

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

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Further delays may stymie Lloyd's reconstruction plan

LONDON—Lloyd's of London is admitting it may have to delay its long-awaited reconstruction and recovery plan.

The delay, expected to be about a month, could result from the complexity of calculating reserving requirements for Equitas Ltd., the planned runoff reinsurer, and the amounts loss-making names will have to contribute.

A Lloyd's spokesman said the timing depends on the Department of Trade and Industry, which must give final approval. Last
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Mental health fight escalates

By MEG FLETCHER

WASHINGTON—Employers are stepping up efforts to convince a congressional conference committee—and the White House—to drop or modify a provision in a health care bill that would require employers to offer the same benefits for mental health problems as they do for general medical care.

That requirement would mean the end of the tighter restrictions that many employers put on mental health care services, which would increase utilization and claims costs by tens of billions of dollars, the Congressional Budget Office says.

Most large employers probably would adopt more managed care screening to control claims, rather than cut back on benefits, though they may require workers to pay higher premiums, employers and consultants say. Small employers, though, would be more likely to reduce coverage for all health care rather than pay for better mental health benefits.

Employer groups have withdrawn their backing of the entire health reform bill in an attempt to get the conferees to remove the mental health requirement. They are also making their case to White House staffers.

The National Assn. of Manufacturers "will be writing letters to conferees

Employers challenging benefit parity proposal



Sen. Pete Domenici says mental health benefit discrimination is rampant.

and asking our member companies to do the same," said Sharon Canner, vp-human resources policy. NAM also is increasing its visits to legislators' offices and working with other business groups to develop data on the likely costs that would be created by the requirement.

The ERISA Industry Committee, an umbrella group for 130 large employers, wrote senators last week that the amendment is causing them to withdraw their support for the entire health care reform measure.

"Employers and those concerned about this proposal need to treat it very seriously," said Frank McArdle, a consultant with Hewitt Associates L.L.C. in Washington.

The mental health provision, co-sponsored by Sens. Pete Domenici, R-N.M. and Paul Wellstone, D-Minn., is part of a broader bill passed by the Senate this month that would limit the use of pre-existing condition exclusions. That would make it easier for employees to keep their coverage when they switch jobs.

An earlier health care reform bill passed by the House does not include a comparable provision on mental health benefits. That and other differences between the two bills will have to be ironed out by a conference committee.

The 65-33 vote on the Domenici-Wellstone amendment reflected unexpected support for the provision, which observers attribute to the sponsors' personal revelations about how their lives were affected by the mental illness of a daughter and brother, respectively, and how in some cases cov-

See Mental on page 50

Travelers/Aetna hits Street running

But only after resolving SEC flap, adding \$750 million to reserves

By JUDY GREENWALD

Travelers/Aetna Property Casualty Corp., whose initial public offering was briefly held up by the Securities and Exchange Commission, received a warm Wall Street welcome last week, even though most commercial property/casualty stocks are trading water lately.

The Travelers/Aetna IPO went forward after agreement on how the company would account for a reserve increase of up to \$750 million that Travelers determined it needed to make after reviewing the Aetna business. That hefty addition is to cover cumulative injury claims on the Aetna business and other factors.

Despite the success of the Travelers/Aetna offering, which raised \$886 million excluding an underwriters' over-allotment option, commercial property/casualty stocks as a whole are trailing the market this year. Analysts say their future performance will depend primarily on the direction of interest rates, though they continue to recommend a wide variety of stocks (see story, page 49).

The Travelers/Aetna Property Casualty Co. was formed by Travelers Corp.'s 1995 purchase of the property/casualty operations of Aetna Life & Casualty Corp. (BI, Dec. 4, 1995). The price, initially pegged at \$4 billion, rose to \$4.16 billion, primarily because of the interest that has accrued, according to the offering prospectus.

Travelers/Aetna shares, 35.4 million of which were sold for \$25 each in the IPO, rose 10% to \$27.50 in their first day of New York Stock Exchange trading last Tuesday and rose to \$27.63 Friday. At 14.4 million shares traded, it was the Tuesday's most active issue. Travelers will control 82% assuming the U.S. underwriters' over-allotment option is exercised. The company also sold \$700 million dollars in debt securities.

The IPO was expected to be completed the week of April 15, but was briefly delayed as the company and the SEC haggled over how to account for the up to \$750 million reserve addition that Travelers determined it needed.

Analysts say the company had hoped to treat it as goodwill and amortize it over up to 40 years, as pur-
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Ignoring safety warrant may cost Caterpillar

By DEBORAH SHALOWITZ COWANS

YORK, Pa.—Two Caterpillar Inc. officials could be jailed and the company could be fined as much as \$10,000 per day if a U.S. District Court judge finds the company in contempt of court for refusing to allow federal health and safety officials, armed with a warrant, to inspect its York, Pa., plant.

Caterpillar on April 16 refused to allow two investigators from the National Institute for Occupational Safety and Health, accompanied by two representatives of the United Auto Workers, to enter the plant—even though they had a federal warrant authorizing them to inspect the facility.

"It's very rare to get a warrant and even more rare to be turned away with a warrant in hand," a NIOSH

spokesman said. NIOSH is the research arm of the Atlanta-based Centers for Disease Control and Prevention. The agency provides information only; it does not have the authority to demand changes or levy penalties.

Caterpillar maintains that the agency's request to search the plant is "unreasonable" and that the agency is not "approaching the is-
See Caterpillar on page 50

EMLICO looked into 'export' in '94

By DOUGLAS McLEOD

BOSTON—"Exporting" the hugely insolvent Electric Mutual Liability Insurance Co. to London to run off its business would create lots of regulatory and tax problems—almost as many as allowing it to be liquidated in its home state of Massachusetts, a London law firm wrote in a 1994 memo.

"A preferable course would probably be to move EMLICO to another jurisdiction, say, Bermuda, which has a lighter regulatory framework and a far more favorable tax regime," lawyers at Clifford Chance & Co. advised EMLICO several months before the company's controversial 1995 move to Bermuda.

One disadvantage of such a move, said

the lawyers: It would be "unusual."

Unusual is right. In an unprecedented step, EMLICO, a longtime General Electric Co. liability insurer, jumped to Bermuda last June and soon afterward filed for voluntary liquidation, declaring itself under-reserved by \$750 million and insolvent by at least \$500 million.

And the memo, dated six months before Massachusetts regulators approved the move, is now at the center of a legal fire-fight between EMLICO and its reinsurers in a Boston court. *Business Insurance* obtained a copy from the court file.

EMLICO is trying to block the release of the document, asserting attorney/client privilege.

But reinsurers want to use the memo, mailed to them anonymously last month, to

show that EMLICO deliberately misled the Massachusetts Insurance Division about its insolvency and liquidation plans to gain approval of the move.

In a June 1995 hearing on the reorganization plan, EMLICO President David St. Laurent told regulators that EMLICO had policyholder surplus of about \$230 million "as we sit today." In approving the plan, regulators found "nothing in the record to indicate that either EMLICO or GE intend" to liquidate the company in Bermuda.

The reinsurers—Allstate Insurance Co., General Re Corp. units, Kemper Reinsurance Co. and Lloyd's of London underwriters—charge that EMLICO's plan was aimed solely at benefiting GE by taking advantage of policyholder-friendly Bermuda liquidation.
See EMLICO on page 51



CN Tower faded into the horizon as the Risk & Insurance Management Society Inc. left town last week. Benefits and workers comp coverage begins on page 3.

Updates

Lloyd's foresees R&R delay

Continued from previous page

month, the DTI conditionally approved Equitas, but the final go-ahead depends, in part, on definitive figures on the sums involved.

Lloyd's also believes it may have to ask names for smaller contributions than previously estimated. Lloyd's has assembled a £2.8 billion (\$4.25 billion) package to help names meet their share of past losses totaling more than £8 billion (\$12.13 billion), but it is still negotiating with brokers and syndicate auditors on contributions they could make to add about £300 million (\$454.9 million) to the settlement offer.

More up-to-date figures also indicate that Lloyd's reserving requirements for the 1986 to 1992 underwriting years may be lower than originally calculated. Lloyd's had estimated the premium needed to be paid into Equitas would be £1.9 billion (\$2.88 billion), but the revised reserve figures could reduce this to about £1.5 billion (\$2.27 million).

The delay is likely to show itself first in a longer wait for the revised figures on their Equitas contributions, which Lloyd's was due to send to 34,000 names next month. It also is likely to mean a postponement of Lloyd's annual general meeting originally scheduled for early June and recently rescheduled for July 15.

Policy jacket clauses upheld

SEATTLE—In one of the first pollution trials to involve first-party, all-risk property insurers, a jury has decided to uphold notice of loss and suit limitation clauses in policy jackets.

Returning its verdict last Tuesday in a suit by the Aluminum Co. of America and subsidiary Northwest Alloys Inc. against a number of insurers, the jury also ruled that brokers involved in two insurance placements acted as agents for the policyholder when it came to delivering information on the policies and associated jackets.

The test case related to cleanup at three Alcoa sites in Vancouver, Wash.; Massena, N.Y.; and Point Comfort, Texas (BI, Oct. 23, 1995).

Alcoa argued that the policy jackets were not part of the full policy, and that even if their brokers had a copy of the jacket, they were acting as agents of the insurers for the purpose of delivery.

Both arguments were turned down by the jury, which considered two policy placements. The first involved a Lexington Insurance Co. policy that ran from 1977 to 1980. The second included a number of different policies from numerous insurers, that ran from 1980 to 1983.

The second phase of the litigation, which will focus on issues including whether the pollution was accidental, starts today and is expected to finish before the end of July.

Deloitte & Touche settles suit

WILTON, Conn.—Deloitte & Touche L.L.P. says its professional liability insurance will cover "a substantial portion" of the \$65 million that it has agreed to pay to settle civil charges that it helped a now-bankrupt alternative energy conglomerate illegally overstate its financial wherewithal.

The bankruptcy trustee of Bonneville Pacific Corp. alleges in a civil lawsuit filed in U.S. District Court in Salt Lake City that many former officials—four of whom also face criminal charges—and professional advisers of Bonneville were involved in the alleged scheme. Vital to the alleged scheme was that many of the Bonneville officials were former partners or employees of Deloitte, which was Bonneville's accounting firm from the mid-1980s through 1990, the trustee said. The trustee alleged that even though the company had been engaged in fraudulent activities since the mid-1980s, Wilton, Conn.-based Deloitte & Touche signed off on the company's annual financial reports without qualification during that time.

Bonneville, which filed for Chapter 11 protection in 1991, is insolvent by several hundred million dollars.

Deloitte & Touche said its services "were performed in accordance with professional standards. It said it settled to free itself from "prolonged, costly litigation with an uncertain outcome."

A spokeswoman for the firm would not comment on Deloitte & Touche's insurance. But, Minet Group confirmed that the firm is covered by the professional liability line slip that the broker has arranged for large accounting firms.

The settlement is subject to federal and bankruptcy court approval.

Briefly noted

The Occupational Safety and Health Administration will be allowed to continue researching a possible ergonomics standard under the budget agreement President Clinton signed last Friday. OSHA's budget was cut by 2%, while the annual appropriation for the Superfund program was increased to \$1.3 billion from \$1.1 billion. . . Louisiana Pacific Corp. says it is trying to determine how much of its insurance will apply to a class-action settlement that will cost it \$275 million to \$375 million over the next seven years (BI, Oct. 23, 1995). A federal judge in Portland, Ore., last week approved the settlement in a suit by homeowners that alleged the company's "oriented strand board" siding material collects water and rots. . . Value Health Inc. has reached an agreement to sell its health care consulting unit, Fairfax, Va.-based Lewin-VHI Inc., to drug development firm Quintiles Transnational Corp. of Research Triangle Park, N.C., for about \$30 million. Value Health's move is designed to remove any potential conflict of interest between its effort to sell managed care products to government agencies and Lewin's government consulting. . . Two California initiatives designed to stop abuses by health maintenance organizations have garnered enough signatures to appear on the November ballot (BI, Jan. 29). . . PCS Health Systems Inc. President and CEO Steven I. Geringer will retire June 1. J.P. Millon, currently chief operating officer, then will assume the top spot. . . Insurers do not expect significant claims from the minor damage from last week's partial explosion of Irish Republican Army bombs under a bridge on London's River Thames.

Drug testing on the rise

Eight out of 10 companies routinely test new hires

By MEG FLETCHER

NEW YORK—Major U.S. companies are testing employees or new hires for illegal drugs more than ever before, according to the latest American Management Assn. survey.

Currently, 81% of major companies surveyed test employees or new hires, up 3% from 1995, and the highest level reported in the 10-year history of the annual survey.

"What was extraordinary 10 years ago has become the norm today," said Eric Rolfe Greenberg, the AMA's director of management studies.

Surveyed firms spent more than

\$22 million on drug testing in 1995.

Since 1987, corporate drug testing has nearly quadrupled to 81% of surveyed firms from 22%, while periodic or random testing of employees has increased to 34% from 2.5%.

In addition, "one-third of U.S. job seekers will be tested for drugs this year, compared with less than 10% when our study began" in 1987, he said.

The New York-based AMA is a not-for-profit organization of 9,500 member companies that provides management training worldwide. Its members employ one-fourth of the U.S. workforce.

The AMA's latest survey results

are based on the experience of a representative group of 961 companies, which tested more than 200,000 employees and 500,000 job applicants in 1995.

"There is no doubt that testing is an effective method of identifying drug users, so long as proper specimen control and validation procedures are used," Mr. Greenberg said. The data does not answer the question of whether drug testing deters drug use, he said.

The surveys have found a general decline in the test-positive rate among employees, which was 1.9% in both 1995 and 1994. That rate was 4.2% in 1990 and dropped to 2.5% in 1991, where it

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Tennessee seizes MEWA

Assets were skimmed, regulators say

By DOUGLAS McLEOD

NASHVILLE, Tenn.—Tennessee insurance regulators are now in control of a multiple employer welfare arrangement whose operators allegedly siphoned away more than \$10 million in benefit fund assets for personal purposes.

A federal judge in Nashville earlier this month froze the assets of International Assn. of Entrepreneurs of America Benefit Trust, a MEWA that has stymied regulators in nearly a dozen states for more than two years with court challenges to state regulatory authority.

The judge also appointed an independent fiduciary—Jeanne Barnes Bryant, receivership director for the Tennessee Department of Commerce and Insurance—to take over administration of the trust.

The order was sought by the U.S. Labor Department, which charged in an April 12 lawsuit that several IAEA officials and benefit plan trustees misused trust assets in acts of "gross self-dealing" that violate federal law.

Those acts included awarding themselves excessive compensation and hiring investment, accounting and travel firms they controlled to do work for the trust.

IAEA Benefit Trust hasn't been declared insolvent. However, See MEWA on page 48

CPA standard proposed

Idea aims to help auditors spot fraud

NEW YORK—The American Institute of Certified Public Accountants' Auditing Standards Board will unveil a proposed standard on detecting fraud within the next few weeks.

The standard would require auditors to specifically assess the risk of material misstatement owing to fraud. It also would provide a list of fraud risk factors that an accountant should consider while conducting an audit.

In addition, the proposed standard would require the auditor to respond to the results of the assessments and to document the assessment. The standard would stress the auditor's responsibility to inform management, the audit

committee and, in some situations, regulators, of the fraud.

In recent years, accounting firms have been hit with fraud liability claims that have sometimes reached into the hundreds of millions of dollars. For example, Arthur Andersen & Co. S.C. and Coopers & Lybrand L.L.P. each were sued by Resolution Trust Corp. alleging negligent auditing of failed savings and loans (BI, Aug. 22, 1994; Aug. 9, 1993).

The proposed standard should be public by the middle of May and will be subject to a three-month public comment period. A final standard is expected to be approved later this year.

—By Mark A. Hofmann

Employment cases slated

for high court

U.S. civil rights laws

at heart of 2 cases

By MARK A. HOFMANN

WASHINGTON—The U.S. Supreme Court will hear arguments in two employment-related cases during its next term.

In *Robinson vs. Shell Oil Co.*, the justices will decide whether a former employee of a company can sue that company under the Civil Rights Act of 1964 for retaliatory conduct. Appeals courts have issued contradictory rulings as to whether a former employee remains an employee for purposes of the act's anti-retaliation provisions.

Charles Robinson lost his job with Shell Oil Co. in 1991 and filed a complaint with the Equal Employment Opportunity Commission charging that he was the victim of racial discrimination. Mr. Robinson charged that Shell had given a would-be employer an unfavorable reference and false information in retaliation for his EEOC complaint.

Mr. Robinson filed another EEOC complaint, charging Shell with violating the Civil Rights Act, which forbids actions against employees who filed civil rights complaints. The EEOC said Mr. Robinson could sue.

Shell countered that the anti-retaliatory provision had no bearing on Mr. Robinson because he was no longer an employee when the alleged action occurred. A U.S. District Court in Maryland agreed with Shell and dismissed the case. Mr. Robinson appealed

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Inside

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• Insurance brokers must adopt higher standards, say speakers at a broker conference. **PAGE 43**

• Catastrophe predictions will remain an inexact science, scientists say. **PAGE 43**

• Men are winning bigger wrongful termination awards than women, a study has found. **PAGE 50**

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Technology placed high on RIMS agenda

New leader calls it, communication keys to future

By MICHAEL BRADFORD

TORONTO—The Risk & Insurance Management Society Inc. can no longer afford to sit parked beside the information superhighway while the benefits of technology whiz by, its incoming president says.

It's time to take advantage of the technology that can enable risk managers to be more efficient and RIMS to better serve its members' needs, said Louis J. Drapeau, manager-insurance and risk management at The Budd Co. in Troy, Mich.

Mr. Drapeau, who on May 1 will take the gavel as the group's 43rd president, emphasized during his inaugural speech last week at its 34th annual conference the importance of improving communications between RIMS members, the organization and other

industry professionals.

One sign of the value of communications is a new RIMS home page on the World Wide Web. It will give basic information on RIMS to all users, and other information and services to those who have paid certain fees and received passwords.

Speaking at the annual membership meeting that kicks off the conference, Mr. Drapeau said, "The dominant theme for the upcoming year is communication: certainly not a novel idea but a fundamental skill that perhaps we take for granted. It's something we need to do well in order for everything else to work."

Risk managers and others in insurance-related jobs can gain tremendous efficiencies from new technology, he stressed. "Our business is, after all, based on the exchange of information: things such as insurance contracts, bid specifications, underwriting information, loss runs, actuarial data and, of course, certificates of insurance."

Risk managers and other professionals will have to work together to take full advantage of technology's potential, he said. "Just like the saying, 'The chain is only as strong as the weakest link,' all of us—risk managers, underwriters, brokers and special service providers—must advance into this information age together."

If everyone isn't working together, someone will suffer, said Mr. Drapeau.

"Suppose my company enters into a contract with another business. The contract requires exchanging certificates of insurance. My certificates are computerized and online, but my colleague's insurance information is maintained in traditional files. Therefore, rather than transmit the certificate electronically within minutes, we have to go through our brokers, who mail the certificates to the respective parties. My company has to slow down so that our business partner can keep up."

Brokers and insurers will experience similar problems if insurance buyers don't keep

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MICHAEL A. MARCOTTE



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MICHAEL A. MARCOTTE



The Risk & Insurance Management Society Inc. passes the torch from outgoing President William J. Kelly, left, to incoming President Louis J. Drapeau.



MICHAEL A. MARCOTTE

Despite the dreary weather, Toronto welcomed the annual Risk & Insurance Management Society Inc. conference with open arms. Conference hotels are conveniently located in the heart of Toronto, enabling conference goers to walk by a bit of city history, including the Old City Hall, top. The CN Tower, middle left, also was hard to miss. Closer to the conference, the many vendors in the exhibit hall kept attendees busy checking out new products.

RIMS Report

Employee Benefits & Workers Comp

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The ERISA fiduciary two-step

Combining preventive audit with insurance should calm fears

By ROBERT KAZEL

TORONTO—As ERISA law gets more complex and volatile, risk managers can still calm their worries with a double shot of caution: the so-called "check-up and a check."

The check-up is an independent audit by consultants or attorneys, and the check pays for fiduciary liability insurance, a shield that companies must know how to use when they even think they might be in trouble.

