless if it is not combined with an active loss control strategy, a broker added.

Large-deductible policies for workers comp risks were introduced several years ago by insurers in response to the growing number of companies that were self-insuring their risks, said Lynn A. Gaughan, director of risk management at footwear and apparel maker Reebok International Ltd. in Stoughton, Mass.

Normally, workers comp insurers insist that policyholders have annual premiums of at least \$1 million before they turn to a

large-deductible program. The deductibles usually range in size from \$100,000 to \$1 million. Losses that fall within the deductible are paid by insurers, which then seek reimbursement from the policyholder, she explained.

Policyholders are required to set up an escrow fund or provide a letter of credit equal to their expected losses under the deductible. Premiums are paid in installments and an audit is performed at the end of the policy period to determine the standard premium and the premium adjustment.

The main advantage of large-deductible programs is a substantial reduction in workers comp premiums.

"You also get enhanced cash flow because there is no pre-funding of losses and there is often a delay of up to three months between the time the insurer pays the losses and when it seeks reimbursement from you," Ms. Gaughan said.

Large-deductible programs also give the benefits of self-insurance without including the administrative burdens or the need to qualify as a self-insurer, she said.

The programs also encourage more attention to loss control. "They are a very strong incentive for you to control your losses and they help to emphasize the need for safety within your organization," Ms. Gaughan said.

But, large-deductible programs are not suitable for all policyholders. Companies with erratic loss experience may find the financial burden too much in bad loss years, she said. "And, if losses are sporadic, the insurer will look at the worst-case scenario and demand a larger letter of credit."

Companies that are in transition should also stick to traditional workers comp insurance policies. "Losses tend to increase when an organization is reducing its workforce or is the target of a takeover bid, so large-deductible plans are not suitable to companies in uncertain circumstances," Ms. Gaughan said.

Large-deductible policies may soon become less attractive for other companies, however. Some state insurance regulators are considering imposing premium taxes on the payments made to insurers on losses that fall within the deductible. If that happened, there would be little advantage in buying or selling the policies, Ms. Gaughan said.

Self-insuring workers comp risks can also be an attractive option for risk managers, said Raymond J. Abromitis, risk manager-North American operations at appliance maker Whirlpool Corp. in Benton Harbor, Mich.

Like large-deductible programs, self-insurance improves a company's cash flow, Mr. Abromitis said. In addition, self-insurance programs enable companies to tailor their own claims administration systems.

"An advantage... is the ability to control and restructure claims management and loss prevention services based on the specific needs of the organization. A self-insured is not limited to the resources of a single insurance company."

But, self-insurance also has its disadvantages.

For example, an employer can take on unlimited liability, which could lead to large losses, Mr. Abromitis said.

"The long-term nature of work-related injuries also makes it difficult to terminate a self-insurance program once it has been initiated," he said.

Self-insuring workers comp also may lead to an increase in premiums for other casualty coverages because the insurer will lose a substantial part of the premium it previously received, Mr. Abromitis said.

Large-deductible programs and self-insurance can only be effective when used in conjunction with a comprehensive loss control strategy, said Catherine D. Bennett, vp/client technical services manager at Johnson & Higgins in Nashville, Tenn. "It doesn't matter how good your financial analysis is, you have to have a good loss control strategy."

To control and reduce workers comp losses, Ms. Bennett recommended that risk managers: analyze loss data thoroughly; vigorously encourage safe practices and safety training; ensure that employees are fairly and speedily compensated for any injuries; contain medical costs through techniques like medical bill audits and case management; and define the organizational structure of a workers comp plan.

"Many companies have a problem in that no one is really responsible for workers compensation," she noted.

The session was coordinated by Ms. Bennett and moderated by Douglas S. Kasten, assistant treasurer-corporate risk management at Nashville-based Northern Telecom Inc. E

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# Outside insight can help work comp administration

By RODD ZOLKOS

NEW ORLEANS—When Cynthia Rigney was given responsibility for Thrifty Corp.'s self-insured workers compensation program a year ago, she knew the self-administered program was something of a "black hole."

With annual cash outflows of about \$17 million in the workers comp area, "we had some real strong financial concerns," said Ms. Rigney, vp of risk management for the Los Angeles-based drug store chain.

Nevertheless, she anticipated that an outside study of Thrifty's workers comp self-administration would conclude that the program should remain self-administered, and the company would simply "clean it up and go."

The study by A. Foster Higgins & Co. Inc. left little doubt, though, that self-administration simply couldn't be reconciled with other corporate goals stemming from Thrifty's financial turnaround effort—namely, saving money quickly.

The Foster Higgins study included a technical claims file audit, an in-depth operational audit of Thrifty's self-administration program and selected outside vendors and an analysis of self-administration costs vs. the expense of third-party administration.

While Thrifty executives had operated under the assumption that it cost the company about \$300,000 to administer its own workers comp program, Foster Higgins found that the annual price tag was closer to \$1.1 million.

Among other things, Foster Higgins also found that many of Thrifty's administration staff weren't sufficiently competent to administer the program.

"We found out that we were dealing with about 35 different attorneys," Ms. Rigney said. "It turns out they were doing a lot of adjuster work because our staff wasn't qualified to do all the things they were supposed to be doing."

If Thrifty had the luxury of time, it could have corrected the problems in its self-administered program. But, needing to "stop the blood from flowing" financially, the company hired Constitution States Service Co., a TPA unit of Travelers Corp.

Thrifty now is realizing about \$3 million in overall workers comp cost savings, Ms. Rigney said.

Ms. Rigney shared Thrifty's experiences as part of a panel on workers comp administration she moderated during the Risk & Insurance Management Society Inc.'s annual conference.

Thrifty's experience with workers comp administration was much different from two other companies on the panel, which was coordinated by Robert Cliff, a principal with Foster Higgins in Los Angeles.

Rosemead, Calif.-based Southern California Edison Co. has self-insured its workers comp exposure since 1918, and is committed to continuing to self-administer what is by all accounts a highly successful workers comp program.

"The program that Southern California Edison has is really a study in how to self-administer the proper way," said Randy

## Three employers find an audit of programs saves money

Jones, a consultant with Johnson & Higgins in Los Angeles. He worked on reviews of all three of the programs discussed during the session while a consultant with J&H's Foster Higgins unit.

But, as well as the program worked, executives at the utility realized the administration program might benefit from an outside look. The result is that "we have sharpened our focus and we

have clearly improved our process," said David Caine, workers compensation manager.

Among other things, Foster Higgins review of the utility's workers comp administration showed that the program was "very disconnected, with the employees stuck in the middle of a program that basically was managed by the employees."

In its place, Southern California

Edison has crafted a coordinated disability management process that connects the various aspects of the workers comp program—from ergonomics and training to medical care to rehabilitation services—in a logical fashion.

The review also drove home the importance of adequate training for the administration staff. Mr. Caine noted that the utility's workers comp litigation defense

costs dropped to \$99,000 last year from \$241,000 in 1991. "Why? Because our reps know how to litigate," he said. "The only thing that we will not allow them to do is take depositions and try cases."

Carl Karcher Enterprises, which runs Carl's Jr. fast-food restaurants throughout California, Arizona and Oregon, has self-insured its workers comp exposure in California since the early 1980s, according to Barbara

*Continued on next page*



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# Comp audit

*Continued from previous page*  
Landis, director of risk management for the Los Angeles-based chain. The program has been a "hot potato" in the company for a number of years, though, moving through different areas of the organization each time losing focus, she said.

As part of a major restructuring of the company in August 1992, workers comp was moved into the risk management area and "management's expectation was a quick turnaround of a program

that had been out of control for a number of years," Ms. Landis said.

The company already employed a TPA to administer its self-insured program, but it brought in Foster Higgins to audit the program's administration in December 1992.

"The results of the audit were fairly disturbing to us," Ms. Landis said.

It revealed a number of shortcomings in the program's administration, she said, including a lack of initial contact with injured workers, incorrect reserving, poor litigation management, inade-

quate file documentation, too great a case load burden on staffers and no evidence of supervisor involvement.

Mr. Jones' recommendation was that Carl Karcher either change administrators or bring administration in-house. Carl Karcher executives saw it as a chance to start with a clean slate with a new TPA and hired Constitution States to administer the program.

The move enabled Carl Karcher Enterprises to reduce open claims, decrease administration costs and reduce overall annual program costs by more than \$1.5 million.

From her experience, Ms. Lan-

dis advises other workers comp executives hiring new TPAs to "form a partnership with your administrator" from day one. She also recommends seeking a TPA that matches your company's needs. Constitution States, for example, had restaurant industry experience and bilingual adjusters, two significant concerns for the fast-food company, she noted.

Ms. Landis also suggested communicating expectations to a TPA upfront, and monitoring their performance closely without micromanaging.

Mr. Cliff coordinated and Ms. Rigney moderated the session. ■

# Employers can trim risk of lawsuits with fairness in workplace

By SALLY ROBERTS

NEW ORLEANS—Employers that work on building partnerships with their employees can reduce their employment liability risks, a benefit consultant says.

Most of the employment discrimination lawsuits today involving race, age and sex are filed by disgruntled employees, said Harry G. Graham, a consultant with The Wyatt Co. in Wellesley Hills, Mass.

While there will always be some dissatisfied workers, employers that try to create a fair workplace and communicate that to their workers can avoid potential liability, Mr. Graham said.

Performance review programs providing honest evaluations of an employee's job performance and career path programs outlining what an employee should do to receive a promotion are two ways to assure workers they are being treated fairly, he said.

Unfortunately, "U.S. companies have not spent enough time putting in performance review systems," Mr. Graham told risk managers attending a session at the Risk & Insurance Management Society Inc. conference last week.

Employers "don't have the muscles to tell an employee he or she is doing a bad job" and is not meeting company expectations. This type of management could lead to a discrimination claim against the company.

For example, an employee may get upset after being passed over for a promotion another employee received and start to ask, "Why am I being treated differently?" Mr. Graham explained. If a good performance review and career path system were in place, the employee would know what he or she was doing wrong and what it took to get that promotion. Without that information, the employee might file a discrimination suit.

"All employees want is to know they are being treated fairly," Mr. Graham said. "If they feel they are being treated unfairly, the federal and state governments have given them enough hooks to hang their hats on."

Such hooks include Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Fair Labor Standards Act and wrongful termination.

All these state and federal laws, coupled with issues like negligence and invasion of privacy, have left risk managers in a "terrible tangled web," said Laura A. Kumin, director of risk management and general counsel of the United Educators Insurance Risk Retention Group Inc. in Chevy Chase, Md.

"We're living in a world that's a roller coaster and it keeps getting steeper," she said.

According to the Equal Employment Opportunity Commission, *Continued on next page*

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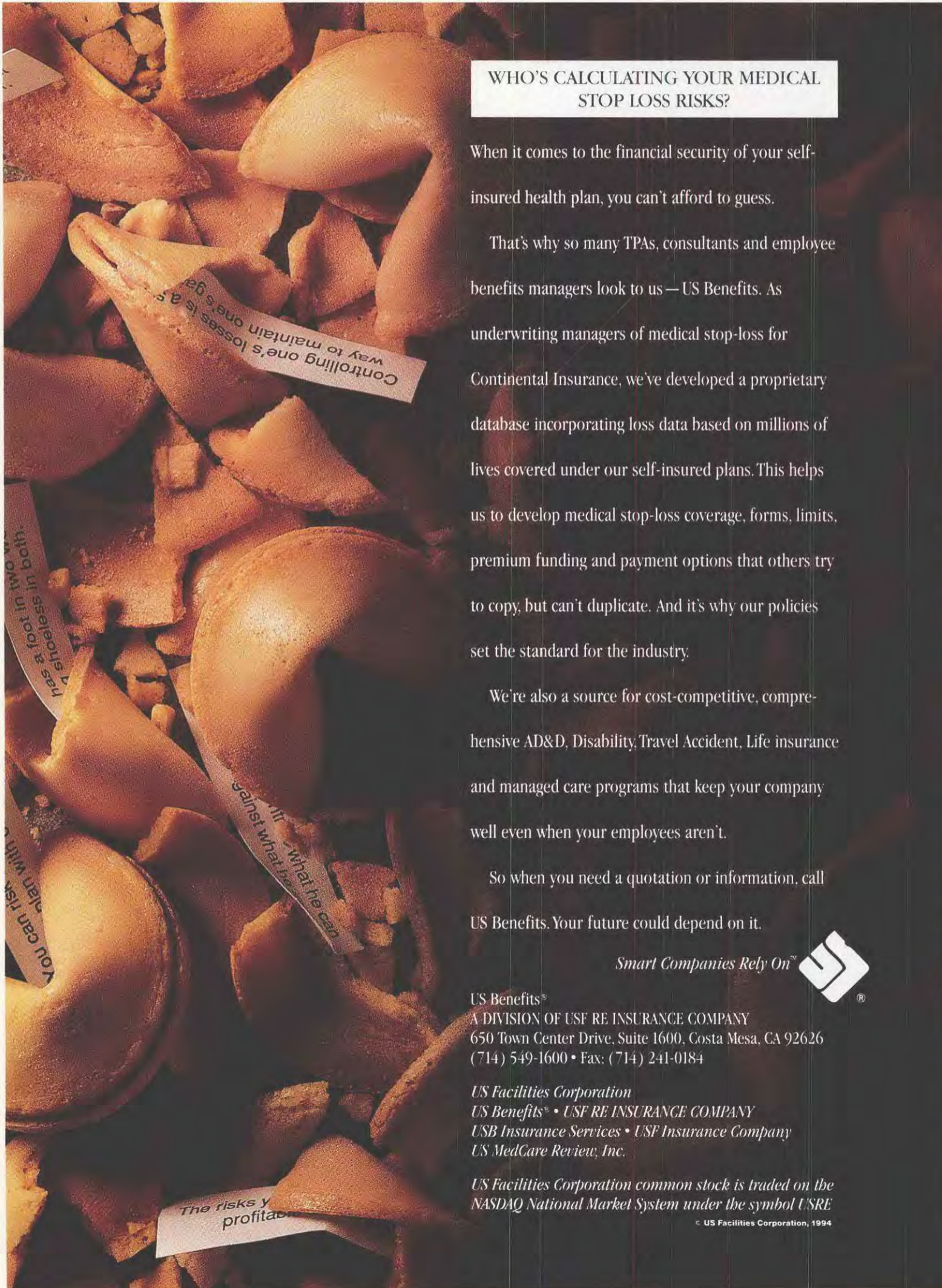


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Continued from previous page

the total number of discrimination complaints received in 1993 was 20% higher than 1992, Ms. Kumin said.

Sexual harassment complaints alone soared to 10,532 filings in 1992, from 6,883 in 1991.

