

# Business Insurance

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## RIMS seeks federal regulation for large commercial insurers

ANAHEIM, Calif.—The federal government should regulate the solvency of property/casualty insurers writing coverage for large commercial policyholders, the Risk & Insurance Management Society Inc. says.

While RIMS currently is not offering a specific proposal, "the time has come for a federal role in regulating insurers," said RIMS President Robert W. Esenberg at the society's 30th annual conference last week. RIMS released a policy statement because "it's time to get involved in the debate,"

*Continued on next page*

# Pollution exclusion confusion

By STACY GORDON

## Federal appeals courts split on N.J. law

BOSTON—The ongoing conflict among state and federal courts interpreting the pollution exclusion clause in comprehensive general liability insurance policies has reached new extremes.

Two federal appeals courts—the 1st and 4th U.S. Circuit Courts of Appeal—each interpreting the pollution exclusion under New Jersey law last month reached diametrically opposite

results. The 1st Circuit ruled in favor of policyholders, while the 4th Circuit ruled in favor of insurers.

And, while the 1st Circuit ruled in favor of policyholders, the Massachusetts Supreme Judicial Court sitting only a few hundred yards away interpreted the exclusion in favor of insurers (see story, page 53). Massachusetts is one of the states within

the 1st Circuit.

"This is a nightmare," said Michael F. Aylward, an insurer attorney with Morrison, Mahoney & Miller in Boston.

Predicting how a court will rule on the pollution exclusion has become "crystal ball gazing," he said.

Nationwide, there are 300 to 400 conflicting decisions on the pollution exclusion, he said.

"There are decisions all over the map," agreed policyholder attorney David Harris of Lowenstein, Sandler, Kohl, Fisher & Boylan in Roseland, N.J., the plaintiff's attorney in the 1st Circuit case. "It is really crazy that a client on one side of the Hudson River is deprived of any coverage and a client on the other side of the Hudson can recover in full. This is an absurd

result," Mr. Harris said.

"Even if this is a slow train, it is a slow train to nowhere but confusion," quipped Mr. Harris.

"This area of law has just created instability, and instability creates more litigation," added policyholder attorney William Greaney of Covington & Burling in Washington, D.C.

"If the function of the law and lawyers is to promote certainty, then the law in this area has not done a very good job," added Mr.

*Continued on page 53*

# Insurer prospects vary

## Soft market and economy spell gloomy P/C outlook

By JUDY GREENWALD

Inertia is still the rule in the commercial property/casualty insurance industry, with no force in sight yet to jolt insurers out of the continuing soft market.

Lower investment yields, increasing underwriting losses, underreserving and catastrophe losses all have failed to stir the market out of its malaise, say observers. And with 1991 net income gains for many insurers, fueled by investment gains and in some cases underreserving, insurer executives and industry analysts predict a market turn will not arrive any earlier than late 1993.

"It's gone beyond any reasonable time frame, any natural time frame," Myron Picoult, managing director and senior insurance analyst with New York-based Oppenheimer & Co., said of the market's failure to turn. Some companies, in fact, are "digging themselves into a hole" from which "they'll never get out," he said.

The property/casualty industry's results "looked almost too good," which means there is no reason to believe the soft market will firm up soon, said Gloria Vogel, first vp with Lehman Brothers in New York.

"The industry remains strongly capitalized, and the results aren't bad enough at this time, frankly, to trigger needed pricing actions, particularly in commercial lines," agreed Bernard C. Hlavac, vp-accounting

## Health insurers see 1992 profits, stable trends

By LORI BLOCK

Indicating that competition may be returning in some small fashion to the group health insurance market, group health insurers say they expect a stable profit picture in 1992 following mixed results last year.

Three major health insurers reported profit decreases in their group life and health segments last year compared with 1990 results, while three reported increases.

However, group health insurers say they are not seeing a cyclical downturn in profits, largely because of more predictable medical inflation trends, which helps them to avoid underpricing their products. In addition, some are seeing improved results in their managed care operations.

Employers can take some measure of solace in the insurers' report that the medical inflation trend has stabilized. Insurers say that rate increases this year will be no greater than those in 1991.

Gloria Vogel, a first vp with Lehman Brothers in New York, *Continued on page 45*

for Sentry Insurance Cos. in Stevens Point, Wis.

"We don't see much evidence that '92 is going to be a turnaround year by any means. We don't see anything happening in '92, and we're not so sure it's going to be anything real dramatic in '93," he said. "We think the commercial lines marketplace is in disarray."

Certainly, there was "nothing to trigger any major reactions" this year in the industry's 1991 results, said Michael Lewis, first vp with Dean Witter Reynolds in New York.

Twenty-five commercial property/casualty insurers surveyed by *Business Insurance* that reported this data posted a 30.3% increase in net income to \$6.79

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# N.Y. ruling allowing offsets may influence other states

By DOUGLAS McLEOD

NEW YORK—Reinsurer and insurer representatives are applauding a ruling by New York's highest court affirming the right of reinsurers to offset amounts they owe to an insolvent insurer with amounts the insolvent company owes them.

The New York Court of Appeals last month upheld a lower appellate court order allowing Kemper Reinsurance Co. to offset loss payments owed to the

defunct Midland Insurance Co. by the amount of premiums Midland owed to Kemper Re.

The ruling not only settles the question of offset rights in New York but it also will serve as a precedent in many other states that modeled their offset provisions on New York's, several reinsurance lawyers predict.

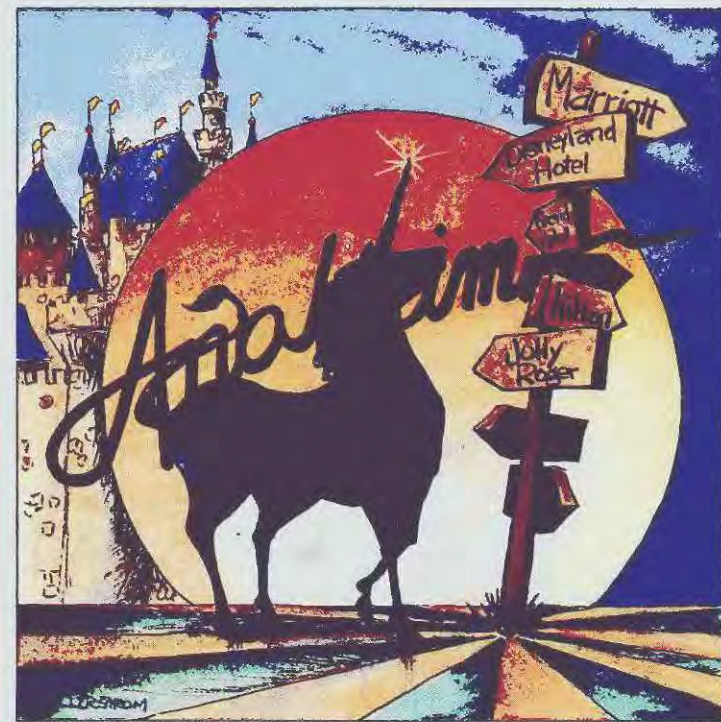
The New York ruling is the first by a state high court affirming offset rights. It follows similar decisions by a state appellate court in California and the 7th

U.S. Circuit Court of Appeals interpreting Illinois law (*BI*, Jan. 8, 1990; July 30, 1990).

Most states—including New York, California and Illinois—have provisions in their insurance codes allowing insurers and reinsurers to offset mutual credits and debts, reinsurance lawyers say.

However, offset rights have been denied by courts in Colorado and Missouri, which were among the few states without

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## The magic of Anaheim

All roads led to Anaheim, Calif., last week as more than 8,000 registrants and exhibitors attended the 30th annual RIMS conference. Reports on employee benefit sessions begin on page 3. Reports on risk management sessions will appear in the May 13 issue.

## Update

## RIMS seeks federal regulation

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said Mr. Esenberg, risk manager for the city of Virginia Beach, Va. RIMS representatives plan to attend a House subcommittee hearing this week that will discuss federal regulation of insurance companies.

Until last week, RIMS had not taken a formal position on the issue of state vs. federal regulation of insurer solvency.

Stressing that RIMS has not drafted a concrete proposal, the policy statement calls for mandatory federal regulation of property/casualty insurers writing coverage for large commercial policyholders. States would continue to regulate insurers writing small commercial policies and personal lines business. RIMS has not decided what criteria would be used to distinguish between small and large commercial policyholders, said Paul Brown, RIMS' director of governmental affairs and general counsel.

Under RIMS' model, insurers with federal licenses would be free from state rate and policy form requirements.

Mr. Esenberg noted that RIMS could not at this time back federal regulatory proposals by the American Insurance Assn. and the Insurance Solvency Coalition, a group of brokers, insurers and policyholders. The AIA proposal would allow all insurers, including personal lines insurers, to opt for federal regulation, while the ISC plan would allow only large commercial insurers to opt for federal oversight (BI, Feb. 3).

However, Mr. Esenberg pledged that RIMS "would continue to work with all facets of the industry"—including state regulators—to create a workable regulatory plan.

William H. McCartney, president of the National Assn. of Insurance Commissioners and Nebraska insurance director, blasted RIMS' position. "This appears to be just another association coming forth with its self-serving version of how it wants to see insurance regulation," he said.

Andrew Wright, the AIA's vp-federal affairs, said he was "troubled" by RIMS' stance that only large commercial insurers should be federally regulated, leaving smaller insurers subject to state regulation. However, he said he was glad that RIMS "is interested in getting involved in the debate."

## Punitive damages bill defeated

ANNAPOLIS, Md.—In a surprise move, a Maryland Senate panel last week killed what would have been the first state punitive damages bill drafted in direct response to a landmark 1991 Supreme Court ruling.

The Judicial Proceedings Committee rejected the bill on an 8-3 vote after it passed the Maryland House of Delegates 82-43 in early March (BI, March 23).

If the bill had been enacted, Maryland would have become the first state with a new law drafted in direct response to *Pacific Mutual Life Insurance Co. vs. Haslip* (BI, March 11, 1991). In that case, the Supreme Court suggested that states look into reforming their systems for awarding punitive damages.

"We are very disappointed," said Martin Connor, president of the American Tort Reform Assn. in Washington, D.C.

## AIDS case comment sought

WASHINGTON—The U.S. Supreme Court is seeking comment from the solicitor general on a lower court ruling that employers can restrict coverage for treatment of AIDS if they self-fund their health care plans.

The high court has not yet decided whether to hear the case.

The lawsuit was filed against H&H Music Co. by an employee who has since died (BI, Aug. 6, 1990). Shortly after John McGann filed AIDS-related claims, the Houston music store switched from an insured to a self-funded plan and set a \$5,000 cap on lifetime benefits for the cost of treatment related to acquired immune deficiency syndrome. The lifetime limit remained \$1 million for all other types of claims.

Mr. McGann's estate is appealing the 5th U.S. Circuit Court of Appeals' ruling that the H&H restriction did not violate the Employee Retirement Income Security Act of 1974 because it applied equally to all employees (BI, Nov. 18, 1991).

## \$87 million to settle S&amp;L claims

NEW YORK—Ernst & Young agreed to pay \$63 million and the law firm Jones, Day, Reavis & Pogue agreed to pay \$24 million to settle civil fraud suits related to the nation's largest S&L failure.

The claims were brought by bondholders of American Continental Corp., parent of failed Lincoln Savings & Loan Assn. Claims against New York-based Ernst & Young related to audits done for American Continental; those against the Cleveland-based law firm stem from work on an American Continental bond offering.

An Ernst & Young spokesman said insurance will cover "virtually all" of its settlement. Jones, Day's coverage from Attorneys' Liability Assurance Society (Bermuda) Ltd. will cover the settlement, said a firm spokeswoman. The group captive provides up to \$25 million per occurrence in professional liability coverage.

Ernst & Young "reluctantly agreed to settle," the spokesman said, noting that the firm resigned the Lincoln account over "accounting disagreements" in 1988, a year before federal regulators seized the S&L. But, he added, "the negative emotions" in the case "were too much to overcome."

Similarly, Richard W. Pogue, Jones, Day managing partner, said in a statement that "there was an increasing risk" that a jury would sympathize with bondholders and that this "would overwhelm the facts concerning the correctness of our actions."

Updates continued on page 54

## More changes possible in NAIC fronting draft

By MEG FLETCHER

SEATTLE—Some risk managers and insurers are more optimistic that they may be able to soften a National Assn. of Insurance Commissioners proposal that would limit fronting arrangements.

But, a regulator is now recommending that the proposed model law also apply to surplus lines insurers, which some states allow to act as fronting insurers in certain cases.

Still, the 11-member Reinsurance Task Force now considering the draft model law offers a new and larger forum of regulators than did the five-member working group that passed it on after

more than a year's work, risk manager and insurer representatives said following the NAIC's spring meeting here last week.

Indeed, the task force is willing to discuss the draft with risk managers and industry representatives at meetings and perhaps a public hearing that would be held before the NAIC's summer meeting in June, said new task force Chairman and NAIC Vp Steven T. Foster.

However, Mr. Foster, Virginia's insurance commissioner, allowed only a few comments during the task force's meeting last week, which he attributed to time pressures.

The Risk & Insurance Management Society Inc. in New York is

"encouraged" that the proposal is now before the task force, which could make more changes in the proposal that are favorable to parents of captive insurers, said Paul Brown, director of governmental affairs and general counsel.

The New York Insurance Department "has come a long way and done a good job" of chairing the working group that first drafted the proposal on limiting fronting arrangements. But, New York regulators have reached an impasse with risk managers and insurers, he said.

The task force will provide fresh views and a good opportunity to fine tune the proposal.

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## HMO premiums steady

Plans cost-effective but dissatisfaction may be increasing, Foster Higgins finds

By STACY GORDON

NEW YORK—Health maintenance organization premiums rose slightly more than indemnity premiums in 1991, but HMOs are still by far the most cost-effective means of providing group health care coverage, a new survey shows.

At the same time, employer satisfaction with HMOs is declining, the survey finds.

HMO premiums averaged

\$3,046 per employee in 1991, or 17.3% less than the \$3,573 average cost for coverage written through traditional indemnity plans, and 10.1% lower than the premiums for indemnity plans with preferred provider organization options, which averaged \$3,355.

However, the average HMO premium in 1991 was 13.5% higher than the \$2,683 average premium in 1990.