These were the observations of two attorneys, both experts on the Employee Retirement Income Security Act of 1974, who spoke last week at the 34th annual Risk & Insurance Management Society Inc. conference. The speakers said that avoiding legal mine fields in the world of ERISA, which delineates the fiduciary responsibilities of benefit plan trustees, requires a cautious two-part strategy: averting fiduciary violations before the fact and knowing exactly what the company's liability coverage is

when possible rough spots arise.

"Most of us (employers) should or are buying fiduciary liability insurance," said Robert N. Sandler, a partner with Saul, Ewing, Remick & Saul in Philadelphia and an expert in ERISA litigation. "This is an age when lawsuits have been occurring fast and furious and this is an area we need to pay attention to."

ERISA, which requires plan money to be held in trust, mandates that a person or entity as-

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Cost management comes to comp

By ROBERT KAZEL

TORONTO—Soaring health care costs forced employers to open the parachute of managed care, and employers' skyrocketing costs in the workers compensation arena are now causing many to also consider jettisoning traditional approaches to workers compensation.

A new industry of cost management firms, old and new, is gearing up to chart the flight paths of corporate America in the workers

Technique takes a turn in new area

comp domain. A panel of employers and experts at the Risk & Insurance Management Society Inc.'s annual conference in Toronto last week told risk managers to expect greater efficiencies and savings from a managed care approach to workers comp. But they also warned that, just as in managed care on the medical benefits side,

weak programs are out there and employers must not be timid about what they demand of the new programs.

Workers comp claims have been dealt with in a traditional fee-for-service manner by virtually all companies until very recently, so evidence on the benefits of managed care-based programs is hard to come by. One employer, however, the Dade County, Fla., public school system, began operating a preferred provider organi-

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Managed

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zation for workers comp claimants as early as 1985 with a group of six hospitals that operated separately from the Miami-based school system's health maintenance organizations on the health benefits side.

"Businesses in South Florida want some relief in the area of workers compensation and we think managed care is a step in the right direction," said Susan N. Weiner, assistant superintendent of Dade schools.

The Dade public schools, which Ms. Weiner said is the second-largest employer in the state with 38,000 full-time workers, already had its discounted negotiated fee schedules and hospital contracts in place for about a decade by the time the state Legislature required workers comp insurers to offer employers a health maintenance organization option for their injured workers.

That requirement goes into effect later this year under a 1993 workers compensation reform law.

The school system was the first corporation to have its managed workers comp program certified by the state in June 1995, Ms. Weiner said.

The program has since matured into a full-fledged preferred provider organization over the past year, with Dade officials working

together with Irvine, Calif.-based CorVel Corp., a managed care services provider to manage the occupational care network.

Many companies are looking at managed care for workers comp in anticipation that cost-conscious state legislators will enact a requirement similar to Florida's, or to comply with a law already passed, said Mandy Harmon, an account executive with CorVel. But others will find it a sensible choice regardless of state policy, she said.

"If you're not part of a 'managed care state,' you can still do managed care," she said. "It's just good business."

What's not good business, though, is becoming mired in a relationship with a workers comp service provider that doesn't produce efficiency, worker satisfaction or good long-term relationships with providers. The dangers exist.

"The medical providers are coming out of the woodwork to jump on the bandwagon for workers comp," said Scott B. Clark, director of risk management for Dade public schools.

Some of these companies, according to Mr. Clark, are experienced with medical managed care networks but know nothing about handling workers compensation cases.

Obviously, therefore, let the buyer beware. There is a long list of specific elements present in a good workers comp plan, said Ms. Har-



James W. Smirles, national brokerage marketing officer for Kemper National Insurance Cos., received RIMS' prestigious Dorothy and Harry Goodell Award (see story, page 22).

mon, that risk managers should look for when evaluating programs:

- A good telephone triage system, by which a registered nurse is immediately available to listen to an injured or sick worker, give advice and in many cases avoid a hospital visit.

- Effective telephone or onsite case management within 24 to 48 hours. Attention from a case manager with a friendly attitude can often make the employee feel cared about and the worker may be less likely to pursue a workers comp case against the company.

- Excellent utilization review and pre-certification procedures.

- Management information reports spelling out the bottom line impact of workers comp medical management. "They should be able to report back to you what you've saved," Ms. Harmon said. "They should want to do that."

- Enough hospitals and clinics in the network so workers don't have to drive more than 30 to 60 minutes to see either primary care physicians or specialists.

- Physicians with proper credentials. Licenses, pending malpractice

claims and board certifications should be verified, and doctors should be recertified in specialties yearly.

Physician education on workers comp issues also should be required, and provided, by the network.

Building a well-oiled managed care machine for workers comp also means studiously separating the workers comp providers from medical plan providers, because each has distinctly different outlooks and approaches to practicing medicine, Ms. Weiner said. Doctors on the medical side, even in a health maintenance organization where charges are capitated, will be in no special hurry to see the employee return to work and are usually as understanding as possible with patient complaints, she said.

On the other hand, workers comp doctors see back-to-work issues as supreme and aren't so concerned about making "friends" to secure lasting patient relationships.

The implication of that view, the panelists agreed, is that while the idea of 24-hour coverage that integrates workers comp care with health care plans may be starting to be in vogue, it amounts to asking one person to play good cop-bad cop.

Carol A. Erbs, risk manager of Post, Buckley, Schuh & Jernigan Inc., a Miami engineering and planning company, moderated of the session. **BI**

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MICHAEL A. MARCOTTE

For the second year, RIMS TV newscasts provided conference goers with on-the-spot coverage of the day's events. Attendees could catch each day's newscasts on their hotel room televisions.

ERISA

Continued from page 3
 assume a formal fiduciary role for it. All corporate executives should ponder who is classified as a formal fiduciary of the company's ERISA plans, where they work and who has assumed that guise informally through function, he said.

"Titles are irrelevant," Mr. Sandler warned, speculating that even a company president's golf buddy who regularly gives investment advice regarding the company's pension funds might be considered a fiduciary. Although lawyers, third-party administrators, actuaries and insurance agents generally are not classified as such, sometimes a thin line separates even these from individuals deemed liable for the plan's well-being, he said.

A fiduciary named officially in

plan documents cannot give up his or her liability even if the actual work of running the plan resides with someone else, such as an investment manager, Mr. Sandler noted.

"They can delegate to investment managers who are registered investment advisers, banks or insurance companies. If you delegate to someone else, you haven't delegated fiduciary authority," he said. The party that delegates authority must monitor closely the activities of those to whom tasks have been delegated, he said.

"I try to impress on my clients that all members of the (plan) committee have equal responsibility and that if the person to whom you have delegated among yourselves does not do the job, you're all responsible," Mr. Sandler said.

The changing face of ERISA law, which is challenging even for specialists in the field, accentuates the

need for solid fiduciary liability coverage and the knowledge of when to use such policies appropriately, said Carol A. Noer, vp and underwriting counsel for Warren, N.J.-based Chubb & Son Inc.

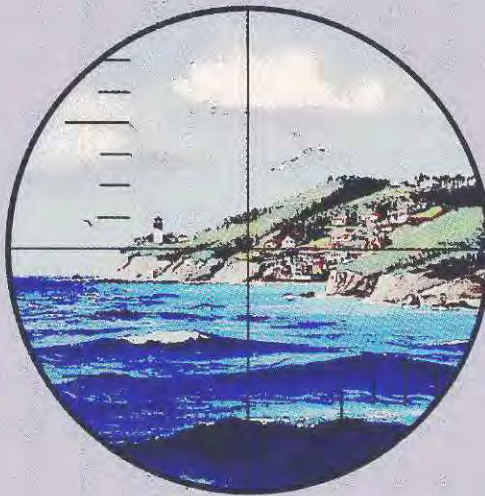
In the past few years, the number of fiduciary liability claims has been mounting, Ms. Noer said. "It could be because people are seeing a pot of gold out there in insurance coverage," she said. "We don't know."

These cases are getting more expensive and harder to settle out of court, with 40% now going to trial—an unusually high percentage. "I can tell you that the majority of cases in other fields, such as directors and officers liability, are settled," she said.

The reluctance to settle ERISA cases is unclear, but Ms. Noer said it is possible that many of the hold-outs are employers: They may, for instance, vow to fight ERISA suits all the way for fear of creating precedent within their companies by granting more liberal benefits to a disgruntled plan participant.

About 60% of ERISA suits are about benefits, with other issues such as imprudent use of investments trailing far behind but still of concern, she said. These are responsible for much larger claims,

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on average, than benefit suits.

With fiduciary liability coverage at hand, plan sponsors must be vigilant in watching for potential claims and notifying their insurer of hazards in the road, Ms. Noer said. It is not necessary to wait for a formal ERISA suit to sound the alarm.

"If you see things coming down the track, rough times ahead, you might want to give me a laundry list," she said. Attentive, written notification of the insurer or broker of an ERISA dispute will help to guarantee payout under the policy.

Employers also need to be aware of notice requirements spelled out in the insurance contract. Some companies require the plan sponsor to file claims within the policy period, others merely as soon as practicable, Ms. Noer said.

Insurance, of course, cannot guard against all potential ERISA problems, Mr. Sandler said. Many of the ERISA violation cases typically pursued by the Internal Revenue Service involve operational gaffes committed by plan sponsors, such as the mere failure to file routine forms on schedule, he said. Such cases have nothing to do with the fiduciary aspects of the plan, yet can be very costly to employers if penalties are assessed.

Moreover, because such problems don't involve a breach of fiduciary responsibility, insurance policies won't cover them, Mr. Sandler said.

He recommended the traditional salve to the worried corporate manager, a thorough ERISA audit, for those looking to head off problems before they reach more expensive stages. Such an audit is usually conducted by experts in ERISA law, though some companies opt for a less expensive route and purchase materials from consulting firms to launch an internal audit.

The workshop was coordinated by William L. Granahan, senior consultant with Milliman & Robertson Inc. in Wakefield, Mass. **BI**

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Opinions



For clean, modest reform

CONGRESS IS AT LAST within striking distance of passing modest—but still meaningful—health care legislation.

Last week, the Senate joined the House and approved a bill to curb pre-existing condition exclusions.

As we have said many times before, such exclusions are a disgrace. If coverage doesn't apply to all individuals' medical problems, what is the value of that coverage?

The legislation would be a boon to employees—who could change jobs without fear of losing health insurance—and we don't think it would hurt employers. That is because if all health plans have to abide by the same rules, the cost impact should be minimal.

However, this reform could be held up by extraneous provisions, mainly in the House bill. The House bill, for example, also would give tax-favored status to medical savings accounts.

We are ambivalent about the value of MSAs. On the one hand, MSAs—coupled with a high-deductible health policy—could make employees more careful about using low-end medical services, or so MSA supporters contend.

On the other hand, critics argue that MSAs would mostly attract younger, healthier and wealthier employees, driving up the cost of employers' other health plans.

We don't know which group is right and, therefore, believe that such issues should be debated in separate legislation, rather than be attached to the measure to curb

pre-existing condition exclusions. Our advice to legislators: Remove the MSA provision from the bill.

Similarly, House and Senate negotiators should also remove a provision in the House bill that would transfer to the U.S. Department of Labor from the states the authority to regulated self-funded multiple employer welfare arrangements. Frankly, we don't think the Labor Department has the resources to regulate MEWAs, special vehicles to provide health coverage to small employers.

The Senate bill is not without its potential shortcomings, either. Our concern centers on a requirement that health plan sponsors provide the same benefits for mental health care as they do for other conditions.

What would be the ramifications of such a change? Would mental health benefits be abused? Would employers cut back on other benefits to pay for upgrading mental health coverage? These are important issues and ones that Congress has not even begun to look at. Certainly, these issues should be carefully examined before—not after—the law is changed.

We hope congressional negotiators strip such controversial and potentially damaging amendments from the bills and craft a measure that will make the modest change originally intended: limit pre-existing condition exclusions. If they stick to that strategy, an important and long overdue reform can at last be passed and signed into law.

Letters

Clinton's blind spot on product liability veto

To the editor: Late last month, President Clinton delivered a major blow to risk managers, small businesses and ordinary consumers and workers when he locked arms with the rich personal injury lawyers and announced he would veto the "Common Sense Product Liability Legal Reform Act of 1996."

Congress went ahead and approved the measure anyway, with votes coming from Republicans and Democrats. There are several reasons that the president should reconsider his decision to sin-

gle-handedly kill this bill.

First, what the president has pledged to veto is an exceptionally modest bill, nearly two decades in the making, that will reduce legal costs, encourage workplace safety and open courthouse doors to claimants. When he uncaps his veto pen, the president will be rightfully portrayed as the chief defender of a status quo that benefits only the personal injury lawyers.

President Clinton is also dangerously exposed to charges of "flip-flopping" on this issue. As governor of Arkansas, Mr. Clinton was part of a National Governors' Assn. that voted unanimously to support federal product liability reform. And just last year, President Clinton said, "The administration supports the enactment of limited, but meaningful, product liability reform at the federal level."

The president's biggest mistake in this is to be caving in to the monied, powerful personal injury lawyers for purely political reasons. Actually, were he to

deliver to America's small businesses, consumers and workers this "limited, but meaningful, product liability reform at the federal level," the president likely would benefit in some key, politically marginal states without suffering one bit at the hands of his elite trial lawyer allies. Where, after all, does he think they're going in 1996?

The public is tired of status quo, offended by public officials who say one thing and do another, and mistrustful of a national administration seemingly captured by a wealthy, politically powerful special interest. A Clinton veto of the product liability bill exposes the president on all three fronts. Instead, he should sign the measure into law and accept the public's applause for doing so.

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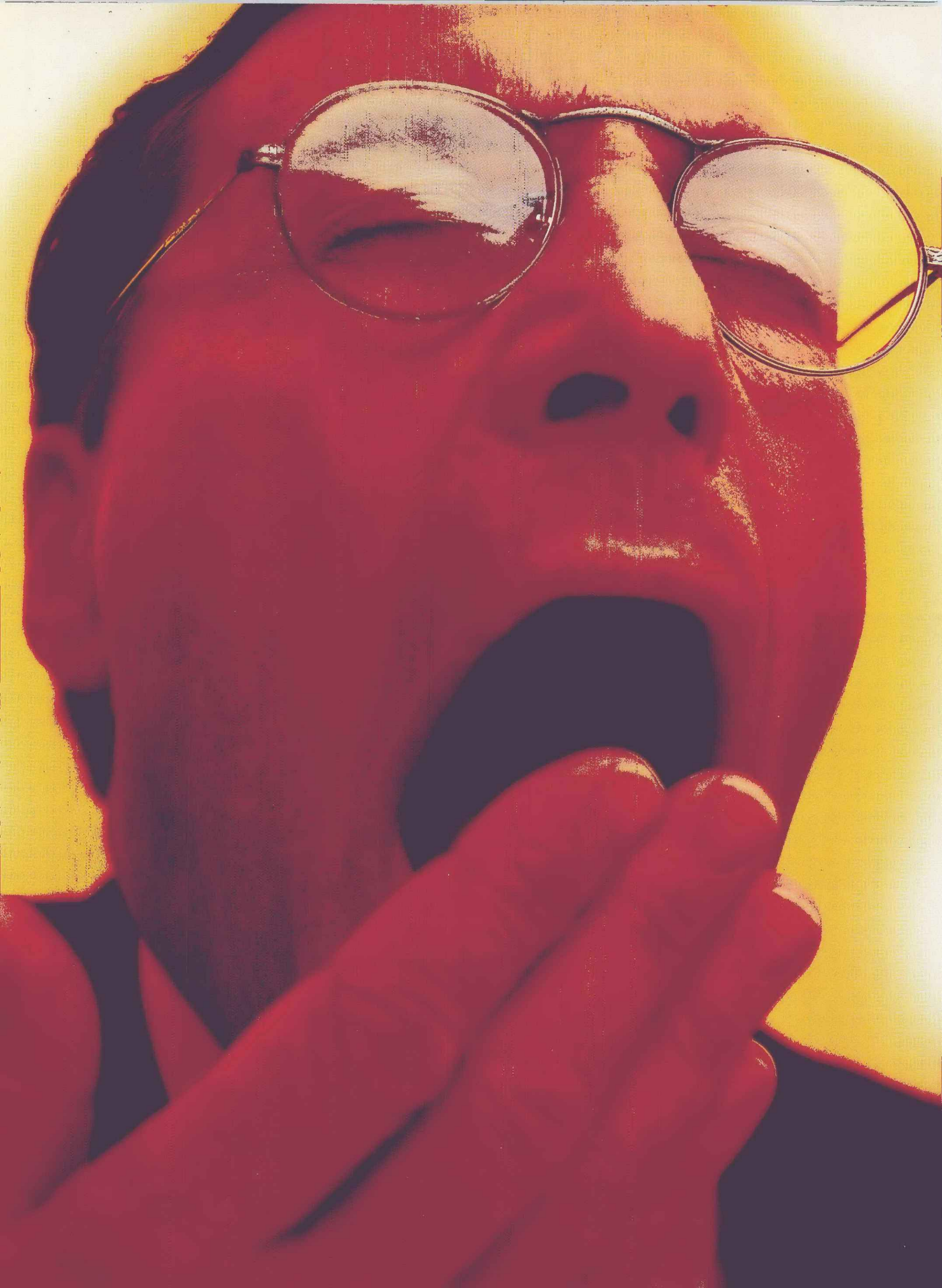
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A targeted message helps cut comp costs

By **RODD ZOLKOS**

TORONTO—No matter how hard they've worked to reduce workers compensation costs, risk managers can't completely crack the workers comp cost problem unless they educate top managers, line supervisors and employees in language that hits home to each group.

"I have quickly learned that risk managers are marketing professionals," said Catherine D. Bennett, a consultant with Cost Control Concepts Inc. in Madison, Tenn. And, given the misconceptions about workers comp at all levels in business, "the better we can educate the people throughout our organization—the managers, the supervisors, the employees—the better and the more cost-effective our programs can be," she said.

Ms. Bennett offered her thoughts on educating management and employees on workers comp as coordinator and speaker on a panel last week at the annual Risk & Insurance Management Society Inc. conference.

When Lake Buena Vista, Fla.-based Walt Disney World Co. embarked on an aggressive health and safety awareness program in 1992, one of the first things risk manage-

ment focused on was "dispelling the myth that there was nothing we could do about our workers comp costs," said Jeanette L. Minor, director of risk management services for the Florida properties of Walt Disney Co.

do to get them interested is a cost-allocation system," said Terry L. Varner, director of risk management at Perkins and the session's moderator. The company implemented its cost-allocation program in 1989. Individual restaurant managers "do a lot of whining, but our president is committed to it," Mr. Varner said.

At Disney Florida, area management is asked to call an injured worker within 24 hours of the injury to show concern and make ongoing follow-up calls. "If they know you care, if they know you want them back, you're not going to drive them to an attorney," Ms. Minor said.

Workers comp adjusters make presentations to area managers to give them a better understanding of the system, and adjusters partner with each area to help identify light-duty

opportunities in their own areas. Adjusters also attend staff meetings to provide updates on injured workers and review trend data.

Educating employees might be most important because "if we don't educate our employees about the work comp system, someone else will," Ms. Bennett said. "And in many cases those parties are simply misleading and misinforming."

Workers should be told the purposes of workers comp, and the company should communicate care and concern and explain benefit entitlements to the employees. The education also should walk employees through the workers comp claims process, and the company should explain the return-to-work program to them before an injury occurs.

"Don't hesitate to communicate

that you will take a tough stance with respect to fraudulent claims."

Companies need to be creative in their workers comp communications with workers, Ms. Bennett said, but some useful tools include brochures, posters, safety committees, newsletters, telephone information numbers, payroll stuffers, incentive programs and games, e-mail and wallet cards.

If needed, employers must meet the needs of non-English-speaking workers in those materials. "Put together great brochures and posters, just make sure language isn't an issue," Ms. Bennett said.

At Disney Florida, workers with non-emergency injuries are required to report to an onsite first-aid station where they are given a pamphlet answering frequently asked workers comp questions. Workers also are given return-to-work information and a phone number to call for a message explaining their workers comp benefits. **■**



ment focused on was "dispelling the myth that there was nothing we could do about our workers comp costs," said Jeanette L. Minor, director of risk management services for the Florida properties of Walt Disney Co.

Disney Florida risk management also emphasized educating management on the cost containment opportunities of an aggressive return-to-work program and accountability through providing injury frequency rates and details directly to local management and by allocating the ultimate loss dollars to those operations. Disney Florida's program has reduced lost-time frequency rates 42% in the last three years and the company still is experiencing a downward trend.