"No employer escapes these liabilities," she said, adding that the average cost for legal defense fees in an employment law case is \$80,000, according to Horsham, Pa.-based Jury Verdict Research.

Age discrimination lawsuits resulted in the highest aggregate jury awards—\$450,289—during 1988 through 1992, Ms. Kumin said.

Sex discrimination awards averaged \$255,734; race discrimination awards averaged \$176,578; and disability awards averaged \$151,421.

There are ways risk managers can avoid these costly suits, Mr. Graham said, but prevention is "something many aren't doing right now."

One reason is the "split" between corporate counsel and risk managers, he said.

"Inside counsel knows what's going on, but doesn't clue (risk managers) in."

Ms. Kumin referred to risk managers as "underutilized resources" who should be part of the company's employment liability team.

Risk managers especially need to be in on the design side of employee benefits, according to Mr. Graham.

With an increasingly diverse workforce, risk managers need to be involved with the design of qualified benefit plans to reveal potential liability, he said.

For example, he explained that some states prohibit employers from discriminating against workers who smoke off of the work premises. Risk managers need to be aware of these laws and the risks involved, especially if the company's corporate life insurance policy makes a distinction between smokers and non-smokers, he said.

This is a prime example where "inside counsel and risk managers must be in sync," he said.

Employers must keep their managers and supervisors up to date on all the new discrimination laws and train them in how to conduct themselves, Mr. Graham said.

"I've never seen a law case where a manager or supervisor had no idea what was going on" or should have known. Rather, he said, "They just didn't act on it."

Legal issues risk managers must be aware of include:

- Age discrimination.

"It amazes me that companies still have disability policies that shut off benefits at age 70," he said. "An employer cannot still do that. If you implement that kind of policy, you are liable."

In addition, employers need to be aware that as company workforces are trimmed, there is a growing population of highly qualified older people looking for jobs.

"You can't discriminate against age," Mr. Graham said.

- The Americans with Disabilities Act.

This is a law whose impact employers are just beginning to see, according to Mr. Graham.

"Congress has no earthly idea of what they did," he said. ADA claims and awards "are going to go through the roof."

However, if employers use "basic common sense, you'll be OK," he said.

For example, an employer institutes a managed care plan that

would require a disabled employee to switch from a very conveniently located dentist to an in-network dentist across town. The employer should be willing to work with the employee to avoid a possible ADA claim.

"There is nothing wrong with paying the same rates for the disabled employee to continue going across the street" to the out-of-network dentist, Mr. Graham said.

Another ADA issue is how the law relates to workers compensation, he said.

For instance, if a worker has been injured on the job, the work-

**There are ways risk managers can avoid these costly suits, but prevention is 'something many aren't doing right now,' says Harry G. Graham of The Wyatt Co. One reason is the 'split' between corporate counsel and risk managers, he says.**

ers comp claim has been settled and the employee is no longer working, the employer need not keep the worker on the payroll for fear of a later ADA claim.

The employer can terminate the worker and not be held liable un-

der the ADA if it documents that it offered a doctor-approved job accommodating the worker's injuries but was declined, Mr. Graham said.

- Sexual harassment.

"Not enough time is spent com-

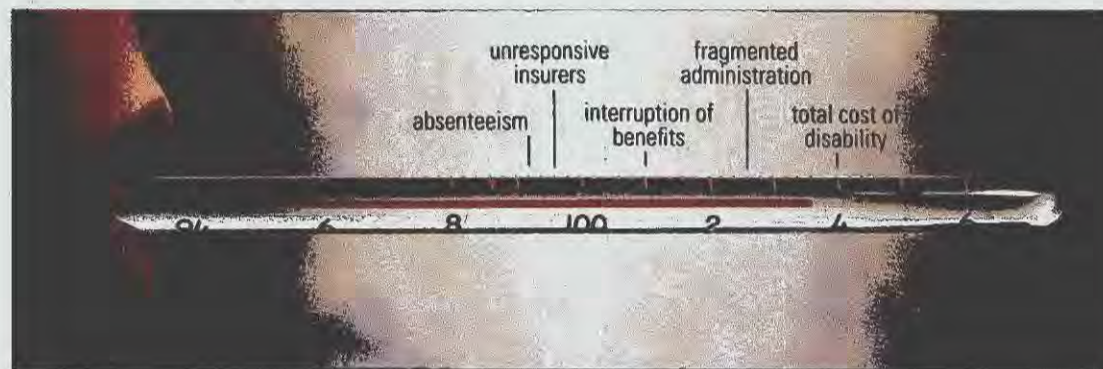
municating sexual harassment policies and procedures," Mr. Graham said.

Employers tend to give employees big packages at their orientation, explaining the company's policies and procedures from "cradle to grave" but then fail to recommunicate these policies, he said.

Employers should highlight their sexual harassment policies at least semiannually, Mr. Graham advised.

Jane Y. Rastallis, a consultant for The Wyatt Co. in Wellesley Hills, Mass., coordinated the ses-

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## Haggar investment in health education cuts medical costs

By MICHAEL SCHACHNER

WASHINGTON—For employers with self-insured medical plans, few medical procedures are more costly than the delivery and postnatal care of a premature baby. Thus, prenatal care programs that stress health risk assessments, a healthy diet and regular prenatal physician care are invaluable, according to the health and wellness director of a major clothing manu-

facturer.

While paying for doctor visits during the prenatal period, covering dietary supplements and paying all delivery fees does create costs for self-insured employers, the reduced frequency of preterm babies that results from such benefits is well worth the added expenses, said Anne Hunt, wellness coordinator with Haggar Apparel Co. in Dallas.

Haggar, which employs about 4,000 women with little formal education in its South Texas manufacturing facilities, is an example of a firm that has reaped benefits from its commitment to prenatal care and overall wellness programs. It has had a sophisticated prenatal care program since 1988, and has since added other wellness programs and incentives.

The programs have succeeded in influencing healthier lifestyles among Haggar's workforce and have led to reduced health care costs, especially fewer low-birth weight babies, Ms. Hunt said during a session on innovation in women's health care at the Sixth Annual National Managed Health Care Congress, held April 11-14 in Washington.

Haggar aims to make available as many resources as possible to educate employees and their spouses on how to take the best care of themselves during this critical time, she explained.

Under the apparel maker's prenatal program, employees are encouraged to attend prenatal education classes offered at each plant. Haggar offers the well-known "Babies and You" program through the March of Dimes, and employees can receive an infant car seat or booster seat for attending five sessions.

Ms. Hunt explained the company's attitude: "The more education we can impart, the better off we all will be."

"These classes allow our people to learn what questions to ask their doctors. And, the doctors appreciate it because their time with patients is limited."

Prenatal education is especially important for Haggar's employees, she said, because the majority are not familiar with good prenatal care practices.

"We were seeing a lot of low-birth weight babies and premature babies and weren't sure why. We quickly realized that our medical plan had a \$500 deductible, so our pregnant workers weren't seeing a doctor until delivery. It was at that time we went to 100% coverage."

In addition to the prenatal care program, which covers all doctor visits during pregnancy, vitamins and all delivery fees, Haggar has implemented several health promotion programs in the past few years aimed at improving the general health of its workforce.

Last year, Haggar began offering voluntary health screenings and health risk assessments that include an annual blood test for HIV, thyroid problems, cell counts and 23 other blood chemistries.

"The purpose of this is simple. We're trying to help the (employee) identify any possible health problems which may need further evaluation or medical attention," Ms. Hunt said.

Haggar employees, which the company refers to as "associates," can also undergo a complete health

*Continued on next page*

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# Good news for employers on workplace depression

By MICHAEL SCHACHNER

WASHINGTON—The direct and indirect cost of depression in the United States is roughly equivalent to the costs associated with heart disease, according to a business consultant.

Paul Greenberg, vp with Analysis Group Inc. in Cambridge, Mass., said depression produces symptoms just as physical illnesses do, and employers must

handle depression in the workplace as if it were a physical illness.

"The indirect costs of depression can cripple a business. Absenteeism and reduced productivity are highly prevalent in the workforce as a result of clinical depression."

Speaking at the Sixth Annual National Managed Health Care Congress held earlier this month in Washington, Mr. Greenberg cited a study his company conducted that found 11 million Americans suffer from clinical depression. Of that group, most are between the ages of

18 and 44, and two-thirds receive no treatment.

"The financial impact of depression is at least \$44 billion per year, which is comparable to heart disease in terms of direct and indirect costs," he said.

Analysis Group estimates, based on 1990 data, that direct treatment costs for depression are about \$12.4 billion per year, while indirect costs related to suicide, absenteeism and reduced productivity are greater than \$31 billion.

"Three-quarters of costs associ-

ated with depression are indirect, so depression doesn't get the due that illnesses with high direct costs receive. But, from the employer's perspective, they're feeling the brunt of depression," Mr. Greenberg said.

Not only do depressed employees tend to perform poorly and miss work, but they have a habit of "dragging down their colleagues," he added. "Most cases of depression lead to productivity impairment of more than one person."

To combat the negative impact of depression, he suggested that em-

ployers consider the following:

- Reduce the level of participation the depressed person has with mainstream job personnel until that person has undergone treatment.

- Pay depressed people less in salary until they have proved that they have emerged from their depressed state and are ready to resume full work duties.

- Intervene with employees suffering from clinical depression, in order to reduce the number of deep depressive episodes an employee falls into, as well as the duration and severity of those episodes.

Mr. Greenberg did not address

*Continued on next page*

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risk assessment paid for by the company. The assessment blends clinical test results with lifestyle and demographic data and then outlines what steps an employee can take to reduce identified health risks.

Lastly, associates in Haggar's Dallas office can undergo a free cancer screening, which focuses on virtually all types of potential cancers, including breast, abdominal, skin, lymph node, thyroid, prostate and testicular cancers.

While only 24 associates availed themselves of the exam last year, seven were identified with abnormalities. "It was very good to identify these problems at an early stage," she said.

To get employees on a path toward health and wellness, Haggar offers incentives and gifts to those who take part in the company's programs.

Earlier this year, for example, Haggar offered a free sports bottle and sun visor to anyone who followed a dietary program that called for drinking five glasses of water a day for at least 20 days and eating three fruits or vegetables a day for 20 days. The promotion also called for employees to exercise for at least 20 minutes at least once a week.

Haggar is currently offering another promotion, which offers a T-shirt and hand weights to anyone who drinks six glasses of water per day for 25 days and eats four pieces of fruit or vegetables for the same period. The plan calls for 20 minutes of exercise twice per week.

"The point isn't really what you offer, but just that you're willing to award something for participation. It makes the target audience feel like you care," she said.

Smoking cessation programs have not fared well at Haggar, Ms. Hunt acknowledged, but a weight control program is being adhered to by 7% of the company's workforce.

"Our workforce has a weight problem because their diets are high in fats. Exercise isn't really popular, so our people are diabetes risks. Now it's just a matter of getting the associate to endure the length of the program and make some real progress."

Like so many other benefit programs, the key to successful health and wellness plans is upper management's support, Ms. Hunt said.

Communication and tracking and recording are also vital. "From the custodians to the security guards, you need to talk to as many people as possible. And tracking and recording help you review your progress and helps to identify problems quickly. The quicker you know about a problem, the faster it can be resolved," Ms. Hunt said.

Virginia Proestakes, manager of managed care programs with Southern New England Telephone Co., also spoke at the session about her company's prenatal program (BI, July 12, 1993). The session was moderated by Gerry Martens, manager-benefits planning with New Haven, Conn.-based SNET.

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# Health care reform requires some rationing, says expert

By MICHAEL SCHACHNER

WASHINGTON—Rationing health care in some form is the only way the United States can allocate limited health care resources while still maintaining quality of care, a leading health care policy expert contends.

Much of the health care reform debate in Washington is still focused on universal health care and cost-control via administrative savings, said David M. Eddy. But national leaders must begin amending current health care reform proposals to focus more on weighing and justifying the cost-effectiveness of approved treatments and medical services, said Mr. Eddy, a professor of health policy

and management at Duke University in Durham, N.C., and a senior health policy adviser for Kaiser Permanente's Southern California division.

Speaking at the Sixth Annual National Managed Health Care Congress in Washington earlier this month, he said that national politicians involved in the health care reform debate have been selling Americans "false promises" by claiming universal care can be provided through savings achieved by administrative and logistical improvements.

"All the health care proposals are stuck in a vise because it's very difficult to improve quality and access and still cut costs. We have some high-value treatments in this country that are underused, while we also have some low-value treatments that are being overused. We have to

transfer attention to the high-value treatments," he said.

But with such a transfer process comes sacrifice, and health care reform leaders are not facing up to this fact, Mr. Eddy added. "It's not possible to make this transfer without giving something up that has some benefit." Thus, the harsh but mandatory decision to ration some treatments will draw opposition from various physicians, patients and hospital administrators, he said.

But if political leaders accept Mr. Eddy's theory that cutting back on certain services is the only way coverage can be provided to all Americans without sending costs through the roof, they must spell this out to the public.

So far, "no politician has articulated in a straightforward manner that cutting costs will require sacri-

fices. I would love for someone to say that for costs to come under control, the following must be understood," said Mr. Eddy, who then offered a string of quotes he would like to hear from national political leaders.

- "There are limits on the resources this country has to spend on health care."

- "Because resources are limited, it's valid and important to look at the costs of all services and medical procedures and then set priorities on what can be covered."

- "When we decide to allocate resources, we must do so objectively so as to maximize resources for the entire population, not just individuals."

- "All approved treatments must be proven and cost-effective, and there needs to be empirical evidence supporting it."

- "The burden of proof that something is cost-effective is on the person promoting it."

"I think that without leadership and moral support, it's cowardly to impose cost-control on the public and providers," Mr. Eddy said.

While cost-control is an admirable goal, zero inflation is impossible given that the population is growing at 9% per year.

"There is no way we can afford to get to a point where one-third of our gross domestic product is put toward health care. Sooner rather than later, we have to stabilize costs at an acceptable level," he said.

Areas to target for cost savings, he said, are drug company profits, non-durable goods consumption, administration, defensive medicine, doctor fees and research.

Meanwhile, Paul Ellwood, chairman of Interstudy, a managed care think tank in Minneapolis, as well as a leader in the Jackson Hole health care reform group, predicted rationing of medical services will occur only if "all else fails."

Dr. Ellwood said "it won't be on the same level as in England or Canada, but more like what already exists in Oregon."

Oregon has eliminated Medicaid coverage for hundreds of services that have little or no impact on health outcomes, spending those savings on extending coverage to more of the state's uninsured (BI, March 22, 1993).