That increase is greater than the 13% increase in premiums for traditional indemnity plans, although it is slightly lower than the 13.7% hike in premiums for indemnity plans with PPO options, reports the new survey from benefit consultant A. Foster Higgins & Co. Inc. of New York.

The reason employers saw HMO premiums increase faster than indemnity premiums in 1991 is that the increase in indemnity plan premiums last year was the lowest since 1989, according to John Erb, a Foster Higgins managing consultant in New York. Foster Higgins in January released a report detailing group health care costs in 1991 (BI, Jan. 27).

HMO premiums have increased steadily at about 13% to 14% for the past several years, he observed. However, the 13% rise in indemnity plan premiums last year is dramatically lower than increases of 21.6% in 1990 and 20.4% in 1989.

Premiums for indemnity plans

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## Employers like savings, employees like choice

## Point of service grows

By MICHAEL SCHACHNER

WASHINGTON—Point-of-service health care plans are not a passing fad that will give way to health maintenance organizations, an insurer asserts.

Private and public sector employers will increasingly offer point-of-service plans, especially those affiliated with HMOs, says Stephen A. George, vp-managed care and chief medical officer with Provident Life & Accident Insurance Co. in Chattanooga, Tenn.

Employers believe the plans

place a high priority on cost containment while still providing an acceptable level of employee choice, he said.

In addition, insurers and benefit consultants appear committed to the point-of-service concept and will be vigorously pushing these programs over the next three years, Mr. George said at the annual National Managed Health Care Congress conference in Washington, D.C., last week.

Point-of-service plans offer

HMO-style benefits while still allowing plan enrollees to use non-network providers at a higher out-of-pocket cost. And, like with an HMO, enrollees' care is directed by a primary care physician, or gatekeeper.

However, point-of-service plans are not always built around HMOs. Some use preferred provider organizations as their centerpiece.

"Demand for these plans is increasing because it's the one type of plan that lines up both the employer and providers on the sub-

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## Inside

✓ This week's editorial reviews the reasons why many employers would not give up their group health care plans under a national play-or-pay system. **PAGE 8**

✓ A new strategy of using an 'outsourcing vendor' to merge a company's risk and benefits functions can lead to considerable savings for self-insurers, says Jerry Buckley of California Interactive Computing Inc. in Perspectives. **PAGE 31**

✓ A managing agents group predicts that Lloyd's of London's overall market loss for 1989, which closed at year-end, will be as high as \$3.09 billion, much higher than earlier forecasts. **PAGE 47**

✓ Investors in brokerage stocks share the pain of managements after a lackluster 1991, says stock analyst Leonard Wilson. **PAGE 55**

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## Skyrocketing costs for health care, work comp top managers' worries, says BI opinion poll

By JERRY GEISEL

ANAHEIM, Calif.—Top corporate management is more concerned than ever about rising health care and workers compensation costs, professionals attending the Risk & Insurance Management Society conference said last week.

Risk managers, benefit managers and insurance industry executives also say it is time for the federal government to require employers to offer a health plan or pay a new tax to support a public plan for the uninsured.

However, they oppose a federal takeover of the health care delivery system, though they are nearly evenly divided on whether the federal government would do a better job of keeping health care costs under control.

And even though they are dissatisfied with state insurance regulation, they are not certain whether the federal government could do a better job.

These findings are based on the responses of 362 risk and benefit managers, as well as insurers, brokers, consultants, third-party claims administrators and others who responded to the second annual *Business Insurance* "One-Minute Opinion Poll" while touring the exhibit hall last week at the 30th annual RIMS conference.

The latest survey found that top management generally is much more concerned than they were a year ago about rising health care and workers compensation costs.

Of the 321 people who answered the question, "How concerned is your top management about rising health care costs?" 33.6% said it was a top priority, down only slightly from 34.4% last year. But, 61.4% said top management was very concerned, up from 39.4%, and 3.4% said top management was moderately concerned, down from 25.6%. Just 1.6% said top management was unconcerned, compared with less than 1% last year.

Of the 354 people responding to a similar question about workers compensation costs, 35.9% said rising costs were a top priority for senior management, up from 32.3% last year.

In addition, 42.9% said senior management was very concerned, up from 35.9%; 18.4% reported top management was moderately concerned about workers compensation costs, down from 27.6%; and 2.8% said top management was not at all concerned, compared with 4.1% in 1991.

Many people said if there were one thing they could do to improve the workers comp system, they would limit or even eliminate attorney involvement.

One respondent said he would "eliminate political control over rates and the state work comp bureau."

Another said he would "limit employees' ability to deal with their own physicians."

Others endorse regulation of doctors' fees and expanded investigation of questionable claims.

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### Grabbing management attention

Attendees at the Risk & Insurance Management Society conference were asked:

How concerned is your top management about rising health care costs?



How concerned is top management about rising workers comp costs?



Source: BI survey

GRAPHIC BY JOHN SMITHER

# Finding most efficient providers key to cost containment results

## Sophisticated buyers negotiating best savings

By CHRISTINE WOOLSEY

ANAHEIM, Calif.—Direct contracting, point-of-service managed care and managed mental health/substance abuse carveouts each are effective medical cost containment strategies when used by sophisticated health care buyers, according to a panel of experts.

Employers that have implemented these strategies have been able to tailor provider networks to their liking, reduce health care claims costs and lower health care cost trend increases, said Steven J. Richter, a consultant with The Wyatt Co. in Sherman Oaks, Calif., during last week's 30th annual Risk & Insurance Management Society conference.

In addition, Mr. Richter said, employers have been better able to direct employees and dependents to seek care from the most cost-efficient providers and in the most appropriate setting.

When directly contracting with physicians, hospitals and ancillary medical service providers, "employers have to be more critical and more aggressive," suggested David Hoskinson, vp of managed care with Catholic HealthCare West, a San Francisco-based network of 15 hospitals in the West.

"Direct contracting is very difficult," Mr. Hoskinson said, adding that providers will take advantage of unsophisticated buyers.

"It's important for you to know that 6% to 8% of all people who go into hospitals contract additional diseases in hospitals. And, it's important for you to know that most medical procedures are not scientifically proven—at least 20% to 30% of all health services aren't really needed," Mr. Hoskinson said.

To illustrate the type of confusion that can arise when dealing with the medical community, he posed a question to the audience: "Will HMOs or PPOs use APGs or RBRVs for the fee-for-service SCPs in the IPAs?"

"If you don't understand all those acronyms, you aren't going to be a very sophisticated direct buyer," he said.

Financial risk sharing is key when directly contracting with providers, whether they be hospitals, physicians or ancillary firms that provide services like laboratory tests or radiology treatment, he said.

Five key players are involved in the health care system—the government, private payers like insurance companies, employers, consumers and providers.

Plan design changes—like increasing deductibles and co-payments—can influence employee health care purchasing behavior, he explained.

Health care providers also need incentives to deliver the best, most cost-effective care, Mr. Hoskinson said.

Financial risk-sharing arrangements with providers can encourage them to deliver good care, Mr. Hoskinson said. But, he reiterated, "employers need to be more sophisticated, not about benefit design, but about the technicalities of buying medical care."

Discounts make for "sloppy buying," Mr. Hoskinson maintained. Discounts of 10% on services, for example, do not ensure a good deal because employers don't know if the base price is fair, he explained.

Per diem payment arrangements—which link the number of bed days to a specific medical episode—are a little better, he said.

Still better are risk-sharing payment arrangements like capitation or linking a percent of premium to claims costs. These enable employers to get the most value for their dollar and prevent unsophisticated buyers from being taken advantage of, Mr. Hoskinson said.

Using capitation—which typically pays a provider a set fee per patient per month regardless of the services used—"gives the provider a budget it

therapy, he explained.

Adhering to the APG payment schedule may be easier than relying on capitation for outpatient services because it is difficult to predict which outpatient setting an employee will be put in by a provider, Mr. Hoskinson explained.

"Employers must become familiar with these types of fee schedules because the government is already using them. And, if the government does a better job at capping provider payments, then providers will simply cost shift to private payers," he said.



Clockwise, from top left, Eric C. Sohlgren, Steven J. Richter, Bud Martinez, David Hoskinson and Lea Sirota discuss managed care at a RIMS session.

has to work with," he said.

Understanding the different kinds of physician fee schedules is important to buyers paying capitated fees, he pointed out. For example, the government uses diagnostic-related groups to assign charges for certain procedures performed on Medicaid patients.

A new payment schedule—the ambulatory payment grouping, or APG—is now being established by the government for outpatient services, he said. That schedule assigns fees for services like outpatient surgery, radiology, lab tests and physical

Other risk-sharing arrangements—like linking claims costs to the premium employers pay to HMOs—also can encourage providers to deliver proper care, Mr. Hoskinson said. These types of arrangements typically involve setting a target amount of health care claims. If claims come in below target, the HMO will be rewarded; if they come in higher, the employer may receive a refund.

Point-of-service managed care plans can also save employers money, said Bud Martinez, vp of welfare benefits planning for Security Pacific

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# Apple flex plan saves money, widens employee choice

*In benefits, like computer technology, firm wants to be a leader, manager says*

By JERRY GEISEL

ANAHEIM, Calif.—Apple Computer Inc., known for being ahead of its time in personal computer technology, is trying to keep its flexible benefit plan up to date.

Five years ago, Cupertino, Calif.-based Apple became one of the first Silicon Valley companies to offer a flexible benefit plan.

Apple wanted "to lead in benefits" and flex was a way to focus on employee needs and to improve benefits by giving employees more choices, said Sally Gottlieb, Apple's manager of

benefits administration.

Among other things, the Apple flex plan gave employees the option of shifting unused company-provided benefit credits to their 401(k) plan or taking the credits in cash.

"Employees loved the plan. Apple is a leading edge company and flex is a leading edge benefit plan," Ms. Gottlieb said.

At the 30th annual Risk & Insurance Management Society conference last week, Ms. Gottlieb said that two years ago—in the wake of slipping gross profit margins and escalating medical costs—Apple did a comprehensive study of its compensation

and benefit programs.

One finding: Medical costs—\$28.1 million in 1990—would double in five years.

"When top management saw these projections, they said 'Whoa, we have to do something,'" the benefits manager recalled.

At the same time, Apple found that its medical benefits were richer than those at 20 other similar-sized firms.

"We wanted to be above market in every benefit category, but not necessarily No. 1. We also needed to build a foundation to keep costs under control," she said.

As part of a multi-step cost control plan, Apple last year added features like a hospital pre-certification program and is now raising deductibles.

More substantive changes have begun and will continue over the next several years. The most significant changes involve Apple's pricing of the various health care options.

Among other things, Apple didn't make enough of a distinction in "price" to give employees an incentive to choose the medical plan with the most employee cost sharing.

For example, Apple employees received 300 "benefit dollars"

for medical coverage.

An Apple basic plan, which has a \$150 deductible for individual coverage, costs 56 benefit dollars for employee-only coverage.

As a result, an employee who selects the basic plan would have 244 unused credits or dollars that could be applied toward other benefits or taken in cash or rolled over into the 401(k) plan.

However, if that same employee had selected Apple's richer, so-called preferred plan, which costs 141 benefit dollars, the employee would have had 159 unused credits.

That gave little economic incentive to choose plans with the most cost-sharing.

But under Apple's new pricing schedule, which is being phased in over the next several years, the differences in how the medical plan options are priced will widen.

For example, employees will receive 900 benefit dollars to purchase medical coverage. An employee selecting individual coverage from the basic plan, which will cost 110 benefit dollars, would have 790 unused credits.

By contrast, an employee choosing individual coverage from the preferred plan, whose price will be 580 benefit dollars, would have 320 unused credits. That's 470 fewer than if he or she had chosen the basic plan.

"We wanted to put more money on the table so there would be more of a distinction between the plans" Ms. Gottlieb said.

At the same, Apple is increasing the price of family coverage.

The company found that many employees with working spouses were opting for family coverage even though their spouses may have been offered coverage through another company's plan.

"Over half of our costs are for dependents," Ms. Gottlieb said.

Meanwhile, Apple is upgrading the administration of the flexible benefit plan.

The company intends to do away entirely with paperwork processing of employees' benefit choices during annual enrollment periods, Ms. Gottlieb said.

Employees will use computers to make enrollment choices with the information going to a file server and then processed by Apple's plan administrator, Hewitt Associates.

Charles Ginsberg, managing director of research and training services in the Newburyport, Mass., office of The Alexander Consulting Group Inc., who also spoke at the session, said employers should consider new design approaches for their flex plans.

One approach, Mr. Ginsberg said, would be to tie the number of flexible dollars or credits a company provides to its economic performance or to the job performance of individual employees.

For example, if a company had an especially good year, it could add bonus flex credits the following year.

The session was moderated by Penelope J. Troup, vp of risk management at Freedom Newspapers Inc. in Irvine, Calif.

The coordinator was W. Lee Carter III, director of research and development for Alexander & Alexander Inc. in Dallas. ■



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# Dim future seen for benefit bills pending in Congress

By JERRY GEISEL

ANAHEIM, Calif.—A slew of employee benefits related legislation is pending before Congress, but legislators are unlikely to complete action on those proposals as the legislative session enters the home stretch, a consultant says.

Those proposals include: sweeping health care reform legislation, so-called small group or incremental health care reform, changes to give the federal Pension Benefit Guaranty Corp. better protection from big losses, pension simplification and family leave proposals.

The family and medical leave legislation has the best chance—

but even its prospects are cloudy, said Charles E. Ginsberg, managing director of research and training services at Alexander & Alexander Consulting Group in Newburyport, Mass.

Speaking last week at the 30th annual Risk & Insurance Management Society conference, Mr. Ginsberg said public opinion polls may dictate the fate of the medical and family leave bill.

Under measures H.R. 2 and S. 5, now awaiting final action, employers with fewer than 50 employees would have to provide up to 12 weeks of unpaid leave for an employee's own illness and that of a parent, spouse or child, or to take care of a newborn or adopted child.

During that time, the employee's health insurance would have to be continued on the same basis as before the leave began. Also, employees would have to be guaranteed the same or equivalent positions when they return.

During the last legislative session, President Bush vetoed a similar bill, and Congress was unable to override the veto.