"Employees see the workers compensation program exactly as their boss wants them to see it," Ms. Bennett said. "And sometimes that's a hard sell to senior management."

In talking to senior management, the risk manager should equate loss costs to revenue or production costs, numbers that senior managers understand, she said, along with explaining the hidden costs of workers comp such as reduced productivity during lengthy worker absences.

"Senior management also needs to have an overview of the work comp system. They must understand the purpose of workers comp," the consultant said, adding that risk managers also should "humanize" the subject for them by walking them through the claims process with concrete examples.

Senior management must understand its roles and responsibilities in the workers comp program, must promote the program throughout the organization and must create an environment in which managers are held accountable for their operations' workplace injury performance.

To drive home the workers comp cost message to supervisors, risk managers should show how the problem hits supervisors directly in terms of the ability to make new

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Boston comp manager saved city \$1 million

By ROBERTO CENICEROS

TORONTO—Until recently, The City of Boston's Workers' Compensation Department did little or nothing to reduce claims and their costs.

Disability benefits continued to be mailed to one employee, thought to be merely disabled, two years after the employee had died. Another received payments for her diabetes medication for nearly 10 years even though her work-related injury was a back strain, recalled Patricia A. Morey Walker, workers compensation agent for the city.

"(The department) was literally a black hole," Ms. Morey Walker said last week during a session titled "Going Our Way? A Self-Insured Work Comp Program on the

Union was big obstacle in campaign to reform a 'black hole' claims office

Right Track" at the annual Risk & Insurance Management Society Inc. conference.

"An employee would fill out a claim and go to the comp office and drop off the claim and it would disappear into this black hole forever. No one understood what comp was, and no one understood what the office did," Ms. Morey Walker explained.

In 1994, Boston Mayor Thomas Menino appointed Ms. Morey Walker to head the workers comp department. Since her appointment, she has restructured the department. Expected savings in 1996: \$1 million.

Ms. Morey Walker also consulted to the department prior to her employment there.

The Workers' Compensation Department is responsible for a self-insured, self-administered program for 15,000 employees, which excludes uniformed police and fire personnel.

The department has recently installed new computer systems to track claims, and has launched early intervention, case management and modified work programs.

The efforts are paying off. In its first two years, the return-to-work program has increased pro-

ductivity, reduced spending on overtime and substitute workers and has won praise from workers compensation judges, said Ms. Morey Walker.

How did she handle Boston's union? asked a workers compensation manager who was in the audience.

Ms. Morey Walker said her plan was to try to convince union leaders and employees that it was better for workers to participate in a modified-work program, returning to perform part of their original duties for 100% of their salary and benefits than to collect workers comp benefits. Under Massachusetts law, benefits can be as high as 60% of average weekly salary.

She found an opportunity to set her plan in motion when a custo-

dian called her department, saying he was out with an injury, but wanted to come back to work.

But the union opposed Ms. Morey Walker and her plans.

"Initially they filed every grievance in the book against me," Ms. Morey Walker said. "They wanted to bring me to court. They slandered me in their custodian newsletter. I actually got threats on my answering machine. It was really nasty."

But she was persistent, she said, and kept meeting with union leaders, telling them, "Look, the reason I'm doing this is because your membership wants it," she explained.

"And then I did a little networking with the membership outside the union and sure enough the membership got to the leadership and they started to buy into it more."

The strategy appears to be working. She recently received a telephone call from one union leader asking for help with "his" return-to-work program. But letting him take credit for the program is OK with her as long as workers comp costs come down,

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she said. "It really has been a success story with them and they are one difficult group to deal with," she said.

Ms. Morey Walker restructured the department by splitting it into four units, one for initial action on a claim, one for medical case management, a legal unit and one for non-medical case management.

Under the old system adjusters handled all claims from beginning to end. But that tested their ability in too many diverse areas such as legal case management and early intervention, she said.

She hired a consultant to help train the city's adjusters, making them the backbone of the operation.

They learned how to treat injured employees well early on, so the workers don't become cynical about the city's role, she said. An employee who feels it is them against the city is more likely to stay away from work.

But an adjuster must also balance care and sympathy with sternness and conviction.

"We want (the adjusters) to be fair and aggressive and not passive or abrasive," she said. "We wanted to teach them to treat the employees that are injured with respect. However, if the employees are going to mess with us then we are going to mess with them. You have to understand we are paying people with tax payer money and we are not going to let these employees walk all over us. It is a tough balance to have (adjusters) understand that they need to be tough and they need to follow (some) people closely."

Ms. Morey Walker was coordinator and moderator of the session.

She was joined by Loredana DeVardo, utilization review nurse supervisor for Boston and Tack Fu, network consultant for AT Data Inc. in Brighton, Mass., and Nancy Segreve, field service representative for CRA Managed Care Inc. in Newton, Mass. Both Mr. Fu and Ms. Segreve consult for Ms. Morey Walker's department.

Addressing AIDS at work

By SALLY ROBERTS

TORONTO—Not only is AIDS now the leading cause of death among people age 25 to 44 in the United States, it is also one of the fastest-growing areas of employment discrimination lawsuits.

Whether it is compassion, cost or compliance, employers must address the issue of AIDS in the workplace to dispel fears and misconceptions employees have about it, which in turn will reduce the number of discrimination claims and possibly save lives, two experts agree.

The statistics are alarming.

According to the Centers for Disease Control and Prevention, one in 250 people in North America is infected with human immunodeficiency virus, which causes AIDS. In

Written policies, educating workers vital, experts say

employment terms, on average at least one worker is or has been infected at one in 10 of the very smallest companies (those with fewer than 500 employees) and at two-thirds of the very largest companies (those with more than 2,500 employees).

No workforce or population is risk-free, said Eileen M. Oswald, senior vp for the health care risk management division of Near North Insurance Brokerage Inc. in Chicago.

"It's a bottom line issue and an issue of compassion," said Angie Hammock, director of two CDC programs, Business Responds to AIDS

and Labor Responds to AIDS, in Atlanta.

During a session at the annual Risk & Insurance Management Society Inc. conference last week, Ms. Oswald and Ms. Hammock addressed workplace educational programs as well as the responsibilities employers have under the Americans with Disabilities Act and standards set by the Occupational Safety and Health Administration.

If employers think their workforce understands HIV and AIDS, they are wrong, Ms. Hammock said. One in seven people in the labor force admit knowing little to nothing about AIDS, she said, citing a national CDC survey. And one in 12 managers admitted to knowing little or nothing about HIV or AIDS.

"While these people seem to know

how AIDS is transmitted, they clearly do not understand how it is not," she said. The CDC survey found many people still incorrectly think it can be transmitted through casual contact, bathrooms and mosquitoes. "There is where you find the fear and resulting discrimination issues," and the lawsuits, she said.

In part to combat increasing legal costs, Ms. Hammock recommends employers implement a five-prong HIV educational program.

The program starts with a written policy that defines company practices related to infected employees.

Many companies have an informal or unwritten corporate philosophy on HIV and AIDS, but "with all the litigation, businesses cannot afford that luxury anymore," she said.

The written policy needs to address such issues as benefits, medical facts associated with transmission of the disease, first aid and infection control procedures, expected em-

ployee reactions to infected co-workers, methods for preventing discrimination, as well as maintaining confidentiality for HIV-positive or AIDS-diagnosed employees.

After the written workplace policy is in place, employers need to train supervisors on the policy, Ms. Hammock advises. Then supervisors need to teach employees how to prevent HIV transmission in the workplace, she said.

For instance, employers should not wait until after the first spill of blood or other bodily fluids to provide and educate employees on personal protection equipment, such as gloves, masks and mouth guards, as well as to educate employees about where the first aids kits and cleaning materials are located, Ms. Oswald of Near North said. Employers need to "treat every body fluid spill as a potential AIDS exposure."

Employers also need to take an active role in community service and volunteerism to promote HIV and AIDS awareness, she said.

"People learn more by doing," she said. "If employees are participating, they are less likely to be fearful and have less understanding of AIDS."

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workplace HIV program is voluntary, employers with employees who could "reasonably anticipate" contact with blood or body fluids are required to comply with OSHA's bloodborne pathogens standards, which were implemented in 1992.

Employers are required to have written exposure control plans that cover first aid, precautions and treatment for bodily fluid spills, Ms. Oswald said. Employers not only are required to provide personal protective equipment, but they also must provide a written schedule for cleaning in case blood is spilled while in the workplace, she said.

Employers also are required explain these requirements to workers annually, she said.

Many employers violate those rules. Between March 1, 1994, and June 1, 1995, OSHA cited 1,381 employers for not having an exposure control plan in place and about 1,180 for failing to provide information to employees.

Not only do employers have to comply with OSHA standards, but they have to obey the ADA as well.

As of June 1992, individuals diagnosed with AIDS-related conditions are among those "qualified" applicants or employees for whom the disabilities law requires employers to make "reasonable accommodations."

People infected with HIV and AIDS are considered qualified under the ADA because they are living and working longer, Ms. Oswald said. According to the CDC, for example, for 50% of the people with HIV, it will take 10 years to develop AIDS.

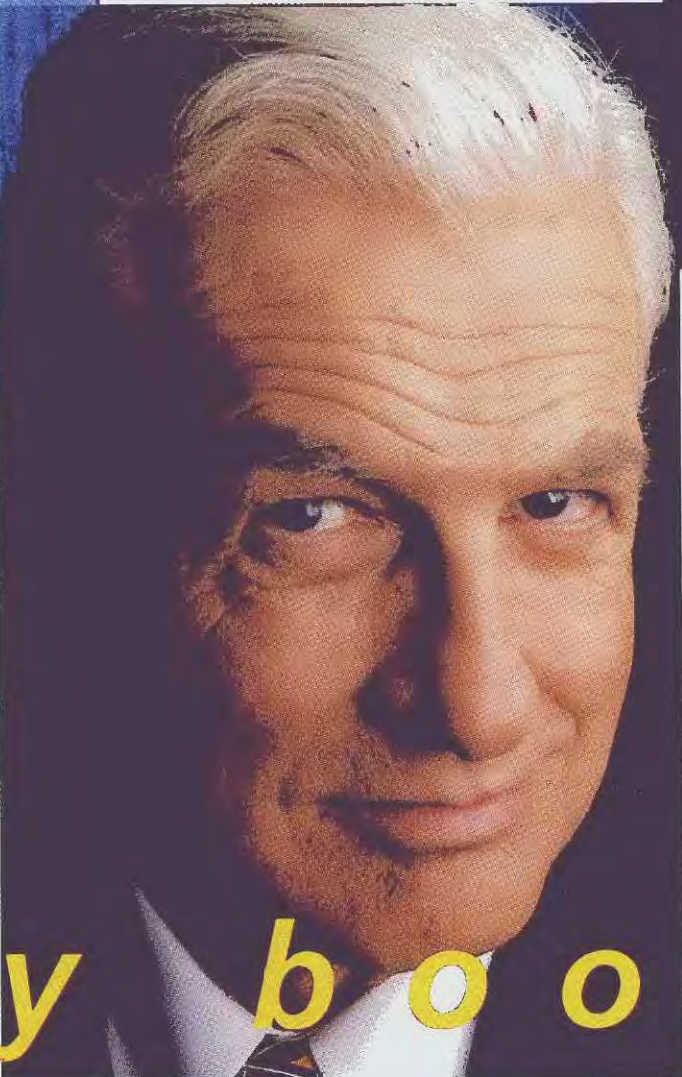
"Clearly this is an issue of reasonable accommodation," Ms. Oswald said. While there are not many jobs that a person diagnosed with AIDS will be precluded from performing, "if there is, reasonable accommodations must be made," she said. These accommodations can include making workplaces more accessible or changing schedules.

For more information on HIV and AIDS in the workplace, call the CDC at 800-458-5231.

Glenn Klinksiek, director of risk management at the University of Chicago, moderated the session. Elizabeth Simor, a vp at Near North, was coordinator.



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Behavior modification at work

Improving safety starts with analyzing activities, attitudes

By MARK A. HOFMANN

TORONTO—Risk managers who follow a philosophy of behavior-based safety will almost certainly be rewarded with a better accident record.

"We typically wait for an accident to happen," said Garnett L. Payne, a senior consultant with Behavior Science Technology Inc. an Ojai, Calif.-based consultant.

By observing and correcting the behaviors that cause workplace accidents, companies can deal with some of these losses before they even happen, Ms. Payne said.

She stressed that behavior-based safety works as a process rather than as a program. It is an ongoing effort

that builds credibility, requires more work on the part of the people involved with it and yields long-term results. Behavior-based safety requires operational definitions, which describe the behavior that must be measured. This requires observation of the behavior and creation of some sort of mechanism to put the data gathered to use.

"To be successful, you have to add a fourth component," which is a mechanism to get workers involved in the effort, she said. "The hourly folks really become the key. They have a lot to gain from the process and a lot to give to it," she said.

In the behavior-based safety process, an observer, usually a worker armed with the definitions, records

safe and unsafe behaviors. He or she then talks to co-workers. This should be done in the open, said Ms. Payne.

In some circumstances the instant feedback can correct the behavior but in others changing the behavior requires an extended period of time.

Ms. Payne said that behavior is simply an "observable act." For those who might not like using the word "behavior," she suggested that the process might be called an activities-based approach.

But regardless of the name used, the process requires identifying at-risk behaviors and correcting them.

Ms. Payne illustrated the concept of a critical behaviors inventory with a slide that showed a worker using a rod to clear a plugged line. Caustic

substance sprayed on the employee's face when the line suddenly cleared, causing an injury. Ms. Payne asked her audience to look at the slide and describe the at-risk behaviors.

Her audience pointed out that the worker had no face shield, no gloves and no protective clothing. No one had fully closed the cutoff valve in the illustration, there were no precaution or warning signs in the area and one observer questioned whether the worker needed to have his face so close to the pipe.

Ms. Payne then asked her audience some of the corrective steps that should be taken so this accident would not recur. As might be expected, wearing eye and face protection was high on the list, as was the worker moving his face away. Other responses included depressurizing the line before allowing anyone to clear it and using a tool designed and approved for clearing a line.

But behavior is more complex

than simply identifying the "what," that portion of behavior that can be observed. Risk managers also have to identify the "why," said Ms. Payne.

Attitudes learned from experience—and habits—serve as internal guides for individual behavior.

Organizational culture serves as behaviors external guide. Organizational culture is hard to change and can have a somewhat insidious impact.

"When you get used to a culture, you just don't see the risks anymore," she said.

Therefore it is key to get people talking about risky behavior, because that's the only way to change the culture. This means that hourly

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and management people alike should be involved.

Ms. Payne offered what she called an "A-B-C Analysis" to further explain behavior-based safety. In this framework, "A" stands for antecedent, which is anything that triggers behavior. "B" is behavior, which is an observable act. "C" is consequence, or anything that directly follows from the behavior.

"Antecedents influence behavior to the extent they accurately predict consequences," said Ms. Payne.

"Yesterday's consequences are today's antecedents," she added. Someone who got away breaking the speed limit without getting caught yesterday could be tempted to do the same today.

Consequences in turn depend on three factors: timing, consistency and significance. A consequence experienced soon after an act is more powerful than a delayed consequence. A consequence that is certain as the result of an act is more powerful than one that is not. Both positive and negative significances are equally powerful, she said.

Ms. Payne also pointed out a series of barriers to continuous safety improvement. One was a system of rewards and recognitions that might reward at-risk behavior. For example, rewards for perfect attendance encourage people to stay on the job when they are sick and thus more prone to accidents. Some management systems bound in red tape hamper correction of problems.

Poorly maintained equipment can cause loss, as can production pressures that lead workers to take short cuts. Personal choices, such as the choice to forgo wearing a safety mask because it is uncomfortable or inconvenient leads to problems. This type of personal choice is particularly receptive to peer-to-peer feedback, she said.

Ms. Payne said that BST's data collection has shown that the longer a behavior-based safety approach has been in place, the greater the results.

For example, a BST study showed that 11 companies that had their processes in place for four years experienced a 54% reduction in the rate of reportable injuries over the period. Companies in the top 20% of the category experienced more than 80% reduction, she said. Even companies that had only engaged in the process for a year experienced a 34% reduction in the rate of reportable injuries, she said.

Moderating the session was Jayan S. Panikkar, claims manager of the Canadian Universities Reciprocal Insurance Exchange in Oakville, Ontario. Theodore Hidley, conference coordinator for BST, coordinated the session. **BI**



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Import Canada's health system?

Wouldn't work for a variety of reasons: Experts

By MICHAEL SCHACHNER

TORONTO—The virtues of the Canadian health care system—universal access, a single payer and moderate costs as a percentage of the gross national product—make it seem like the perfect model for changing the U.S. health care system.

But is it a practical model? Health care experts in both countries say it is not. "Is it a model? Potentially. But only if people in the U.S. were more like Canadians. So in reality, it's not," said Dr. Michael R. McGarvey, senior vp-health industry services with Blue Cross Blue Shield of New Jersey in Newark. "Americans hate taxes and they want choices, and universal access isn't the issue it is in Canada."

As tantalizing as it might sound to U.S. employers and individuals to have one health care system for all Americans, with all basic medical bills paid by one source and more than 75% of funding coming from the government, stark cultural differences between the United States and Canada make a single-payer system

Cultural differences and different opinions about the right to health care are also major factors preventing a single-payer, universal system. In addition, demographic changes that the United States is experiencing are not being felt to the same degree in Canada, said Dr. McGarvey.

He noted the U.S. population will reach 300 million by 2010, and much of that growth is being spurred by immigration. With such growth, it would be impossible to maintain current moderate health care inflation and ensure universal access, a tenet of the Canadian system.

Another difference involves managed care. With managed care growing in the United States, it is beginning to move northward across the

border into Canada, where the federal government in Ottawa as well as the 10 provincial governments are seeking ways to maintain a system that Canadians view as invaluable.

"We are beginning to integrate managed care into our system and that has been borrowed from the U.S.," said Mr. Allen. But heavily managed care will never be as necessary in Canada as it has become in the United States.

"We are far less reliant on expensive technology here. In 1994, there were 3,000 MRI units in the U.S., compared with only 28 in Canada. That's 11 per million versus about one. That's called effective utilization of resources and that's what we do to maintain our system," he said.

Greater efficiency is also seen in the Canadian doctor's office, Dr. McGarvey said.

"About 43% of a doctor's income in the U.S. goes to overhead, while in Canada, it's about 16%." As a result, physicians in Canada have the same take home pay as their U.S. counterparts, though lower gross incomes.

When it's all spelled out and the dollars are compared, the Canadian system comes out as the more efficient and cost-effective system. Even long-standing criticism that patients have to wait for services and doctors are underpaid have subsided, said Mr. Allen.

So, why shouldn't the United States adopt Canada's system?

Mr. Allen quoted Robert Evans, a scholar at the Center for Health Services and Policy Research at the University of British Columbia, in giving his answer: "Nations do not borrow other nation's institutions.

The Canadian system would not fit because you do not see the world, or the individual or the state as we do. The point is that by examining others' experiences you can extend your range of perceptions of what is possible."

For his part, Dr. McGarvey said the reason is simple. Canada's system relies heavily on tax dollars. And, in Canada, talk is growing that for the system to remain as is, tax revenues must be increased.

Mr. Allen said, "We must use current resources more effectively, build on our strengths, especially administration and ration existing care, if necessary. The one thing we can't do away with ever is universal access."

The session was moderated by Sanford Bragman, vp-risk management with Tenet Healthcare Corp. in Dallas. David Maslen, managing director with Alexander Consulting Group in Newburyport, Mass., coordinated the session. **BI**



based on the Canadian model ill-suited for the United States.

"The rational argument is that our system is a model because it's very efficient and Canadians love it," said Simon R. Allen, a senior consultant with Alexander Consulting Group Ltd. in Toronto. "The New England Journal of Medicine estimates that we're at least 25% more efficient than the U.S. But the U.S. can't get to a single administrative system. You can't impose the Canadian system on 270 million people."

Last week at the annual Risk & Insurance Management Society Inc. conference, Mr. Allen and Dr. McGarvey completed another chapter in the ongoing debate over whether Canada's single-payer health care system is ripe for export to the United States. Canada's system covers virtually every basic health service for all Canadians at a cost of about 9.7% of GNP. The fragmented U.S. system doesn't even reach about 39 million people, but still consumes about 14.3% of the American GNP.