Rationing can be avoided by improved medical outcomes, greater uniformity in the amount of treatment given by different managed care plans and "more careful selection of what goes into the standard benefits package," he said.

In the meantime, more effort must be spent ensuring quality, he said. "Our group is pursuing the concept of quality. We'd like to see a health security commission that promulgates standards for quality accounting, and we also need a FASB-type board that would make standards proposals for the health security commission to approve or reject."

Despite the snags that have popped up throughout the health care reform process, Dr. Ellwood said that the debate is stimulating and "unlike anything that's going on elsewhere. But you can't have a great health care system without accountability." **BI**

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## Depression

*Continued from previous page*  
how to manage an individual's depression. In fact, he said, "It's not easy to implement programs" to reduce the impact of depression on the workplace.

But, Carol Trawick, chief executive officer of Bethesda, Md.-based computer company Trawick & Associates, said the way to treat depression is through tried-and-true inpatient and outpatient counseling and pharmaceuticals.

"Clinical depression is an illness that's 80% curable. It's like the flu in most cases. Thus, the bottom line is that company-paid mental health coverage is a smart thing to do. The loss of one employee especially hurts small businesses."

Mr. Greenberg agreed. "Depression costs businesses about \$3,000 per depressed employee each year," a number that can be reduced if employers aggressively treat depression.

The study Mr. Greenberg's group performed appeared in the November 1993 issue of the "Journal of Clinical Psychology."

The session was moderated by Gerry Martens, manager-benefits planning with Southern New England Telephone Co. **BI**

# Programs

Continued from page 2

Under a conventional retro workers comp plan, an insurer charges an upfront premium that takes into account expected losses, claims expenses and the insurer's profit. If a policyholder's losses exceed expectations, the policyholder must pay additional charges that usually result in a profit for the insurer. This, at least theoretically, gives an insurer little incentive to help the policyholder control losses.

Under the American Home program, the upfront premium, or basic charge, is larger than under a traditional retro policy. However, American Home stresses that the policyholder's losses are more likely to be reduced because of the extensive cost-containment measures that the insurer will offer policyholders.

Among the services that will be stressed are managed care, early return to work, claims control, claims validation and claims investigation, said Stanton F. Long, president of AIG's cost containment division.

But, if actual losses still exceed expectations, the insurer pays a portion of the additional losses by cutting the retro policy's loss equalization factor to less than 1.0, explained Frank Neuhauser, senior vp at American Home. "The difference is that under the new plan, the insurance company picks up a piece of the difference between the estimated and the actual losses."

The insurer is justifiably penalized if losses are not reduced, said Jeffrey W. Greenberg, executive vp of AIG.

"We agree on the level of likely losses, and that becomes the basis for judging our performance. If losses are at or above the likely level, then we have not done the job which we set out to do," he said.

"What it does is align our interests with our clients," Mr. Greenberg said. "If their loss costs are reduced, we both benefit. And if they don't, then we won't profit from the increased losses."

If losses equal expectations, the policyholder's total premium will equal what it would have under a traditional retro policy.

The Gain Share program, which currently is available in 39 states, is designed for employers that are serious about reducing their losses and pay more than \$1 million of workers comp premiums annually, Mr. Greenberg said.

Other insurers say they will negotiate with M&M to cut worker comp premiums for employers that implement the cost-containment programs the insurers consider necessary.

"You get the advantage of cost-containment at the front end of the deal rather than waiting for the advantages later on," said Tom Clarke, senior primary casualty marketing officer for M&M.

Insurers that will entertain submissions from M&M include Travelers Corp., AIG, CIGNA Corp. and Kemper National Insurance Cos. Travelers already has offered the upfront premium discounts to several M&M clients.

And, Mr. Clarke says that many more insurers told him at the RIMS conference that they would consider offering the upfront premium discounts to employers that are committed to reducing their workers comp losses. "They're all lining up and willing to do it."

M&M's "Up-Front Discounts" program is designed for employers with high-frequency exposures and higher-than-average workers comp costs for their size and industry.

The program is designed for scattered-site employers with predictable medical and lost-time losses of \$4 million to \$5 million annually and single-site employers with \$1 million

of annual losses.

M&M is not looking for employers that already are doing a good job controlling their workers comp costs because negotiating premium discounts for them would be difficult.

The broker also is not seeking employers with losses that are generally attributable to severe injuries rather than a high frequency of claims, like construction contractors that work on skyscrapers or bridges.

The upfront premium discounts will vary from employer to employer depending on how much insurers expect they can cut an employer's workers comp costs. But, M&M will strive for at least a 10% to 15% premium discount, Mr. Clarke said.

For employers with retrospectively rated programs, the broker will attempt to negotiate maximum premiums.

The cost containment programs that employers must implement also will vary. **BI**

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Risk Management**

# Risk managers' duties expanding: Survey

By JOANNE WOJCIK

Today's risk managers are more versatile than ever, as corporate downsizing forces them to juggle a multitude of tasks.

Not only do most risk managers negotiate coverage placements and oversee claims handling, self-insurance administration and risk financing, but they frequently are responsible for safety and fire loss control engineering and corporate data security.

Many risk managers, especially those at large companies, also are responsible for managing and administering captive insurance companies.

And, a growing number of risk managers—even at large companies—are assuming responsibility for employee benefits administration, including pension and profit-sharing administration.

"It's the state-of-the-art risk managers—those who keep up with the trends—who are more apt to survive corporate downsizing," observed Bill Perry, president of Logic Associates Inc., a New York-based executive search firm specializing in risk management.

"We are asked to find risk managers who know strategic planning, who recognize the effect of risk management on the bottom line, who use a 'what if?' scenario, who understand cost control, who are a catalyst for instituting risk management in all departments and at all levels, who acknowledge problems like safety and do something about them, who advance their education and who have people skills, leadership ca-

increasing number of women are entering the profession, according to Mr. Perry.

Unfortunately, while "we are seeing more and more women risk managers, we're not yet seeing breakthroughs at the multimillion-dollar corporations."

Indeed, there are more women risk managers at smaller companies: 31% at companies with less than \$200 million in annual sales and 34% at companies with \$201 million to \$500 million in annual sales. Those percentages are about level with 1992 survey findings.

At midsize companies—those with \$1 billion to \$2 billion in annual sales—the percentage of women risk managers is only 19%, but that represents an increase from 15% in 1992. And at the largest companies—those with more than \$7 billion in annual sales—women make up just 3% of the risk management professionals, though that level is up from 2% a year earlier.

While a majority of risk managers have some responsibility for risk financing, self-insurance financing and coverage placement negotiations, risk managers at large companies are more apt to head a captive insurer, the Logic survey found.

Approximately 80% of the risk managers at companies with more than \$7 billion in annual sales reported using an average of 1.8 captives in 1993. Of these risk managers, 48% have hands-on captive management responsibility, while 31% play either an advisory or supervisory role.

In addition, 52% of the risk managers at large companies have hands-on responsibility for captive administration, while 28% either supervise or advise others in the administration of their company's captive insurer.

In contrast, only 8% of risk managers at small companies have captives, while about 32% of risk managers at midsize companies have captives.

At small companies—those with less than \$200 million in annual sales—6% of

risk managers with captives have direct, hands-on responsibility for captive management, while 2% play either an advisory or supervisory role. Also at small companies with captives, 3% of risk managers have hands-on responsibility for captive administration, while 5% play either an advisory or supervisory role.

At midsize companies, 22% of risk managers with captives have hands-on responsibility for captive management, while 10% play either an advisory or supervisory role. And, 19% of these risk managers have direct, hands-on responsibility for captive administration, while 13% play either an advisory or supervisory role.

While many risk managers have either direct or supervisory responsibility for claims handling and safety and fire loss control engineering, risk managers at

smaller companies are more likely than their large-company counterparts to be responsible for benefits administration.

For example, while 54% of risk managers at small companies have direct, hands-on responsibility for benefits administration, only 19% of risk managers at companies with more than \$7 billion in annual sales have this responsibility.

It is more likely that large-company risk managers will have either supervisory or advisory responsibility for benefits administration, according to the survey.

And, with corporate downsiz-

ing, that responsibility appears to be increasing.

For example, among the largest companies, 50% of risk managers have supervisory or advisory responsibility for benefits administration, up from 48% in 1992.

And, at companies with \$4 billion to \$7 billion in annual sales, 63% of risk managers at companies had either supervisory or advisory responsibility for benefits administration, a significant increase from 59% in 1992.

However, fewer large-company risk managers are responsible for at least one employee benefit: pension and profit-sharing ad-

ministration.

Just 44% of risk managers at large companies reported having either supervisory or advisory responsibility for pension and profit-sharing administration, down from 46% in 1992. And at companies with more than \$7 billion in annual sales, 58% reported having such responsibility, down from 71% a year earlier.

Copies of the "1993 Risk Management Compensation Survey" are available for \$65 each from Logic Associates Inc., 170 Broadway, Suite 814, New York, N.Y. 10038; 212-227-8000.

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### Key risk management responsibilities

Company size generally dictates whether a risk manager has hands-on or supervisory responsibility for certain tasks.

Legend: Responsibility	Percentage with:	
	Hands-on responsibility	Supervisory or advisory responsibility
	By company sales in millions of dollars	
	\$0-\$200	\$7,000+
Responsibility	52 / 31	36 / 39
Risk financing	57 / 36	30 / 41
Safety/fire loss engineering	54 / 29	19 / 50
Benefits administration	6 / 2	48 / 31
Captive management		

Source: Logic Associates Inc.

GRAPHIC BY JOHN HALL

pabilities," he said.

Another trend Mr. Perry has spotted while placing risk managers is the increasing need for computer literacy. "Computer system use is definitely up."

Indeed, automated risk management information systems increasingly are standard in risk managers' offices, according to the "1993 Risk Management Compensation Survey" conducted by Logic Associates.

Nearly all—97%—of the respondents from the largest companies have a computerized RMIS, compared with 79% of the risk managers at midsize companies and 54% at smaller ones.

The prevalence of RMIS in risk management departments is comparable to 1992 levels (BI, April 26, 1993).

While the risk management field is still dominated by men, an



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# Towers

Continued from page 2  
est Ponzi schemes in history.

He pleaded not guilty to the New York charges at an arraignment last Thursday, and will also plead not guilty to the Illinois charges, said his lawyer, Jeffrey Hoffman, with the New York firm of Hoffman & Pollok.

He faces statutory maximum sentences of 60 years and \$2.5 million in fines if convicted on the New York charges and 70 years and \$3.25 million in fines if convicted on all the Chicago charges. Any actual prison sentence would likely be lower under federal sentencing guidelines, however.

Towers' involvement with Associated Life and United Fire began in 1987: The two insurers were then owned through a holding company, United Diversified Corp., by Ernest M. Solomon. Mr. Solomon also controlled Cadillac Insurance Co., a Michigan insurer that itself was ordered into liquidation in 1990.

Associated Life and United Fire had run into financial trouble by early 1987 and were placed in conservation by Illinois regulators.

United Diversified then hired Towers to help raise capital for the insurers as part of a rehabilitation plan, according to court filings.

Towers soon decided to buy the two insurers, though. Illinois regulators approved the sale in October 1987, with the understanding that Towers would contribute \$3 million to the surplus of United Fire.

Though Mr. Solomon had sold his interest, the two insurers also were to maintain their relationship with Cadillac: United Diversified was to act as a managing general agent for Cadillac and an affiliate, which would serve as fronting insurers for Associated Life and United Fire, court papers show.

Previously, United Diversified had produced business for Cadillac under an administrative agreement that allowed the holding company to retain 99.5% of the premiums it generated for Cadillac, from which it would pay losses and expenses on the business.

In a matter of months, however, Illinois regulators concluded that Associated Life and United Fire were insolvent. The insurers were placed in conservation in July 1988 and ordered into liquidation about a month later.

The Illinois Insurance Department sued Mr. Hoffenberg, Towers and several Towers officers in federal court in Chicago in 1991.

Among other things, the complaint charged that Towers never intended to contribute capital to the insurers but instead diverted millions of dollars of the companies' assets to benefit Towers and Mr. Hoffenberg personally.

The suit charged, for example, that United Fire funds had been used to buy stock in Emery Air Freight to benefit Towers. Mr. Hoffenberg also illegally made himself sole signator on accounts of United Fire and United Diversified and issued dozens of checks to cover his own and Towers' expenses, the suit alleged.

Mr. Hoffenberg and the other defendants later settled the litigation, paying \$3.5 million to the insurers' estate, confirmed Barry Gross, a lawyer with Shefsky & Froelich Ltd. in Chicago, representing the Illinois department.

The 13-count fraud indictment handed up against Mr. Hoffenberg in Chicago last week mirrors many of the charges the Illinois Insurance Department leveled in its complaint.

The indictment charges that Mr. Hoffenberg and others devised a scheme to divert more than \$3 million from the Illinois insurers and conceal the misappropriations from regulators, policyholders and others.

In November 1987, for example, Mr. Hoffenberg used some of the insurers' bonds as collateral in securities brokerage accounts to buy Pan Am stock as part of an attempt by Towers to take over the airline. When the takeover failed, the insurance companies suffered \$80,000 in trading losses, the indictment says.

Between December 1987 and June 1988, Mr. Hoffenberg also used the insurers' bonds as collateral to buy Emery Air Freight stock in another ill-fated Towers takeover attempt. In addition, a \$1.8 million capital contribution Mr. Hoffenberg had made to United Fire was used to pay for Emery stock, the indictment charges.

The two insurers lost more than \$1 million when the Emery takeover failed.

In late 1987, prosecutors charge, Mr. Hoffenberg also removed blank checks for United Fire and United Diversified from the companies' Des Plaines offices. Over the next eight months, he issued more than 50 checks, many of them covering his personal expenses or expenses unrelated to

the insurers' operations, the indictment alleges.

The expenditures totaled more than \$3 million and included checks covering tuition at Wellesley College and credit card bills of Mr. Hoffenberg's stepdaughter; payment to Towers and one of its affiliates of \$1.1 million; payment of investment consulting fees for Towers; payment of private airplane leasing expenses; and purchase of Emery stock, the indictment says.

Mr. Hoffenberg and others took various steps to cover up the alleged fraud, prosecutors charge. For example, he routed securities trade confirmations and other correspondence with brokerage firms to Towers rather than to the insurance companies; created false entries in the insurers' books and false documents for discovery purposes in legal proceedings brought by state regulators; and committed perjury during regulators' investigations of the companies and in related legal proceedings, prosecutors allege.

Towers and several affiliates filed for Chapter 11 bankruptcy protection in New York last year.