But President Bush may be more reluctant this time around, Mr. Ginsberg said. "The (public opinion) polls may well dictate what President Bush will do."

In fact, there is overwhelming public support for the concept of employer-provided family and medical leave, said Jim Klein, director of personnel at Kawa-

saki Motors Corp. U.S.A. in Irvine, Calif. More than 75% of those in a recent Gallup poll said companies should be required to provide family and medical leave, he said.

"There is a high preference for mandated leave," Mr. Klein said.

A lack of consensus, both in Congress as well as in the nation, will doom comprehensive health care reform legislation during the remainder of the session as well as during the next several years, Mr. Ginsberg observed.

For example, while a number of representatives, led by Rep. Marty Russo, D-Ill., favor a Canadian-style national health insurance program, many concerns have been raised about a Cana-

dian-style plan.

Among other things, some have argued that the costs of the Canadian program are higher than believed and that there are long waits for elective services, Mr. Ginsberg said.

A rocky future also awaits various proposals in the House and Senate to require employers to offer health care plans meeting federal minimum standards or pay a new payroll tax.

Depending on the proposal, an employer would have to pay a tax equal to as much as 9% of payroll if it didn't offer a health care plan.

"One of the problems is that it (offering a health care plan or paying a tax) is too costly for small employers," Mr. Ginsberg said. In the absence of a consensus on comprehensive health care reform, incremental reforms "are likely to be the wave of the present," he said.

Elements of incremental reform packages include curbing the ability of insurers and employers to deny coverage to those with pre-existing medical conditions and barring small-group insurers from denying coverage to any individual in a group.

On the pension side, legislation that would strengthen the PBGC's status as a creditor in bankruptcies appears doomed during the current session, he said.

The legislation, which also would restrain PBGC's guarantees for underfunded pension plans that continue to increase benefits, "is too technical," Mr. Ginsberg asserted. "Nobody is interested in it. It won't pass."

On the other hand, in theory, pension simplification should pass because those proposals have not generated any controversy, he said.

An array of pension simplification provisions was included in a tax bill approved by Congress, but later vetoed by President Bush (BI, March 30).

Pension simplification could die because of all the political maneuvering, Mr. Ginsberg commented.

Meanwhile, stiff employer and insurer opposition will probably doom legislation that would expose insurers to state remedies, such as punitive damage awards, for mishandling health insurance claims.

That legislation, which earlier cleared a House panel, would overturn a 1987 Supreme Court decision that said claims handling penalties in group health plans are limited to those set by the Employee Retirement Income Security Act of 1974: claims costs and, at the discretion of courts, attorneys' fees.

If group health insurers were subject to punitive damage awards, those costs will be passed on to employers, he said.

"Industry opposition kept the legislation from passing last year and will likely do so again this year," Mr. Ginsberg said.

Also speaking at the session was Patricia Johnson, senior vp for consumer service at Blue Cross of California in Woodland Hills. The session was moderated by Jerry Lane, assistant vp-insurance at McDonald's Corp. in Oakbrook, Ill. The coordinator was W. Lee Carter, director of research and development at Alexander & Alexander Inc. in Dallas.



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## Opinions

## Employers stick with plans

**E**MPLOYERS STILL ARE in the game.

Benefit managers say they would not drop their health care plans under a "play-or-pay" system in favor of paying a tax to support a new public plan for the uninsured—even if it made economic sense to do so (BI, March 30).

Employers want to stick with their health care programs for several reasons.

Some worry that terminating employer-provided plans in favor of paying a tax would reduce the quality of care for their employees. For example, fewer physicians and hospitals would be willing to treat employees in a public plan if the government would—as could be expected—slash payments to providers to save money.

At the same time, benefit managers doubt that the government would provide the diversity of health care programs, like flexible benefit plans, that companies now provide to meet their own and their employees' needs. Innovation and freedom of choice, hallmarks of employer plans, are incompatible with government programs and their one-size-fits-all structure.

Finally, employers note, quite correctly, that while the taxes needed to fund a public health plan might initially cost them less than their own health care programs, that cost advantage would likely erode over time.

As one benefit manager said, the government's dismal track record in regulating savings and loan associations, as well as administering the Medicare and Medicaid programs, does not exactly inspire confidence that it could competently administer a new public health program while keeping costs under control.

We hope legislators keep these sound observations in mind as they consider play-or-pay proposals and even more far-reaching ideas to replace employer health care plans in favor of a national single-payer health care system.

If the government replaces employers as the major provider of health care benefits, quality of



care would suffer without any assurance that costs could be controlled.

Certainly, legislators can play a positive role in making health care more affordable and thus more available to employers and their employees.

Legislators can make sure that federal regulations and laws don't drive employers from offering health care plans. For example, the late Section 89, with its outrageous paperwork demands, provided a powerful disincentive for employers to offer health care plans.

Legislators also can make sure that Medicare and Medicaid pay their fair share of costs to reduce the pressure on providers to shift costs to patients insured under employer plans.

Certainly, there is a lot wrong with the nation's health care system. Costs remain out of control and too many people lack good coverage. But making government the primary source of coverage would create more problems than it would solve.

## Letters

## Prevention key to 'holistic' workers comp strategy

To the editor: Your March 9 article, "Workers Comp Fuels Demand for Advice," amplified the fact that companies (clients) are looking at all types of ways to reduce comp costs.

The article referenced a number of comments: "Risk managers' largest concern 'is the escalating costs in the workers comp area'"; "Workers comp is something that is providing us with an awful lot of activity..."; "It's the 'hot button' in the industry right now..."

What I found most interesting was the comment about Tillinghast: The company "decided to package a set of workers comp-related services last year" in an attempt to "start focusing on the bottom line," and that is Tillinghast's version of "a 'holistic' attack on workers comp costs."

My dictionary defines "holism" as "the theory that the whole is greater

than the sum of its parts." Assuming this is correct, what I hear the companies saying is that the best way to reduce comp costs is after something—like an accident—happens. Thus, the comp solutions are aptly named: case management, risk management, claims management, disability cost management, etc.

Although these are effective services that will reduce comp costs somewhat, they do not solve the employer's problem: workplace injuries. Doesn't the equation, no injuries = no comp problems, make sense? The only real "holistic" approach would involve both pre- and post-injury solutions, with the main emphasis on pre-injury. The goal is zero injuries.

Wouldn't it be great if a number of ergonomics firms, product manufac-

turers and consulting firms joined together to collectively attack workplace injuries and the resultant comp costs, and do it in a cost-effective manner? I know of a consortium of companies that does this very thing.

From my perspective, a "holistic approach" encompasses prevention as well as grappling with the problem after it happens. However, unless senior management personally directs this type of process at their companies, the hubbub regarding workers comp will continue until federal or state legislation mandates the employer to take control of his workplace like he should have in the first place.

**Gerard A. Grabinski**

President

Workplace Ergonomics Inc.  
Furlong, Pa.

## Less emphasis on claims sought

To the editor: I have great respect for Joseph P. Decaminada, the new chairman of the American Arbitration Assn. (BI, March 16). However, I disagree with his statement that the nature of the insurance industry is "claims, claims, claims." He probably thinks that way because he's a lawyer and, as we all know, lawyers love claims. In my opinion, loss prevention and

risk control are more important and should be the emphasis of any official of an insurance company. It's obvious from the loss ratios of most insurance companies that claims come first and loss prevention does not.

**R.A. Zadenetz**

Manager-Department of Insurance  
Chicago Housing Authority  
Chicago

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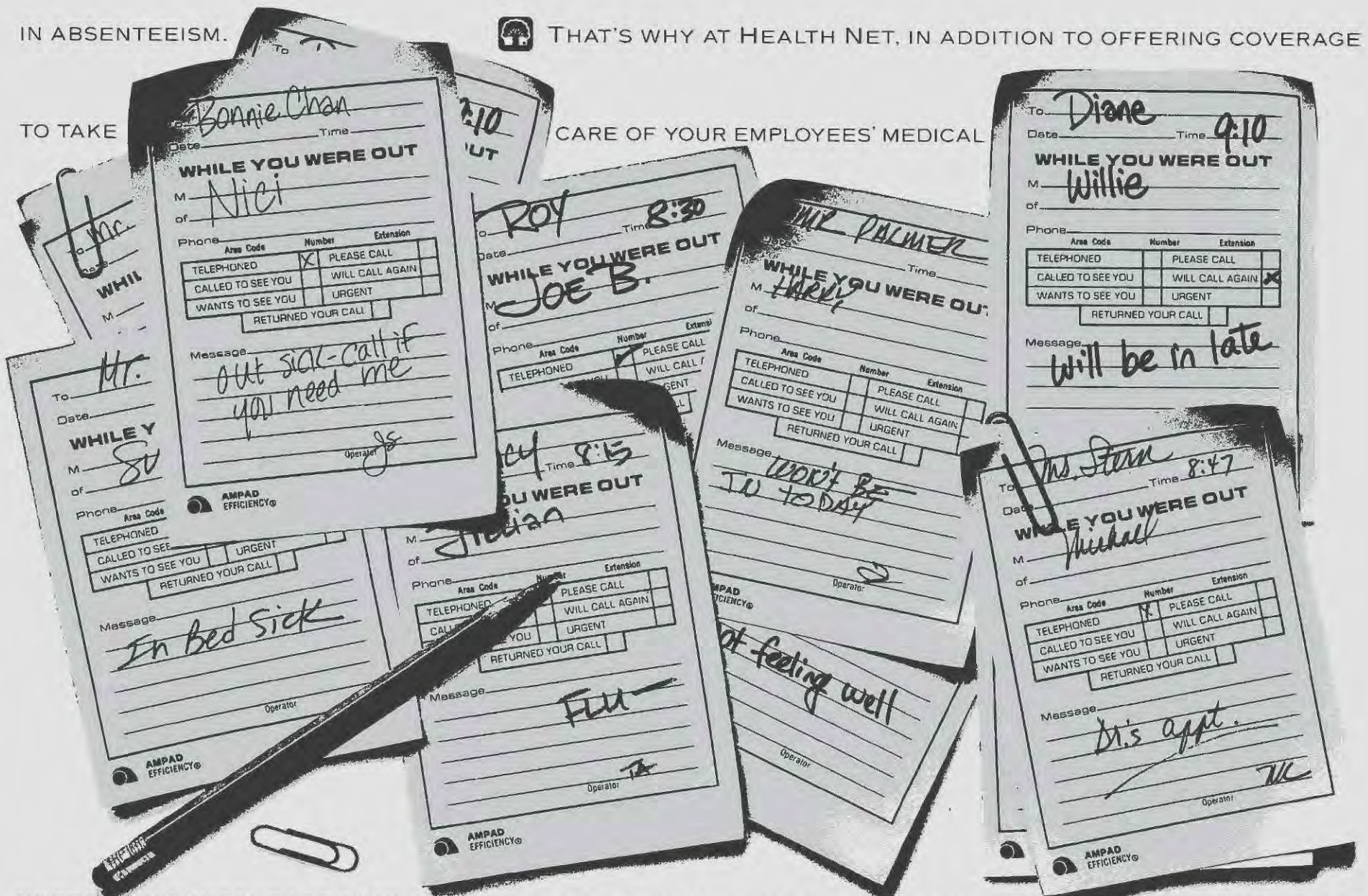
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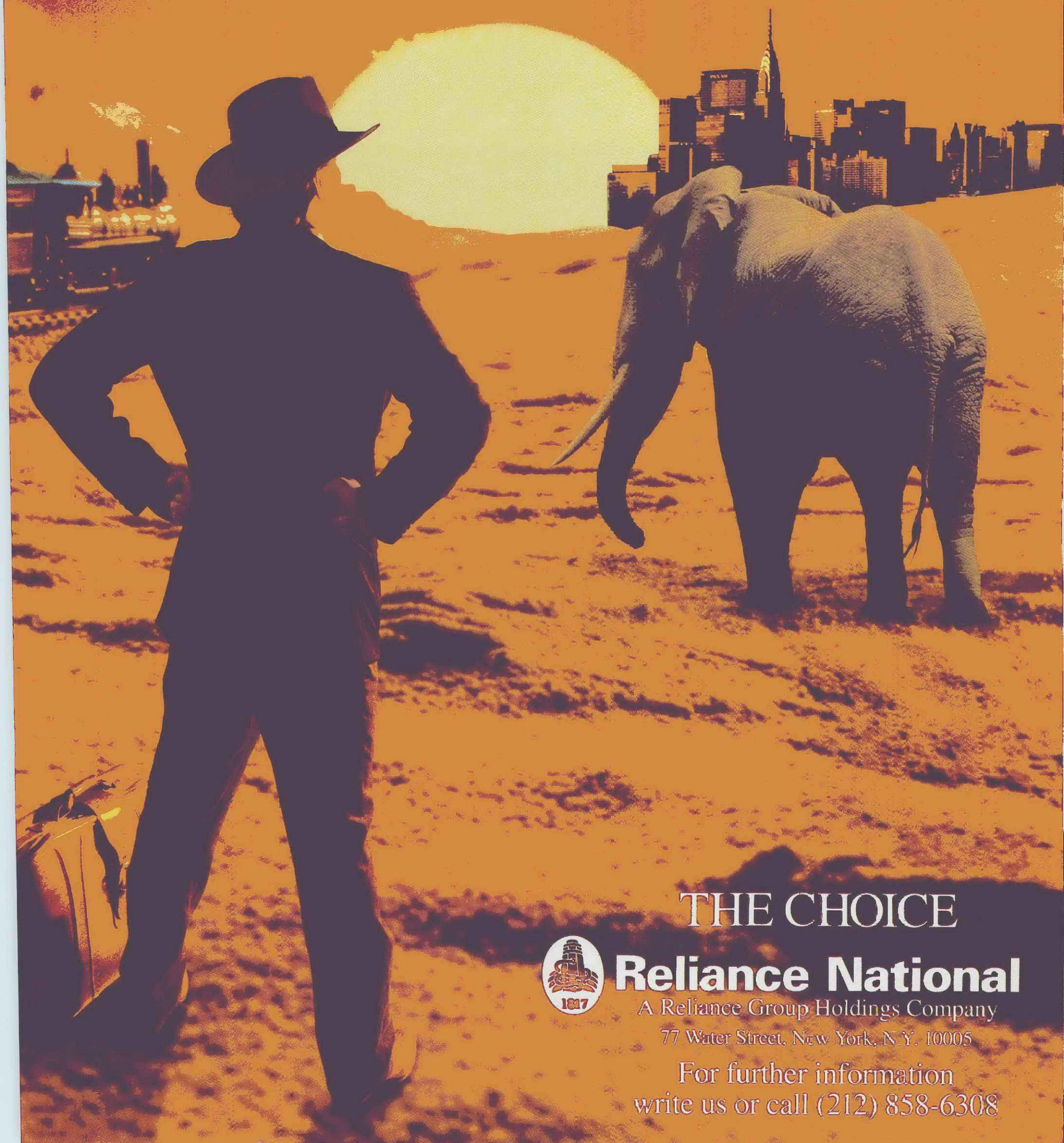
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# Dispelling mental health myths

## EAPs effective for employee problems, vendor says

By **MARK A. HOFMANN**

ANAHEIM, Calif.—Employee benefit managers must be aware of four myths about mental health care when confronting employee problems.