And, like many discussions held on this topic over the past few years, the conclusion reached by the two health care experts is that despite all of their similarities, the cultural differences between the United States and Canada are too great for there to be identical health care systems.

"Health care systems generally reflect the structure and style of the communities they serve. Canadians are very proud of their system and 85% believe it's either good or excellent, and they would never want a U.S.-type of health care system. But we're 29 million people in total, which is less than California by itself. We have about seven people living in each square mile of Canada. In the U.S., it's about 77 people per square mile," said Mr. Allen.

Reasons like those are why, despite the attractiveness of the idea, the United States is unlikely to replace its system with one that raises taxes to pay for 100% of hospital and physician care and a percentage of prescription drug costs.

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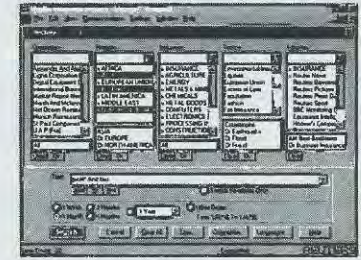
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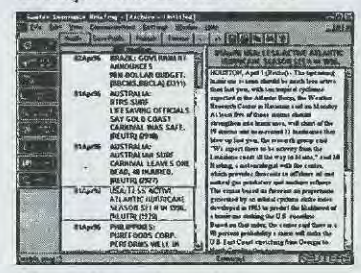
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MICHAEL A. MARCOTTE

The Risk & Insurance Management Society Inc. took advantage of the chance to introduce thirsty risk managers to its online services.

Technology

Continued from page 3
up technologically, he added. "In order for all of us to reap the benefits of technology, we must advance together."

RIMS is trying to make sure that risk managers keep up with technology, Mr. Drapeau said.

The group "identified some time ago that our members have much to gain not only from our service providers but each other," he noted. "Through RIMSNET, our proprietary computer network, risk managers have a service plaza on the information superhighway. Now, with amazing ease and accuracy, we have the ability at our fingertips to communicate with an almost unlimited

number of people around the globe instantly. This is not the future. This is today."

RIMSNET is now accessible via the group's home page by members with passwords, said Anne Weathersby, executive vp of Information Inc., a Bethesda, Md., Web site development firm that worked on the RIMS site (<http://www.rims.org>).

Also available on RIMSNET are a daily news service, legislative updates and information about RIMS and other aspects of risk management. The service also provides e-mail links to other subscribers.

While emphasizing the role of technology, Mr. Drapeau says he will not ignore old-fashioned methods of communicating.

"Technology will play an increasingly important part in effective

communications, but it's only one part," he said.

"One of the building blocks and greatest strengths of RIMS is its chapters," he remarked. By showcasing their accomplishments in the Chapter Recognition Awards (see story, page 22), the group tries to communicate to all chapters the most effective ways to attract new members and serve existing ones.

"Why should one chapter have to reinvent the wheel if another chapter has already done it and learned some valuable lessons in the process?" Mr. Drapeau asked. "In the coming year we will continue to focus on communications at the chapter level."

RIMS membership has been declining for years, but keeping the decreases small is actually something of an achievement in a business world marked by consolidation and layoffs, said William J. Kelly, outgoing RIMS president and senior vp at J.P. Morgan & Co. Inc. in New York.

In his State of the Society address at the membership meeting, he said RIMS is hard at work to recruit new members. "We continue to work to increase the strength and number of chapters. This year we have conducted membership drives in Newfoundland, Ohio and Nevada."

The group's 91st active chapter, was just formed on New York's Long Island. A chapter in Alaska is being reactivated, and Mr. Kelly said he hopes one in Puerto Rico will reactivate.

The society also is seeking to increase its ranks through its middle market initiative, a program designed for officials at small companies and whose responsibilities include risk management.

A session in Naples, Fla., drew 20 guests, and eight other chapters have scheduled the course, according to Mr. Kelly. "I believe momentum has now clearly been established and we have an excellent opportunity to increase membership."

On another front, RIMS is taking a higher profile in the mainstream press, said Mr. Kelly, citing its annual cost of risk survey produced with the Tillinghast division of Towers Perrin. "This survey was reported in over 40 newspapers across the country, including the Wall Street Journal, the Los Angeles Times and the Washington Post," he said.

While membership numbers slip, other figures are encouraging.

Financially, 1995 was a record year. Net income rose to about \$800,000 from \$191,000 in 1994, and the balance in RIMS' general fund is about \$3.5 million, up from \$2.7 a year earlier. The society's annual budget was \$9.2 million.

"In addition to a favorable investment climate, our record earnings also result from a very successful conference in San Francisco and a better-than-expected return from the Monte Carlo risk management forum," Mr. Kelly said.

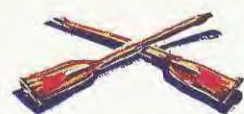
Although Mr. Kelly proclaimed the "state of the society is excellent," he also warned that it can be dangerous to become complacent in a dynamic business world.

Therefore, RIMS is reviewing its bylaws to make sure it is in step with the rest of the professional world. "This review may present us with opportunities to consider how we might recognize some of the changing realities within the larger professional community," he said.

"It has been a year of record earnings, record participation in professional development courses and of groundbreaking new initiatives," said Mr. Kelly. "But most importantly it has been a year in which we have remained focused on the quality of the services provided to all our members while at the same time taking unprecedented action to assert RIMS' leadership role. **BI**

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Goodell award to Smirles

By MICHAEL BRADFORD

TORONTO—James W. Smirles, national brokerage marketing officer for Kemper National Insurance Cos., is the recipient of this year's Dorothy and Harry Goodell Award, the Risk & Insurance Management Society Inc.'s most prestigious honor.

Mr. Smirles accepted the award last week at the annual RIMS conference.

"I'm totally surprised, shocked and honored by this," said Mr. Smirles. He called it the proudest day of a career that began as a Kemper safety engineer in 1952.

He has been an instructor for RIMS' "Techniques of Loss Control" course, and has been on the exhibitors advisory committee and the Spencer Educational Foundation

Inc. board of directors. He has also been a leader in safety organizations such as the Public Employee Section of the National Safety Council and the American Society of Safety Engineers.

Mr. Smirles also is active in his community, having spent 20 years on the village board of Glenview, Ill., eight of them as mayor.

"I've come to know Jim through his involvement in the exhibits advisory board, which he helped found, and the Spencer Educational Foundation," said Louis J. Drapeau, who took over this year as RIMS president. "For many, many years he has been a dedicated supporter of RIMS and a congenial host of Spencer Foundation activities."

The award was established by former RIMS President Harry Goodell

in 1978 to recognize outstanding achievements in advancing the goals of risk management and the group.

It was Mr. Smirles' second trip to the podium. Earlier in the meeting, Kemper was awarded the RIMS Executive Director's Award to Industry. Mr. Smirles and Mark O'Brien, vp of risk management services at Kemper, accepted that award, which is given annually to a company that works closely with RIMS to help foster the risk management profession.

Kemper was cited by RIMS Executive Director Eugene Ricci as "being in the vanguard of companies that have consistently supported us." He said the insurer has "actively taken part in programs to enhance the effectiveness of the risk manager's function."

RIMS presented its Cristy Award

to Timothy W. East, manager of risk management business process at The Walt Disney Co. in Burbank, Calif.

The annual award is presented to the risk manager with the highest cumulative average in the three exams required for the Associate in Risk Management designation. It is named for Jim Cristy, a former vp-education of RIMS, who was instrumental in encouraging the Insurance Institute of America to develop the ARM program in the 1960s.

Denise Hamilton of Shell Canada Ltd. was awarded the Fred H. Bossons Award for scoring the highest average in courses required for Canada's Certificate in Risk Management Designation. The award was presented at last fall's Canadian Risk Management Conference in Vancouver, British Columbia.

The RIMS San Diego chapter grabbed honors in all five categories of the Chapter Recognition Program.

Among chapters of its size—those

with 26 to 60 members—the San Diego chapter took top honors in the categories of Outstanding Chapter Programming, Advancing the Risk Management Profession, Outstanding Member Services, Outstanding Membership Development and Overall Chapter Excellence.

The Smoky Mountain chapter grabbed top honors among small chapters—those with fewer than 25 members—in the areas of Outstanding Chapter Programming and Outstanding Member Services. The Greater Quad Cities chapter was tops in Outstanding Membership Development and Overall Chapter Excellence for small chapters.

The Houston chapter was tops among those with more than 60 members in three categories: Advancing the Risk Management Profession, Outstanding Member Services and Overall Chapter Excellence. The Atlanta chapter was tapped as best in Outstanding Chapter Programming and Los Angeles got the nod in Outstanding Membership Development.

Honorable mentions went to the Rocky Mountain chapter in Outstanding Chapter Programming and to Central Ohio in Advancing the Risk Management Profession.

A special commendation was awarded to the Canadian Risk Management Council on behalf of all Canadian chapters for their commitment to the society and their efforts in advancing the profession. **BI**

Drapeau, council elected by RIMS

TORONTO—Louis J. Drapeau officially begins his term as president of the Risk & Insurance Management Society Inc. on May 1, along with a new executive council.

Mr. Drapeau, manager-insurance and risk management at The Budd Co. in Troy, Mich., was elected along with the council members at the RIMS' annual conference last week.

Mr. Drapeau was elected to the executive council in 1991 and has been treasurer and vp of the education, business and industry liaison, conference and finance committees.

Stephen M. Wilder, vp-risk management at The Walt Disney Co. in Burbank, Calif., was elected first vp, the traditional steppingstone to the presidency. The 1990 *Business Insurance* Risk Manager of the Year was first elected to the executive council in 1993 and has been vp-education and research.

Other council members are:

- Judith M. Lindenmayer, vp-conference. She is director of risk management at Fidelity Investments Inc. in Boston.

- John R. Rath, vp-education and research. He is director of risk management and insurance for Milwaukee County, Wis.

- Susan R. Meltzer, vp-environmental. She is director-risk management and insurance for Bell Canada in Toronto.

- David R. Haight, vp-government affairs. He is director-risk management at CF Industries Inc. in Long Grove, Ill.

- Georges Balcer, vp-health and safety. He is director of risk management at Bowater Inc. in Greenville, S.C.

- Freida L. Jackson, vp-industry liaison and treasurer. She is president and risk manager of Park South Associates Inc. in Charlotte, N.C.

- Mark A. DeLillo, vp-international. He is vp-risk management services at Jim Walter Corp. in Tampa, Fla.

- Richard C. Sadler, secretary and vp-membership and chapter services. He is risk manager-worldwide sales and support at Microsoft Corp. in Redmond, Wash. **BI**

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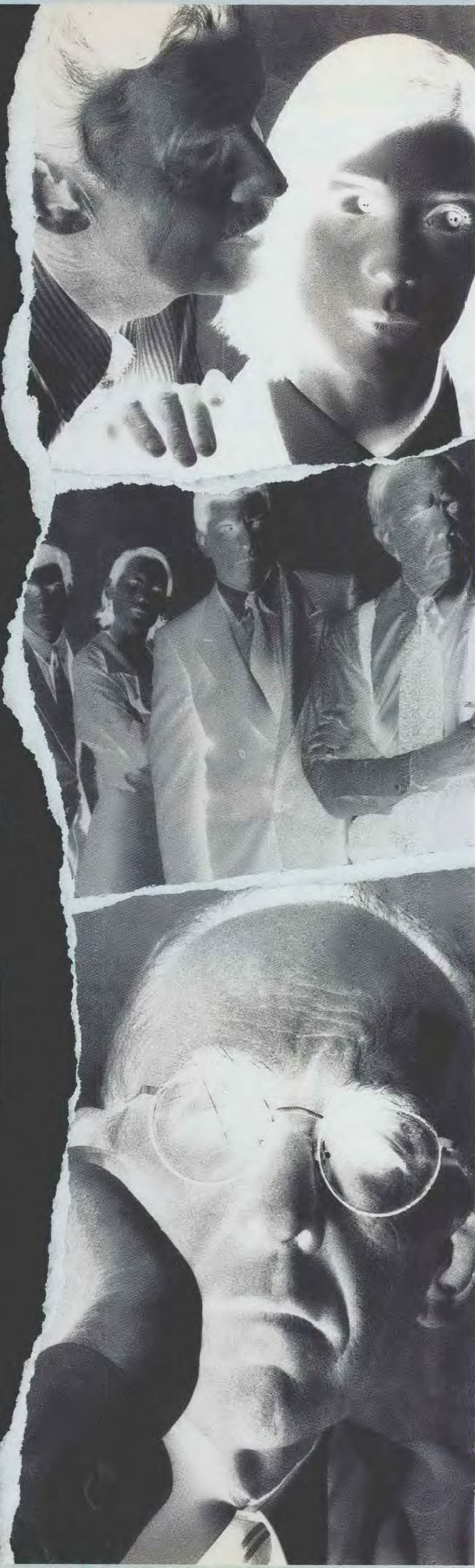
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A little creativity goes a long way in integrating comp, health plans

By ROBERT KAZEL

TORONTO—Weaving together health benefits with workers compensation programs to create a seamless, efficient fabric will be a demanding task for many companies.

But it is not impossible for those willing to buck tradition and step artfully around state-imposed barriers to create systems that work as though they are integrated.

So said a panel of experts last week in a session at the annual Risk & Insurance Management Society Inc. conference. Speakers told risk and benefit managers that they should expect little help from state governments in revamping workers comp laws to permit 24-hour coverage, in which administration of workers comp is combined with

of Chicago-based Sigma Underwriting Managers. The key, he said, is not to change state workers comp law but for the employer to design its workers comp and health benefits plans so the worker will go to the same managed care provider no matter what the cause of the illness or injury.

An immediate advantage of such a move, Mr. Bischoff said, is the elimination of double dipping at the workers comp and medical benefits troughs, a practice that has been estimated to account for at least 5% of corporate health care costs.

A few states are looking at proposals for integrating benefits, though

actual programs are rare. The exception is Portland, Ore.-based Esco Corp., a steel manufacturer that began a 24-hour coverage pilot program as part of a state-sponsored experiment beginning in 1992. The pilot, which was started with a grant from a foundation, shows that some states are attempting 24-hour coverage trials but on a modest scale and, so far, with no clear results.

Using Kaiser Permanente as an integral part of its new combined approach, Esco is finding it easier to send workers to the same provider for all types of claims and is finding case management to be superior to the old dual system, said Patricia

Bishop, supervisor of health services.

The company assesses a capitated fee for workers comp insurance based on the average of its previous five years of workers comp rates.

Four years into the pilot, the state has collected no persuasive data yet on whether 24-hour coverage is producing savings. The program "resembles" seamless care but is not fully integrated because of state restrictions on the pilot, she said.

"It's too soon to tell if there would be long-term advantages for employers or employees," she said.

And though promising and worthy of pursuit, in Canada 24-hour programs aren't wonder drugs and have not proven to be decisive in saving the national health care system money, said Rudolf Henkel, moderator of the session and director of risk management and insurance of George Weston Ltd., a Toronto food producer and distributor. Ottawa's workers comp program is about \$12

billion in debt, he said, and employers there already have integrated coverage.

Movement toward 24-hour coverage has been halting in Florida, where the state legislature has authorized two companies to engage in an integrated care pilot, said Julio Cantillo, senior vp of Sarasota-based Riscorp Managed Care Solutions Corp., a managed care service firm that is taking part in the pilot.

"In the end, we have had one delay after another in implementing this program in the state of Florida," Mr. Cantillo said. "We were supposed to be, by now, fully operational." Now the program is slated to start in May, he said.

"We've just started to crawl is where we are," Mr. Ridley said. "Oregon is ahead of the pack."

The workshop was coordinated by Lance Ferris, corporate risk manager at Zurich-American Insurance Co. in Schaumburg, Ill. **BI**

The Alexis philosophy – No. 6 in a series



health benefits or disability coverage.

A serious obstacle to any company seeking to institute such a plan is the fragmentation of legislative jurisdiction over workers comp policy, according to Robert W. Ridley, a partner in the law firm of Ridley & Farmer in Los Angeles and a specialist in integrated care issues.

State lawmakers are sensitive to any potential threat to their authority in this area. And they are especially concerned that employers might use federal legislation such as the Employment Retirement Income Security Act of 1974, or the Taft-Hartley Act, which preempts state workers comp law when collective bargaining agreements are at issue, to circumvent legislative control over workers comp programs.

Creative uses of federal law to gain power over the workers comp apparatus threaten to overturn states' well-established machinery that cannot regear to a changing marketplace, Mr. Ridley said.

"These are old, they are entrenched, the states have built a massive background of case law, bureaucracies, filing cabinets, offices, dispute resolution people, lawyers," Mr. Ridley said. "States have a great interest."

Tremendous legal difficulties exist for companies that wish to integrate health benefits with workers compensation, he said. Aside from dealing with turf politics of state legislators and regulators, state insurance codes may have to be changed before health insurance and workers comp can be combined. For example, it might be difficult to do unless co-payments and deductibles were permitted for workers comp claims—a major shift.

Still, some in the insurance industry say that a establishing a workers comp and health system that is largely integrated, efficient and cost-effective is within employers' capability—existing state laws and all.

"I'm talking about the risk manager, the employer, the business, taking into their hands the structure of their benefits within existing law, but in such a fashion as to promote integrated care for hospital care, for doctor care, for pharmaceuticals, for disability to the extent they want disability," said John R. Bischoff, vp

Syn

Introducing:

Risk manager jury is out on ADA

By ROBERTO CENICEROS

TORONTO—It was no surprise when a room packed with risk managers acting as jurors found in favor of a defendant employer during a mock trial during a session titled "The Americans with Disabilities Act Goes to Trial" last week at the annual Risk & Insurance Management Society Inc. conference.

The emotional claims of an employee in a wheelchair that he was denied restroom privacy because of inadequate arrangements for handicapped people did not convince jurors that his employer, We Don't Accommodate School District, had not met the ADA standard of "reasonable accommodation" when it modified restrooms for him.

But a typical jury might be less

Mock trial examines disabilities and employer accommodations

sympathetic to the employer, warned Dennis J. Walsh, a partner in the Los Angeles firm of Walsh & Declues. In his real practice, Mr. Walsh defends employers. But, in the mock case, he acted the part of plaintiff's attorney, representing Chris Complainer.

Lawsuits over reasonable accommodation are the most common ADA complaints employers face, Mr. Walsh explained following the presentation. To limit them, he told the session audience, employers must have a policy and a designated person in their company responsible for addressing ADA issues. Larger companies have whole committees dedi-

cated to the task.

Regardless of company size, it is best that whoever tracks compliance not be in a direct supervisory role, Mr. Walsh advised.

"It's very difficult to have the supervisor in that position" during trial, he said. "I have always recommended that anybody making a hiring or firing decision about a particular employee not be involved. Because if ultimately the case is one where the employee is fired, it is always going to raise questions about the credibility of their reasonable accommodation decision."

Plaintiff's attorneys will claim supervisors "didn't do a proper evalua-

tion. There is going to be dirt thrown on your supervisor."

Compliance checklists and reasonable accommodation forms—which document that an employer tracks ADA concerns for prospective and existing employees—are a must, he said. "You have got to document this stuff, because if the EEOC is called in to do an investigation they are going to ask for it," he said. "Just give it to them. If you are talking about good faith, the first thing you can show in good faith is that at least you wrote it down."

Such forms also must show compliance with ADA requirements.

Encouraging employee complaints is a desirable goal, Mr. Walsh added.

"As crazy as that sounds, when it comes to ADA or any form of discrimination, your procedures and

policies should be such that your people want to come forward and tell you what is wrong," he said. "Nip it in the bud now because the worst-case scenario is when I get the lawsuit and they allege it has been going on for five years and no one did anything about it. You need to have a system in place where people don't think it's a pain in the neck to deal with these issues but that they are important."

Employers also must track workers compensation claims for situations where the ADA may apply, Mr. Walsh warned. In California, workers comp attorneys will sign off on a workers comp settlement then send their clients to a civil litigation attorney to file ADA suits, he said.

"You would be amazed at how many employers don't realize that you can follow the laws of workers comp with regard to a work-related injury, and guess what? The ADA applies to certain work-related injuries. They have to be permanent. They have to be of substantial impairment of their ability to perform essential job functions. But guess what? You can follow all the laws of workers comp and violate the ADA at the same time."