The bankruptcy court has since approved a plan under which most of Towers' assets—including its health care debt collection business—are being taken over by an affiliate of CF Healthcare Finance Inc., a Delaware corporation involved in medical debt funding and collection.

The transferred assets also include ownership of Towers International Reinsurance Corp., a Barbados reinsurance unit now headed by Martin I. Hoffman.

Mr. Hoffman—who said he testified before the Chicago grand jury investigating Mr. Hoffenberg—has long experience with the New York financier. Mr. Hoffman was originally hired by Towers in 1987 to perform a due diligence review of Associated Life and United Fire. After Towers bought the companies, Mr. Hoffman became the insurers' president.

He said he resigned in April 1988 over concerns about Mr. Hoffenberg's management.

"I resigned for the specific reasons he was indicted for," Mr. Hoffman said.

Mr. Hoffman then went to work

as an MGA for Cadillac. After Cadillac collapsed, though, a Michigan judge found Mr. Hoffman and his New York agency liable for \$6.2 million in damages to the Cadillac estate.

This included losses on business for which Mr. Hoffman allegedly failed to remit premiums, along with unpaid fronting and administrative fees.

Settlement discussions on the damage award are scheduled for this week, according to Mark Zausmer, a Farmington Hills, Mich., lawyer representing Cadillac's liquidator.

Mr. Hoffman then rejoined Towers in 1991 as a consultant to help it form TIRC.

Asked why he rejoined Towers after his previous experience with Mr. Hoffenberg, Mr. Hoffman replied, "I needed the income."

He worked as a consultant for Towers on and off until the bankruptcy filing and has since been hired as president of TIRC, he said.

The Barbados reinsurer will write general property and casualty reinsurance, Mr. Hoffman said. E1

## Why Is This Claims Detective Heading For Belize?



When the organizers of the 14th Caribbean Insurance Conference were looking for a fraud expert to speak, they called on InPhoto's president, Bill Kizorek. The dates of the conference in Belize City are May 29th through June 1st.

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## Kansas, Iowa and Utah act to curb fraud against insurance industry

A new anti-fraud bill signed late last month by Kansas Gov. Joan Finney will provide stiff penalties for insurance fraud in the state.

The bill, S.B. 677, establishes severity levels for fraud and outlines penalties for any person who defrauds a personal or commercial lines insurance company.

The law amends the Kansas Fraudulent Insurance Act, which did not previously outline penalties.

The new law makes any insurance fraud totaling \$500 or more a felony. Fraud amounting to \$25,000 or more is punishable by up to 26 months in prison and up to a \$100,000 fine.

Also under the law, anyone who defrauds a commercial or personal lines insurance company must make restitution.

In a similar move April 5, the Iowa Senate passed an insurance anti-fraud bill.

The bill, H.F. 2314, has been sent back to the House for concurrence on several amendments that are described as "non-controversial."

The amended bill, among other things, would establish an insurance fraud bureau within the insurance division of the Department of Commerce and would set up a felony penalty for fraudulent submissions.

This penalty is punishable by up to five years' imprisonment and up to a \$5,000 fine.

Separately, a new Utah law sets up a four-person insurance fraud unit that will begin operating in the state Insurance Department on July 1.

—By Sally Roberts

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## Merger

*Continued from page 1*

At the center of that project, which ran for six months at a Massachusetts site, was a network of about 400 preferred providers chosen jointly by labor and management. Workers could use only those doctors; even for second opinions, when seeking treatment for work-related injuries and illnesses. A nurse acted as case manager and patient advocate and all disputes were to be resolved within 60 days.

Another cornerstone of the project was an alternative dispute resolution system. Injured workers were required to take their claims first to a Bechtel-paid ombudsman. Only after Bechtel had five days to respond were workers allowed to proceed to a jointly selected mediator.

The Pioneer Valley project eliminated injury-related lawsuits and

improved safety, according to Knut Ringen, director of the Center to Protect Workers' Rights, a research unit of the AFL-CIO Building and Construction Trades Council.

But in testimony before a House subcommittee last week, Mr. Ringen also urged lawmakers to view the results cautiously. Only about 300 workers were involved and both labor and management were anxious to demonstrate success, he said.

What's more, most states do not permit companies and unions to negotiate alternatives to the workers compensation system. Laws in only several other states could be interpreted as allowing such deals.

Beyond permitting these alternatives, the AIA-labor union proposal would differ in several ways from both the Clinton proposal and current workers comp practices.

It would, for instance, allow injured workers to "voluntarily" waive their right to choose a doctor and instead receive care from a doctor recommended by their employers or their employers' workers comp insurers. In return, workers would receive the assurance that doctors could not bill them or their employers for services that the insurers refuse to cover. This would include charges in excess of fee schedules or for services deemed unnecessary.

The AIA-labor proposal would also regulate, at least indirectly, medical fees. Fees for medical services provided under workers comp policies could not exceed those charged for similar treatment to other people. Medical providers would also be prohibited from presenting bills to worker comp or automobile insurers that contained unbundled or upcoded services.

Under the proposal, state workers comp systems would retain their autonomy. Also, a planned federal commission to study the feasibility of fully integrating the workers comp medical care and medical benefits covered by auto insurance into the overall health care system would be scrapped (BI, Oct. 18, 1993).

Managed care also gets a boost under the proposal. Auto insurers would be permitted to require policyholders to use a designated managed care entity for medical treatment. States also would not be allowed to restrict insurers from establishing or maintaining an interest in a managed care entity that provides workers comp or auto medical services.

The alternative to Title X of the Clinton health bill came as Congress began scrutinizing more closely the idea of merging worker comp medical care into a reformed health care system.

Last Wednesday, the House Education and Labor Committee's Subcommittee on Labor Standards, Occupational Health & Safety, focused specifically on Title X. Three union representatives, including Mr. Ringen of the Center to Protect Workers' Rights, and three business representatives addressed the panel, which is chaired by Rep. Austin J. Murphy, D-Pa.

After listening to the union representatives, whose testimony tended to favor the president's approach, Rep. Cass Ballenger, R-N.C., asked if they favored federalizing the workers comp system. The witnesses denied that was the case.

Sounding somewhat bemused, Rep. Ballenger, also wondered whether the profitability of workers comp insurance companies wasn't being exaggerated by the witnesses. If workers comp insurers are making so much money, why aren't they breaking down the door of my plant to sell me coverage? he asked rhetorically. **[B]**

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## INTERNATIONAL

## Lloyd's agents cancel members for 1995

By STACY SHAPIRO

LONDON—Tempers are flaring at Lloyd's of London over the unprecedented move by four managing agents to cancel some or all of their syndicate members' participation for 1995.

Three managing agents have given notice of cancellation in the past month to members backing syndicates through members agency pooling arrangements. MAPAs are investment vehicles that allow Lloyd's members to spread their capital over a market basket of syndicates (BI, Aug. 30, 1993).

Cancellation notices have been given by: G.S. Christenson & Partners for non-marine syndicate 958; Christopherson Heath Ltd. for motor syndicate 218; and Hardy (Un-

derwriting Agencies) Ltd. for non-marine syndicate 383.

In addition, senior underwriter Michael Cockell has given notice of cancellation for 1995 to his entire membership on syndicate 570, managed by M.H. Cockell & Partners.

Two other managing agents are expected to follow these agents in canceling members participation.

Under Lloyd's rules, managing agents must notify members by the end of May if they are going to cancel their participation for 1995.

The reasons given for the cancellations vary.

G.S. Christenson & Partners' executive partner, Philip J. Oxford, said in a letter to members agents that he questions the solvency margin of MAPAs. Members in MAPAs only have to deposit 25% of their

premium income limit in Lloyd's, while individual members have to deposit one-third of their premium income limit and corporate members have to deposit 50%.

Mr. Oxford contends that MAPAs' lower solvency margin "substantially reduces the underlying security of the Lloyd's policy." He also stated in the letter that MAPAs created a "false market" this year, bolstering some syndicates that would have collapsed without their support.

Stewart Weldon, director and agency manager for Hardy, said he didn't expect MAPA capacity to be so large this year, so his syndicate 382 is reviewing its capital for 1995. Syndicate 382's capacity increased 58.5% to 65 million pounds (\$96.2 million) this year, from 41 million

pounds (\$62.1 million) in 1993. Mr. Weldon stated in a letter to members agents: "We have made no secret that we dislike the MAPA concept with its lack of communication between agent and principal..."

He also acknowledged that corporate capital will play a larger role in Lloyd's in the future.

"In view of the uncertainties, we wish to be free to consider the future of the syndicate and the best way forward for its supporting capital," stated Mr. Weldon.

Christopherson Heath and M.H. Cockell & Partners cited uncertainty surrounding the different categories of membership as their reason for cancellation. Christopherson Heath in particular noted that it is uncertain what to charge individual, corporate and MAPA members for

managing agency fees, profit commissions and syndicate expenses.

"I don't understand the rules," said Mr. Cockell. "There isn't just one reason for giving notice."

Mr. Cockell's syndicate 570 had 67 million pounds in capacity this year (\$99.1 million at the appropriate exchange rate), up 48.9% from 45 million pounds (\$68.2 million) last year, and will make a profit in 1991. MAPAs provided about 50% of the syndicate's 1994 capacity.

Mr. Cockell said he awaits rules being developed by Lloyd's on pre-emption rights and syndicate value. Pre-emption rights allow current syndicate members to have first refusal to increase their capacity before it is offered to new members.

A committee headed by Lloyd's

*Continued on next page*

## Industry awaits China's insurance law

By KATE McILWAINE

BELJING—The Chinese government is providing few details about the nation's first formal insurance legislation, which is expected to be enacted soon.

China prefers to keep draft legislation secret until a final decision is made, say insurance industry analysts who have been observing the Chinese market.

But, even without seeing the legislative proposal, which has been in the works since 1991, analysts believe that it will allow foreign insurers and brokers to be licensed to conduct business in the People's Republic of China.

American International Group Inc. and Sedgwick Group P.L.C. already have been licensed by the People's Bank of China to operate there (BI, July 12, 1993; Oct. 19, 1992).

The Chinese government has allowed other foreign insurers and brokers to set up representative offices, but they must operate those offices for a minimum of three years before they can apply for an insurance or brokerage license.

The three-year minimum requirement is likely to remain intact under the proposed insurance law, industry sources said.

The draft laws were prepared by the Insurance Law Drafting Group, set up by the People's Bank of China in October 1991, to review and consolidate interim laws. The People's Bank currently regulates insurance under the Interim Regulations on the Management of In-



AP/Wide World photo

Commercial potential abounds in China's huge market.

urance Enterprises, approved by the State Council, an arm of the national government, in March 1985.

With a population of 1.2 billion and many infrastructure projects in progress, China represents a fertile market for both life and non-life insurers, said Bill O'Shea, Melbourne, Australia-based head of the Minter Ellison Morris Fletcher law firm's China practice group.

Mr. O'Shea said that in addition to enacting legislation, China also should establish a regulatory authority for insurance rather than rely on the People's Bank of China to oversee the expanding insurance market.

Currently, the People's Insurance Company of China, the state-owned insurer set up in 1949 after the Communist takeover, commands

90% of the market. In 1992, it had net premium earned of \$2.77 billion for fire, automobile, marine and general liability coverage. The company earned an underwriting profit of \$382 million in 1992.

Mr. O'Shea said liberalization of the Chinese insurance market will continue because Hong Kong-based insurers will "want a slice of the market" after 1997, when Hong Kong reverts to Chinese control.

The potential markets for non-life insurance lines in China are mainly limited to property and general liability coverage, he said. Workers compensation coverage is not written because Chinese companies maintain welfare funds for their employees. And, because litigation is uncommon, lines like professional liability are not expected to be widely marketed.

Last year, Sedgwick became the first licensed foreign broker in China, and has had a representative office in Beijing since 1981. The broker opened a Shanghai office April 15 and a Shenzhen office last week.

John Williams, general manager of Sedgwick Insurance & Risk Management Consultants (China) Ltd. in Beijing, said he understands the Chinese State Council has agreed in principle to implement insurance legislation. But the draft legislation that branch of the government is considering may be revised before any law is passed.

*Continued on next page*

## Schneider collapse will lead to claims on credit policies written in Germany

BONN, Germany—German credit insurers are beginning to receive claims from companies affected by the recent multibillion-dollar collapse of the Juergen Schneider A.G. property empire.

Juergen Schneider filed for bankruptcy April 15, owing more than 40 banks more than 5 billion deutsche marks (\$2.94 billion).

The company's owner and chairman, Juergen Schneider, 59, disappeared earlier this month and was recently reported to be living in Florida. German prosecutors are investigating the company's collapse, but no arrest warrants have been issued. The company, based near Frankfurt, held 75 commercial properties in Germany and was considered Germany's leading property developer.

Mr. Schneider's remaining cash reserves were estimated at just 5 million deutsche marks (\$2.9 million) when his company filed for bankruptcy.

More than 100 businesses near Frankfurt and Leipzig are reporting losses exceeding 50 million deutsche marks (\$29.4 million).

A spokesman for credit insurer Hermes Kreditversicherungs says several companies have filed for bankruptcy as a result of the Schneider scandal.

Losses to tradesmen and small businesses could exceed 250 million deutsche marks (\$147 million), says Deutsche Bank A.G., the largest underwriter of the Schneider holdings.

The bank says its own credit exposure totals about 1.2 billion deutsche marks (\$705.5 million) in secured loans.

Gerling Kreditversicherung expects only marginal losses from the collapse. "A smaller percentage of companies hurt by the Schneider bankruptcy are insured," a spokesman said. Gerling estimates its own losses will not exceed 2 million deutsche marks (\$1.2 million).

Lorenz Stech, Gerling's credit insurance director, said he expects the collapse to create a German credit insurance boom.

"Companies are exposed," he said. "And many are rethinking their position as a result of the Schneider collapse."

—By Don Lewis Kirk

## French insurers dispute ratings

By STACY SHAPIRO

LONDON—Depressed insurance rates, a collapsed real estate market and aggressive international expansion are three reasons why Standard & Poor's Insurance Ratings Group downgraded three of France's top insurers earlier this month.

However, the insurers contend S&P's downgrades are more a commentary on the general state of the French insurance market rather than on their individual performance.

And other analysts have questioned whether S&P was looking backward rather than forward when it issued its ratings.

S&P emphasizes that the French insurers still remain "among the strongest multiline insurers in Europe and the U.S."

However, on April 12, S&P downgraded to A1, from A1+ the commercial paper of:

## S&amp;P attributes slight downgrades to privatization, other factors

- Union des Assurances de Paris.
- Assurances Generales de France.
- AXA Group.

A1 is S&P's highest rating category for commercial paper, and the plus modifier designates extremely strong safety characteristics.