Miriam Fretthold, vp-professional practice for St. Louis-based Personal Performance Consultants Inc., which provides employee assistance programs and managed mental health care services, listed the myths during a discussion of EAPs during the 30th annual Risk & Insurance Management Society conference last week.

According to Ms. Fretthold, the four myths are:

- The longer a treatment program lasts, the better it is.
- An expensive treatment program must be better than a cheaper one.
- Inpatient treatment is better than outpatient treatment.
- Psychiatrists provide the best treatment, and psychologists rank second within the hierarchy of mental health care providers with social workers following behind.

According to Ms. Fretthold, the idea that prolonged treatment is better treatment is not only false, it's downright dangerous.

Removing people suffering from mental health problems, especially children, from their usual surroundings for an extended period of time can be "toxic" and exacerbate problems.

The idea that more expensive care is necessarily better is equally false, she said.

Some effective substance abuse treatment may cost only a few hundred dollars a day, but employers are willing to pay many times that in the mistaken belief that cost equals quality.

The idea that inpatient treatment is better than outpatient treatment ignores the differences among individuals and their problems, she said.

The notion that there is a rigid hierarchy among mental health practitioners also ignores reality, Ms. Fretthold said.

The best treatment comes from the provider who best understands the problem, and understanding does not necessarily come with a medical school degree, she said.

She cited the success rate of Alcoholics Anonymous as evidence of this truth. "More people have recovered through AA than all other programs combined," she pointed out.

Ms. Fretthold also said that the popular notion that inpatient substance abuse treatment should last for 28 days is based on a misconception.

According to Ms. Fretthold, this standard stems from the U.S. Navy's practice of granting 30-day leaves for treatment, with one day tacked on each end of the treatment for travel.

What is not a myth or misconception is that EAPs can reduce employer mental health care costs and will probably become increasingly important, said Deborah L. Hirschfelder, vp-corporate account services for Personal Performance Consultants. Ms. Hirschfelder also served as the session's coordinator.

She noted that EAPs have evolved considerably since they were first established during the 1960s. Early EAPs were informal, in-house programs focusing on alcoholism. Throughout the 1970s and 1980s, the programs grew

more formal and began dealing with other problems, including drug abuse, she said.

Ms. Hirschfelder noted that, unlike physical wellness, mental health is difficult to measure. As a result, EAPs have had to rely on "soft data," like asking someone how he or she feels, rather than being able to measure a patient's condition objectively, she said. Thus, employers often are skeptical about the value of an EAP.

The value of the programs can also be clouded because employees can be reluctant to talk about problems and often don't seek help early enough, she said.

But, despite these problems, there is definitely a place for EAPs in corporate America, Ms. Hirschfelder said, noting that about 30% of all absenteeism is due to personal problems and about 66% of all terminations involve personal problems.

Corporations pay about \$100 billion annually for personal problems that could be mitigated through EAPs, she said.

Ms. Fretthold said that EAPs, unlike most managed care programs, benefit from their emphasis on prevention and early treatment, but that the employees must be educated about what the programs are designed to do before they can

be successful in holding down costs.

"Consumer education comes in the form of brown bag lunches, home mailings and paycheck stuffers," Ms. Fretthold said. She pointed out that home mailings reach the women who generally make family health care decisions.

EAPs provide treatment only after the client has gone through a face-to-face interview, not on the basis of telephone contact as can be the case with traditional managed care programs, she said.

If treatment is needed, the patient is referred to a prescreened provider.

To document the success of EAPs, the two speakers pointed to a study of workers at McDonnell Douglas Corp. in St. Louis, whose EAP is managed by Personal Performance Consultants. The study was conducted by Alexander &

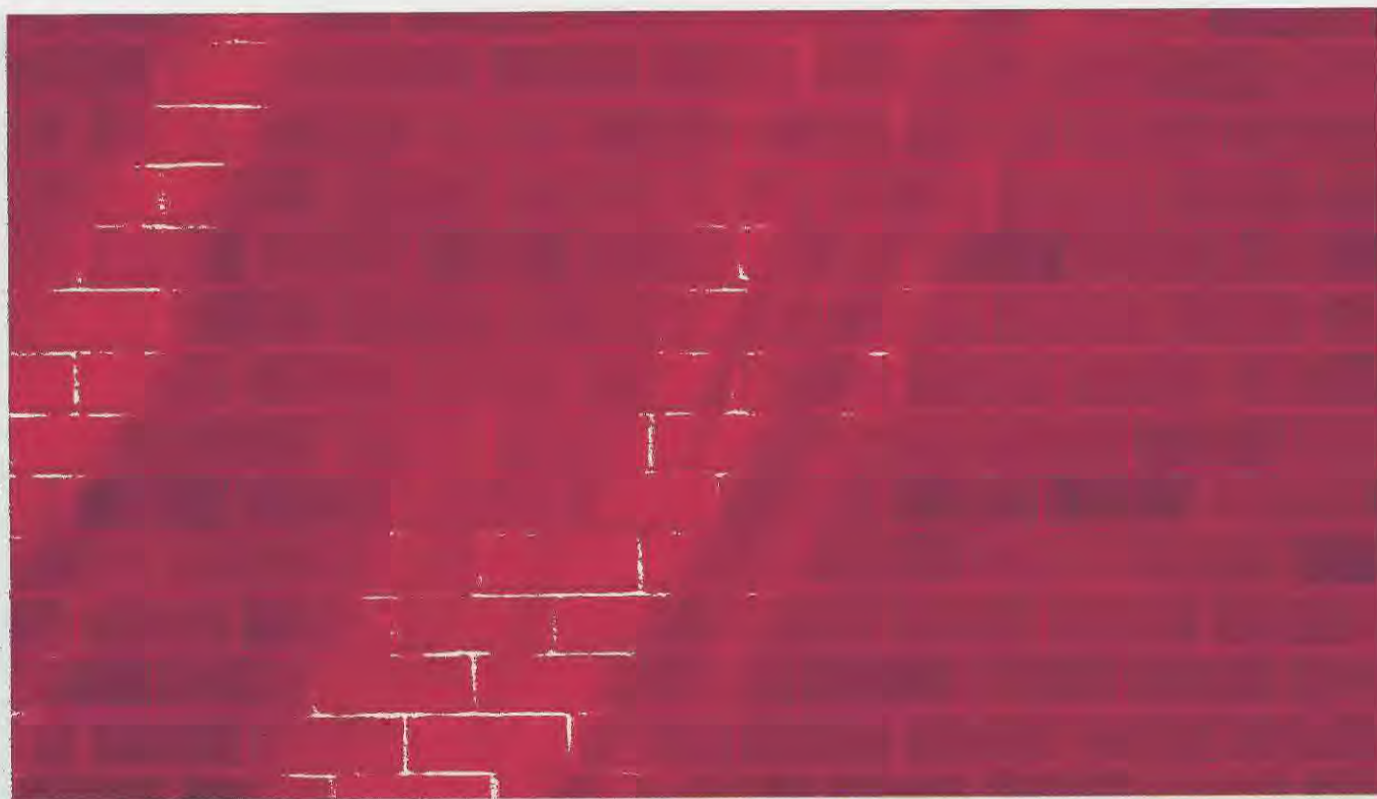
Alexander Health Strategies Group of Westport, Conn.

The survey compared the performance of two groups of employees: those who used the program for help with personal problems and those who did not.

The survey showed that, among other things, fewer than 8% of the employees using the EAP who were treated for a chemical dependency from 1985 through 1988 either quit or were terminated, compared with 40% of the employees with chemical dependency problems who did not use the EAP.

Also, the medical claims costs of EAP patients treated for chemical dependencies were \$7,370 less on average than the costs incurred by those who did not use the EAP.

Millie Workman, director of corporate risk management for Belz Enterprises in Memphis, Tenn., moderated the session. ■



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# Cash balance plans win popularity contest

By JERRY GEISEL

ANAHEIM, Calif.—The popularity of cash balance pension plans is on the rise because the plans meet both employee and employer needs, a benefit consultant says.

The plans, described as a pension hybrid, include the best elements of defined contribution and defined benefit plans, says Joseph A. Salzillo, a principal with A. Foster Higgins & Co. Inc. in Los Angeles.

"Very simply, they are a hybrid. They are part defined contribution plan and part defined benefit plan. They are a balance between the two," Mr. Salzillo said.

Speaking last week at the 30th annual Risk & Insurance Manage-

ment Society conference, Mr. Salzillo said that cash balance plans include the same features—individual account statements and benefit portability—that have made 401(k) and other defined contribution plans such a hit with employees.

Typically, a cash balance plan is set up to replace a defined benefit plan. When establishing a cash balance plan, an employer will calculate the actuarial present value of employees' vested benefits in the old plan.

That amount is converted into an opening account—or cash balance—in the new plan.

Individual statements detail employer contributions—based on a percentage of compensation—and

interest earned.

As a result, employees can instantly tell how much money they can take when they leave a company.

"That is why the plans are so popular among employees. The benefits are very easy to understand and appreciate. Employees want to know how much they can get now," Mr. Salzillo said.

By contrast, a defined benefit plan statement will project an employee's monthly benefit at retirement age.

At the same time, like defined contribution plans, cash balance plan benefits are portable. An employee can take his or her account balance as a lump sum when terminating employment and then roll

over the lump sum into the new employer's defined contribution plan, if allowed, or into an Individual Retirement Account.

"Employees like the lump sum feature. They can say, 'This is my benefit now,'" Mr. Salzillo said.

Defined benefit plans typically provide a monthly annuity at retirement.

While offering individual account balances and other defined contribution plan-type features, cash balance plans are legally defined benefit plans and provide all the advantages of those plans.

For example, cash balance plans are considered defined benefit plans because they promise a specific benefit. A company, for instance, may promise a benefit

credit equal to 6% of pay.

In a defined contribution plan, such as a profit-sharing plan, the company only promises to contribute to a plan.

A company's contributions will vary, or even stop, based on its performance.

In addition, like a defined benefit plan, cash balance plans shield employees from investment risk. Account balances increase at a guaranteed interest rate, such as the one-year Treasury bill rate, plus 1%.

If a company earns a higher rate of return on plan assets, it can cut back on future contributions or increase benefits in the cash balance plan, Mr. Salzillo said.

On the other hand, if a cash balance plan suffers an investment loss or returns are less than expected, an employer will have to kick in additional contributions.

Defined contribution plans, though, do not protect employees from investment risk. If an employee, for example, invested part of his 401(k) plan contributions into an equity fund and the fund later declined in value, the employer would not have to compensate the employee for the loss.

As a result, employees tend to be very conservative on how they invest their defined contribution plan funds. This conservatism can reduce the investment income gains and ultimately the benefit they will receive at retirement or when they terminate employment, Mr. Salzillo said.

By contrast, with a cash balance plan, employers retain control over investment of assets and can invest for the long term, resulting generally in greater returns on investments.

Changing workforce demographics also are fueling the growth of cash balance plans, Mr. Salzillo said.

Traditional defined benefit plans, known as final average pay plans, provide rich benefits to employees staying 20 or 30 years, but comparatively small benefits to short-service employees, those leaving after five or 10 years.

But few employees now spend their careers with one employer. As a result, employers are asking, "Why are we offering such a rich plan that benefits so few employees?" Mr. Salzillo said.

By contrast, cash balance plans, as career average plans, are designed to provide much richer benefits for shorter-service employees than final average pay plans.

Beefing up benefits for shorter-service employees can make it easier for employers with cash balance plans to recruit new workers, Mr. Salzillo said.

Meanwhile another consultant says employers need to do a much better job of telling employees how their retirement plans work.

Many companies will simply provide a benefit formula instead of advising employees on how much money they will need to maintain their lifestyles when they retire, said Dennis Ackley, a principal with William M. Mercer Inc. in San Francisco.

At the same time, employers wait too long to begin pre-retirement counseling to their employees. If the counseling doesn't begin until an employee is 60, it will be too late for an employee to change his savings strategy for retirement, Mr. Ackley said.

The session was moderated by Robert Erickson, director of corporate risk management at Jacobs Engineering Group Inc. in Pasadena, Calif.

Mr. Salzillo was the coordinator.



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Mary Pesch-Holevas  
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By SARA J. HARTY

# Benefit execs look beyond mementos

## Guiles and smiles spark curiosity in booths

ANAHEIM, Calif.—While benefit managers had little time to enjoy the warm temperatures and nearby beaches of southern California, many still went home from the 30th annual Risk & Insurance Management Society conference with mementos of the surf and sun.

Most exhibitors found that company information and literature was enough to attract benefit managers touring the exhibit hall in the Anaheim Convention Center last week.

But also offering free sunglasses, beach towels, Frisbee disks and golf accessories, among other trinkets, didn't hurt.

Provident Life & Accident Insurance Co. employed a local band to play "surf music" at its booth, as risk and benefit managers wandered the exhibit hall Monday eating box lunches. Provident also enticed conference goers by dishing up soft serve frozen yogurt.

Representatives of the Chattanooga, Tenn.-based group life and health insurer answered questions about its array of group health insurance coverages, utilization review services, case management for catastrophic illnesses, prenatal care programs, preferred provider networks and wellness plans.

PROCLAIM, Provident's claims administration system, is integrated with the same data base that its UR providers and case managers use. Dovetailing the systems and products into "a cohesive program leads to more efficient case management," said Hugh B. Everhart, associate group manager of the western regional sales office in Los Angeles.