As for the mock trial, Mr. Walsh was joined by John R. Rath, moderator and director of risk management and insurance for the Milwaukee County Department of Administration. He played the role of Judge Hang 'Em Harry. Roberta K. De Grandis, risk manager for the City of Los Angeles Department of Airports, played Joanne Clueless, a defendant and the principal of We Don't Accommodate School. Kevin C. Burke, vp-operations for Tristar Risk Management in Culver City, Calif., sat in

ergy

RIMS Report

Employee Benefits & Workers Comp

a wheelchair portraying the frustrated Chris Complainer, while Mia D. Farber, a senior associate in Los Angeles for Walsh & Declues, portrayed a convincing defense lawyer. Mr. Walsh coordinated the session.

The defendant argued that the school district failed to provide a special seat so that he could ride on school buses in his role as a basketball coach. "Mr. Complainer" also claimed the school had not adequately provided for his restroom needs. Several modifications to existing restrooms were problematic, forcing him to restrict his dietary intake so he would need to rely on them less, he said. At times, he had to empty a colostomy bag in trash sacks kept in his car.

The school district should not be allowed to get away with it, Mr. Complainer testified. And his attorney argued that the school had failed in attempts to improve the restrooms or even follow up by asking Mr. Complainer if they met his needs.

At the least, they bungled up this job of trying to help him, Mr. Walsh said in his closing arguments. "Every time they did something, they messed it up. Is that reasonable? That is up to you to decide. I think it is pretty clear from the evidence."

But the audience was swayed by the defense's point that it had enlarged a door in one restroom, built ramps and made modifications to other restrooms, denying the plaintiff the burden of proof that the defendant did not provide any reasonable accommodation.

The defense also noted that Mr. Complainer agreed before accepting the basketball coach position that he would drive his own car to basketball games. **EB**

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Exhibit

Continued from previous page
vices themselves," said Thomas Diffily, chief operating officer. "But, with corporate downsizing, we now work with all sizes of companies."

He said providing corporate medical direction constitutes the bulk of its health care-related work. "We have a network of medical providers for these jobs. We have five physicians that are board-certified in occupational medicine as well as 10 nurses certified in occupational nursing."

"In addition to the nursing and the corporate medical director work, we're also doing a fair amount of OSHA compliance work and a lot of drug and alcohol testing," said Mr. Diffily.

Employers with overseas workforces or executives who are constantly traveling may have been in-

terested in talking to a pair of companies that provide overseas medical assistance, transportation and referrals for local health care.

With offices in Baltimore, Beijing, and Brighton, England, MEDEX Assistance Corp. specializes in insuring employers for the cost of transporting or evacuating employees injured while on overseas business trips. While MEDEX does not cover the medical costs of an injured employee, its services can make a big difference in moving sick or injured employees to appropriate care facilities quickly, especially in undeveloped nations.

"Transportation, referral to local care and full-scale evacuation is what we do. Anything from a severe stomach ache to a broken ankle sustained while jogging is no problem," explained Joseph Stetka, an account executive with MEDEX in Timonium, Md. "We have the U.S. government contract for the Agency for

International Development, which handles a lot of developing countries and we handle about 300 to 400 cases per week overall.

"Anything from a broken tooth to swallowing a bottle cap to getting hurt in a mugging is what we see. We'll get your employee to the right hospital or doctor and if it's really bad we'll evacuate them back to the United States," Mr. Stetka said.

A competitor of MEDEX, U S Assist, a unit of Societe Francais d'Assistance of Paris, also does care referrals, transportation and evacuations, "but we also spend a lot of time on the preventive consultative side," said Leigh Miller, senior account representative. "When you talk to companies about what can happen before employees travel, it really impacts costs. The employees sustain fewer injuries."

U S Assist is getting ready to launch an overseas health insurance
See Exhibit on page 32

Sneak peak at benefits on the Net

By SALLY ROBERTS

TORONTO—Although benefit-related Internet sites are still in their infancy, a few exhibitors at the Risk & Insurance Management Society Inc. conference last week introduced risk and benefit managers to new online offerings.

A majority of the exhibitors marketing products and services specifically for benefit managers, when asked about the Internet, either said their company had an Internet site but was not exhibiting it, was in the process of constructing a home page on the World Wide Web or was not even thinking about it.

However, some large companies, like American International Group Inc., Willis Corroon Group P.L.C., Kemper National Insurance Cos. and Crawford & Co., showcased in-

dividual company home pages on large and oftentimes multiple screens. Potential customers could either "surf" individually or watch company demonstrations.

The information on the Web sites was very limited, though. Tables of contents listed product offerings, including a hypertext link—underlined or bold faced words on Web pages that users can click on to view related documents—to descriptions of the company's disability, group health or workers compensation benefit products.

Further illustrating the Internet's fledgling status in the benefit arena were various problems in the exhibit hall.

One company that was introducing a home page had nobody on hand to field questions about the home page and the company's future on the Internet.

And another company's home page was not working properly for part of a day.

Booths with up and running computers did draw the curious.

RIMS Report Employee Benefits & Workers Comp

AIG, for instance, gave a sneak peek at its Internet product, dubbed Access AIG, which won't be released until the end of this summer.

In its first release, Access AIG will be exclusively for brokers. It provides detailed product listings, electronic mail and background information about the New York-based insurance giant. Access AIG is the company's response to a survey that found brokers' No. 1 concern was difficulty in finding the right person at AIG to do business with, said William Tobin, a vp in New York with AIG's general insurance information services division.

AIG also took the time to publicize its Web site. The site—at <http://www.aig.com>—offers the same information about AIG's accident, medical and dental coverages, and workers comp coverages that is available on Access AIG, but in less detail, Mr. Tobin said.

Kemper Risk Management Services also showed off its home page on the Web.

Located at <http://www.kemper-national.com/>, it gives benefit managers access to a description of Kemper's workers comp program known as KemperCare, among other property/casualty products and services. It also lists the names and phone numbers of brokers that benefit managers can contact by state if they want further information about any of Kemper's products.

On several computers at its booth, Willis Corroon displayed its home page (<http://www.wilcor.com>), which offers risk and benefit managers a look at its products and services, including its employee benefit and workers comp products.

In addition to offering a table of contents with hypertext links to its different products and services, Crawford & Co.'s new home page also offers benefit managers a link to its eight publications, which cover topics including disability management, workers compensation and loss prevention.

At this point, however, benefit managers only can subscribe to the publications over the site, which is at <http://www.crawco.com>. ■



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AIG

Exhibit

Continued from page 30

product for companies with employees who travel frequently. "It will be medical coverage for Americans working abroad and it will be available in per trip and annual limits," Mr. Miller said, adding the coverage probably will be available within the next month or two.

One of the few RIMS regulars in recent years with benefit offerings has been CIGNA Corp.'s Intracorp unit. This year, the company was touting Smart Choices, a new plan that accompanies any managed health care plan and is designed to help people make educated choices about the care they pursue.

Sue Fazo, director of corporate communications for Intracorp, said Smart Choices, which just became available Jan. 1, provides 24-hour nursing and triage information via an 800 phone number.

"It's supposed to help employees maneuver through the health care system. It fits any program, HMOs or whatever. We hope that it will be the glue that brings our systems together," she said. To entice people to make that call, Intracorp was giving away five-minute phone cards.

One of the few pharmacy benefit management exhibitors was Managed Pharmacy Benefits Inc. of St. Louis. Despite the lack of competition, MPB still was holding a drawing for a Mont Blanc pen.

Mark Osborn, regional sales director, said the company can jointly manage workers comp and medical prescription drug plans, but group health plans remain its bread and butter.

"I know a lot of people are saying that all the waste has been squeezed out of prescription drug plans, but that really depends on where the employer is," said Mr. Osborn. "If you've already gone to heavy management, you probably have squeezed out any excess dollars. Then you need to move on to

whether what's being dispensed is right or wrong."

Mr. Osborn said MPB now has a bulletin board that clients can access on their PCs. This bulletin board tells insurers, TPAs and employers what employees in their plans are taking. "Clients aren't interested in standard reports on the groups. They prefer to know what's being dispensed and consumed individually."

For employers seeking to analyze hospital bills, Preferred Payment Systems of Naperville, Ill., was showing a system that scores hospital bills on a 10-point scale. Tom Bartlett, senior vp-corporate marketing, said large payers like the Guardian Life Insurance Co. use the system to evaluate the appropriateness of hospital bills.

The bill is scored on four criteria: total bill price and length of stay; how the price for a bill compares to the provider's historic charges; details of the hospital's financial status; and how the charge stacks up against mean charges for the same ailment.

To show passers-by how up-to-speed PPS' technology is, it played music videos at its booth featuring performers like Sade, Antonio Banderas and Ziggy Marley.

For colorful still images, rather than videos, one needed to look no further than Creative & Effective Communication Solutions' booth.

The Waterloo, Ontario-based company specializes in creating catchy, colorful informational signs for the workplace. And, while much of what the company was exhibiting related to safety in industrial workplaces, Greg Pinnington, a sales representative, said they have made many signs for companies encouraging good health and health-related safety.

"We can do signs promoting AIDS awareness and warnings about other blood-borne pathogens. Here, we're showing safety because it's primarily a risk management conference, but there's no reason why we couldn't do health care and benefits signage," he said. **BI**

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A poor forecast for fiduciaries

Wave of benefit litigation foreseen

By **RODD ZOLKOS**

TORONTO—Fiduciary liability exposures arising from employer-sponsored benefit plans are not likely to slacken in the next decade, insurance professionals say.

The phenomenon of aging Baby Boomers reaching retirement age without adequate savings, as well as a more activist stance on retirement-related issues by Congress and the U.S. Department of Labor, are cited as key factors likely to increase the risk of fiduciary liability suits.

Continuing merger and acquisi-

tions activity, a plaintiffs bar looking for new business opportunities and the increasing complexity of retirement plans further add to fiduciaries' exposure, say the members of a panel last week at the annual Risk & Insurance Management Society Inc. conference.

A 1993 Watson Wyatt Worldwide survey found 44.1% of fiduciary liability claims arose from benefit disputes. Administration error caused 10.4%, communications 8.9%, misrepresentation 5.9%, reduction in benefits 5.4%, discrimination 5.0%, plan termination 5.0% and other

causes 15.3%.

"Quite often the reason for the claim, and the exposure that arises from it is that the employee and the employer don't have the same expectations of the benefits the plan is to provide them," said Frank M. Baron, a vp with Reliance National Insurance Co. in New York.

With more employers moving to replace defined benefit plans with self-directed defined contribution plans, many retiring Baby Boomers may soon be among those who find their retirement plan doesn't live up to their expectations.

"There will probably be future litigation over investment education and investment options chosen in defined contribution plans," he said.

What's more, the lengthy bull market on Wall Street may have given some defined contribution plan participants unrealistic expectations about investment performance.

Cathy L. Cummins, a senior vp

with Minet Inc. in New York, who coordinated the session, cited Employee Benefit Research Institute statistics that support the notion many Baby Boomers don't have a clear understanding of what their defined contribution plan will provide.

EBRI statistics show that 25% of



Baby Boomers participating in defined contribution plans don't know the size of the contribution they make to those plans and 20% don't know whether the contribution is matched by their employer.

What's more, less than 50% of those who received an early distribu-

tion of benefits because of a job change or job loss rolled the funds over into their new employer's plan or an individual retirement account.

"The bull market has lulled people into forgetting the risk of securities," Mr. Baron said. "One factor to keep in mind is that 42% of today's retirement savings are in equity securities. Those will provide long-term positive results but there is some volatility in there."

The sorts of investment instruments chosen for retirement plans also will be cause for exposure, particularly with plans that sustain losses on derivative investments.

Mr. Baron noted the prudent person rule in the Employee Retirement Income Security Act sets a standard for choosing those investments, but it's a rule that is open to broad interpretation, particularly when those selections are viewed in hindsight. "Obviously there will be a difference of opinion on what is prudent, and this has led to litigation," he said.

As a result, fiduciaries must examine investment choices in terms of how they might be portrayed by someone second-guessing that choice in the future, he said.

As corporate mergers and acquisitions continue, those deals also could portend future litigation as investments made today may be second-guessed in the future by a new fiduciary of the program.

Mergers and acquisitions could increase the liability exposure of fiduciaries involved in supplemental executive retirement plans, as well.

"Essentially the supplemental retirement plan represents a promise by the employer to make a certain payment to the participant later on," Ms. Cummins said.

Supplemental plans, which are often used by employers to make up retirement income to highly paid employees whose qualified plan pensions are restricted by Internal Revenue Service regulations, are both non-qualified plans under ERISA and often not prefunded. That can cause an employee to have a hard time later making good on that earlier employer's promise, she said.

Supplemental plans can give rise to predecessor liability cases following mergers or acquisitions when the original sponsor is no longer on the scene.

"Predecessor liability is a huge exposure for the sponsors of some plans," she said. "With the increase of mergers and acquisitions, interpretations of the benefits a participant may be owed from an unfunded unqualified plan may be an issue."

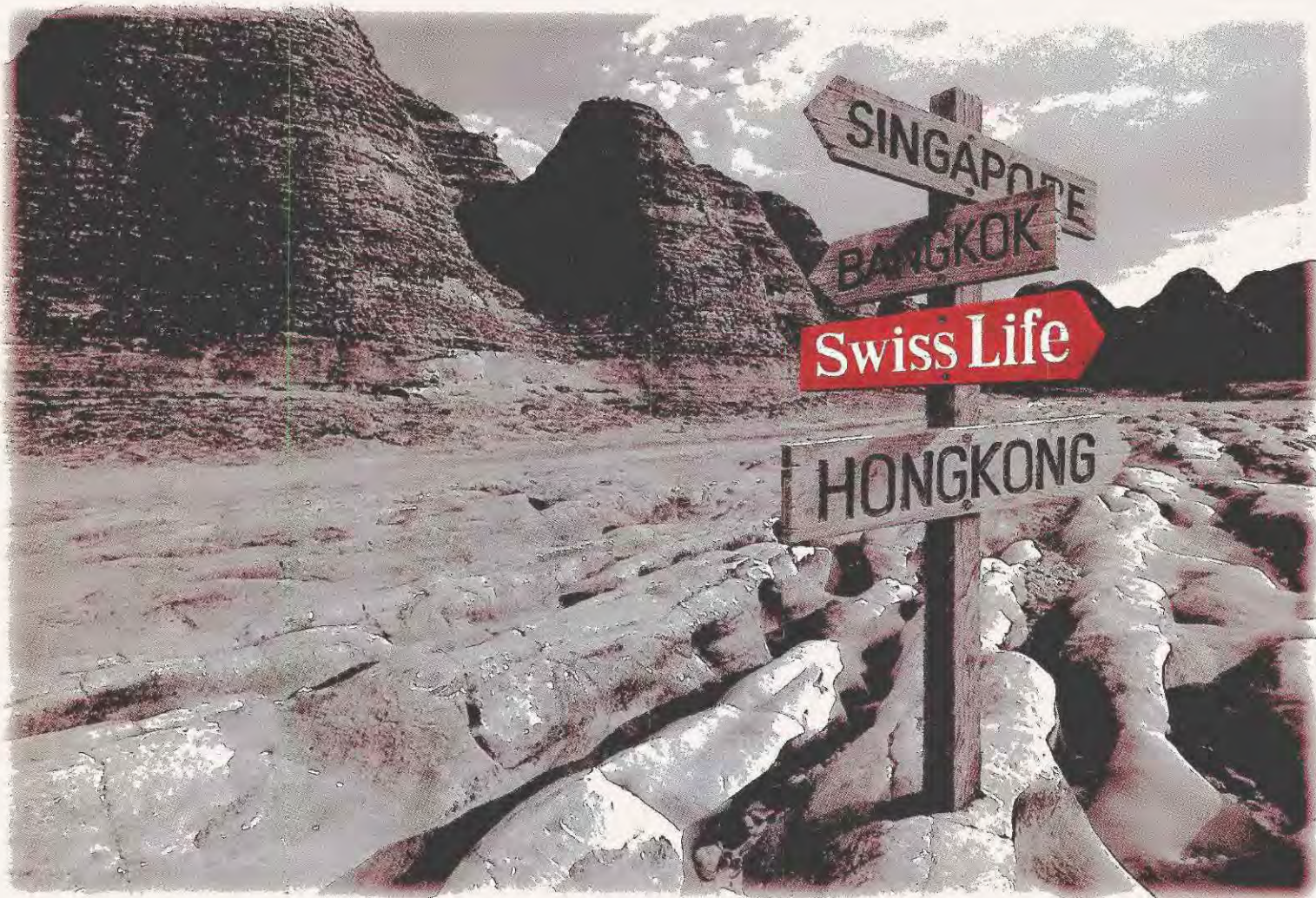
While supplemental plans are not subject to ERISA, they are subject to other regulations such as state laws, "which could significantly increase the exposure to underwriters," Ms. Cummins said. The possibility that they might be subject to Securities and Exchange Commission regulations at some point and possible accompanying exposure to securities violation suits adds to the concern.

Mr. Baron offered several suggestions for limiting exposure to fiduciary liability exposure in the years ahead. He suggested that sponsors "keep plans simple," that they set and adhere to investment guidelines and that they adhere to ERISA requirements as closely as possible.

He also suggested they err on the side of conservatism in changing benefits and that they choose their brokers and underwriters carefully.

Ms. Cummins noted that ERISA is both complex and "still evolving," and said, "As a sponsoring employer of ERISA plans, it's important to understand your responsibilities and duties and proceed accordingly."

Joanne E. Byrnes, manager of international risk management for Purchase, N.Y.-based PepsiCo Inc., moderated the session. **EBI**



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Mishaps abroad can test work comp policy at home

By SARAH GODDARD

TORONTO—Risk managers of U.S. multinationals cannot assume that global workers compensation policies alone are enough to protect employees overseas, insurers say.

When an accident occurs abroad, employers must act fast, or an employee's injuries could prove critical, they warned last week at a session at the annual Risk & Insurance Management Society Inc. conference.

Brokers and policyholders commonly believe U.S. employees injured overseas are automatically covered by workers comp, said Howard Endean, vp and manager-West Coast regional claims department of AIU North America Inc. in San Francisco, a unit of American International Group Inc. "There is no such thing as worldwide coverage," he said. Although standard coverage exists, there are no guarantees that U.S. employees injured overseas are going to be covered, he said.

Business travelers generally are covered by U.S. workers comp policies for both business and associated personal travel endorsed by the cor-



poration, but only inasmuch as their behavior is not beyond "reasonable deviation" from their work, he said.

The biggest exposure to overseas claims comes from U.S. employees in Third World countries, where risk of illness is higher. Adding foreign voluntary workers comp to a global program can plug that gap, Mr. Endean said.

Because risk managers usually see accident reports first, they should determine whether a claim is valid and immediately tell the insurer, Mr. Endean advised. Then the claim can be managed to control medical treatment, curb costs and prevent greater injury to the employee.

The Third World isn't alone in creating big problems for U.S. corporations. Even countries that seem culturally and socially much closer can throw a wrench in the works.

Australia's workers comp system probably is closest to the U.S. model, said Larry Warner, risk manager at Mars Inc. of McLean, Va. Each of its seven states has its own distinct program, and are two federal programs.

Self-insurance is possible, but there are onerous demands, including having assets of at least \$200 million Australian (\$157 million) in certain states. "But, the benefits can be just as great as what we see in the U.S.," including substantial cost savings and control over medical programs, Mr. Warner said.

Workers comp issues in Europe are changing as some governments realize they cannot keep up generous social programs.

The United Kingdom requires corporations to carry employers liability coverage separate from any global master program. Until Jan. 1, 1995, coverage was unlimited. Then, insurers started offering minimum limits of £2 million (\$3 million) with standard limits of £10 million (\$15.2 million) and up to £25 million (\$37.9 million) available. Rates have fallen with limits, said Michael Dower, regional director of global risk management at CIGNA Corp.'s international division in Chicago.

Ireland, a traditional upfitable

market for EL insurers, has had "an incredible amount of high awards given to minor injury claims," Mr. Dower said. Such awards could lead to similar levels in other E.U. countries as litigation grows in Europe.

But other countries, particularly in Eastern Europe, remain less litigious and have little concept of liability. In many of these countries, the systems just don't exist to file claims against employers liability programs, though the panelists agreed companies should be aware that such areas are in upheaval and exposures can change from day to day.