S&P also downgraded the claims-paying ability of some insurance subsidiaries of UAP and AGF to AA, which it defines as "excellent financial security," from AAA, "superior financial security."

S&P explained that the downgrades "reflect several external factors that have undermined the profitability and balance sheet strength of French insurers in recent years."

In particular, there has been "intense competition" in the French insurance market, which has depressed premiums, the rating agency said. "The non-life market became espe-

cially unprofitable in recent years, due to severe price cutting for industrial property risks and soaring claims in personal auto insurance, partly attributable to a rise in thefts following the opening of Eastern Europe."

Insurance rates have increased lately, but S&P said it "expected a faster and more robust improvement in non-life results" than has occurred.

In the past, French insurers were able to offset weak non-life results with investment income from increasing stock and real estate values.

However, in the past few years, depressed real estate prices—which earlier had hit the United States, United Kingdom and Nordic countries—struck France "with a vengeance," said S&P. "Opportunities to realize capital gains disappeared and

insurers, belatedly, began to focus on underwriting profitability."

The decline in real estate and stock values has also affected the French insurers' capital strength and caused havoc in UAP's and AGF's banking subsidiaries.

Aggressive expansion into foreign markets "has also weakened the capital bases of these companies," said S&P. Some French insurers have taken writedowns on various acquisitions, and none of the purchases comes anywhere near earning an appropriate rate of return on the invested capital, S&P said.

S&P also penalized UAP in particular and AGF to a lesser extent in anticipation of their upcoming privatization.

UAP last week was marketing its 50% government-held stake to insti-

*Continued on next page*

## INTERNATIONAL

## France

Continued from previous page  
tional investors in New York and Boston. A price for the stock is expected to be struck in the next few weeks, but stock analysts estimate the total value of the shares to be between \$2 billion and \$3 billion.

AGF expects its 57.1% government-held stake—valued at about \$2 billion—to be floated this fall.

The French stock market overall is depressed at the moment, so no one is sure how successful UAP's offering will be.

"It's a wait-and-see situation,"

said Jean-Paul Rignault, general manager of UAP U.K. His colleagues in Paris did not return calls.

S&P warns that "current privatization plans will not bolster UAP's capital position." UAP has said it is willing to issue additional stock to improve capitalization, but S&P does not think it will "significantly change" its capital position.

Having a AAA-rated government shareholder "was a nice backstop" for the state-owned insurers, said Karen A. Knoller, an S&P director of insurance analysis in London. Without government backing, "they'll have to be self-sufficient."

She rejected some observers' con-

tention that S&P's analysis is outdated by business developments.

For example, Tim Dawson, insurance analyst for Lehman Bros. in London, says S&P is responding to history and not current circumstances. "The companies are trying to put measures in to improve their profitability."

French insurers generally have been increasing non-life rates by about 20% for all classes in the past two years and will again this year, though it's been difficult to raise rates in personal lines, he said.

"We were expecting such a downgrading, but all (French) insurance companies have been downgraded.

## Canceled

Continued from previous page  
Deputy Chairman Robert Hiscox has been studying the issue of whether syndicates have a value that could be traded like stock (BI, Feb. 28). They will publish their conclusions early next month.

Some Lloyd's executives and underwriting agents are furious with the managing agents' move. They believe the real reason for the cancellations are the managing agents' fears of losing control of the quality or quantity of their syndicates' capacity when the Hiscox syndicate value report is published.

"It's disappointing that they've taken the decision before the syndicate value proposals," said Malcolm Mackenzie, chairman of Lloyd's Underwriting Agents Assn. and managing director of D.P. Mann Underwriting Agency Ltd. He said the managing agents are trying to protect the ownership of the syndicate capacity.

He also disagrees there is any problem with MAPAs' solvency.

Mr. Oxford told *Business Insurance* there is a general unease in the market about the future. "You can't plan your business if you don't know what the goalposts are or whether we're still playing." He wishes Lloyd's senior executives

would consult more with the market before making decisions. He plans to reduce his syndicate 958's capacity next year to about 40 million pounds (\$59.7 million) from 49 million pounds (\$72.5 million) this year because the market is softening. MAPAs accounted for 22 million pounds of capacity this year.

Like others, Anton Members Agency Ltd. is trying to find out whether managing agents can lawfully cancel membership and if there is a right to appeal to Lloyd's Council, said John Robson, managing director of Anton. Ninety percent of Anton's 350 million pounds (\$517.8 million) in capacity was placed via MAPAs this year. **BI**

It's more the insurance market that's been downgraded than the company," an AGF spokeswoman said.

AGF's net income has fallen sharply to 977 million francs (\$165.3 million at appropriate exchange rate) in 1993, from 1.5 billion francs (\$271.6 million) in 1992, and 2.7 billion francs (\$521.2 million) in 1991.

But, its premium volume rose 9.9% to 65.3 billion francs (\$11.05 billion) last year from 59.4 billion francs (\$10.75 billion) in 1992.

AGF's earnings last year suffered from exceptional charges for restructuring and depreciation of goodwill for troubled Spanish units AGF Seguros and Union y el Fenix. Under an agreement between UFE investor Banesto Group and AGF, the two Spanish companies will merge this year. AGF Group will control slightly over 75% of the company (BI, Jan. 24) and plans to return it to profitability within two years.

Problems in the real estate sector cost AGF banking subsidiaries 2.52 billion francs (\$425.4 million) last year, the company said.

Despite the downgrade, S&P said AGF has a "strong position in the French insurance market" and "capital available to support operations remains strong."

Meanwhile, UAP is still one of the strongest companies in Europe, said Mr. Rignault.

UAP's year-end results were in line with analysts' expectations, with net income increasing 31.5% to 1.42 billion francs (\$34.1 billion) from 1.08 billion francs (\$19.6 million) in 1992. S&P said these results were "disappointing."

But, attention remained focused on UAP's banking sector, namely its Banque Worms unit, which lost 1.6 billion francs (\$270.8 million) last

year, said Mr. Dawson.

UAP's premium volume rose 12.4% to 141.5 billion francs (\$24.6 billion) last year from 125.9 billion francs (\$22.79 billion) in 1992.

AXA is puzzled by S&P's downgrading, said K.W. Haddon, chief executive of AXA Reinsurance (U.K.) P.L.C. in London. "They seem to be a year behind in their assessments."

AXA believes it is being downgraded as part of the French market and not individually, even though the group's executives spoke to S&P in the past few months to explain its position, he said. Executives in Paris were unavailable for comment.

S&P acknowledged that AXA Group's net income recovered last year, but said it still fell below original expectations. In fact, AXA Group reported a 35% increase in net income to 2.7 billion francs (\$456.9 million) in 1993, from 2 billion francs (\$362.1 million) in 1992.

S&P noted that AXA's capital position remains strong, but said the degree of strength has diminished from "significant declines" in the insurer's real estate holdings.

S&P also notes that AXA's aggressive expansion into foreign markets, including the United States, where it owns Equitable Life Assurance Society, requires capital.

In the meantime, state-owned Groupe des Assurances Nationales last week announced lower-than-expected 1993 consolidated net profits of 414 million francs (\$70.1 million). The results—expected to be about 700 million francs (\$118.5 million)—were affected by real estate devaluations totaling 18.4 billion francs (\$3.11 billion).

GAN's net profits have been falling since 1989, when it earned 2.5 billion francs (\$432.8 million). **BI**

## China

Continued from previous page

China's major governing body is the People's Congress, which meets annually in October. Mr. Williams said that body would promulgate the laws, but they could be in practical use before then.

Insurance laws would strengthen the "fairly loose" rules currently governing insurance, he said.

Mr. Williams said he believes Sedgwick was licensed "as a test." It took two years to gain approval "because we were the first, and there were no procedures in place."

Sedgwick is the reinsurance broker for the PICC.

One of Sedgwick's first projects in China was a nuclear power plant near Shenzhen. The broker placed a construction risk policy in international markets and a nuclear risk policy with a London-based nuclear insurance pool.

Under current regulations, property insurance must be placed 100% with a locally based insurer, unless the required sum insured cannot be provided locally, he said.

Marsh & McLennan Cos. Inc. last week opened a representative office in Beijing, which will receive sup-

port from M&M's Hong Kong office.

Another broker with offices in China is Bain Clarkson Ltd.

Meanwhile, AIG has been licensed since 1992 to do business in Shanghai for foreign-owned companies and since the 1980s has had a representative office in Beijing.

James L. Williams, senior officer for China at AIG's American International Assurance Co. Ltd. unit in Shanghai, said the company writes property, casualty and marine business for joint ventures and other foreign businesses in Shanghai, as well as writing life insurance for Chinese citizens and foreign nationals.

"No one knows when" insurance legislation would become effective, he said. "A lot of people have been trying to get details" of the new laws, but they are not available.

AIG was first to get a license, Mr. Williams said, because it had "been trying for a very long time to be active in this market. . . . But, it is inevitable other foreign insurers will be able to enter the market."

China's market potential is "fantastic," he said, adding that competition would "add to the market's skills, provided it was professional."

Since 1988, the Chinese government has allowed several domestic insurers to set up in competition to the PICC, but premium rates and policy wordings are regulated.

Other domestic insurers are:

- China Pacific Insurance Co. Ltd., based in Shanghai. CPIC, owned by the Bank of Communications of China, writes mainly fire and marine cargo business.

- Ping An Insurance Co. in Shenzhen, which writes mainly fire and marine.

Other U.S. insurers that have representative offices in mainland China are: Aetna Life & Casualty Co., Chubb Group, CIGNA Corp., Lincoln National Corp. and Transamerica Life Cos. **BI**

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## LEGAL NOTICE

## BRYANSTON INSURANCE COMPANY LIMITED

Bryanston Insurance Company Limited has obtained court approval for its scheme of arrangement which received strong creditor support at a meeting in January, 1994. On March 29, 1994, an order was granted by the U.S. Bankruptcy Court for a permanent injunction under section 304 of the U.S. Bankruptcy Code. The order sanctioning the scheme of arrangement was filed with the registrar of companies on April 13, 1994, making the scheme effective from that date. As a result, Richard Boys-Stones and Colin Bird of Price Waterhouse have been released as provisional liquidators by the court and appointed as scheme administrator pursuant to the terms of the scheme.

# Costs

Continued from page 1

ment consulting for Towers Perrin in St. Louis. "As risk management staffs decrease, they will spend more time on strategic thinking. Routine, day-to-day activities such as renewals will be outsourced to brokers and consultants."

Even as risk managers saw their departments shrink, their responsibilities grew. More risk managers are purchasing health insurance for their organizations, managing health care claims and formulating their companies' disaster and catastrophe plans, the survey found.

Nearly one-third of risk managers said they were responsible for buying group health insurance in 1992, up from 24% in 1991. And, risk managers with responsibility for health care claims jumped to 70% of respondents from just over half in 1991.

A survey conducted by Logic Associates Inc. also found that risk managers have increased responsibility for benefits administration (see story, page 36).

"Although the risk management function may have decreased for some respondents, we believe it actually may have expanded for others, but the responsibility has been pushed out to individual facilities throughout the organization rather than being handled in a central location," explained Mr. Miccolis. "The source of technical expertise necessary to analyze and negotiate coverage, measure and finance risk and develop and implement risk control programs is an important issue for these companies."

All but the very largest companies experienced downsizing. Only corporations with more than \$5 billion in revenues saw their risk management departments increase, adding an average of 1.5 staffers to bring total staff to 11.6 on average.

Large companies also saw the largest increase in the total cost of risk, though their total costs are far below average.

Overall, U.S. companies paid an average of \$7.10 per \$1,000 in revenue to fund risk in 1992, up more than 10% from \$6.40 per \$1,000 in 1991, the survey found.

Organizations with revenues of more than \$5 billion experienced a 41% increase in the cost of risk to \$4.80 per \$1,000 in revenue in 1992 from \$3.40 per \$1,000 a year earlier.

The cost of risk for smaller companies, those with revenues of less than \$100 million, fell 19% to \$27.80 per \$1,000 from \$34.20 per \$1,000.

The cost of risk as defined by the survey includes: net insurance premiums; unreimbursed losses, including self-insurance, deductibles and retentions; and administrative costs.

Large companies' commitment to self-insurance despite the soft market shows they "have decided not to play the market," said Mr. Miccolis. Large corporations are committed to risk management strategies of retaining more risk even if it means paying more in soft-market years.

One possible reason for the larger increase reported by large companies is that they may be measuring and reporting their retained risk more accurately than smaller firms, according to the study's authors.

In addition, large companies may have more of their premium dollars in catastrophic layers, which are more susceptible to price swings. By contrast, small companies are less likely to self-insure and are more likely to buy primary lines of insurance, which have remained soft.

Even though small companies still paid six times more than large

ones for the cost of risk in 1992, the gap is shrinking: In 1991, smaller companies paid 10 times more.

The cost of risk also varied widely by industry, the survey found.

The insurance industry paid the least, at 90 cents per \$1,000 in revenue, while the transportation service industry paid \$37 per \$1,000. However, that represents a 17% decrease from 1991, when transportation services paid \$44.60 per \$1,000.

Despite the persistent soft market, companies continued to increase the retained portions of their losses. In 1992, retained losses accounted for more than half—52%—of the cost of risk, while premiums accounted for 44.6%. The remainder was consumed by administrative costs.

In 1991, premiums accounted for 49.1%, while retentions accounted for 47.4%.

Continued on next page

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# Costs

Continued from previous page

In the 1990 survey's figures, premiums totaled 55.9% and retained losses were 42.3%.

Retained workers compensation losses accounted for much of the swing, increasing to 29.1% of the cost of risk dollar in 1992, up from 25.9% in 1991 and 19% in 1990.

And the most recent survey shows retained liability losses in 1992 for the first time exceeded premiums paid for liability insurance, 18.8% vs. 18.1%. In 1991, the figures were 17.9% and 18.5%, respectively.

On the property side, premiums

accounted for 9.1% of the cost of risk in 1992, while retained losses accounted for 3.6%.

While those figures are down from 1991—when property premiums accounted for 11% and retentions 3.7%—they could rise in next year's survey because the property market in 1993 was slightly firmer, particularly for windstorm exposures (BI, July 19, 1993).

Although workers comp retentions rose, overall increases for the workers comp component of the cost of risk slowed, the survey found. Total workers comp costs rose only 6.7% to \$3.20 per \$1,000 in revenue in 1992, up from \$3 per \$1,000 of revenue in 1991. Workers

comp costs in 1991, though, represented about a 20% increase over 1990 costs of \$2.49 per \$1,000.