Although many exhibitors used a sunny California theme, one exhibitor was well prepared for the possibility of rain at RIMS.

Travelers Corp. offered red umbrellas—both decorative and practical models. The tiny red umbrella pins seemed to be nearly as big a hit with benefit managers as the lifesize umbrellas.

Representatives from Travelers were demonstrating LINK, a personal computer-based software program that connects Travelers' clients electronically to

their benefit plan information and account representatives.

The system allows clients access to their own data so that employee questions on eligibility, for instance, can be answered by the employer.

Depending on the size of their benefit staff, some employers may choose not to share the data with employees but instead to limit the system's usage to answering administrative needs, said Michael A. Montalvo, the Universal City, Calif.-based sales director of managed care and employee benefit operations.

Benefit managers can also use LINK to send electronic messages and information to their contacts at Travelers in a matter of seconds.

Magic was the calling card used by a Travelers subsidiary, Conservco, to put attendees under its spell.

The smooth patter of professional comedian and magician Sam Simon helped lure benefit

managers to the Tampa, Fla.-based medical and disability management company's booth.

Mr. Simon's repertoire of tricks included folding an audience member's \$1 bill into a \$100 bill, and back again into a \$1 bill.

The transformation symbolizes a claim that is costing \$100 for every \$1 it should cost, Mr. Simon explained. Conservco is the force that turns those expenditures back into their true \$1 cost, he said.

The magician introduced the audience to Conservco's services, which include a PPO network, UR services, retrospective bill review and case management.

After Mr. Simon's show, many members of the audience plied Conservco staffers with questions about its products.

Some asked about Conservco's medical case management programs, like "Bright Futures," a pre-pregnancy/early pregnancy intervention plan, said Catherine

Johnson, vp-marketing.

"Case management for neonatology cases—very sick babies—is very expensive," Ms. Johnson said.

By avoiding complications in the beginning of a pregnancy, everyone—including employee and employer—comes out ahead, she said.

Using light humor also played a big part in Intracorp's appeal to exhibit hall visitors. Representatives from the Berwyn, Pa.-based health care management company invited benefit and risk managers to stop by for a round of The Art of Health Care Concentration.

Numbered cards covered well-known paintings. Contestants took turns calling out two numbers. Under the numbered cards were terms that either related to the health care industry or specifically to Intracorp. Each card had a mate on the painting and when a pair was successfully matched, the cards were removed from the painting.

The object of the game was to guess the name of the painting and painter as quickly as possible, while possibly learning something about Intracorp.

Hosted by professional comedian Scott Bloom, a.k.a. Art Canvas, the game moved quickly. Contestants who were less than qualified as art critics received

*Continued on next page*



Continued from previous page  
clues from Mr. Bloom.

One featured painting was "Whistler's Mother," whose painter the contestants could not identify.

Mr. Bloom tried hints suggesting the obvious, like "Who is buried in Grant's tomb?" and "What was the color of George Washington's white horse?" to give clues to the painter.

However, these elicited the answer "Grant White," rather than James McNeill Whistler.

Besides helping along with the game, Intracorp staff members discussed with benefit managers the importance of applying the right level of service to a medical situation, said Jackie Mazoway, director of sales training and communication.

"The fact is that every medical situation does not call for UR," she noted. Depending on geography, age and complicating diagnosis, some hospitalizations are routine and should be treated as such, she said.

For example, a 24-year-old having an appendectomy in a medium-sized city does not warrant intervention. However, an older person having a heart transplant in a rural hospital in Mississippi sends out a number of red flags, Ms. Mazoway said.

In the spirit of nearby Disneyland Park, Deloitte & Touche Insurance Consulting Services updated its ever popular "photograph in a keychain" gift with Minnie Mouse ears for the women and a Goofy hat for the men. Most visitors to the exhibit hall could not pass up the chance to be photographed with one prop or the other.

Benefit managers were primarily interested in hearing about the consulting firm's strategies for containing health care costs, said Sri Sagadevan, senior manager in Los Angeles.

The consultant likes to evaluate a company's current benefits plan and the level of employee satisfaction with the plan before recommending new cost control measures, Mr. Sagadevan said.

"What is done to contain costs depends on the extent to which the employer is willing to go. Such efforts are not necessarily embraced by employees," he noted.

Another photo opportunity was available at an annual favorite for animal lovers—Mutual of Omaha Insurance Co.'s booth. The animals in the booth were less than cuddly this year: featured animals were an iguana, a five-foot alligator, a six-foot boa constrictor and an extremely colorful macaw.

Benefit managers who stopped to chat could help themselves to a variety of literature discussing, among other things, the company's long-term disability, claims administration and employee assistance programs.

Mutual of Omaha's EAP has been very successful "working in conjunction with the company's mental health and chemical dependency program," said John D. Kohanek, manager of group product development in Omaha, Neb.

One software vendor was pleasantly surprised to find several benefit managers from larger companies—those with 20,000 to 25,000 employees—expressing an interest in his company's employee benefit information systems. Companies with 3,000 to 6,000 employees is the size company that previously seemed most interested in his product,

said William W. Whitmore, director of marketing for Goleta, Calif.-based Telos Computing Inc., formerly S.W. Systems Inc.

The maroon mugs and coasters touting Telos' Total Healthcare Integration System attracted several benefit managers interested in learning more about the employee benefit information system.

Many benefit managers stopping by California Psychological Health Plan's booth mentioned that while their company has never offered a mental health plan before, the weak economy and the pervasive belief that no job is secure has increased stress levels and made it something employers are taking another look at, said Walter Wilson, marketing coordinator in CPHP's Los Angeles office.

CPHP's programs include psy-

**The animals in Mutual of Omaha's traditional booth were less than cuddly this year.**

chologists, psychiatrists and case managers to provide stress management and other appropriate therapy.

And, benefit managers could help themselves to a CPHP Frisbee to work off a little RIMS week stress between sessions.

For those that prefer to toss a football more than a Frisbee, Hertz Claim Management Corp. complied with bright-yellow pint-sized foam footballs, autographed by none other than O.J.

Simpson.

Mr. Simpson spent some time in the exhibit hall on Tuesday and Wednesday shaking hands and discussing Hertz programs with conference goers.

Benefit managers could stop to discuss HCM's claims administration, UR and data management services.

Interest at the HCM exhibit was particularly high for the company's PPO network, said Joanne Dence, director of business development and sales, benefits in the company's Park Ridge, N.J., headquarters.

As usual, prescription drug companies were well represented in the exhibit hall, and one well-known player sponsored a RIMS booth for the first time this year.

"We are getting more into marketing ourself" as an alternative to other mail-order pre-

scription drug services, said Larry Sampson, manager of marketing for prescription programs in the health services department at Walgreen Co., based in Deerfield, Ill.

Walgreen is trying to set itself apart from other mail-order operations by emphasizing prompt individual service, Mr. Sampson said.

Another advantage is a computerized network that provides UR services as well as clinical information and enables Walgreen customers to have their prescription filled anywhere in the country, he said. That same system is used in the mail order portion of its business.

Many conventioners took a Walgreen golf towel along with some information on Walgreen as a mail-order prescription drug company. ■

**The problems  
are traditional.  
The solutions  
are not.**

# Minimizing liability from cost controls

## Employers advised to clearly outline responsibilities

By CHRISTINE WOOLSEY

ANAHEIM, Calif.—Self-insured employers may be held liable for employee injuries caused by cost controls like utilization review, selective contracting with providers and risk-sharing payment arrangements, warns a health care lawyer.

As a result, employers should carefully word any direct contracts with managed care companies, hospitals, physicians or review firms, said Salwa G. Spong of Kitch, Saurbrier, Drutchas, Wagner & Kenney in Detroit.

Contract wording is particularly important because there are few insurance policies designed specifically to cover this sort of liability, noted Corbette S. Doyle, a senior vp at Willis Corroon Corp. in Nashville, Tenn.

Both women spoke at a session at the 30th annual Risk & Insurance Management Society conference last week.

"This is a very new area of the law," Ms. Spong said. "We are talking about theories" because to date, no court has ruled specifically on employer liability for cost containment program injuries.

But, she said, it is reasonable to assume that liability theories that have been applied to insurance companies, health maintenance organizations and others will apply to employers as well.

Three types of cost containment programs present the greatest liability concerns, Ms. Spong said.

First and most important is utilization review and utilization management.

"UR probably affords the employer the most in terms of effectively managing health services," but it also carries the most risk of liability, she said.

UR typically involves three major services: preadmission certification, concurrent review and retrospective review.

Self-insured employers that directly contract with UR firms or do the reviews in-house open themselves up to both contract and tort liability.

Wording contracts carefully, said Ms. Spong, is the "most critical thing" employers can do to manage contract liability, which typically is the basis for actions for wrongful claim denials.

For instance, she advised self-funded employers to spell out in plan documents and contracts who determines "medical necessity." If the plan itself is to make the determination, "when a patient challenges your UR decision, you shouldn't be second-guessed," she said.

Courts may find an exception to this if an employee or dependent can prove the plan "abused its discretion" in determining medical necessity, Ms. Spong noted.

An example of such an abuse, she said, is a company that refuses to pay for a procedure that had traditionally been considered experimental but is now widely accepted as medically appropriate.

Ms. Doyle—the Willis Corroon executive who also coordinated the session—agreed that it is vital for benefit documents to define who determines medical necessity. "If you don't explicitly

give the plan discretionary authority, the courts will decide who has it, and you may lose the discretion," she said.

And, she said, employers should use their plan documents to clearly tell employees what the plan is responsible for, which services are covered and which are not.

Employers performing UR in-house or contracting with UR vendors should also be concerned about the criteria used to determine medical necessity, Ms. Spong said. Using standards similar to those used by local doctors should help minimize conflicts.

Self-insured employers can also do other things to protect against contract liability.

Contracts should "clearly describe all plan provisions that affect benefits, including appeals procedures," said Ms. Doyle. Employee handbooks should spell out the appeals procedures and, she stressed, that information should be given to spouses in case employees themselves are unable to appeal.

Quality of care disclaimers should also be put in contracts and plan documents, Ms. Doyle said. "Make sure that the providers in your network are quality providers, but don't say your

HMO is the best in town."

And, she said, written materials should "clarify that employees and their physicians are responsible for determining appropriate care." Employers also should clarify that the health plan "will only determine what care will be paid for, not whether someone will get care or not."

Finally, employers that offer several plans should have employees acknowledge in writing that they understand the plans they have selected and the implications of those plans, Ms. Doyle said.

Tort liability also poses risks for employers.

Patients injured as a result of

cost containment programs, like UR, may be able to recover damages from plan sponsors.

That warning comes from a widely cited 1986 case, *Wickline vs. State of California*. A California appeals court said third-party payers of health care bills can be held accountable for medically inappropriate decisions caused by defects in the design or implementation of cost controls (*BI*, Sept. 19, 1988).

Ms. Spong pointed out that the court did not find the benefit plan, in this case the California Medicaid program, liable, but said that the case became widely known for the warning that payers may, in some circumstances, be held accountable for the conduct of a UR program.

Employers can minimize their risk of accountability by con-

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*Continued from previous page*  
tracting with quality UR vendors, Ms. Spong said. Employers should check the qualifications of UR personnel and make sure physician reviewers actively practice in the area being reviewed, Ms. Doyle noted. Also, they should make sure providers are credentialed on an ongoing basis and that review criteria is continuously updated.

A second cost containment strategy—selectively contracting with specific providers—can also increase employer liability.

Employers that directly contract can expose their plans to potential liability for malpractice of the doctors and hospitals, Ms. Spong explained.

The theory of "ostensible agency" is applicable in these cases. Under that theory, she said, employers may be held ac-

**'Be careful about how you structure your relationships with providers,' cautions Sally Spong.**

countable for malpractice claims against physicians if the patient perceived the physician was an agent of the employer.

Employers may be responsible not only for the actions of primary care physicians with whom they contract, but also for any specialists to whom that doctor refers patients, Ms. Spong pointed out. As a result, "you need to be careful about how you structure your relationships with providers. And, you have a duty

to make a reasonable investigation about the quality of providers serving employees," she said.

A third cost containment technique—putting providers at risk through payment arrangements—may cause trouble for employers, Ms. Spong said.

In general, payment arrangements should not discourage providers from practicing good medicine, both women agreed.

There are several things employers can do from an insurance coverage standpoint, said Ms. Doyle of Willis Corroon. For example, employers can incorporate hold harmless agreements into contracts with providers.

Or, employers can ask to be named as an additional insured on providers' errors and omission policies, she said. However, she warned, employers should check carefully because they may

be one of 50 additional insureds on a policy with only \$1 million in limits.

Employers can also amend their own general liability policies to cover more than "incidental medical malpractice" claims, Ms. Doyle noted. Some insurers will agree to this, but some won't, she said.

Employers also can purchase separate vicarious liability coverage for contingent exposures. That coverage is available now for UR vendors, HMOs and PPOs and it is "dirt cheap," with premiums ranging from \$3,000 to \$10,000. Employers should be aware that these policies typically do not cover punitive damages, Ms. Doyle said.

George F. Sullivan, vp of safety for Guardsmark Inc. in Memphis, Tenn., moderated the session. ■

## Leadership role urged for business on AIDS education

*Employers warned on benefit limits*

By JOANNE WOJCIK

ANAHEIM, Calif.—Rather than running away scared from the growing number of AIDS cases, employers should take the lead in educating employees about AIDS, a panel of benefits experts says.

Employers that try to restrict benefits for employees and dependents infected with the disease are now likely to face uphill battles in the courts because they may be violating state and federal laws designed to protect the disabled, they warn.

"American business has to take a leadership role in AIDS education," said W. Reese Smith, director of employee benefits for Levi Strauss & Co. in San Francisco.

Rather than thinking of acquired immune deficiency syndrome as restricted to homosexuals, employers should treat it like "any other life-threatening illness," Mr. Reese said at the 30th annual Risk & Insurance Management Society conference held here last week.

Many employers once considered AIDS a disease restricted to homosexuals, but the disease is increasingly inflicting women, children and others that previously were considered low-risk groups.

"AIDS is a killer in our midst," said Mark E. Doherty, director of research for the Society of Actuaries in Schaumburg, Ill. "While today we have a better understanding of this disease, there is still no cure."