Ariel Silva, assistant vp at Johnson & Higgins of Washington Inc., was moderator and coordinator of the session. **EI**

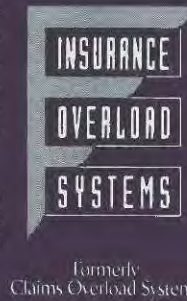
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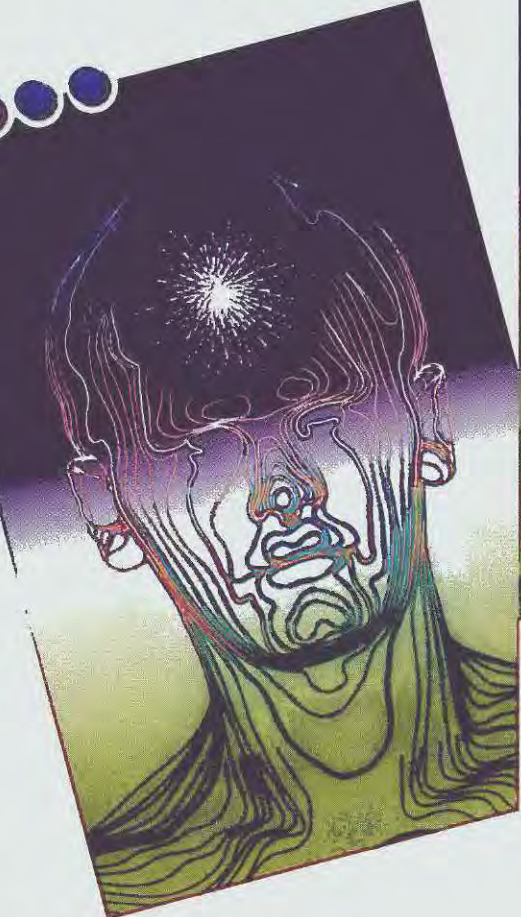
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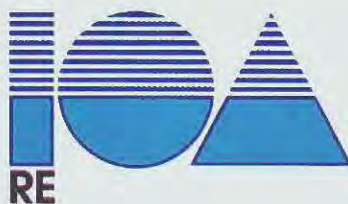
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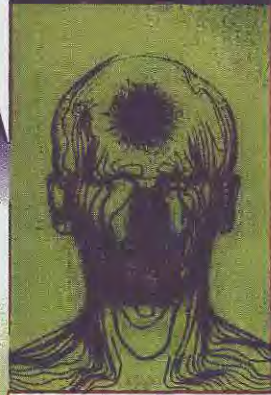


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Mix risk and benefit staffs?

A few companies have succeeded despite resistance

By ROBERT KAZEL

TORONTO—To understand why more companies aren't combining employee benefits and risk management into a single department, imagine the hurdles involved in a hypothetical unification of the United States and Canada.

Although logical reasons may exist for the union of stars, stripes and maple leaves, key differences in customs and even psychology would ignite fear that change is not only unnecessary but dangerous.

That same apprehension inhibits many companies that are considering integrating all insurance staffs. But according to speakers last week at the annual Risk & Insur-

ance Management Society Inc. conference, lack of understanding and even outright animosity between risk management and benefits staff can be overcome through management's attention to alleviating tension and facilitating inter-office communication.

Some companies already have achieved a linkage of insurance staffs, either as a result of corporate downsizing or as a way to increase efficiency and refine corporate strategy, without necessarily laying off anyone. One large employer, Woodcliff Lake, N.J.-based Ingersoll-Rand Co., combined risk and benefit management departments more than a year ago and has changed the attitudes of work-

ers in both disciplines who previously were hostile or feared for losing their jobs, said William M. Menaghan, director of benefits administration and risk management.

Ingersoll-Rand, an international manufacturer of industrial equipment and components with 41,000 employees, began uniting its risk and benefit management areas in February 1995.

The move was accelerated in May 1995 when Ingersoll-Rand acquired Clark Equipment Co., a South Bend, Ind.-based manufacturer of golf carts and other products, with about 5,000 employees. Mr. Menaghan is responsible for all insurance functions and reports directly to the chief financial officer

of Ingersoll-Rand.

The new Clark Equipment subsidiary became a "test tube environment" in which Ingersoll-Rand watched the success of integrating benefits and risk management staff, Mr. Menaghan said.

The most important thing learned, he said, was that the attitudes of employees as well as top management—the negativity or positiveness they brought to the effort of unification—could make or break the entire initiative. And it was up to the company to structure employees' work so they felt needed and wanted and part of a logically structured team that truly depended on their skills.

"Unless people know what your experience and your expectations and your roles are, nothing works well," said Mr. Menaghan. "The program has to be well spelled-out, it needs to be clear, concise and communicated to the right people."

Motivating disparate staffs was not simple. "When I first took over responsibility I was struck by the different cultures that we had," Mr. Menaghan said.

The differences were so apparent that managers from both sides seemed separated by a vast psychological chasm, he said.

Those on the benefit side were used to operating on a hierarchical basis, with rank being measured by a manager's supervisory responsibilities. Benefit managers' time seemed consumed by the "fire du jour," he said, or "what happened today that we need to fix."

Risk managers, in contrast, were responsible for specific product lines and gained advancement by helping to create long-term, complex insurance programs.

RIMS Report Employee Benefits & Workers Comp

Mr. Menaghan himself, a former auditor and controller at Ingersoll-Rand, said he had trouble getting used to the sheer magnitude of the benefit staff's role, the risk of costly error and the demand on benefit staff's time due to employees calling in with questions about their benefits.

So that employees from all disciplines can participate in the revamped, combined insurance department, Ingersoll-Rand brings risk managers and benefits specialists together and organizes their work by teams. One team might study medical trends, another 401(k) plan issues, and each is composed of managers with unique experience or skills that make them valuable—regardless of their roles under the old structure.

Informal assurances to employees that their skills are still valued, as well as lots of patience to give workers time to make the adjustment, are also critical, he said.

"What we call it is warming people up to change," Mr. Menaghan said.

"You can't have too many conversations with people. Ask them how they're doing," he said.

But that approach may not be enough to thaw the ice separating benefit managers from risk managers elsewhere. Some companies that have tried to merge these departments find that turf fighting turns the workplace into a virtual battlefield, said Jane Y. Rastallis, a consultant with Watson Wyatt Worldwide in Wellesley Hills, Mass.

"In the end, everybody hates everybody else," she said, adding that in her experience this is most true for managers at non-profit institutions, who perhaps are more influenced by the weight of tradition than business needs.

Despite the difficulties, Ms. Rastallis, coordinator of the session, advised that companies might at least attempt to put integration of benefit management into the hands of risk management departments, to "stop doing it the old way and take risks—do what works."

In the end, of course, the only thing that may placate risk and benefit managers when their staffs are merging is the knowledge of job security. This is rarely a given, though Mr. Menaghan at Ingersoll-Rand said only "a couple" of his company's employees were displaced.

"It wasn't radical, much to the dismay of the controllers," according to Mr. Menaghan. "But c'est la vie."

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Safety over the long haul

Don't sacrifice long-term improvement for short-term gain

By GAVIN SOUTER

TORONTO—Risk and safety managers must abandon traditional methods of evaluating safety performance to reach world class standards, an expert on quality says.

Most organizations still use outdated techniques to rate their safety record and then make changes that sacrifice long-term improvement for short-term gains, he says.

Instead, safety processes should only be tampered with when a thorough analytical review has been performed that assesses the real safety record of an organization, he says.

Most organizations with poor or average safety records start from a fundamentally flawed corporate culture, said Jay T. Deragon, executive director of the Quality Insurance Congress in Nashville, Tenn.

That culture is marked by management's inability to understand the interdependencies and interrelationships among the myriad parts of the organization, he said last week in a session at the annual Risk & Insur-

of accountability for line managers, Mr. Deragon said.

These organizations also have cyclical safety records as reforms are imposed and later ignored, he said.

And they do not look at the root causes of safety problems, he said.

For example, a safety manager may see that a certain truck driver is having an unusual amount of accidents while reversing his truck. He then sends the driver on a course to improve his driving, ignoring that the truck is too large for the space the driver is required to back it into, Mr. Deragon said.

In this situation, expense is wasted trying to resolve the problem with added training but still the problem is not really addressed, he said.

By contrast, in "world class" organizations safety is seen as a line management responsibility and a good safety system is seen as a good business investment, he said.

In these companies accidents are intolerable; safety is seen as an aspect of management effectiveness; there is long-term planning and difficult decisions are taken; responsibilities and expectations are defined; and communication with all employees is open and encouraged, he said.

In these organizations the safety function is blended into the operating system and is invisible, he said.

To reach this higher level, organizations must first effectively analyze their data on a long-term basis, Mr. Deragon.

"We have always been prepared to compare accidents quarter by quarter or month by month but it doesn't tell you anything about the original process," Mr. Deragon said.

Typically, senior managers will review safety records and if they see a blip in the data for one month they immediately react and tell risk and safety managers to cure the problem, he said.

They often set numerical goals that cannot be met and this, in turn, leads to a poorer understanding of the problem because data is then tampered with or hidden in order to meet those goals, Mr. Deragon said.

"There is nothing wrong with the actual process they are trying to improve. It is stable and you should not touch it until you fully understand it because you will create more variation," Mr. Deragon said.

If managers use a control sheet to view accident data over at least 18 periods they would see that the occa-

sional sharp rise in accidents during a short period is normal, he said.

Once managers fully understand the data they are better able to add improvements to a safety system, Mr. Deragon said.

The managers must then educate employees so that they become integrated in a safety system for the organization, he said.

"Everybody has to understand that what they do impacts safety," Mr. Deragon said. Safety objectives must be clearly defined and understood and the objectives should be frequently discussed and fine-tuned.

And to encourage this improvement, bonuses and performance evaluations should be linked to safety performance, he said.

The session was coordinated and moderated by Thomas J. Soles Jr., group director, insurance and safety at Sheet Metal & Air Conditioning Contractors National Assn. Inc. in Chantilly, Va. **BI**

RIMS Report

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ance Management Society Inc. conference.

"They should think systematically and see the organization itself as a system and then see how safety fits into that system. Too often, organizations look at safety after the fact—when an accident has already happened," Mr. Deragon said.

The organizations with the worst approaches to safety are marked by several flawed management characteristics: accidents are accepted as flukes; they have an autocratic style; there is minimal planning for safety issues; the solutions to problems are reactive and short-term; communications are fear-based and line managers are warned to cut accidents without input from management; and they have "make do" attitudes toward safety equipment.

These companies fail to perceive that most accidents are the results of systems breaking down rather than individual fault, Mr. Deragon said.

"Ninety-six percent of safety problems are due to a failed system, only 4% have to do with the performance of an individual," he said.

Workers deliberately injuring themselves to file a workers comp claim should not be treated as an individual problem, since safety should be seen as part of the training and recruitment process, Mr. Deragon said. "Who let him in?" he asked of such workers.

Companies with poor safety systems typically have high costs, excessive losses, poor employee relations and are ignorant of safety laws, Mr. Deragon said.

Most organizations have better quality safety policies but these alone still are totally inadequate, he said.

The average organization typically has a safety program in which: accidents are "excused away" rather than properly analyzed; management always looks for the easy way to tackle safety problems; they have many poster programs, which rarely instill any action in employees; there are significant political problems regarding who is responsible of safety; only results are looked at rather than the whole system; and there is a lack

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Selling comp cost allocation

By MICHAEL BRADFORD

TORONTO—Keep it simple, sell it to senior management, then thoroughly explain a workers compensation cost allocation system to the workforce, advises a panel of experts who have developed and implemented such systems.

Whether it's changing a current system that allocates costs to the company's locations or putting in place a new system, risk managers have to be prepared to help sell the concept, the panelists agreed.

"It's very important you get management to buy in at the senior level and then communicate that down through the organization," said Timothy J. Bunt, vp-corporate risk management at The Prudential Insurance Co. of America in Newark, N.J.

"Communication is very, very important," agreed Thomas M. Regan, director, corporate risk management at Becton Dickinson & Co. in Franklin Lakes, N.J.

The panelists discussed allocation systems last week at the annual Risk & Insurance Management Society Inc. conference.

Mr. Regan urged risk managers to communicate the concept in simple terms and show "the simplicity of the approach that's involved. And by keeping it simple and taking away the mystical and magical Ouija boards... you'll have an easier time getting through a difficult conversation."

When considering an allocation formula, companies have to choose between a guaranteed-cost system that presets amounts that divisions

will be charged or a system that charges divisions retrospectively based on their actual claims costs.

A good actuary—whether independent or one related to an insurer or broker—will be needed early in the process of determining which formula is better, said Steven H. Lawrence, senior consultant at Coopers & Lybrand L.L.P. in New York.

Questions like how to establish "premiums" for each division will have to be answered, he pointed out. The actuary can estimate, for example, the probability of losses that cost between \$250,000 and \$2 million.

For losses at that level, "Give them a premium, fix it for them because that's not where your frequency is. Your frequency is going to be in your first \$250,000 and that's why you focus so much attention there to

reduce those losses," Mr. Lawrence recommended.

While fixed charges for high levels may make sense, in the lower levels where a high frequency of loss occurs, retrospective charges based on actual losses are more effective, the panelists agreed.

A retrospective charge "seems to make the most sense in how you hold an operation accountable," said Mr. Lawrence. "But you really have to look within your organization. Some organizations will just sit there and say, 'We don't want to do it that way. We just want to give them a guaranteed cost and try and work at it from another direction,'" like the use of safety manuals, memos and meetings to emphasize loss control, he said.

"It doesn't always have to be the

retrospective charge," added Mr. Lawrence, but a retro cost allocation program appears to work better because there is more incentive to control losses when the amount of the charge is tied to actual costs.

Further incentive can be found when companies tie managers' bonuses to the success or failure of reducing workers comp claims, Mr. Lawrence pointed out. "The bonus element is continuing to increase" as a practice by companies that allocate costs, he said.

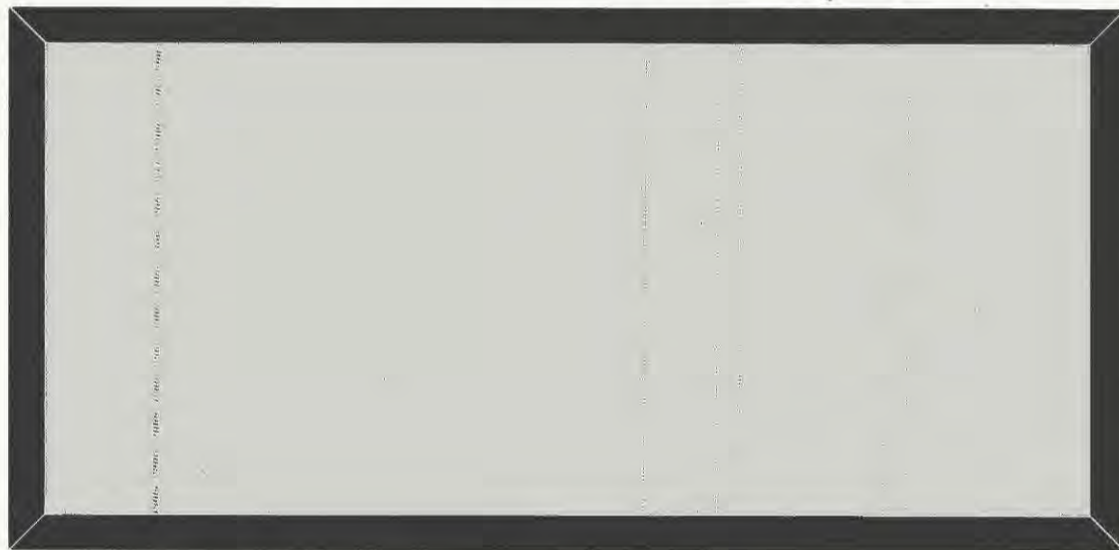
"The challenge, clearly, is to impact the operations manager's behavior," said Mr. Regan of Becton Dickinson, and a system is more effective if it rewards or penalizes those responsible for controlling losses.

Although senior management's backing is critical, an allocation plan won't work without also generating support from heads of operating units and the rest of the workforce, according to Mr. Regan.

Without operational support, "you're going to have a difficult time getting any kind of results," he said, because that's where safety and loss control changes have to be made so that comp costs eventually fall.

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said Mr. Regan. "Give the operating entities an opportunity to lower their expenses, challenge them to do that and let them benefit from the result of lowered expense. Then they've got a selfish buy-in and we think that's important as you move forward."

Senior management and operations will have to be convinced there is a reason for buying in, Mr. Regan noted. "It is important to have benchmark data" that will show how other companies are doing on workers comp costs, he said.

That data can be gathered from brokers, insurers, RIMS and other organizations that compile such information, Mr. Regan said.

Selling the allocation system to operating units may mean some time away from home for risk managers.

Becton Dickinson sent a team on the road with the charge of explaining changes to its system and throughout the course of a year the group stopped at "each operating company, every factory in the United States... to talk about the allocation formula," said Mr. Regan.

That way, individual sites could plug in their own claims data to the formula for a quick look at how improved loss control and claims management could eventually reduce the expenses related to workers comp at their location, he explained.

Mr. Regan pointed out that Becton Dickinson took along a claims representative from its insurer to use claims from the locations as personalized case studies. Claims that were open could be discussed in terms of what could be done to return workers to the job and hold down expenses. "You begin to show people how they can influence the expense."

It's important to communicate that the system isn't just being discussed but is going to be implemented, Mr. Regan emphasized. He said those who are presenting the details to an operating unit should be armed with a memo indicating that top management has committed to the project.

"Otherwise known as the velvet hammer," said Mr. Bunt of Prudential.

Mr. Regan was the session moderator. **BI**

Avoiding a crisis of cumulative trauma

By JOANNE WOJCIK

TORONTO—Risk managers need to frame cumulative trauma prevention in terms of its bottom line impact if they are to win support from senior management for an effective program, loss control experts say.

"It may not be the right thing to do but, in some cases, companies may find it's cheaper to replace the people" than to pay for loss control techniques designed to prevent cumulative trauma disorders, said Chuck Tucker, a branch manager of Crawford Risk Control Services, a unit of Crawford & Co., in Winston-Salem, N.C.

The corporation is "not a humanistic entity," he explained. "The corporate objective is to maximize profits."

That's why risk managers need to "address it in terms of how it affects profits," Mr. Tucker said

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last week during a session on establishing a cumulative trauma avoidance system at the annual Risk & Insurance Management Society Inc. conference.

"Safety people don't talk the same language as management," concurred Jim Sybert, a vp with Crawford in Atlanta.

Some risk managers are already at a disadvantage since many people in their companies think all they do is buy insurance, he observed.

To get through to upper management, risk managers "need a way to convey as simply as possible what risk management is all about," he said.

Risk managers also need to explain to upper management that merely taking corrective action after an injury has occurred will not protect the company from future incidents, Mr. Sybert pointed out.

"Protective equipment doesn't prevent injury, it just minimizes the severity," he said.

Companies that really want to reduce the incidence of CTDs need to also train and educate their workers on how to prevent these injuries.

And companies will get the most bang for their buck if their equipment and systems are ergonomically designed in the first place, Mr. Sybert said.

To show upper management how these injuries diminish company profits, Mr. Tucker suggested that risk managers obtain as much CTD cost data as possible from internal sources, including: first reports of injury, accident investigation reports, first-aid logs and summaries, insurance loss runs, employee surveys, human resources data, operations and production data and the annual summary provided to the company on its workers comp experience by the Occupational Safety and Health Administration.

Data should also be obtained from outside sources, such as the state and federal bureaus of labor statistics, industry associations and the National Council on Compensation Insurance, Mr. Tucker said.

The data should be presented in

a manner that shows how each CTD claim's costs contribute to overhead in various aspects of the company's business, he said.

When presenting this data analysis to upper management, risk managers should identify trends, highlight problem areas, portray the data geographically, and succinctly summarize their observations and conclusions.

A good CTD prevention program cost-benefit analysis will also estimate the costs of lost productivity, retraining and replacing permanently disabled employees, he added.

It also should establish benchmarks, identify potential savings and formulate a plan of attack, said Mr. Tucker.

Other information to include

'Protective equipment doesn't prevent injury, it just minimizes the severity,' says Jim Sybert.

are worksite evaluations and task analyses conducted by a professional ergonomist, as well as interviews with personnel, line managers and claims adjusters.