Workers comp is excluded when measuring Canadian companies' cost of risk because provincial governments pay most of the tab. Canadian risk managers' overall cost of risk decreased 26% to \$2.40 per \$1,000 of revenue in 1992 from \$1.90 in 1991.

Nearly 100 Canadian companies participated in the survey this year, the most ever. However, the narrower respondent base makes the data more susceptible to fluctuations than the wider U.S. base. Also, the average revenue size of Canadian respondents increased 18%

and companies with larger revenues tend to have smaller costs of risk as a percentage of revenue.

Unlike for U.S. companies, property and liability risk financing consume equal shares of revenue for Canadian firms. Canadian companies are also much less likely to retain their losses than their southern neighbors. Canadian property and liability insurance premiums accounted for 13% of revenue, compared with 5% for retained losses.

As proof that the U.S. tort crisis is crossing international borders, Canadian companies are spending a greater portion of their cost of risk dollar on liability costs. Liability risk financing costs for Canadian

companies accounted for 44.4% of their total cost of risk, up from 35.1% in 1991. Property risk financing costs decreased to 51.2% in 1992 from 59.3% in 1991.

Surveys were sent in September to RIMS' 4,500 member companies based in the United States and Canada. Six hundred fifty-six responses were received from U.S.-based firms and 96 from Canadian companies.

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# Minnesota

Continued from page 1

tals and physician groups are busily combining forces in an attempt to form so-called "integrated service networks" before rules for such entities are set by MinnesotaCare.

In essence, the market is now evolving ahead of the legislative process. Some observers say it's possible that new operating rules, solvency regulations and other requirements for providers crafted by state lawmakers will no longer fit the state's newly aligned health care market.

Employers and representatives from insurance, provider and consumer groups say these same questions and problems are certain to emerge on the federal level as national health care reform is implemented. Watching how those problems are dealt with on a smaller playing field may provide valuable insight to federal policymakers.

One reason Minnesota has been successful in implementing meaningful reform is the Legislature's ability to avoid deadlock by passing reform components on which there is a consensus and postponing action on more difficult questions like financing and provider regulation.

"Up to this point, it's been a very amicable process. The Republican governor and the Democratic Legislature have worked closely together to get things done," said Dianne Eberlein, a consultant with Hewitt Associates in Minneapolis. "By breaking pieces of health care reform apart, they've been able to get certain things accomplished."

The MinnesotaCare program began providing subsidized health coverage for low-income, uninsured Minnesotans in October 1992. Initially, the program covered only families with children, but the program is expected to include single adults and couples without children on July 1, if adequate funding is available. Currently, the program is subsidized by a tax on provider revenues and an increase in the state tax on cigarettes.

Currently, slightly more than 66,000 individuals are enrolled in the program.

MinnesotaCare also implemented reforms in the small group insurance market, including guaranteed issue. The positive effects of that program can be seen by the declining number of individuals covered by the Minnesota Health Care Assn., a pool that serves as the state's health insurer of last resort.

"Our enrollment has declined to 35,200, the lowest level in 16 years," said Lynn Gruber, the pool's executive director. "Exit surveys showed that part of the reason for the decline is people are finding coverage in the private market, in some cases from small employers who could not offer coverage before."

"The architects of MinnesotaCare were able to avoid getting hung up on cost" and the desire for immediate universal coverage, said Stephen Ogren, a principal with Deloitte & Touche in Minneapolis. "That got the marketplace moving."

At the national level, health care reform advocates are calling on Congress to pass meaningful reforms this year, even if they are only incremental changes. However, many reform advocates fear that political infighting over the most contentious details of reform will cause Congress to drop the matter completely.

President Clinton already has scaled back his expectations for health care reform several times, most recently by approving several health reform scenarios that Sen. George J. Mitchell, D-Maine, has

Continued on next page

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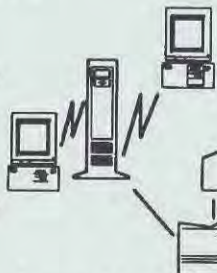
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# Minnesota

Continued from previous page proposed to Democratic leaders in the Senate (see story, page 1).

"By dealing with issues of agreement, rather than issues where there is no agreement, you may see some positive changes," said Hewitt's Ms. Eberlein.

Minnesota's lawmakers were able to achieve progress by delaying decisions on certain contentious issues, like whether to legislate an employer mandate, she explained. "By not dealing with an employer mandate, and passing basic insurance reform, setting gross spending targets and loosening antitrust rules, the market is moving ahead."

The key is not having an all-or-nothing attitude, agreed Mr. Ogren of Deloitte & Touche. "President Clinton's message when he visited Minnesota earlier this month was: 'Call your congressmen and tell them to compromise on everything, because we need lawmakers to get something done.' But then he said he wouldn't compromise on universal coverage. I would say back off from that a little and pass other reforms so we can get things moving."

"What is happening here in Minnesota... is relevant to the nation not just because it tends to reflect the complexity of all of this" but because it illustrates that activity in the private sector can move ahead of legislation, said George Morrow,

an independent health care consultant in Minneapolis.

However, some consultants say Minnesota's health care market may now be moving ahead too rapidly as providers anticipate further reforms. Some politicians worry that consolidation among providers will lead to a market where the biggest and strongest survive and smaller operations flounder.

U.S. Sen. Paul Wellstone, D-Minn., for example, has voiced concern that free market competition in Minnesota will suffer if the largest health care providers have too much power and influence over the market.

Indeed, the biggest providers in the Twin Cities area—Blue Cross & Blue Shield of Minnesota and HMO giants Medica and Allina, both of which were formed by mergers—dominate the market. Residents in outlying areas, though, continue to search for more provider options.

Minnesotans say federal health care officials should take careful note of changes in the marketplace as providers anticipate federal regulation.

Large HMOs across the country already are merging in an attempt to increase their market share. For example, FHP International Corp. and TakeCare Inc. earlier this year agreed to combine forces (BI, Jan. 17). And, major metropolitan and teaching hospitals around the country are creating alliances in anticipation of relaxed antitrust rules and

the necessity to run leaner operations.

"This wouldn't have happened if health alliances and health care purchasing cooperatives had not been proposed," said Deloitte & Touche's Mr. Ogren.

"Many providers, insurers and other players in Minnesota resisted certain behavior when there was no threat of legislation," he noted. "But, when there was momentum to develop integrated service networks in the legislation, then we saw the marketplace respond."

ISNs would require affiliated providers to function like HMOs, billing on a capitated basis. Providers not willing to join ISNs can function in-

dependently as part of a regulated all-payer option, but their fees will be set by the state.

Minnesota's top health care official has asked the Legislature this year to delay implementation of ISN rules and the state-regulated all-payer system so as not to interrupt the service of Minnesota residents already receiving health care coverage. The rules were to go into effect July 1, but Health Commissioner Mary Jo O'Brien said major policy issues need to be resolved by the Legislature during the 1994 session.

But, "legislators are concerned that if they slow down the pace of rulemaking, the market will move ahead of them even further," said

Ted Chien, a senior consultant with Coopers & Lybrand in Minneapolis.

Others see free market movement as a positive.

"Clinton's biggest contribution was to set off something like the Oklahoma land rush" in the health care market, said Mr. Morrow, who as a consultant helps health care providers form ISNs.

And, providers in Minnesota are content to lead the way, he added. "Their attitude toward state lawmakers is, 'You've got some interesting ideas, but you're about six months behind the market. Why don't you just get out of the way and let us do it?'" **BI**

## Reforms

Continued from page 3

find their hands tied. Instead of having responsibility to plan and design benefit programs, those professionals will be left administering and communicating the requirements of a federally imposed health care plan, Messrs. DeNiro and Weston said.

"There really is a lot of anger out there among large employers," said Michael Murphy, a consultant in the Atlanta office of Hewitt Associates. "But, when benefit managers gripe about health care reform, they are talking about the Clinton plan. And, frankly, the Clinton proposal

is DOA."

The reforms outlined in the president's proposal will not be passed, Mr. Murphy asserted. Although that plan has become the benchmark for comparison, it's not a valid baseline because it won't be enacted, he said.

"In the absence of a clear consensus on what health care reform will look like, the time is right for employers to form coalitions. You should get together with other employers to determine what you want and then voice those desires to Congress."

Unfortunately, it is hard to achieve a consensus among employers. And, some employers have found themselves stymied by state health care reform laws.

For example, Mr. Weston said, the Pinellas County School Board was unable to make suggestions for state health reform because "government entities in Florida are excluded from the health care reform process." Nonetheless, the state passed significant reforms last year that will impact the school district (BI, April 12, 1993).

Evidently, benefit managers around the country are feeling a bit bewildered about health reforms.

According to a survey of 300 benefit managers and chief financial officers conducted last month by CIGNA Corp., 68% said they were only "somewhat familiar" with key health reform issues, while 11% said they were "not very" familiar with key issues. Only 21% indicated they were "very familiar" with the issues.

Yet, those same benefit managers and chief financial officers indicated their jobs as employee health plan designers and administrators would change significantly under health care reform, said Margaret Spyers, vp of marketing for CIGNA Group Insurance in Philadelphia and coordinator of the panel discussion.

The other panel members agreed that federal reform will alter the landscape of the employee benefit department.

"There are a number of changes I expect to happen," Mr. DeNiro said. "First and foremost, the benefit function will shift from gathering information on the plan design options available to us to an administrative function. We will have to administer, administrate and administrate what will be a huge bureaucratic mess" created by reform, he said.

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Secondly, benefit professionals will be engaged in less strategic, active planning and will spend more time reacting to external changes and communicating those changes to employees.

"There will be immense confusion about the regulated system and its intended outcomes," Mr. DeNiro predicted. "As our customers, who are our employees, use the new system, there will be a lot more questions and complaints. We will be explaining a lot more about the regulations, telling them, 'It's done this way because of...'"

"Today we feel we can control the outcome of our benefit plans," but that won't be the case in the future, he said.

Perhaps the most devastating change benefit managers and employers will experience under federal reform is a loss of buying-decision clout, Mr. DeNiro said. "This is most critical. We are customers now and we feel we can impose certain things on our vendors. That will shift as we become more of a benevolent intermediary for our employees."

Benefit departments will find themselves spending a lot more time explaining to employees how the government-regulated system works and trying to help them with the paperwork and other details, he predicted. "The benefits position will have one role: to educate, educate and educate. It will be our job to help employees understand how the system works, what its components are and how they can use it."

That education won't be easy, said the school board's Mr. Weston. Right now, employers have a hard enough time trying to get employees to carefully read and understand their benefit plan documents. "The need to educate will increase substantially if reform passes."

On the other hand, employee benefits may become much less of an employee recruitment tool if reform sets a standard health benefit package, Mr. DeNiro said. "The benefits component will likely diminish over time as part of a job applicant's review process. That's been happening already because of the tough job market. People don't typically have four or five job offers to choose from anymore, so benefits is less of a factor in their decisions."

Health reform holds other disadvantages. As employers see their power to influence the design and planning of benefits eroding, it's unlikely they'll be able to do anything to fight increased health care costs, Mr. Weston said. And public employers will be hurt more than private employers by that change.

"For us, we don't have the opportunity to make more widgets" if health costs increase under a reformed health care system, he explained. "Under the Clinton plan, if employers are mandated to pay for 80% of employees' health care, that would cost us an additional \$20 million. That's 750 teachers I'd have to lay off." **BI**

# Congress

Continued from page 1

all companies with fewer than 5,000 employees to join the alliances.

Rep. Williams would replace alliances primarily with what he calls "cooperatives" set up within "community rating areas." These areas could not be smaller than a metropolitan statistical area. The self-employed, unemployed, part-time employed or those employed by a company with fewer than 5,000 workers would be covered under the community-rated cooperatives.

Under the Williams bill, states would be given three options for setting up cooperatives.

First, states could establish a mandatory "consumer purchasing cooperative" that would be a non-profit entity governed by a broad-based board. This cooperative would function like an alliance as proposed by President Clinton, but would lack the alliance's regulatory powers.

Second, states could establish voluntary consumer purchasing cooperatives. Individuals could participate in the cooperative or buy coverage directly from insurers. All plans would be community rated.

Finally, states could forego the cooperative altogether and have one or more state agencies carry out the coverage purchasing function.

Rep. Williams also proposed:

- Lowering the cap on employer health care contributions for companies with fewer than 25 employees earning an average wage of \$12,000 or less to 2% of payroll from the president's proposed 3.5%. For employers with 25 to 75 employees, the payroll cap would range from 3.4% to 7.9% on a sliding scale.

- Expanding basic benefits for women and creating a new delivery system for mental health and substance abuse benefits.

Rep. Williams said he wanted the subcommittee to remain open to better ways to achieve universal coverage, but he warned, "If this nation attempts to do health care on the cheap, we will be back here in a decade trying to fix it," he said.

Rep. Roukema praised Rep. Williams for his flexibility on alliances, but said all the House panels dealing with health care reform have "totally been unrealistic on financing."

She offered a Republican alternative based on the H.R. 3080, the bill drafted by House Minority Leader Robert Michel, R-Ill. The GOP plan

# Actuaries knock Clinton estimates

WASHINGTON—Still another group is weighing in with an assessment that the Clinton administration underestimated the premiums for its health care reform plan.

In a report released Thursday, the American Academy of Actuaries concluded that the Clinton premium estimates for its basic benefits package were understated by about 20%.

That means the plan could increase the federal deficit by more than \$100 billion during the last five years of the decade, the group said.

Private consulting firms and government agencies have released similar assessments of the Clinton projections in recent months.

would require all employers to offer, but not fund, a basic benefit package. It would also encourage multiple-employer purchasing groups.

Rep. Roukema said she hoped that Congress would not adjourn without passing a bipartisan bill. She admitted that she was not certain that could be accomplished.

Also last week, in an unrelated attempt to rally partisan support for the president's measure, Sen. Mitchell began circulating a trio of cost-cutting alternatives to the Clinton plan. The measures, which apparently have at least tacit White House approval, were unveiled during a retreat for Democratic senators.

The first proposal would cap employer health care contributions at 12% of each worker's individual wage rather than at 7.9% of a company's average wage, as called for by the president's plan. The proposal would also lower the threshold for mandatory participation in regional alliances to 1,000 employees from 5,000 and assess all firms with more than 1,000 employees a 1% payroll tax. These changes would cut approximately \$50 billion from the president's plan over six years.

The second proposal would be the same as the first, except it would also cut the value of the basic benefits package by 5%, resulting in savings of as much as \$115 billion from the president's current plan.

The third proposal would reduce the portion of employee health costs that employers would have to pay to 50% from the 80% the president proposed. It also cuts the value of the basic benefits package by 5%, lowers the threshold for mandatory participation in alliances to 1,000 employees, adds a 1% payroll tax, and caps employer health care contributions at 7.9% of individual wages. Projected savings under this plan: more than \$150 billion.