Two out of three people with AIDS die within 2.1 years of infection, according to early estimates made by the Society of Actuaries.

Mr. Doherty pointed out that while the number of men with AIDS rose 3.7% last year to 39,093 from 37,676 in 1990, the number of women with AIDS soared 17% to 5,730 in 1991 from 4,888 in 1990.

And, the number of pediatric AIDS cases skyrocketed more than 137% to 683 in 1991 from 288 in 1990, according to Mr. Doherty.

However, this growth rate is far lower than early insurance company projections.

At first, insurance companies viewed AIDS morbidity and mortality as "extra mortality—above and beyond what we anticipated in the 1980s," Mr. Doherty explained.

As a result, insurers overreacted by increasing premiums, restricting renewals and requiring blood tests.

But after a while, "we realized that what we are here for is to pay claims, not to figure out how

*Continued on next page*

# The Alternative Answer.



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## AIDS panel

Continued from previous page to not pay claims," he said.

In addition, case management and the increasing use of hospice care has reduced lifetime AIDS medical costs to as little as \$40,000 per patient (BI, Oct. 7, 1991).

Still, the number of AIDS cases is significant, and the disease "is making its way out into the general population," Mr. Doherty said.

That's why Levi Strauss launched an education program to dispel the myths surrounding the disease, according to Mr. Smith.

In 1982, when AIDS was first identified by the federal Centers for Disease Control, "a group of gay employees approached Robert Haas, the great-great-grandson of Levi Strauss, and asked to set up an information table on AIDS," Mr. Smith recalled.

"But he said 'No,' because he didn't want it to be seen only as a gay disease," Mr. Smith said.

Instead, Levi Strauss' top management manned the information table and has taken the lead in communitywide AIDS education ever since.

The San Francisco-based apparel manufacturer offers its 23,000 U.S. employees AIDS counseling and referral services; provides grants through the Levi Strauss Foundation and employee-based fund-raising efforts to fund public educational activities; and has produced in-house videotapes in both English and Spanish to inform employees about AIDS.

The company also developed a program for employees' dependents called "Talk About AIDS with Your Family" after realizing "that employees' children were having sex and could be infected with AIDS," according to Mr. Smith.

And, last month, Levi Strauss began offering company-sponsored health care benefits to its employees' domestic partners to make corporate practice reflect the company's anti-discrimination policy, the benefits manager said.

"Last month's announcement, though not tied directly to AIDS, shows how the company is committed to helping employees," he said.

If more employers followed Levi Strauss' lead on AIDS, there would be less litigation associated with the disease, observed David Maslen, a research attorney with The Alexander Consulting Group Inc. in Newburyport, Mass.

Many AIDS-related lawsuits have entered the court system, he said.

"There are approximately 1,000 cases either pending or decided," he said. Plaintiffs often charge, among other things, employer discrimination and negligence by hospitals and blood banks for providing AIDS-tainted blood for transfusions.

Employees who test positive for HIV or who are diagnosed as having full-blown AIDS are protected under both federal and state laws, Mr. Maslen said.

The Americans with Disabilities Act, state fair employment practice laws and the Rehabilitation Act, which applies to federal contractors, prohibit employers from discriminating against employees who are infected with the virus.

The ADA, which became effective

Jan. 26 for state and local government employers, becomes effective in stages beginning July 26 for all private-sector employers.

"The ADA says employers can't discriminate against qualified individuals if they can do the job with reasonable accommodations, such as job modification, job restructuring—taking out some non-essential functions—modified work schedules to provide time off for treatment or reassignment," Mr. Maslen said.

For example, under the ADA employers cannot reassign workers with AIDS because they think the infected workers would feel uncomfortable continuing to work in their departments or areas, according to Mr. Maslen.

Furthermore, employers cannot discriminate against healthy employees if their spouse or child

### At Levi Strauss, the chairman 'didn't want it to be seen only as a gay disease,' says W. Reese Smith.

is infected with the disease, he said.

Mr. Maslen believes that the ADA prohibits employers from requiring job candidates suspected of having AIDS to submit to a pre-employment physical or health inquiry.

However, he said that employers can require workers to undergo job-related physicals to determine whether AIDS can influence their ability to perform their jobs.

In addition, employees of medical labs who work with the HIV virus can be tested to ensure they have not been infected with the disease, he said.

While the ADA seems stringent, state laws can be even more restrictive, he said.

For example, New York anti-discrimination laws apply to employers with as few as four employees, Mr. Maslen said.

And, even though self-funded employers that restrict AIDS benefits are winning in federal court, they are losing cases filed under state discrimination laws, he said.

Most noteworthy among the cases so far is *McGann vs. H&H Music Co.*, a federal district court case pending before the U.S. Supreme Court (see update, page 2).

The federal court held that the

Employee Retirement Income Security Act of 1974 does not prevent self-insured employers from capping AIDS benefits (BI, Aug. 6, 1990).

"The court ruled that self-funded employers can change their benefits any time for any reason," Mr. Maslen said.

But, in an action brought only under state civil rights law, a state civil rights commission in Indiana found that employers could cap coverage for certain procedures—like blood transfusions—but not for specific diseases (BI, Dec. 24, 1990).

The session was moderated by Ross W. Eyer, assistant manager of staff benefits at the University of Michigan in Ann Arbor.

W. Lee Carter III, director of research and development at Alexander Consulting Group coordinated the session. ■

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# 24-hour cover's promise outweighs pitfalls

*But observers say the barriers are 'tremendous'*

By LOUISE KERTESZ

ANAHEIM, Calif.—Despite the barriers to setting up so-called 24-hour coverage, employers, insurers, consultants and regulators remain interested in its potential to control workers compensation costs.

That was the consensus of a panel entitled "24-Hour Coverage—Promises and Pitfalls" at the 30th annual Risk & Insurance Management Society conference last week.

Combining workers comp and medical benefits into a 24-hour system would let workers receive care the same way, regardless of whether an injury is sustained on or off the job.

Nationwide, workers comp costs are a "a real frustration" to employers, said Galt Grant, a vp at Frank B. Hall & Co. of Massachusetts in Boston. Formerly risk manager at Polaroid Corp., Mr. Grant also coordinated the panel.

Millions of people without health insurance, typically workers at small firms, are putting pressure on the workers comp system, he said.

To workers who need medical care, this system represents "an unlimited benefit," agreed Casey

Young, administrative director of the California Division of Workers Compensation in San Francisco. "There's no deductible, no benefit limit and typically no managed care."

It's not surprising, then, that injured workers, often prompted by doctors, try to "get into the system," he said. For example, medical bills for back problems that are not necessarily job-related are often submitted as workers comp claims, Mr. Young observed.

As a result, workers comp costs are increasing at a faster pace than basic medical costs.

With the workers comp system "melting down" in Texas and several other states, the concept of 24-hour coverage seems appealing,

Mr. Young said.

"Everybody believes it's a key," agreed Charles E. Ginsberg, managing director of Alexander Consulting Group in Newburyport, Mass.

An A&A task force on workers comp is studying 24-hour coverage for several clients, but the barriers in its way are "tremendous," Mr. Grant said. The biggest is the cost of such comprehensive coverage to employers that do not now offer health insurance or short-term disability pay, he said.

Another major barrier is the Employee Retirement Income Security Act, which would pre-empt state laws allowing employee benefits to be combined with workers comp.

But the act should not be con-

sidered "insurmountable," Mr. Young asserted. "I don't see changing ERISA as a big deal. . . Laws can be made and changed."

"Perhaps the biggest roadblock to 24-hour coverage is the politics of the interest groups that have a vested interest in the system," such as the plaintiffs' attorneys who would be out of work if employers didn't contest the source of workers comp claims, he said.

"The bureaucracies involved" are a major barrier to 24-hour coverage, Mr. Grant agreed. Buyers, brokers, consultants, insurers, the government and the legal profession all have their own bureaucracies, he explained.

For example, separate divisions of far-flung insurance companies "have to come together and understand what each is talking about" to offer comprehensive benefits, Mr. Grant said.

And "separate bureaucracies" within brokerage firms or industrial companies could also cause problems.

Within a corporation, "power bases of individuals" may stand in the way of a 24-hour program, said Mr. Grant. "The risk manager is going to feel threatened by the benefits area" because of the expertise that has been developed in designing and administering group health programs.

Another barrier: different medical benefits. Health plans typically require workers to pay a deductible and copayments, while workers comp laws require employers to provide first-dollar coverage.

The benefits difference "always comes up" in discussions of 24-hour coverage, conceded Mr. Young. But he said one insurer told him, "Give us a deductible on the medical side and we will waive it on the industrial side."

And health maintenance organizations have told him that "the opportunity to manage care is more important than a copay," Mr. Young said. Insurers are indicating that "what we need is a way to share costs," and there are ways to get around the prohibition of deductibles and copayments, he said.

Despite his enthusiasm for the concept of 24-hour coverage, Mr. Young urged proponents to "hold your horses."

Among the most notable proponents is John Garamendi, the California insurance commissioner, who recently incorporated 24-hour coverage in a universal health care proposal (BI, Feb. 24).

"I'm very nervous about jumping in with both feet," Mr. Young said. Instead, he favors pilot programs like one authorized by a Florida statute (BI, Dec. 16, 1991; March 18, 1991).

Pilot 24-hour programs may also be set up in California "in a year or two," said Mr. Young.

Meanwhile, large companies like Polaroid are going a long way toward providing virtual 24-hour coverage for their employees, Mr. Grant points out.

"You've got to do it yourself," agreed Theodore C. Surdam, manager-corporate insurance at Polaroid, the panel's moderator.

"There should be no difference whether you've lost a worker to a sickness or an accident," that worker is not on the job and should be brought back as quickly as possible, Mr. Surdam said.

Polaroid staff in several departments, as well as company doctors, work with an ill or injured worker to return the employee to work. Meanwhile, though an injured worker receives only 60% of wages under Massachusetts workers comp law, Polaroid makes up the difference, Mr. Surdam said. ■



# Wiser health care consumers

*Educating workers critical to success of cost containment*

By SARA MARLEY

ANAHEIM, Calif.—Companies must teach their employees to be informed consumers of health care in order for managed care and other aspects of medical cost containment to be effective, several experts say.

"Employees are conspicuously absent from health care decisions although their own financial liability continues to grow," said Dr. Robert J. Ailes, chief medical officer and senior vp of Intracorp, a managed care firm in Berwyn, Pa.

"Company health care programs must include employees. Otherwise they are receiving only episodic sick care, not health care," Dr. Ailes said during a panel discussion titled "Enlisting Employees as Partners in the Health Care Cost Containment Effort" last week at the 30th annual Risk & Insurance Management Society conference.

Employers must encourage employees to question doctors about the cost and appropriateness of care, Dr. Ailes said.

"This is the age of consumerism in everything but medicine," he said. "Where else does the buyer of a service give the seller carte blanche?"

Doctors also need to communicate better with patients, said Donna Lynne, first deputy commissioner, labor relations/employee benefits program for the city of New York. Communication could even include showing employees videotapes of procedures and the recovery process to help them make health care decisions.

One reason employees are passive as health care consumers is that they "suffer from the misconception that it's not their money. They see it as the domain of the employer to foot the bill," Dr. Ailes said.

Employees should be told what the company pays for the plan, Ms. Lynne said.

Employers also should make clear to employees that managed care expands rather than limits their health care choices, Dr. Ailes said. When employees call their utilization review firm for preadmission certification, they can ask about the procedure, alternatives and what questions to ask the doctor before undergoing the procedure.

Educating employees about their health care plan makes them more willing participants, Ms. Lynne said. Once a program is explained, "employees are very receptive to it," she said.

Companies will "continue to move into managed care. There is a great deal of satisfaction once you get over the initial hump," Ms. Lynne said.

Recognizing and rewarding employees in situations where they have acted as aware consumers and demonstrated compliance with managed health care requirements is another way to encourage employee acceptance of managed care, Dr. Ailes suggested. For example, employees who spot overcharges or mistakes in bills should be rewarded.

"Get creative," Dr. Ailes urged, citing those firms that give child car seats to parents who complete prenatal courses.

Another company developed a Medical Bill of Rights to tell employees what they need to know about their health care. The rights include choosing one's doctor, changing doctors, knowing how much procedures cost before they are performed and knowing all available alternatives before making choices, said Dr. Ailes.

Personal meetings with employees are the most effective way to talk about health care, said Dr. Ailes. Families of employees should also be informed through the mail.

But personal meetings aren't practical for the 330,000-employee

plan managed by Ms. Lynne. Instead, she reaches them through the labor unions that represent 96% of the city workers.

"Unions are an integral part of the process," Ms. Lynne said. "Then they sell the ideas to their membership."

She noted that a union health care panel that meets twice a month with city representatives asked for managed care to be added to their health care program. The unions were involved in the planning, administration and financing of the plan.

After studies and trial and error

with various utilization review vendors, they found that any expenses attributed to UR "were far outweighed by savings. The unions found it was worth spending money" on the managed care program, she said.

And "there are ways of enlisting support without going directly to employees," Ms. Lynne said. In New York City, benefit managers have appeared on radio and cable television question-and-answer shows, through a program organized by her department.

Before benefit managers can take their plan to their employees, they must be fully informed about it themselves, she said, which includes knowing the most common diagnoses and the risks

of various segments of the employee population. And plan administrators should sell their superiors on it before taking it to the rest of the employees.

Employee education is necessary for the next phase of cost containment: wellness programs that attempt to promote healthy lifestyles and prevent future illnesses.

"Employees who control their blood pressure, weight and smoking keep down the company health care costs and their own out-of-pocket," Dr. Ailes said.

Stephen Ficarra, director-risk management for Holiday Inn Worldwide in Atlanta, moderated the session. Sue Fazo, director-corporate communications for Intracorp, was the coordinator. ■



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# Analyzing HMO data to ensure cost savings

Information gives employer bargaining power, experts say

By CHRISTINE WOOLSEY

ANAHEIM, Calif.—Employers must collect data from their health maintenance organizations to ensure they are stretching their health care dollar as far as possible, says an HMO data management firm official and a benefits consultant.