"One thing you have to have is good internal data," said Mr. Sybert. "And you want to use the data to your advantage."

If the company already has a CTD prevention program, but one

that is inadequate, the risk manager should also review the current plan and identify its weaknesses.

Risk managers shouldn't be afraid to explore such "touchy-feely" areas as behavioral or cultural barriers to injury prevention, such as poor interdepartmental communication.

Once management buys into the idea that a cumulative trauma avoidance system is needed, the risk manager should develop a plan that identifies what needs to be done, how it will be accomplished and by whom, how much it will cost and establish a time frame for implementation of the plan.

Remember, Mr. Sybert said, "you want to spend the least

amount of money possible to maximize profits."

After the system is implemented, risk managers should continuously evaluate its progress and measure results, also in dollar terms, Mr. Tucker said.

Once everyone in the company's management realizes the impact CTDs are having on their operational expenses, it will affect a cultural change that will make it easier for the risk manager to implement an effective injury prevention program, Mr. Sybert assured.

"Usually there's no money in the budget for CTD prevention," he said. "This system is designed to get everyone involved to show implications for all departments."

The session was moderated by Gerard F. McCabe, director of risk management for Burlington Industries Inc. in Greensboro, N.C. **BI**



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Get to the root of comp loss

By MICHAEL BRADFORD

TORONTO—It was almost too late before someone at Ryder System Inc. got the idea that a greater emphasis on employee safety might help bring down the company's soaring workers compensation costs.

"In the '80s, we were the poster child for workers comp, and that's not a good thing to be," said Tad DeOrio, vp and general manager at Ryder Services Corp., a Miami-based claims management unit of Ryder.

Mr. DeOrio was referring to workers comp problems at the parent company, the truck leasing giant that also operates other transportation divisions like one that transports automobiles for manufacturers. By 1989, he said, Ryder was chalking up workers comp costs of \$90

million per year, up from \$10 million per year in 1982.

Mr. DeOrio was a panelist in a discussion of strategies for controlling workers comp costs held during last week's annual Risk & Insurance Management Society Inc. conference.

At a time when Ryder was growing rapidly, its workers comp costs were out of control. Mr. DeOrio, who was director of accounting at Ryder during the last half of the 1980s, pointed out that the \$90 million paid out in 1989 would have bought 2,000 new rental trucks, created 3,000 jobs or purchased 450 of the truck carriers the company uses to haul automobiles. It also amounted to 61 cents per share of Ryder stock at the time.

Despite the big payouts, the company spent most of its time trying to control costs associated with claims

handling and various expenses related to claims rather than attempting to reduce workplace accidents that were the real culprit behind the company's zooming costs, he said.

But the \$90 million paid out in 1989 was an eye-opener. "It's always darkest before the dawn, and that actually got us moving," he recalled.

The steps Ryder took, which ultimately led to a 50% drop in comp costs over five years, point the way for other companies to avoid the problems the transportation company encountered.

Some of the symptoms that indicated the problem was becoming critical were missed by Ryder, Mr. DeOrio acknowledged, but they are red flags that any company should heed.

Apart from rising comp costs, in-

jury frequency and lost-time days were increasing. Corporate goals ignored safety. There was confused accountability for the problem. "When the numbers hit \$90 million, the finger-pointing was really, really a science," Mr. DeOrio said.

What was to blame most for the soaring injury rate and workers comp costs?

Management priorities simply didn't include dealing with workplace injuries, he said. In addition, there was some "panic hiring" during the company's rapid growth and inadequate training and supervision of employees. Safety programs were either non-existent or cut back.

To compound the problem, there was a lack of communication between labor and management, and between management and the claims staff, said Mr. DeOrio.

The company's core values were quality, profitability, growth and customer service, he said. "Not until

we hit that 1989 watershed did anybody think that safety needed to be a core goal."

When the message finally got through, Ryder set out to change its corporate culture to reflect a new commitment to employee safety.

The action plan focused partly on greater involvement of managers and employees in creating a safer workplace. "We had to focus on the real problems, get people moving on those problems then take a look at where we were periodically and move on from there."

Managers were told they were in charge and would be held accountable for results, Mr. DeOrio added.

Safety personnel and claims handlers were stepping into each other's territory. Therefore, Ryder drew new boundaries so that they knew their responsibilities and didn't duplicate each other's efforts, he explained.

"We built a safety database so that we had some really credible data about what happened and where it happened," noted Mr. DeOrio, and the information is used to help prevent future losses.

Ryder also emphasized return-to-work programs and required managers to implement those programs.

Those and other efforts not only clipped the company's workers comp costs in half within five years but also nipped injury frequency by 40%

RIMS Report

Employee Benefits & Workers Comp

and cost-per-claim by 30% over the period.

Another panelist explained how important it is to have someone in the role of facilitator in getting the injured worker back on the job.

A "claims coordinator" has to have the qualities of an enthusiast, a cheerleader, coach and facilitator, said Nancy Wood, senior consultant, claims cost control at Lockton Cos., a Kansas City-based insurance broker that provides programs to help companies control their workers comp costs.

"I need someone that has a sales background," and can function as an employee advocate, she added. The claims coordinator must be able to deal with doctors to find out, for example, if a worker is legitimately able to move about the house but cannot make the same effort in a light-duty role at the workplace.

"You need someone who can go beyond just the answer of 'no' and ask questions," Ms. Wood said. "These characteristics are more important than the educational background."

She suggested never hiring an adjuster to fill the role of claims coordinator. "They tend to stay in the discipline they do best, they adjust. And we need someone who is an employee advocate."

The claims coordinator makes contact with an injured employee weekly and after each doctor's visit, Ms. Wood said. The employee must be queried about the extent of his injuries and his understanding of them. And all this needs to be done in a reassuring manner for the worker, she said, because "we want them to come to the employer versus going to an attorney."

The workforce has to be knowledgeable about and participate in efforts to reduce workers comp costs, she said. "You need to educate people throughout your company. They need to understand workers comp."

The session moderator was Lucille Gallagher, vp-risk management at ConAgra Refrigerated Foods in Greeley, Colo. **BI**



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Benefits change with families

By SALLY ROBERTS

TORONTO—Combine downsizing and non-nuclear families and many companies with traditional benefit plans see a loss of productivity, morale and loyalty.

But this need not be the case, even in times of cost containment, said work/family specialists at a session last week at the annual Risk & Insurance Management Society Inc. conference.

One way to maintain morale and productivity in a restructuring—or just in the faces of the stresses of balancing work and family life—is to liberalize the meaning of family and offer benefits that better meet the needs of today's workers.

"It's a real business decision, if you're losing your employees to competitors because of your benefit plan," said Jane Y. Rastallis, a risk management consultant for Watson Wyatt Worldwide in Wellesley Hills, Mass., who successfully urged her employer to implement a work/family benefit program.

For one benefit in particular—extending health benefits to non-traditional dependents—senior managers

plans" do not cover dependents, leaving employees to shoulder that expense, he said. And if employees are going to pay the full cost, the issue becomes: "Shouldn't they have the right to pick the dependents they want to cover?"

Employers' traditional definition of dependent includes a spouse of opposite sex, a common-law spouse of opposite sex, natural born children, and adopted children.

Today, though, for employers to attract the best candidates, and to improve loyalty and productivity, their benefit programs need to recognize the other, different types of families that exist.

Lynn A.W. Maloney, manager of finance at Old Dominion Electric Cooperative in Glen Allen, Va., was session moderator and Ms. Rastallis coordinator. **BI**

RIMS Report
Employee Benefits & Workers Comp

often find that gains in morale, productivity and employee retention outstrip any added costs of covering more dependents, said Ms. Rastallis. "It just makes good economic sense."

High costs for unscheduled absences and disabilities related to stress are prompting many companies to change their work/family approaches.

Watson Wyatt recently found that more than 75% of Canadian companies offer at least one family-friendly benefit. Most popular are flexible working arrangements. Some 75% of the companies offered some part-time work to employees, while 30% offer compressed work weeks and 29% offer telecommuting. Similar trends are seen in the United States.

Ms. Rastallis and Mr. Norton encouraged the sparse audience at the RIMS session to consider implementing a "caring benefits policy."

"Employers need to define a family by function not form," advised Ms. Rastallis, saying that only 15% of households today are traditional families. In this way, "family" would be defined as one that cares for the emotional and physical needs of a dependent; provides them with love and security; shapes their values and social skills; and provides them a haven from outside stresses.

"If looked at that way, it doesn't matter what family is, as long as it functions like this," Ms. Rastallis said.

One issue employers are facing as the make-up of families changes is whether they should keep subsidizing dependent health coverage, Mr. Norton said.

"An increasing number of employers are saying they are responsible to provide benefits to their employees, and while they will make available the insurance to cover their families, those costs will be borne by employees," he said.

Rising costs are prompting many companies to shift greater costs to employees and to reconsider their policy of subsidizing coverage for dependents of employees, Mr. Norton said.

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INTERNATIONAL

Weather

Continued from previous page

by 35 kilometers, but this has been improved to one of 10 kilometers (6.2 miles) by 10 kilometers. This has provided a strong degree of reliability to predict weather effects over a five- to six-day period, improving the performance of public authorities' early warning systems for impending storms.

Catastrophic storms' effects may be mitigated by countries setting up efficient early warning systems, said Mr. Beysson. For example, an October 1987 hurricane that hit northern France and then hit southern England with winds of 134 mph caused 18 deaths in the United Kingdom but only two in France, he said. Mr. Beysson

explained that the warning system had not worked as well in England as in France.

But there is little headway so far in predicting earthquakes noted Vincenzo Petrini, professor at the Politecnico de Milano in Italy. However, scientists may be able to forecast material damage by developing a scale that takes into account waves of seismic energy through different geological conditions, surface soil conditions and structures.

Mr. Petrini also pointed out that a region's vulnerability to earthquakes depends also on the proportion of the population affected. There is a large economic difference between the 5,000 deaths out of a local population of 20 million, in the case of the 1995 Kobe earthquake in Japan, compared with 4,000 deaths in a 1903

earthquake in southern Italy in a region whose population was only 500,000.

Attitudes to flood risks and their mitigation are full of contradictions, said Colin Green, research manager of the Flood Hazard Research Institute at Middlesex University, Enfield, England. "Flooding is only a problem when human activities are affected. Flooding is natural, but is seen by the public as a human failure. Flooding is someone else's run-off."

Mr. Green said flood risks are increasing with changing patterns of flood plane development. But rivers cannot be managed as a flood problem since they are an important environmental resource. Sometimes the development of a flood plane, for industrial or residential use, is a less

expensive option than the development of higher ground.

Western Europe in particular has a high degree of flood plane development, largely because of the lack of alternative land.

In the future, flood losses will rise due to inflation, increases in land value, the increasing intensity of flood plane development, and the new technology and industrial concentration, which makes areas more vulnerable than before. Despite calls for greater government involvement in flood mitigation and compensation, the insurance sector will still have a role.

Governments will need the insurance sector because they see themselves as lacking in the expertise in delivering compensation and insuring losses, he said. "They don't like taxes." ■

Disaster cover responsibility still debated

By MARIA KIELMAS

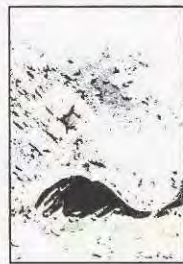
Governments take diametrically opposing roles in natural disaster insurance for the U.S. and the continental western European markets, according to experts speaking at the recent SCOR Forum, "Are Natural Disasters Insurable?"

Despite an estimated \$8.8 billion annual disaster exposure in the United States, disaster coverage—except for flood insurance—is almost entirely in the private insurance sector's hands, said Jack Weber, executive director of the National Disaster Coalition, who spoke at the forum sponsored by Scor Reassurance.

But in continental Europe, where disaster exposure is proportionally much lower, governments take a leading role as the reinsurer of last resort.

Some European insurers are seeking a simpler and market-related solution to catastrophe insurance.

France's natural disaster insurance system is



based on the compulsory inclusion of natural disaster coverage in all underlying property policies, at an additional premium. State support is provided through a state-owned central reinsurance fund, Caisse Centrale de Reassurance. Under a 1982 law that established the CCR, the government is not a monopoly reinsurer, but in practice insurance companies reinsure with it because of its unlimited coverage offer.

The reinsurance is based on a quota-share treaty with cessions between 40% and 90%, and a stop-loss protecting the retention.

In 1990, this system was extended to France's overseas departments of Martinique, Guadeloupe, Reunion and French Guiana as well as the Territorial Collectives of St. Pierre and Miquelon and Mayotte. These regions are French territory rather than overseas dependencies or colonies.

But there is room for more competition in the French model, says Bernard Kessler, president of the French insurers federation, Federation Francaise des Societes d'Assurances. Mr. Kessler listed four principal criticisms of the system:

- It is not understandable. Policyholders often do not understand their coverage.
- It does not encourage enough disaster-prevention measures.
- It does not give personal injury damages.
- Even if a more market-based solution were implemented, this would be difficult to apply to France's Overseas Territories, such as in the Caribbean, as one disaster can destroy the entire local economy. These entities are not capable of collecting sufficient premium for potential storms.

Belgium is in the process of devising a state-backed disaster insurance system based on the French model, after abandoning

See Disaster on page 47

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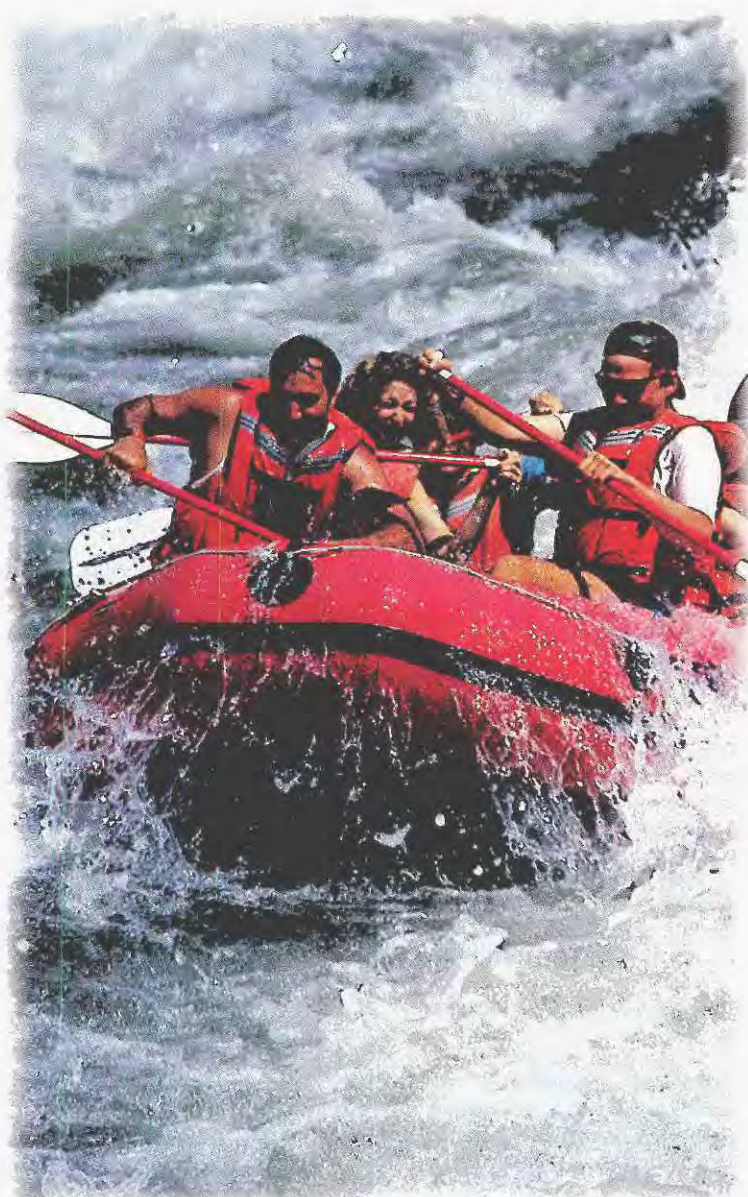
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INTERNATIONAL

Standards

Continued from page 43
he said.

• Brokers and insurers also must pursue closer working relationships.

"The broker must go beyond being an advocate of the insured, and insurers must go beyond being advocates of themselves," Mr. Van Gieson stated. These partnerships must bring an end to insurers giving different quotes to competing brokers, insurers working with a broker one year and then abandoning the broker on renewal, brokers providing insufficient information to the insurer, and insurers accepting risks without sufficient information.

• Finally, recruitment standards must improve.

Insurers and brokers must take on high-caliber people, properly train them and create an environment in which they can be motivated to succeed.

Lloyd's of London Chairman David Rowland said that after its troubles Lloyd's has constructed what he called the best graduate entry program in the insurance industry and pioneered higher academic qualifications.

Begun on a pilot basis last September, the 5-year, part-time course has four students enrolled. It is de-

signed to lead to both the fellowship qualification from the Chartered Insurance Institute and a masters degree in business administration.

Mr. Rowland also said Lloyd's is on course for completing its important reconstruction and renewal program within months. He said those within the Lloyd's market had "learned hard lessons" brought about by past incompetence. But, he

partment responsible for insurance and financial services, called for a multilevel market forum to examine the issue.

Mr. Mogg said any solutions proposed by a forum, which would "bring together the best minds and experience" as well as elements of transparency, clarity and self-help, would be more readily acceptable to E.U. states than legislation imposed

'The broker must go beyond being an advocate of the insured, and insurers must go beyond being advocates of themselves,' says Robert Van Gieson.

added, the market has faced up to its problems, been brave enough to admit its failings and is now in a strong position to engineer recovery.

"We are making good profits, we have attracted £1.5 billion (\$2.28 billion) of new capital in two years and our reconstruction program is close to delivery," said Mr. Rowland.

With regard to recognition of intermediaries' qualifications across the European Union, John Mogg, director general of Director General 15, the European Commission de-

from above.

For this reason, a forum is a better means of seeking a solution to the problems that still prevent insurance intermediaries from operating across the European Union than a new E.U. directive on intermediaries.

A directive could take a minimum of four years to implement. Mr. Mogg cited Greece, France, Luxembourg and Spain as countries that continue to restrict brokers' market access. **EI**

Industry needs breathing room

Broker urges easing of regulatory onus

By EDWIN UNSWORTH

LONDON—Harry A. Koch, president of the Council of Insurance Agents & Brokers, has called for a national approach to some U.S. regulatory issues in areas where the present system of state regulation hampers brokers' ability to respond "coherently" to capacity issues of national importance, such as environmental liability and catastrophe insurance.

Speaking last week at a conference for insurance intermediaries, he said the Washington-based group is committed to eliminating unnecessary regulations and lowering transaction costs.

"If the industry continues to be strangled by burdensome regulations, insurance buyers will seek alternative risk financing mechanisms out of the control of insurance regulation, Mr. Koch warned. "And the impact on the industry will be a shrinking mar-

ket that once gone will never return."

However, Mr. Koch said he recognized that in the current political climate solutions likely still will have to be found at a state level. Fortunately, a number of "reform-minded" regulators are starting to recognize the importance of having a regulatory system that encourages the development of new products and services and allows the industry to operate unencumbered by restrictive and unnecessary regulation, he noted.

Besides regulatory affairs, U.S. brokers also face major challenges from two sources—direct-writing insurers and banks, Mr. Koch said.