Sen. Mitchell has declined to discuss his proposals publicly, but de-

tails were leaked by other senators within hours of the meeting. The majority leader did, however, talk quite a bit about other aspects of health care reform in a speech to insurance agents last week.

After being introduced by his brother Paul Mitchell, a property/casualty agent in Maine, the senator ticked off a list of standards that any health care reform package must meet. These included guaranteed private health insurance for all citizens, cost containment measures, greater emphasis on primary and preventive care, flexibility for states, and simplified administration of claims and payment through common forms.

Sen. Mitchell said he did not think that caps on medical malpractice awards should be part of a reform package. Such matters should be governed by states, he said.

Another major player in the health care reform debate, Rep. Dingell, began circulating a plan to eliminate any health care cost burden on businesses with 10 or fewer employees and to reduce it greatly for firms with 11 to 20 employees.

Under his plan, firms with 11 to 15 employees would pay no health care premiums, although they would be required to pay a 1% payroll tax to help cover costs of the reformed health-care system. Firms with 16 to 20 employees would also be exempt from paying a premium, but would have to pay a 2% payroll tax.

Rep. Dingell's efforts to begin marking up a bill in the Energy & Commerce Committee, though, received a blow Thursday when a committee member—Rep. Jim Slatery, D-Kan.—announced that he would not vote for any employer mandate and would instead introduce an alternative plan combining insurance reform with government subsidies for low-income families.

If the chairman loses one more Democratic vote, he will not be able to pass a bill. ■

If Congress approves a modest reform bill, many question if President Clinton bill would sign it. Indeed, President Clinton has said he would veto any bill that did not assure universal health care coverage.

Ms. Canner observed, though, that President Clinton gave himself plenty of "wiggle room." For example, he didn't indicate that he would reject a bill just because universal coverage would not be achieved until many years in the future, she said.

While the shape of the final bill won't be known for several months, certain provisions initially proposed by President Clinton appear to be finished.

For example, Ms. Canner said the outlook is poor for a Clinton provision that would have the government pay 80% of early retiree health care costs, which would have been a boon for big manufacturers, like the nation's auto and steel companies.

In fact, some legislators appear headed in the opposite direction. The measure passed by the Ways and Means Health Subcommittee would require employers now providing a "portion" of health care coverage for retirees age 55 through 64 to pay 80% of the premium for basic coverage. ■

Meanwhile, many health care reform efforts have been focused at the state level.

States, responding to pressure from physician groups, have been considering a slew of "any willing provider" proposals, said Guy D'Andrea, director of state health policy for the American Managed Care & Review Assn., a trade group in Washington representing managed care organizations.

These proposals, which generally have been only narrowly defeated, could significantly raise the cost of care provided through managed care networks, Mr. D'Andrea said.

Under these proposals, managed care networks would be required to include any physician willing to meet their contract terms, which Mr. D'Andrea said would drive costs up.

Because of their expanded size, networks could become unwieldy and costly to administer.

In addition, such a requirement would slap a burden on networks that legislators wouldn't even consider imposing on other businesses. "Imagine a business being told it must hire every applicant willing to accept the job," Mr. D'Andrea said.

Clorox's Mr. Brown coordinated and moderated the session. ■

# Updates

## Lloyd's reserves questioned

Continued from page 2

business plan lists only 4 billion pounds (\$5.96 billion) in reserves for old-year liabilities—mainly asbestos and pollution—that would be transferred to NewCo to run off the claims.

In addition, of that 4 billion pounds, Fields claims that only 2.6 billion pounds (\$3.88 billion) is held in actual reserves for old-year liabilities—some 1.4 billion pounds (\$2.09 billion) short due to extensive use of financial reinsurance.

Lloyd's Deputy Chairman Richard Keeling, in charge of setting up Lloyd's runoff company NewCo, said three consulting teams are looking into what reserves Lloyd's actually needs to meet liabilities.

"We're trying to set up the most professional view of Lloyd's reserves ever given," said Mr. Keeling. Lloyd's should be able to shed official light on the subject by the end of the year.

Mr. Keeling said he still believes that much of the market is "significantly better reserved than U.S. companies."

## Justices hear punitive case

WASHINGTON—U.S. Supreme Court justices last week uncharacteristically peppered both sides with questions in a case challenging a punitive damages award, but attorneys say the case likely won't affect future awards.

The case, *Honda Motor Co. Ltd. et al. vs. Karl L. Oberg*, centers on whether a provision in the Oregon state constitution violates due process guarantees under the U.S. Constitution.

Honda argues that the provision precludes trial judges from reviewing whether juries' punitive awards are excessive. In court papers, Honda attorney Andrew L. Frey of Mayer, Brown & Platt in Washington says the provision is unique in the nation and violates the standards for judicial review that the high court set in *TXO Production Corp. vs. Alliance Resources Corp. et al.* and *Pacific Mutual Life Insurance Co. vs. Haslip* (BI, June 28, 1993; March 11, 1991).

But, Laurence H. Tribe, the attorney for Mr. Oberg, who was seriously injured in 1985 when a Honda all-terrain vehicle he was riding overturned, contends in court papers that Oregon does not preclude judicial review of punitive damages awards.

The state constitution prevents judges from overturning awards unless no substantial evidence supports the award, said Mr. Tribe, a Harvard law professor. But, the state Supreme Court still assessed the reasonableness of the punitive damages awarded to Mr. Oberg by applying the standards established in *Haslip*, he said. A jury awarded Mr. Oberg \$735,500 of compensatory damages, after finding him 20% at fault for the accident, and \$5 million of punitive damages.

The U.S. Supreme Court is expected to rule this summer.

## Briefly noted

E.I. Du Pont de Nemours & Co. Inc. will pay a total of about \$214 million to settle another 220 liability suits related to its **Benlate DF fungicide**. DuPont had earlier paid out \$500 million to settle Benlate claims and ultimately reached a settlement with X.L. Insurance Co. Ltd. over coverage for those claims (BI, Oct. 25, 1993). DuPont still faces hundreds of lawsuits alleging Benlate damage. . . . Unisys Corp. and lawyers for a group of about 7,000 retirees will present to a judge a tentative **\$111 million settlement** of a suit over Unisys's planned cutoff of retiree medical benefits by 1996 (BI, Nov. 9, 1992). The settlement covers non-union employees of Sperry Corp. and Burroughs Corp., which merged to create Unisys. . . . **Allstate Insurance Co.** now estimates it will lose \$950 million on the Los Angeles earthquake, based on more than 40,000 expected claims. The quake losses, along with severe winter weather, led to a \$220.5 million first-quarter loss after minority interest for Allstate, compared with \$320.1 million in income for the comparable period a year ago. . . . Italian industrial company Montedison S.p.A. is **suing Price Waterhouse for \$611 million**, charging "serious negligence" for alleged breaches of international accounting standards between 1982 and 1992. The accounting firm says it filed counterclaims last week to "vigorously defend" itself. . . . **Anti-insurance fraud provisions** are included in the omnibus crime bill that the House of Representatives passed last week. The provisions are identical to those in a bill the Senate passed earlier. . . . **ITT Hartford Group Inc.** will pay \$13 million to settle a massive suit that 30,000 Texas employers filed against about 270 workers compensation insurers in 1991. The employers say the insurers illegally hiked premiums to recapture their residual market losses. Hartford admitted no liability. . . . House Ways and Means Committee Chairman Dan Rostenkowski, D-Ill., last week introduced a bill, H.R. 4245, that would shore up **Social Security** funds for future generations. Among other things, the bill would raise the normal retirement age to 67, gradually increase the Social Security payroll tax to 8.15% by 2058 and cut the 1995 cost-of-living increase to 2.5% from 3%. . . . **Gordon W. Kreh**, 46, who has been president of The Hartford Steam Boiler Inspection & Insurance Co. since September 1993, was elected CEO last week. Wilson Wilde, 66, will retire as CEO May 1. . . . Peter Williams, former director of Bowring Aviation Ltd., will succeed leading Lloyd's of London aviation underwriter Brian Beagley on Oct. 1 as **underwriter for Sturge syndicates 960/545/998**. Mr. Beagley will become underwriting director of the syndicate's managing agent Sturge Aviation Syndicate Management Ltd. . . . The trial begins tomorrow in the case of 3,100 members of the **Gooda Walker Action Group**, who hope to recover nearly \$900 million in losses for negligent underwriting against dozens of members agents. The trial is expected to be concluded by July. . . . The schemes of arrangement of **Bryanston Insurance Co. Ltd. and Andrew Weir Insurance Co. Ltd.** have been approved by the U.K. High Court, taking the two firms out of provisional liquidation. . . . **Workers comp insurers' combined ratio** after policyholders dividends dipped to 109.5% in 1993 from 121.5% in 1992, the National Council on Compensation Insurance estimates.

# Legislation

Continued from page 3

munity, another panelist noted.

"Five years ago, most employers were opposed to a mandate," said Martin Brown, corporate manager of employee benefits at The Clorox Co. in Oakland, Calif.

But today, the employer community is much more divided, he said. Reflecting that, Mr. Brown said he resents the fact that his company has to pick up the costs of employees' spouses who work for companies that don't offer a health care plan.

On the other hand, Mr. Brown said he is philosophically opposed to the government mandating that employers offer a health care plan.

While about 97% of NAM members offer health care coverage to employees and, thus, probably wouldn't be significantly affected by a mandate, the concept is tough for business to accept, Ms. Canner said. "It is a basic mistrust of government." Employers fear that even a relatively mild mandate—such as one requiring companies to pay 50% of employees' health care premiums—would be stiffened a few years down the road by Congress.

# READER REPLY SERVICE

## PRODUCTS & SERVICES LISTING

### Correction for Issue of April 18

Reader Service #	Advertiser	Page #	Reader Service #	Advertiser	Page #	Reader Service #	Advertiser	Page #
1	AIG Corporate	Cov. 4	29	Frontier Insurance Co.	12	—	NY Life Insurance co.	93
2	Alexis Incorporated	16/17	30	GAB Business Services	24	—	Pepper Hamilton & Scheetz	108
—	Allendale Insurance	22-23	—	General Reinsurance	46-47	—	Pepper Hamilton & Scheetz	117
3	American Technical Services	112	31	GENEX	86-87	56	Pictorial, Inc.	111
80	AON Reinsurance Agency Inc.	68	32	Global Special Risks	36	57	PMA Reinsurance Corp.	28
81	AON Re Worldwide	26-27	33	Great American Insurance Co.	104	—	Professional Indemnity Agcy.	105
4	AON-Rollins Hudig Hall	25	34	John Hancock Mutual Life	110	58	Protection Mutual Ins. Co.	66-67
5	Assurex International	83	—	Hanna Ins. (S B & I Captive)	101	59	Prudential Reinsurance	43
6	The Bank of Bermuda, Ltd.	31	35	Health South Corporation	100	60	Rehability Corp.	114
7	The Bank of Butterfield	38	36	Helmman Management Svcs.	69	61	Reinsurance Solutions Inc.	98
8	Bermuda Government	34	37	Hertz Claim Management	80-81	62	Reliance National	7
—	Business Insurance	37,72,94,126-127,143	—	Hogg Robinson, Inc.	49	63	Reliance National	19
—	British Airways	52	—	Home Insurance	32-33,101,103,105,107	64	Reliance National	89
—	BRMA	65	38	Illinois Insurance Exchange	62	65	Reliance Re	96-97
9	Brownyard/Chubb	83	39	Industrial Risk Insurers	9	66	RFC Intermediaries Inc.	79
10	Brownyard Group	152	40	Intere Intermediaries Inc.	78	67	F. A. Richard & Associates	103
11	Central Bank of Barbados	82	—	Int'l. Advisory Services	54	68	Risk Engineering, Inc.	77
—	Centre Cat	21	41	Intracorp	55	69	Royal Insurance	156
12	Centre Re-Insurance	10-11	—	IPC Re	106	—	Safeco Insurance Company	107
—	Chubb Group of Insurance Co.	77	—	Johnson & Higgins	42	70	Safety Nat'l. Casualty Corp.	130
13	Claims Overload Systems	150	42	Kemper National Insurance	20	—	Schirmer Engineering	38
14	Commonwealth Risk Service	70-71	82	LaSalle Re Limited	35	71	SCOR U.S.	Cov. 2,2A/2B
15	Commercial Risk Re-Insurance	Cov. 3	43	Liberty Mutual	29	—	Shearman & Sterling	147
16	Conning & Company	110	44	Lindsey Morden	123	72	Skandia America Group	30
17	Continental/Rehab Resource	95	45	Wm. H. McGee & Co., Inc.	113	—	Spectrum Insurance Group	129
18	Continental Risk Management	76	—	Mead Loss Control	62	—	Sphere Drake	18
19	Continental Underwriters	64	46	Media/Professional Ins.	109	—	Storm Trak	84
—	Council of Ins. Agents/Brokers	6	47	Minet Inc.	13	73	Swett & Crawford Group	48
20	Cover X	102	48	MultiPlan Inc.	44	74	Toplis & Harding	84
21	Crawford & Company	39	—	Mutual Marine Office, Inc.	116	75	Triangle Brokerage	34
22	CRC	90-91	49	NAC Reinsurance Corp.	53	76	United National Group	4
23	Crum & Forster	58	50	National Reinsurance	74-75	—	U.S. Facilities	99
24	David Corporation	115	51	Near North Ins. Brokerage	109	—	Vermont Captive Insurance	63
25	Dentafits Inc.	131	52	Near North Ins. Brokerage	115	—	Carl Warren	111
—	Discover Re Managers	14-15	53	NILS Publishing Company	60-61	77	Wausau Insurance Company	5
26	ECS Inc.	45	54	North American Reinsurance	73	78	Scott Wetzel Services	59
27	Employers Reinsurance Corp.	40-41	55	North American Reinsurance	56-57	79	Zurich-American Insurance Co.	50-51
28	Environmental Science & Eng.	148						

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Issue Date: APRIL 18, 1994 — R

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  - B Association
  - C Union
  - D Government
  - E Educational Inst
  - F Ins Agent
  - G Ins Broker
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  - I Actry/Conslt Inst
  - J Attorney
  - K Adj/Apprs
  - L TPA
  - M Health care
  - N Other
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  - 2 151 - 499
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| 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 |
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# Superfund

Continued from page 3  
or neither side.

"RIMS views the establishment of an environmental insurance resolution fund as inappropriate and adverse to the public policy interest of avoiding governmental intervention in private party disputes," the position paper says.

- Eliminating a provision in the Clinton proposal to grant community groups veto power over certain environmental activities.