"We feel HMO and other data is essential for overall strategic planning, evaluating plans offered, cost management and making changes to existing benefit plans,"

said Iris P. Masotti, president of National Health Management Corp. of La Jolla, Calif., which collects and analyzes data on HMOs and indemnity plans for employers.

While employers with indemnity plans have been collecting data on their plan participants' utilization for years, some employers neglect to collect the same type of data from their HMOs, Ms. Masotti pointed out at the 30th annual Risk & Insurance Management Society Conference held here last week.

Collecting HMO data is particularly important because many employers are not confident that their HMOs are effectively managing employee health or benefit costs, said Steven R. Swiercz, a principal in the Chicago office of benefit consultant Godwins Inc., a subsidiary of broker Frank B. Hall & Co. Inc.

Many employers complain that HMOs attract only their good risks, while unhealthy, older employees remain in traditional indemnity plans, Mr. Swiercz said.

And, a recent survey indicates that only 33% of employers feel HMOs are effective in controlling costs, he said.

"You have to figure out what you really want from your HMOs, and you have to obtain meaningful data from them," Ms. Masotti said. Above all, "you have to use that data creatively."

Employers can collect from HMOs information that will enable them to negotiate better services from the health care plans, according to Ms. Masotti.

For example, employers may find out that a large number of

HMO members have cardiovascular problems. "Tell the HMO medical director that you'll reward the HMO" with financial incentives, for example, "if they work at decreasing the risk factors of those individuals," she said.

Employers also should seek data from HMOs that will allow them to compare prices, including premiums and administrative expenses, Mr. Swiercz said.

But, he cautioned that employers should not focus exclusively on price when selecting an HMO. "Price shopping ignores a lot, like the internal efficiency of the HMO, its network potential, its quality" and how it guards against adverse selection.

An employer that determines its HMO population is primarily young, healthy employees should be sure that premiums and employee contributions reflect that fact, Ms. Masotti and Mr. Swiercz stressed.

One way for employers to check the fairness of HMO premiums is to compare what premiums would be for an individual enrolled in the HMO vs. a similar individual covered under an indemnity plan, Mr. Swiercz said. Among the factors to consider are age, sex, family size, plan design and geographic region, since health care prices vary in different areas of the country, he said.

Another perspective from which to evaluate an HMO is an efficiency analysis, which looks at how HMO money is spent, Mr. Swiercz noted. Among the data that should be examined in this analysis is the utilization of medical resources, including hospital admissions, referrals to specialists and emergency room visits, he said.

The type and amount of data employers can collect from HMOs varies depending on the employer's size, Ms. Masotti noted. For example, employers with fewer than 100 lives enrolled in an HMO may have to establish user groups with other small employers to collect meaningful data.

User groups also can be effective in pushing for better quality from their HMOs because their combined size gives them increased leverage with providers, Ms. Masotti pointed out.

In addition, smaller employers can use employee satisfaction surveys to measure the performance of their HMOs.

Small employers also can draw up their own internal quality assurance and financial criteria and ask HMOs to agree to meet them before renewing, she noted.

Employers with more than 100 HMO enrollees have a bigger data base to measure HMOs' performance, but they should be sure that the data they are collecting from their HMOs is timely, accurate and similar in content among all of their HMOs, Ms. Masotti said.

Those employers can measure differences among the various HMOs they offer, and they can compare their HMO experience with national norms, like the number of inpatient hospital days each health care plan is responsible for, she explained.

But, employers should not assume that a high number of inpatient days signifies a poor-quality HMO, she said. Rather, employers should check the demographics of the HMO patient population for factors like a high percentage of elderly enrollees.

Millicent W. Workman, risk manager for Belz Enterprises in Memphis, Tenn., moderated the session. Ms. Masotti coordinated the session.



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# Risk management education

*Crager seeks to raise profession by raising knowledge*

By SARA MARLEY

ANAHEIM, Calif.—Globalization, education and participation will be the goals of Suzanne H. Crager when she becomes president of the Risk & Insurance Management Society on May 1.

Speaking at the membership meeting of RIMS' 30th annual Risk Management & Employee Benefits

Conference, Ms. Crager vowed to "broaden horizons in a shrinking world."

Education is needed not only for RIMS deputy members, but also for top management, she said.

"The most pressing challenge our society faces... is to establish the importance of risk management and risk managers with (top) management," said Ms. Crager, assis-

tant vp for risk management and insurance at PNC Financial Corp, a bank holding company in Pittsburgh.

RIMS President Robert W. Esenberg echoed that goal in his farewell address and called on members to take responsibility for their professional profile.

"RIMS can't do the risk management job for risk managers. We

are in charge of our individual and collective destinies," he said.

Mr. Esenberg, risk manager for the city of Virginia Beach, Va., had an ominous warning about the state of business, but expressed confidence that RIMS and its members are up to the challenge.

"It's not business as usual, nor will it be. Our budgets are under intense scrutiny. Jobs are being combined and eliminated," he said. "At the same time, the parameters of risk exposure are ever-widening, and the costs of risk financing are also expanding. The financial underpinnings of the insurance in-

dustry itself are in question... so, too, is the adequacy of the regulatory structure as we know it."

Opening the membership meeting was a "State of the Society" presentation highlighting the dramatic political events of 1991 and what RIMS did last year.

Foremost was presenting the trade group's viewpoint on legislative issues like fronting and the draft of a National Assn. of Insurance Commissioners model act that would limit some fronting arrangements (*BI*, March 16); reform of the McCarran-Ferguson Act; the Insurance Fraud Protection Act; workers compensation; insurer solvency, tort reform; and product liability.

Ms. Crager called for a greater presence for RIMS in Washington, D.C., state capitals and the national media. "We must take on an even greater public posture... on key issues. This is our most visible activity," she said.

As an organization of 4,500 companies and more than 8,000 risk managers who are collectively responsible for \$60 billion in insurance and risk-related purchases, RIMS should be quoted as an authority, she said.

"More and more of our companies are producing and distributing products globally," Ms. Crager said. "RIMS will seek to establish international exchange programs as well seminars in the United States and Canada featuring risk managers from other countries.

"The practice of risk management is rapidly changing, as is the environment in which we function. And at RIMS, we need to be on the cutting edge of education programs."

As the next RIMS president, Ms. Crager would like to expand RIMS' continuing education offerings, offering a course in insurance accounting.

The group also has created a new vice presidency of international activities, which will be held by J.A. Yvon Menard, manager of risk and insurance for Marathon Realty Co. Ltd. in Toronto (*BI*, March 30).

RIMS education efforts must reach out to high school and college students, as well as members and managers, Ms. Crager said. "We must begin to educate young people on the attractiveness of our field as a career path," she said.

Fourteen U.S. college students attended the conference through the RIMS Student Involvement program. In addition, international students and professors also were in attendance.

"Because there is no question that the world is at a turning point, RIMS, too, must consider itself to be at a turning point," Ms. Crager said.

Mr. Esenberg, who traveled to Australia, Japan and Monte Carlo as president of RIMS, said the new strategic plan, expected in July, "adapts to the changing conditions in our universe."

Mr. Esenberg praised Ms. Crager and Executive Director Eugene U. Ricci, who took over last year, as "results-oriented professionals who combine energy and intellect in addressing the tough questions and getting things done."

"I feel privileged to have had the opportunity to serve as your president during this time of such dynamic and demanding change," Mr. Esenberg said.

Ms. Crager confessed trepidation when she became first vp of RIMS a year ago, but said now: "There's no time for hesitation. We've got a lot of work to do and precious little time in which to do it." ■

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## Employers risk lawsuits if access to medical data is not restricted: Panel

By **CHRISTINE WOOLSEY**

ANAHEIM, Calif.—Employers that collect employee medical claims data could inadvertently breach employee confidentiality laws if they do not carefully restrict access to such data, a panel of health experts warn.

Employers have been collecting a significant amount of claims data recently in their efforts to contain spiraling health care costs. For example, many

employers are trying to identify which employees spend the most on health care so they can target cost containment efforts.

That claims data is sometimes shared with other parties—including benefit consultants and managed care companies like utilization review firms.

But, problems can arise if claims data fall into the wrong hands, warned Dr. Michael R. McGarvey, managing director and director of the Health Strategies Group at Alexander & Alexander Consulting Group Inc. in Lyndhurst N.J.

"Dramatic advances in computing technology and the drive to control health care costs have combined to create a situation where the potential for abuse of sensitive health-related data has become a major issue," Dr. McGarvey said at the 30th annual Risk & Insurance Management Society conference here last week.

New techniques permit employers to "gather and manipulate vast data bases containing patient-specific information on diagnoses—like cancer, AIDS, mental illness and venereal disease," he said.

Employers also can collect data on procedures, including vasectomies, abortions and cosmetic surgery.

And, employers now have access to provider-specific data that reveals practice patterns, Dr. McGarvey said.

"These developments raise many questions relating to the responsible—and irresponsible—uses of such data," he said.

Patients who are not confident that information will remain confidential may withhold information that is critical to their care, Dr. McGarvey noted. As a result, diagnosis and treatment can be impaired or delayed, or an ailing individual may avoid seeking any care.

"Individuals may forego care rather than have a 'blot' on their medical record which would keep them from obtaining new employment or being able to obtain health insurance" at a new job, he explained.

The term "medically confidential" has explicit meaning to physicians and other medical personnel, who are trained not to discuss patients in elevators or corridors or leave patient charts lying about, Dr. McGarvey said.

But many other people now work with this patient-specific data, including insurance company staffs, third-party administrators, utilization management vendors and auditors. And, many self-insured employers handle and pay employee and dependent medical claims.

Analysis and expert interpretation of paid claims data is invaluable to employers that want to gain control of the cost of their health benefits programs, Dr. McGarvey acknowledged.

But issues of privacy do arise. "If the populations in a particular work setting are small enough, a reader can put two and two together. An HIV-related illness or a mental health hospital-

*Continued on page 26*

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## Confidentiality

Continued from page 24

ization can pretty easily be attributed to a particular individual," he said.

"Beyond idle human curiosity, I have heard of corporate medical and human resource staff being pressured by management to release medical information on particularly troublesome employees or those who are involved in union activities," Dr. McGarvey added.

"Inadvertent or intentional mishandling of material ranging from medical claims data to actual medical records can have serious consequences," he warned.

For instance, because of the inappropriate release of medical information, people could be denied jobs, promotions or health insurance, Dr. McGarvey said. "They may be subject to embarrassment, harassment or ostracism."

As a result of those circumstances, employers may be sued for invasion of privacy, defamation, slander, libel and for violations of written and implied employment contracts, according to Dr. McGarvey.

Employers that purchase medical claims data software systems should not automatically assume that the systems are secure, Dr. McGarvey said. Such systems can permit employers to access their employees' actual medical claims data, complete with diagnoses, procedures and dates of service.

To guarantee that data is secure, most software firms say patient identifiers are "scrambled" so medical data cannot be linked to individuals, according to Dr. McGarvey.

Still, Dr. McGarvey said he has been "shocked" by some scrambling routines so basic that his name would have been scrambled to "GarveyMc."

Many federal and state laws have tried to define valid and proper use of data and to protect privacy.

But, laws and court decisions can only go so far, Dr. McGarvey said. "Common sense, a genuine concern to cause no harm, and careful adherence to sound procedures make the difference," he said.

Employers could face additional risks when the Americans With Disabilities Act—which prohibits employers from discriminating against qualified individuals with disabilities—becomes law for most companies this summer, said Mark A. Rothstein, a law professor and director of the Health Law and Policy Institute at the University of Houston.

The law, in practice, will make it illegal for employers to request certain employee health information unless it is job-related, Mr. Rothstein said. For example, employers can no longer ask applicants to complete a checklist of their past medical histories.

Employers that do collect medical information about employees or applicants must store those files separately and keep them confidential, Mr. Rothstein said.

Corporate medical departments often are pressured by management to reveal what is wrong with a particular employee, he noted. But the ADA bars such disclosure. "Supervisors and managers may only hear about an employee's work accommodations or restrictions," he said.

Confidentiality problems can arise for employers that do not have a separate, in-house medical department on site, he noted.

There are several ways to deal with the problems, though.

For example, employers could ask independent physician contractors who conduct medical tests for the company to maintain employee medical records, Mr. Rothstein said.

However, most physician contractors do not consider patients they see only once as regular patients, so they may be unwilling to store their medical records.

Employers also could send employee medical records to their corporate headquarters and store them in the corporate medical department, he said.

Or, if a company lacks a corporate medical department, medical records could be stored at corporate headquarters, marked confidential and sealed, he said. Access should be restricted to medical personnel, he noted.

American Airlines Inc. of Dallas/Fort Worth Airport, Texas, has taken several steps to ensure the confidentiality of its employee medical claims data, said

Robert F. Seeman, compensation and benefits counsel.

"American Airlines has a large number of people with access" to employee medical claims data, he said, noting that the self-insured company uses a third-party administrator with a staff of more than 100 people. That TPA processes more than 1 million claims annually, Mr. Seeman noted.

"Quite frankly, when you work in this milieu every day you become blasé about discussing data with co-workers," he said.

But, "we sensitize the TPA staff about the confidentiality of

the information they are dealing with. Letters from American Airlines' president and chief executive officer (Robert L. Crandall) reinforce that message. And, we also hold meetings and training sessions," Mr. Seeman explained.

Jean Kennedy, director of risk management for Medtronic Inc. in Minneapolis, moderated the session.