He cited a recent study by Conning & Co. showing that direct writers, having increased their share of property/casualty business to almost 45% in 1992 from just over 30% in 1972, are set to

See **Burdens** on next page

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Secretaries, Treasurers, controllers and other Financial Personnel 3,028

Risk/Employee Benefits:
Vice Presidents, Directors, Managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 17,213

Sub-total **30,164**
Associations 311
Government, Unions and Educational Institutions 881

Commercial Consumers

Sub-total **31,356**
Insurance Agents and Brokers 8,013
Insurance Companies 7,685
Accountants, Actuaries, Attorneys & Consultants 3,586
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,858
Others Allied to the Field 1,091

Total Qualified **53,589**
Non-qualified 7

TOTAL CIRCULATION **53,596**

* Source Business/Occupational breakdown of qualified circulation, November 27, 1995 Issue, as submitted to BPA for December 1995 BPA Publisher's Statement

Stocks

Continued from page 1

and some concerns earlier in the year about the reinsurance sector. Because property/casualty insurers invest heavily in bonds, their stock

Insurer stocks a bargain

Business Insurance, April 29, 1996 / 47

INTERNATIONAL

Disaster

Continued from page 44
 an earlier plan, said Jacques Boon, president of the Union Professionnelle des Entreprises d'Assurance, an insurance industry association. The plan is to set up the disaster insurance system by Jan. 1. In contrast to the French system, disaster coverage will be restricted to simple risks, since major risks are already adequately insured and re-insured. The new system is aimed at risks of value less than 37 million Belgian francs (\$1.19 million) and include small businesses, schools, offices and commercial buildings. Coverage will be provided for earthquakes of Richter magnitude greater than 4 and for damage within a radius of 3.1 miles of an event, such as floods, subsidence or landslides. The premium rate will be 15% to 16% of the property in-

insurance premium for the property in question, with deductibles of between 30,000 and 50,000 Belgian francs (\$961 and \$1,602). A reinsurance fund, called the Belgian Reinsurance Fund, or the CRB, will be created as a mutual insurance company, and any insurer of Belgian risks will be required to participate. Insurers would subscribe to the social fund proportional to underwriting reserves. The insurers will be obliged to reinsure themselves through the CRB by quota-share and stop loss, beyond the insurers' minimal retention of 10%. The surplus would serve to pay back contributions to the social fund and build tax-free disaster reserves up to a ceiling of 20 times the annual gross written premiums from insurance of this kind. The aim is to ensure that disaster reserves will be tax exempt, which would require approval from the

country's legislature. A questioner from the floor doubted that the Belgian legislators will speed up approval of what amounts to an effective budgetary change. "You have a lot of politics per square kilometer in Belgium," the questioner said. There are further problems with the European Commission, acknowledged Mr. Boon. The EC's directorate general for insurance has indicated that it does not like the mandatory deductible and the

statutory obligation on insurers to reinsure into a preselected fund. Another questioner from the floor noted that if disaster coverage is going to cost 15% to 16% of the property insurance premiums, then there is no attraction for a company buyer who can simply buy a traditional excess coverage program. The European government-backed experience is a far cry from the United States, where the overriding question is who pays for natural catastrophes, said Mr. Weber of the Natural Disaster Coalition. Mr. Weber outlined an apocalyptic scenario of increasing disaster exposure in the United States. Before 1989, there was no disaster loss greater than \$1 billion. Since 1989 there have been 10 such events. The amount of risk has increased. The populations of coastal regions have increased by 140%

over the last 20 years. A large part of the population shift has been to earthquake-prone areas in California and the Pacific Northwest. Insured earthquake losses of between \$50 billion to \$100 billion could be expected if the affected areas were fully insured, he said. With insurance rates regulated in every state and insurance commissioners being elected to their positions in several states, it is unlikely that U.S. insurers will be able to collect sufficient premium to meet potential disaster losses if coverage were more widespread, Mr. Weber noted. However, home and business owners have eschewed buying insurance, waiting for government disaster relief after the event. Mr. Weber said that President Clinton has disbursed more disaster relief, particularly to California, during his first term than all other presidents combined. **BI**

Burdens

Continued from previous page
 take a majority share by 2005 and virtually all of the market by 2027. Agents' market share will be reduced even further by increased competition from banks. Laws that prevented banks from selling insurance products are being eased, and the U.S. Supreme Court ruling in late March permitting national banks to sell insurance in states that ban such activities will, Mr. Koch predicted, "open the floodgates to banks being authorized to sell any line of insurance anywhere" (BI, April 1). This is likely to have a much more serious impact in the near future on sales of life insurance, annuities, and auto and homeowners insurance, he said. However, Mr. Koch said it likely will take years to fully understand the impact of recent court decisions giving banks freer access to financial service markets. **BI**

London 96 takes global focus

LONDON—Nearly 750 delegates from 29 countries attended the "London 96—In Pursuit of Excellence" conference in London April 21-23. It was the first-ever conference jointly organized by the British Insurance & Investment Brokers' Assn., the Council of Insurance Agents & Brokers of the United States and the Bureau International des Producteurs d'Assurances et des Reassurances, which represents international insurance intermediary professional associations. The conference looked at the current situation that intermediaries are facing on a global scale. BIIBA Chairman Simon Arnold warned that intermediaries ignore what is happening on the world stage at their own peril. Large brokerage firms must think globally—forging alliances and business relationships in the far corners of the globe, while smaller firms also need to be aware of what is going on beyond their shores since the problems they face are the same all across the world. The three groups will not hold a joint conference next year. —By Edwin Unsworth

The European government-backed experience is a far cry from the United States, says Jack Weber.

There are further problems with the European Commission, acknowledged Mr. Boon. The EC's directorate general for insurance has indicated that it does not like the mandatory deductible and the

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Mental

Continued from page 1

erage was inadequate. Two other senators shared similar tragedies.

As Sen. Domenici told his colleagues on the Senate floor, those who are mentally ill experience "some serious shortcomings in insurance coverage in America," including significantly lower inpatient and outpatient care allowances as well as significantly lower lifetime caps. "I believe that there is plenty of evidence that the discrimination continues. It grows more rampant."

The two-paragraph amendment says it is designed "to ensure that parity is provided under health plans for severe mental illness services." It would require that group and individual health plans offering a mental health benefit "not impose treatment limitations or financial requirements on the coverage of mental health services if similar limitations or requirements are not imposed on coverage for services for other conditions." However, nothing would prohibit a plan from requiring preadmission screening or "other limitations that restrict coverage for mental health services to those services that are medically necessary."

While 99% of large employers' health plans offer mental health benefits, they typically include tighter restrictions than those that apply to more visible physical ailments.

Sen. Domenici cited health plans that allowed 365 days of inpatient care for general medical care but only 45 days for inpatient psychiatric care. Also, some plans have lifetime caps of \$1 million for general medical care but impose a \$50,000 lifetime cap for mental illness.

Group health care plans typically do provide much smaller benefits for mental health.

For example, 90% of large employers limit inpatient treatment for mental health and substance abuse to a median of 30 days annually. Likewise, they limit outpatient care

to a median of 50 visits, said Hewitt's Mr. McArdle.

Those limits help control mental health and substance abuse claims, which on average equal about 8% to 9% of total health plan costs, consultants and employers say.

"There has always been a feeling that mental health conditions are harder to define, softer in their definitions, than a discrete physical condition and therefore more prone to excessive utilization and potential abuse," said Mr. McArdle.

To paraphrase Woody Allen, "the fear was some people might be using a therapist as an emotional personal trainer," said Henry Saveth, a principal at A. Foster Higgins & Co. Inc. in New York.

Because the definition of mental health and needed medical services is much more "elastic," services are "very, very hard to control," said Helen Darling, manager of health care strategy and programs at Xerox Corp. in Stamford, Conn.

Xerox previously allowed workers unlimited access to mental health benefits but put in restrictions when claims costs got too high, she said.

"Some limits were an attempt to control costs," agreed Art Young, manager of corporate benefits for Hewlett-Packard Co. in Palo Alto, Calif. He said mental health and substance abuse claims total 10% to 15% of Hewlett-Packard's \$250 million in annual health care costs.

Under the corporation's plan, a worker who has met his deductible is allowed eight outpatient visits to a therapist with 80% coverage of usual and customary charges. Once pre-certified for additional care, the worker is eligible for 23 additional visits, but at 60% coverage.

Overall, limits on mental health coverage initially applied to outpatient psychiatric treatment but were extended to inpatient care after costs surged for dependent children, who in some cases were kept in mental health facilities for as long as their insurance coverage allowed, Mr. Saveth said.

Given employers' experience in this area, they were concerned when they heard of the new Senate amendment that would require equal levels of benefits for mental problems and physical ailments.

"This is not about mental health," said Mark Ugoretz, president of the ERISA group. "This is about the mental health industry trying to force employers to pay for whatever services the industry chooses to provide, regardless of impact on jobs, insurance premiums or coverage."

"The Domenici amendment would do extraordinary damage" to health plans by increasing utilization and cost, among other things, according to the Assn. of Private Pension & Welfare Plans, a Washington-based retirement plan organization.

For example, the Congressional Budget Office estimates including the amendment would initially raise premiums 4% for managed care plans and 5.3% for fee-for-service plans. Meanwhile, employer contributions to health insurance would rise only 1.6%, but that is only because many employers would drop health insurance coverage entirely, the CBO said in a letter last week to Sen. Nancy Kassebaum, R-Kan., a chief sponsor of the Senate bill.

Earlier last week, consultants were optimistic that committee will reject the amendment as it irons out differences between the Senate and House versions of the health care bills, probably by Memorial Day.

There is "significant" doubt that the amendment will survive, said Foster Higgins' Mr. Saveth.

In fact, Sen. Kassebaum, who will be on the conference committee, opposes expanding the legislation beyond its core provision of curbing pre-existing medical condition exclusions, while co-sponsor Sen. Edward Kennedy, D-Mass., says he will oppose the amendment if it threatens the enactment of the broader bill.

But, President Clinton's announced support for the measure late last week could change that balance. ■

Mental health plan standards

NCQA to accredit carve-out psychiatric plans in 1997

By ROBERT KAZEL

WASHINGTON—A national accreditation board that sets standards for managed care organizations will begin certifying carve-out psychiatric plans in 1997.

The Washington-based National Committee for Quality Assurance this month issued draft standards for behavioral managed care. After a period of public comment and piloting of standards at three sites, NCQA expects to start reviewing individual managed behavioral health organizations early in 1997.

The proposed standards would, among other things, say that mental health care plans should have a live voice answering calls within 30 seconds, and fewer than 5% of callers at any given time should be hanging up before reaching a representative.

The standards also say that the clients should travel no longer than one hour to receive inpatient services and 30 minutes for outpatient services. The standards set up for the first time a triage system under which experienced clinicians are expected to make referrals according to protocols which define patients by level of urgency, on a spectrum ranging from inpatient to outpatient.

Certifying carve-out mental health plans could fill an information void for employers.

Because employees receiving mental health care may give little or no feedback to the plan sponsor on quality of care, employers often choose plans in the dark.

The value to employers of certification nationally could be significant, considering that NCQA estimates about 300 such organizations are responsible for treating the mental health needs of about 100 million Americans. For the first time, employers will be able to compare the plans against each other—if only to see which ones have earned NCQA's imprimatur.

"Comparability is definitely key," said Veronica Goff, a director of the Washington-based National Business Coalition on Health, which represents local employer-sponsored health care coalitions. "It's a big step forward, and it definitely pushes us in the right direction from a purchasing point of view."

A key feature of the standards is their emphasis on continuity, or the participation of primary care doctors in the mental health treatment of patients through close consultation with behavioral care specialists. "In many cases, we are looking at cases that are chronic and complex, and we need continuity," said Ms. Goff, who was part of a diverse panel of experts that drew up the standards.

In fact, she said, the proposed standards could have gone farther and set up standards for how a patient can be successfully integrated back into the work site in an atmosphere of support.

The new standards are to be issued primarily with independent managed behavioral health care organizations in mind, not for mental health programs that are part of general managed care organizations, such as health maintenance organizations. The standards do not set up a mechanism for collecting data on behavioral care plans so that employers can compare them precisely, but many anticipate the standards are the first step toward such a system much as HEDIS, the Healthcare Plan Employer Information and Data Set, is being developed now by NCQA as an evaluative system for general managed care.

The new standards should be viewed as minimum requirements that will ensure employers and workers are not being taken advantage of by managed care outfits, said Leslie Scallet, executive director of the Washington-based Mental Health Policy Resource Center, a think tank and information clearing house.

"What these standards will do is give a benchmark to employers," she said. "They can rest more assured that they (the plans) are actually doing what they promise to do."

But Ms. Scallet said she was encouraged that the several representatives of managed care organizations who were present on the committee that wrote the new NCQA standards seemed excited about tightening the reins on their industry and being compelled to meet expectations.

"I think they look on it as a way to distinguish themselves from those that are out to make money from those who are not capable of demanding what they are entitled to from their insurance plan," she said. ■

Caterpillar

Continued from page 1
sues objectively."

On April 19, U.S. Magistrate J. Andrew Smyser in Harrisburg, Pa., found Caterpillar in contempt of a federal warrant he issued for blocking the NIOSH and UAW representatives from entering the plant.

Caterpillar responded in a statement that it would "vigorously contest the magistrate's ruling" and "continue resisting the inspection."

Later that day, following a request by the U.S. secretary of health and human services to enforce the magistrate's warrant, U.S. District Judge James F. McClure Jr. said Caterpillar had until Friday to explain why it should not be held in contempt. As of late Thursday, it had not done so. The government then must respond to Caterpillar's filing by April 30.

The UAW and Caterpillar have been discussing whether there are health and safety hazards in the York, Pa., plant for nearly three years, according to Frank Mirer, director of health and safety for the union in Detroit.

In 1993, he said, Caterpillar told affected employees that the results of medical tests required by the Occupational Safety and Health Administration indicated their blood and urine contained elevated levels of the toxic metal cadmium.

In December of that year, Mr. Mirer said, Caterpillar officials discussed health problems among oil cooler department workers at a safety committee meeting held at the York plant.

Mr. Mirer said that the following year, in October 1994, five workers in the oil cooler department were examined by occupational physicians and a common pattern of health problems, including sexual dysfunction, was detected. The UAW then asked NIOSH to perform a health hazard evaluation of the facility, where about 1,450 UAW members work.

A year later, in October 1995, the five oil cooler department workers were tested at another occupational medicine clinic, which also confirmed the common pattern of health problems, including sexual dysfunction.

Last month, at the request of the UAW, NIOSH notified Caterpillar officials that it wanted to conduct a health hazard evaluation of the plant. "From the outset, there was enough information that we felt we had to pursue the request," the spokesman said.

Caterpillar says it had already provided NIOSH with extensive information about the facility, including details on the use of cadmium and workplace safety testing and monitoring.

"The information we provided NIOSH showed that no employees were exposed to levels of cadmium or any other metals used in the manufacturing process that exceeded lifetime exposure limits set by OSHA," Caterpillar VP Duane H. Livingston said in a statement.

In an April 25 letter to employees, Mr. Livingston contended that "NIOSH targeted (Caterpillar's) York facility only after being asked to do so by the UAW during the height of the union's corporate campaign against" the company. Also, NIOSH "is trying to support an unproven medical hypothesis" that cadmium exposure causes low levels of testosterone, the letter asserted. "In fact, when OSHA established current cadmium exposure limits in 1992, they rejected the very theory now being proposed by NIOSH."

Mr. Livingston said company officials are willing to discuss the situation with NIOSH officials rather than inspect the facility, but NIOSH said it has collected as much information as it can outside the facility and must conduct its health hazard evaluation onsite.

Separately, Caterpillar's York facility was cited by OSHA in 1993 for cadmium exposure violations, said an OSHA spokeswoman in Philadelphia. Caterpillar contested the citation and an administrative law judge ultimately vacated it, finding that Caterpillar had reduced the cadmium levels.

Court

Continued from page 2

to the 4th U.S. Circuit Court of Appeals. A panel of judges first upheld Mr. Robinson, but the full appellate court dismissed the case. The court agreed last week to hear the case.

The court also agreed to decide whether a local government that acted within the bounds of state law when hiring an employee can be sued for negligent hiring and training.

In *Board of County Commissioners of Bryan County, Okla. vs. Brown*, the court will decide whether a local government can be held liable under federal civil rights laws for a hiring decision made in accordance with state law.

Bryan County hired a reserve police officer despite his history of misdemeanor arrests and convictions.

The officer stopped a motorist, who said she was injured by the officer as he pulled her from her car and threw her to the ground.

She sued the county and the of-

ficer, alleging negligence under a post-Civil War civil rights act that allows suits in federal court against people who violate federally guaranteed rights. A federal district court jury in Texas found both the county and officer liable and awarded the motorist about \$800,000.

Can a government that acted within the bounds of state law when hiring an employee be sued for negligent hiring?

The 5th U.S. Circuit Court of Appeals upheld the award, and the county appealed. The county held that there's no federal statute or constitutional ban against hiring people with misdemeanor records.

Oklahoma law does not impose such a ban, either. Therefore, the county argued, its hiring decisions are not subject to federal law and the case should be dismissed. ■

collected about \$800,000 from November 1992 to April 1995.

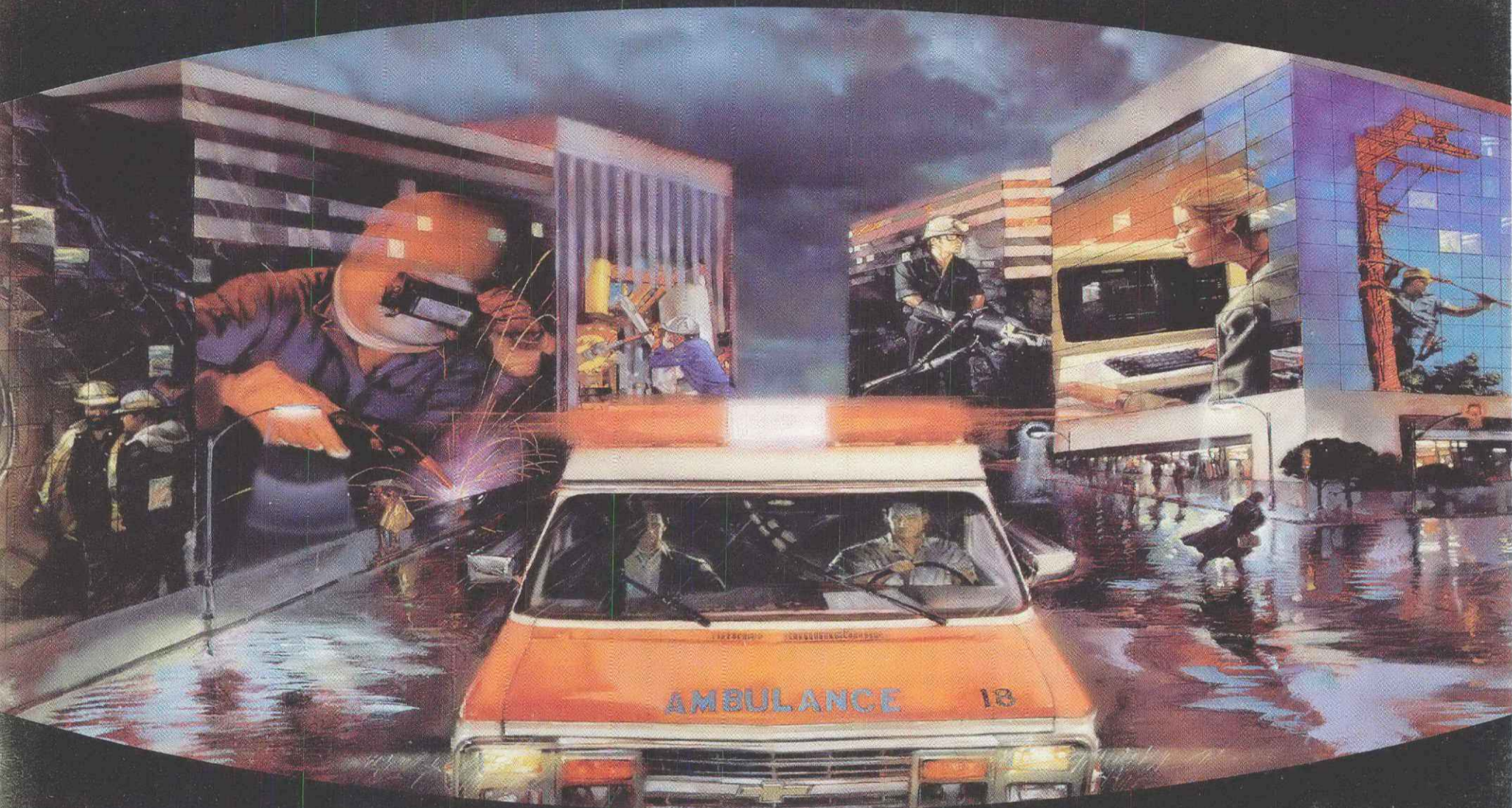
• Mr. Fuller arranged more than \$1 million in unsecured or undersecured loans from IAEA Benefit Trust to friends and associates. In one case,

Mr. Chervenak and Mr. Rosenberg agreed to resign their positions with IAEA and have been enjoined from dealing with benefit plans governed by federal law, the Labor Department announced. ■

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