There is ample opportunity for community input and creating a \$50 million fund for the groups would "likely preclude 'com-

munity legal counsel' and encourage a more contentious relationship than currently exists," RIMS said.

- Defining and eliminating overlapping regulatory oversight by state and federal agencies.

States should not be allowed to reopen Superfund cases and require more cleanup, RIMS said.

RIMS does support the administration's proposal to establish national uniform cleanup standards. The EPA must become more flexible in its remediation requirements and consider what is planned for the site after remediation, Mr. Haight says.

"You have to look at whether it's going to be a playground or a parking lot," Mr. Haight said. **BI**

# Pension bill

Continued from page 2  
shore up the system aren't taken now.

The administration's witnesses said that H.R. 3396 would: strengthen funding rules for underfunded plans; enhance PBGC compliance authority; increase PBGC premiums for underfunded plans; and broaden participant disclosure requirements (BI, Oct. 11, 1993).

Improving pension plan funding would reduce PBGC's exposure when companies go out of business and terminate their pension programs.

Mr. Reich, however, sounded an alarm when he noted that even though most of the defined benefit plans insured by the PBGC are financially sound, the amount of underfunding nearly doubled to \$53 billion in 1992 from \$27 billion 1987.

"This chronic underfunding can potentially undermine our pension system," he warned.

The time to act has arrived courtesy of improved economic conditions, Mr. Reich said. "When the economy is coming out of a recession is the best time for a company to fund its pension plans."

The Democratic members of the committee were supportive of the administration's position, which was hardly surprising given that Rep. Rostenkowski was one of two initial co-sponsors of the bill last fall. The questions they asked were ones for which the administration witnesses had ready answers.

For example, Rep. Rostenkowski asked Mr. Reich about some employers' arguments against the bill on the grounds that requiring greater pension funding would mean lost jobs and possibly even bankruptcy.

The secretary of labor replied that the bill had been carefully crafted to avoid such a scenario. He noted that, under the proposal, companies would be protected from "extraordinary increases in their annual contributions for up to seven years."

Rep. Rostenkowski then asked whether existing laws are adequate to deal with the problem, as he said some companies have asserted.

Mr. Reich said he didn't believe that was the case. After all, the defined benefit pension system already has a shortfall of \$53 billion, he said.

He repeated his contention that while the underfunding problem is not yet a crisis, "we are heading in that direction" and called for action now to turn the situation around.

The committee's ranking minority member—Rep. Bill Archer, R-Texas—was more critical of the administration's proposal.

While welcoming the testimony that the government shouldn't have to fund another major bailout like that of the savings and loan industry, Rep. Archer said he thought current federal pension regulations already discourage the creation of defined benefit plans. Adding heavier regulatory burdens could only mean further discouragement, he said. **BI**

# Fire loss

Continued from page 2

IRI took over as Weirton's property insurer on April 1, less than a week before the fire, industry sources say. Its previous insurer was Protection Mutual Insurance Co. of Park Ridge, Ill.

An IRI official said he could not comment on the fire.

Separately, three other plants have been rocked by explosions in recent weeks:

- An April 13 blast at a Stone Container Corp. pulp and paper mill in Panama City, Fla., killed three workers, injured seven and shut the plant down.

Arnold F. Brookstone, an executive vp with Chicago-based Stone Container, said that the plant will be closed for "weeks" and that the company has no estimate of damages yet. Stone has property and business interruption insurance with a deductible that is "modest in relation to the amount of the loss," he said.

- An April 20 explosion at an AK Steel Corp. plant in Middletown, Ohio, killed four maintenance workers. Property damage was "certainly not extensive," said an A.K. spokesman, who could not provide insurance details.

- An April 20 explosion occurred at the Mont Belvieu, Texas, natural gas plant operated by a joint venture of Trident NGL Inc., Conoco Inc. and Liquid Energy Corp. The cause and size of damages are unknown. **BI**

# A&A says it is close to naming new CEO

NEW YORK—Alexander & Alexander Services Inc. is close to naming a new chief executive officer to replace recently retired Tinsley H. Irvin.

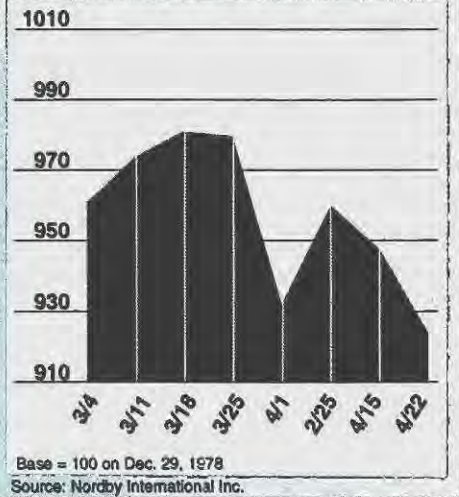
Robert E. Boni, chairman of the A&A board, said Mr. Irvin and President Michael K. White have left A&A's board of directors, and the board is looking for two outside directors to replace them.

Separately, A&A said it expects to report a first-quarter loss of about \$6.5 million, or 15 cents per share. It was expected to announce the quarter's results today.

A&A said the loss was caused primarily by lower-than-expected revenues in its North American risk management and insurance services operations. First-quarter results will also reflect Mr. Irvin's severance package.

—By Judy Greenwald

# BI Insurance Index



Insurance stocks fell last week, as the Business Insurance Index lost 23.3 points to 924.3 April 22 from 947.6 on April 15. Advancing issues for the week were led by: Phoenix Re Corp., up 13.9%; NAC Re Corp., up 12.4%; and Reliance Group Holdings, up 11.9%. Declining issues for the week followed: Alexander & Alexander, down 13.2%; Wellpoint Health Networks, down 8.5%; and U.S. Healthcare, down 8.0%. The most active issue was U.S. Healthcare, 15.6 million shares traded. The BI index fell 2.5%; the Dow Jones 30 Industrials lost 0.4%; the NYSE Composite rose 0.1%; and the Standard & Poor's 500 increased 0.3%.

# British Issues

April 21 Companies	Price pence	P/E	Div. pence	Yield %	1 week	
					High	Low
Comm Union	588	18.7	31.0	5.3	601	588
Genl Accident	606	12.1	34.4	5.7	631	599
Gdn Royal Exch	187	12.1	9.5	5.1	193	186
Royal	264	11.4	9.4	3.6	276	264
Sun Alliance	332	14.8	18.4	5.5	335	323

Brokers	Price	P/E	Div. pence	Yield %	1 week	
					High	Low
Bradstock	134	15.0	6.9	5.1	134	134
CE Health	371	4.2	20.5	5.5	375	371
Hogg Group	234	N/M	7.1	3.0	234	218
JIB Group	192	16.8	9.4	4.9	194	192
Lloyd Thompson	281	19.0	8.4	3.0	285	281
Lowndes Lmbt	426	13.3	18.8	4.4	427	426
PWS Holdings	75	11.0	5.0	6.7	75	75
Sedgwick Grp	194	21.5	7.5	3.9	196	194
Steel Bri Jones	140	N/M	11.3	8.1	140	140
Willia Coroon	224	20.5	8.3	3.7	224	222

Source: Philip Olsen, London\* Estimated; others actual 1993

# BI Industry Stock Report APRIL 18, 1994, THROUGH APRIL 22, 1994

BROKERS	Price	Weekly		Year to date	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value	Price	Weekly		Year to date	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt./Bk. value
		% change	% change		% change	High								Low	% change		% change	High						
Accordia Inc.	26.38	-3.21	7.11	28.25	18.38	52	0.60	2.27	13	10.22	2.38	0.97	23.75	7.95	-20.83	32.75	21.16	168	0.28	1.18	15	5.71	4.16	
Alexander & Alexander	14.75	-13.24	-25.79	28.00	14.50	1101	1.00	6.78	39	6.73	2.19	2.19	27.25	12.37	-6.44	41.75	24.00	489	0.16	3.59	12	19.24	1.42	
E.W. Blanch Holdings Inc.	17.50	2.19	0.72	23.50	15.75	12	0.32	1.83	18	4.10	4.27	4.27	27.63	-3.07	-9.80	39.63	27.13	150	0.16	3.58	9	16.89	1.84	
Gallagher Arthur J. & Co.	30.75	4.24	-13.99	37.13	28.13	42	0.88	2.66	15	7.52	4.09	4.09	19.75	-1.25	-43.57	39.00	16.50	43	0.00	3.00	11	16.99	1.16	
Hill, Rogal & Hamilton	12.25	5.38	-6.67	15.88	11.13	56	0.48	3.92	19	4.51	2.72	2.72	7.88	-0.79	3.28	8.44	6.25	74	0.00	2.00	5	6.84	1.15	
Marsh & McLennan	84.00	1.20	3.23	92.75	77.00	592	2.68	3.19	19	16.76	5.01	5.01	32.25	2.38	-0.77	38.75	26.50	726	0.88	2.73	12	23.87	1.35	
Poe & Brown	18.88	-0.66	4.86	20.50	16.88	75	0.40	2.12	15	3.02	6.25	6.25	61.25	0.41	-4.30	72.00	57.63	171	2.92	4.77	13	47.68	1.28	
BROKERS AVERAGE		-0.6	-4.4					3.3	20															
INSURERS/REINSURERS																								
ACE Ltd.	27.75	0.00	-9.02	36.00	24.50	231	0.40	1.44	5	28.74	0.97	0.97	23.75	7.95	-20.83	32.75	21.16	168	0.28	1.18	15	5.71	4.16	
Acceptance Insurance Cos.	12.50	5.26	7.53	15.63	11.13	30	0.00	0.00	14	9.65	1.30	1.30	27.25	12.37	-6.44	41.75	24.00	489	0.16	3.59	12	19.24	1.42	
AEGON N.V.	51.63	-1.20	-5.71	58.50	43.25	58	1.22	2.36	10	34.71	1.49	1.49	19.75	-1.25	-43.57	39.00	16.50	43	0.00	3.00	11	16.99	1.16	
Aetna Life & Casualty	53.25	2.90	-11.62	66.25	49.00	1360	2.76	5.18	-10	71.84	0.74	0.74	27.63	-3.07	-9.80	39.63	27.13	150	0.16	3.58	9	16.89	1.84	
Allied Group Inc.	23.63	3.28	-5.50	32.75	21.34	227	0.60	2.54	6	10.45	2.26	2.26	19.75	-1.25	-43.57	39.00	16.50	43	0.00	3.00	11	16.99	1.16	
Allmerica Prop. & Casualty	15.38	-6.11	-28.63	22.16	15.00	127	0.16	1.04	4	58.97	0.27	0.27	22.50	13.92	-18.18	38.25	18.50	818	0.28	1.24	7	19.99	1.13	
Allstate Corp.	23.50	-2.08	-21.01	34.25	22.88	3348	0.72	3.06	8	18.43	1.28	1.28	25.75	-2.83	-18.58	31.88	25.63	79	1.04	4.04	-13	26.38	0.98	
American General	26.00	-7.96	-8.77	36.50	25.50	1950	1.16	4.46	23	22.09	1.18	1.18	32.25	2.38	-0.77	38.75	26.50	726	0.88	2.73	12	23.87	1.35	
American Heritage Life Ins.	17.50	-2.10	-6.04	25.34	17.00	17	0.60	3.43	11	12.42	1.41	1.41	10.63	3.66	-15.84	19.63	10.13	27	0.36	3.39	8	16.08	0.66	
American Indemnity/Fin'l	13.00	-3.70	0.00	16.25	8.00	2	0.12	0.92	4	16.18	0.80	0.80	1.75	-6.67	0.00	2.13	0.31	68	0.00	0.00	-1	1.90	0.92	
American International	87.00	-0.14	-1.28	100.25	78.41	3113	0.40	0.46	14	45.25	1.92	1.92	24.90	-6.67	-19.01	31.00	21.75	78	1.12	4.57	15	23.11	1.06	
American Re Corp.	27.25	2.83	-3.54	39.25	23.50	92	0.00	0.00	12	14.80	1.84	1.84	15.88	-1.55	-3.79	21.63	14.63	59	0.12	0.76	7	12.17	1.30	
Aon Corp.	46.38	-1.59	-3.89	58.50	45.00	370	1.92	4.14	11	33.10	1.40	1.40	12.25	-4.85	-2.00	14.75	9.75	246	1.00	0.82	5	8.65	1.42	
Argonaut Group	26.75	-4.46	-12.30	35.50	26.75	73	1.00	3.74	8	27.85	0.97	0.97	18.00	-4.00	-20.44	28.00	17.63	578	0.20	1.11	-9	18.49	0.97	
AVEMCO Corp.	16.25	-0.76	-13.33	22.00	14.50	19	0.44	2.71	13	8.13	2.00	2.00	9.13	-7.59	-16.09	13.98	9.13	55	0.24	2.63	7	8.93	1.02	
Baldwin & Lyons Inc.	14.25	-1.72	-4.20	16.25	11.16	0	0.20	1.40	9	12.59	1.13	1.13	62.50	-2.72	15.74	67.00	49.25	6	0.37	0.59	-	57.72	1.08	
Berkley W.R. Corp.	35.75	-2.05	9.16	48.00	32.00	135	0.44	1.23	12	28.12	1.27	1.27	39.13	2.29	-12.57	59.75	37.88	764	1.12	2.86	10	17.35	2.26	
Berkshire Hathaway Inc.	15450.00	-4.04	-5.36	17800.00	12350.00	1	0.00	0.00	24	8115.28	1.90	1.90	47.75	0.00	-10.54	61.50	45.38	146	0.36	0.75	13	29.60	1.61	
Capital Re Corporation	19.25	0.65	-25.24	28.50	18.50	118	0.20	1.04	8	21.66	0.69	0.69	35.25	-0.70	-9.32	49.50	31.22	5002	0.48	3.36	9	33.35	1.06	
Capsure Holdings Corp.	13.25	-3.64	-1.85	19.38	12.75	31	0.00	0.00	12	13.08	1.01	1.01	35.75	0.70	-7.74	48.00	33.25	29	1.00	2.80	10	26.00	1.38	
Chubb Corp.	76.88	0.33	-2.23	93.38	70.75	949	1.84	2.39	20	46.59	1.65	1.65	38.50	1.99	6.									



*Each year, in late October, Canada Geese sense the onset of winter and begin their seasonal migration southward. This journey takes some of the geese over 2,000 miles in search of the warm marshes that will sustain them through the winter.*

## Knowing That Change Is Coming Is One Thing. Doing Something About It Is Another.

Reacting to change as it happens isn't enough. To survive and flourish, the successful company must be able to see change coming and be ready to deal with it.

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