W. Lee Carter III, vp and director of research and development for Alexander & Alexander Inc. in Dallas, coordinated the session. ■

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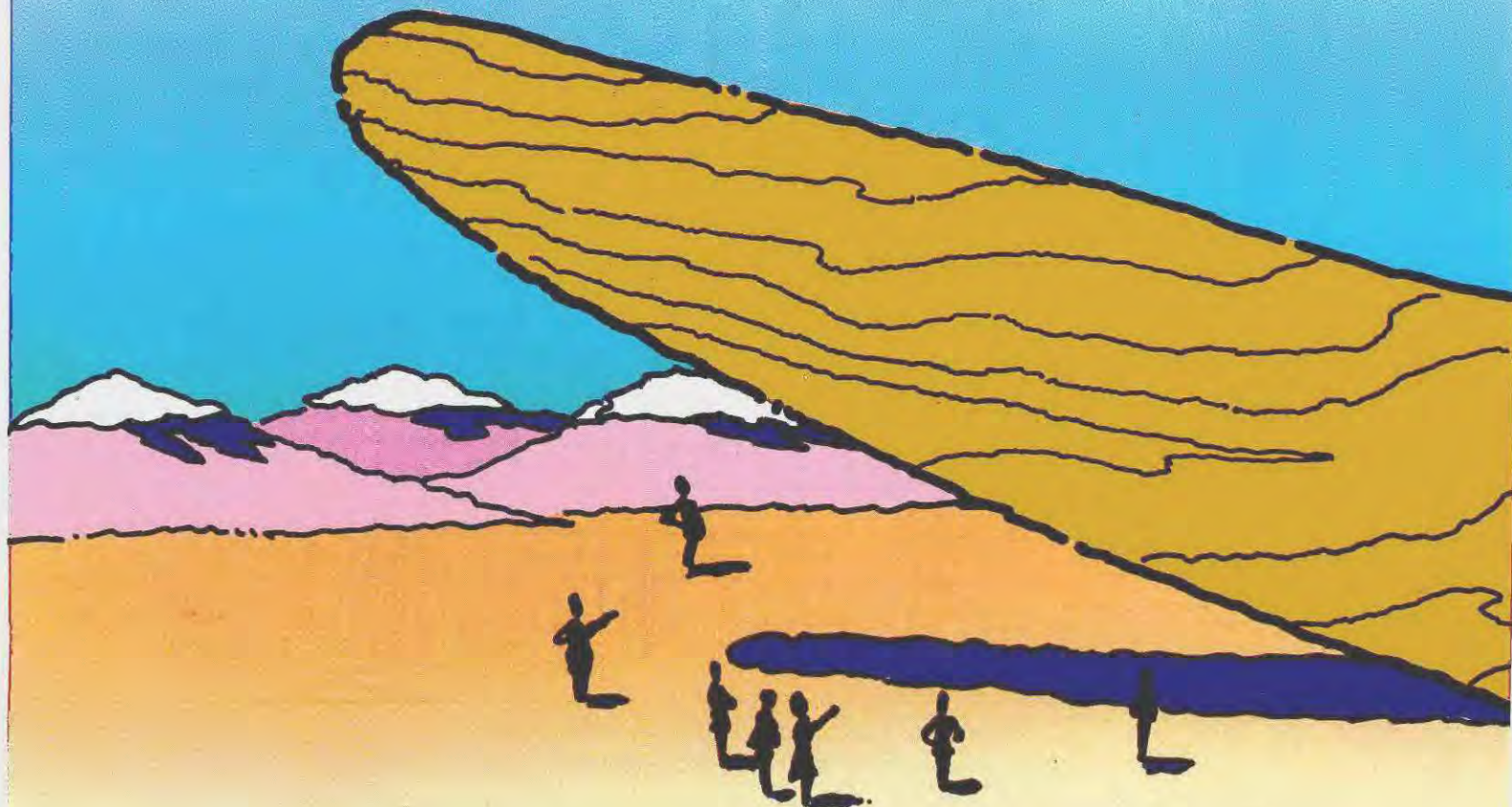
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# Benefit communication risks

## Panel explores ways to reduce employee suits

ANAHEIM, Calif.—Employee claims of benefit plan misrepresentation are on the rise, but a well-informed and well-prepared employer can reduce the exposure, several experts say.

"The '90s is the age of the employee lawsuit against the employer," said William L. Granahan, senior consultant with Betterley Risk Consultants in Worcester, Mass.

Mr. Granahan was coordinator of "What Happens When I Misinform an Employee?" a panel discussion at the 30th annual Risk & Insurance Management Society conference last week.

Employees are suing for benefits

when a benefit manager makes an unintentional oral or written mistake in communicating the company's benefits. And as benefits become more complex, expanding to flex plans and managed care, the chance of making an error becomes even greater.

Misinformation can occur "almost as often as a supervisor speaks or a personnel department issues a statement," said Elizabeth M. Barry, an attorney with the

Boston law firm of Ropes & Gray.

"The bottom line is, those kinds of misstatements are getting to court," Mr. Granahan said.

"It's a minefield and only the informed can avoid the bombshells," Ms. Barry said.

To avoid and reduce this risk inherent in offering employee benefits, employers can educate benefit managers about the danger of misinforming employees; hire an outside third-party administrator, insurance company or benefit consultant to handle the plan; conduct periodic audits for compliance with the Employee Retirement

Income Security Act of 1974; and purchase professional liability coverage for benefit administrators.

"Provide employees with easy access to someone who can answer detailed questions," Mr. Granahan said. If a third party is used, the employer should monitor its performance periodically and make sure the administrator has \$3 million to \$5 million in professional liability coverage, he said.

Internal benefit managers should also be properly covered, which often requires buying an endorsement that does not specifically exclude ERISA liability. "I recommend a separate fiduciary liability policy," Mr. Granahan said.

ERISA compliance audits are a "relatively new service" and one that is particularly important to companies that offer several retirement and profit-sharing plans, he said.

"Pay particular attention when changes are made in plans," Mr. Granahan said. Employers should take care to update informal brochures and handbooks going out to employees, as well as the official plan documents.

Exactly what constitutes an official document is often the subject of lawsuits, Ms. Barry noted.

ERISA requires summary plan descriptions for employees "in plain English," she said.

"If the plan terms are unambiguous, the plan terms will govern," she said. "Although there is a general rule, courts are doing more and more to keep employers on the hook for those promises."

ERISA favors the written over the oral and expressly prohibits informal oral modification, Ms. Barry noted. Before ERISA, employees could sue under state contract law, which was often interpreted more liberally in favor of the oral promises made to employees.

Today, "employees are often out of luck. It seems inequitable. Under ERISA, employees may have less protection than they did before," which is the opposite of the law's goal, Ms. Barry said.

Nevertheless, "courts have started to hold employers to informal promises," in some cases ruling them "interpretations" of individual circumstances, rather than wholesale modifications of benefit plans, she said.

Also at issue are statements that third parties like hospitals or other health care providers make to employees regarding coverage.

In addition, providers are also appearing as plaintiffs in suits against companies that inadvertently misinform employees, Ms. Barry said. Hospitals are suing employers to pay for services that the company mistakenly told either the provider or the patient were covered, she explained.

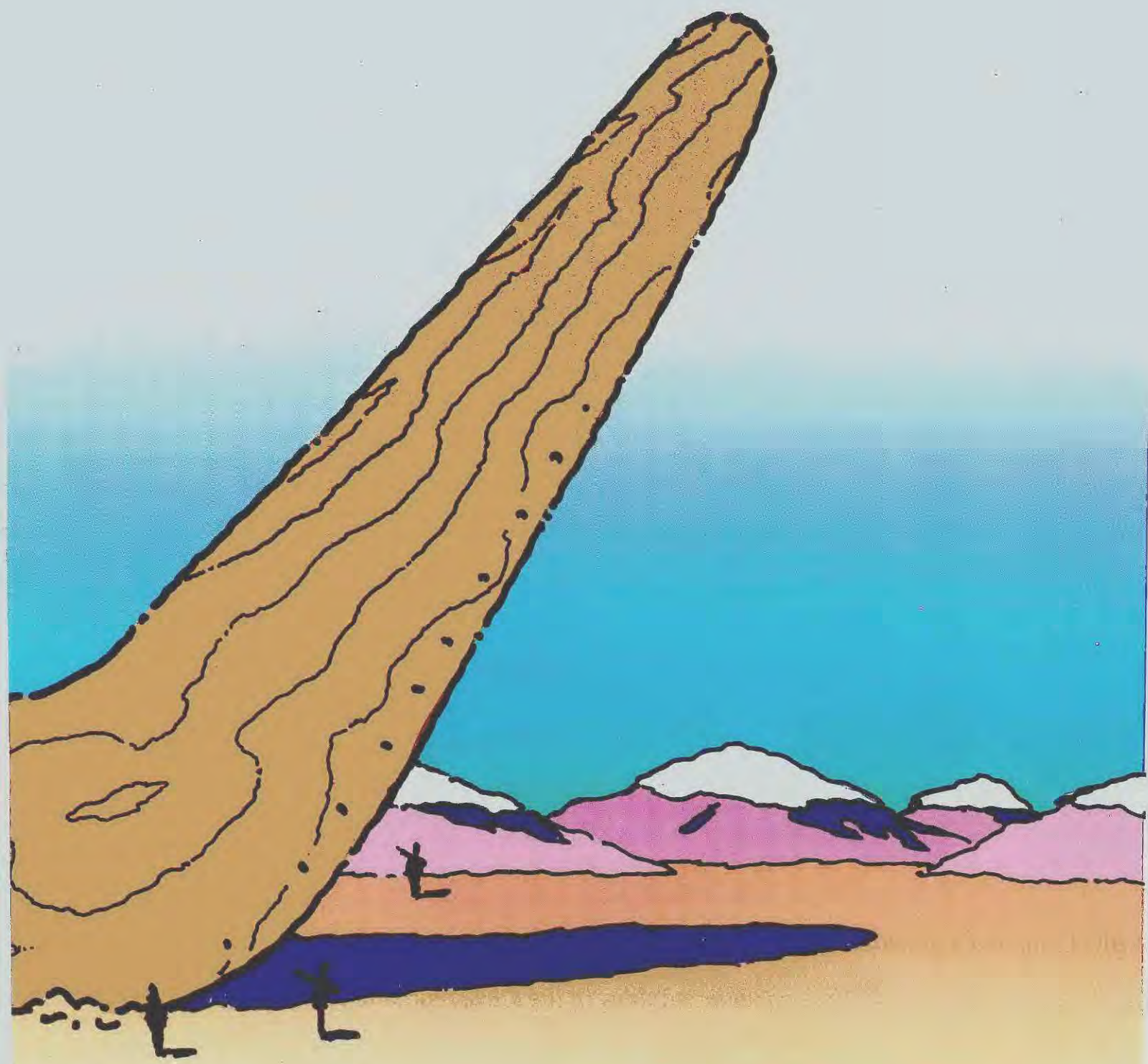
All awards resulting from benefit misinformation tend to be large, because employees generally sue for coverage when it is needed after a catastrophic accident or illness, she noted. Typically, though, the award only covers the benefit promised and legal fees, Ms. Barry said. Employees generally cannot recover damages like pain and suffering or emotional distress, she said.

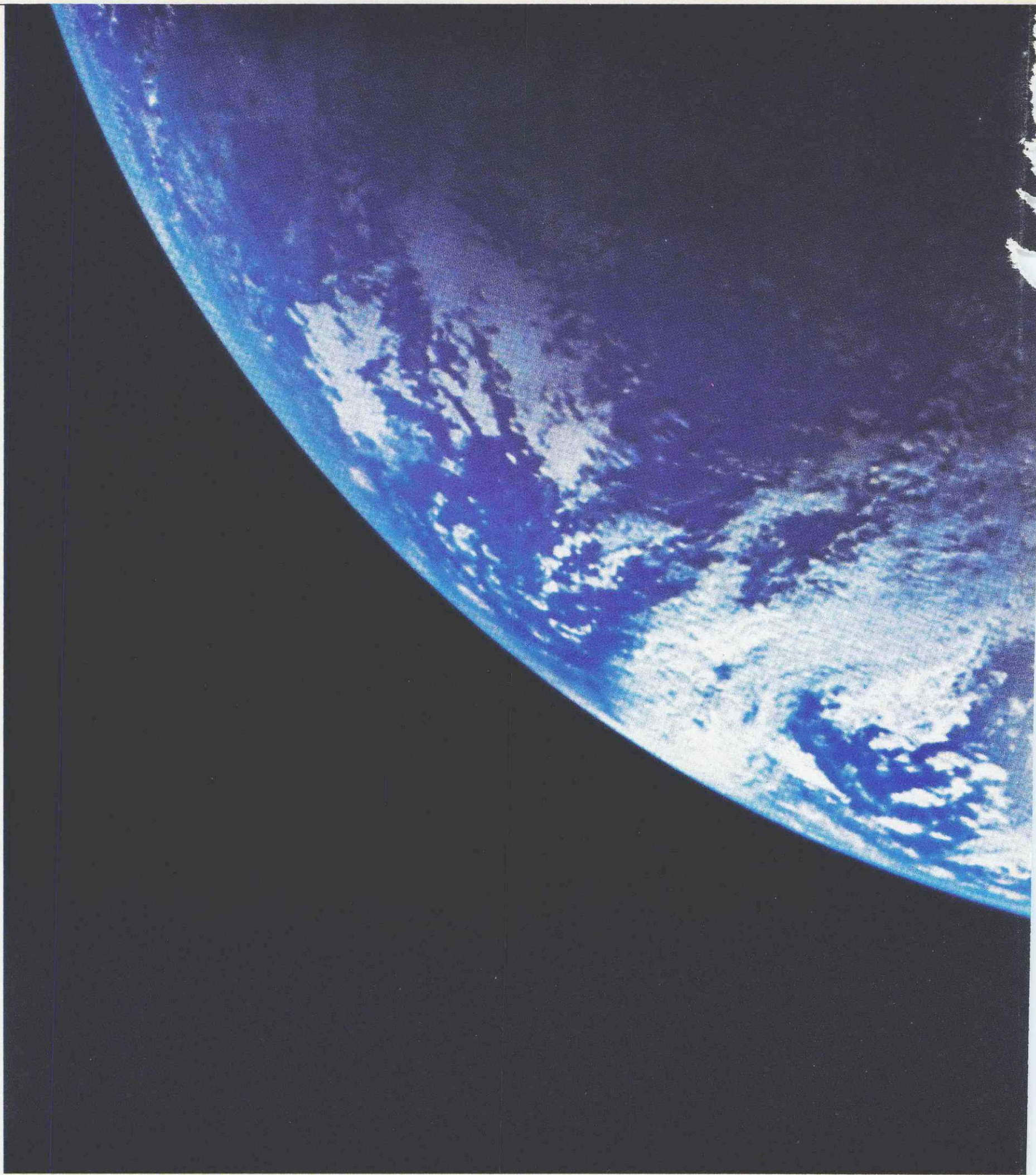
In addition, because the suits are brought in federal court, they are probably more expensive than if they were brought in state courts, she said.

Thomas Phillips, risk manager of the city of Santa Monica, Calif., served as moderator.

—By Sara Marley

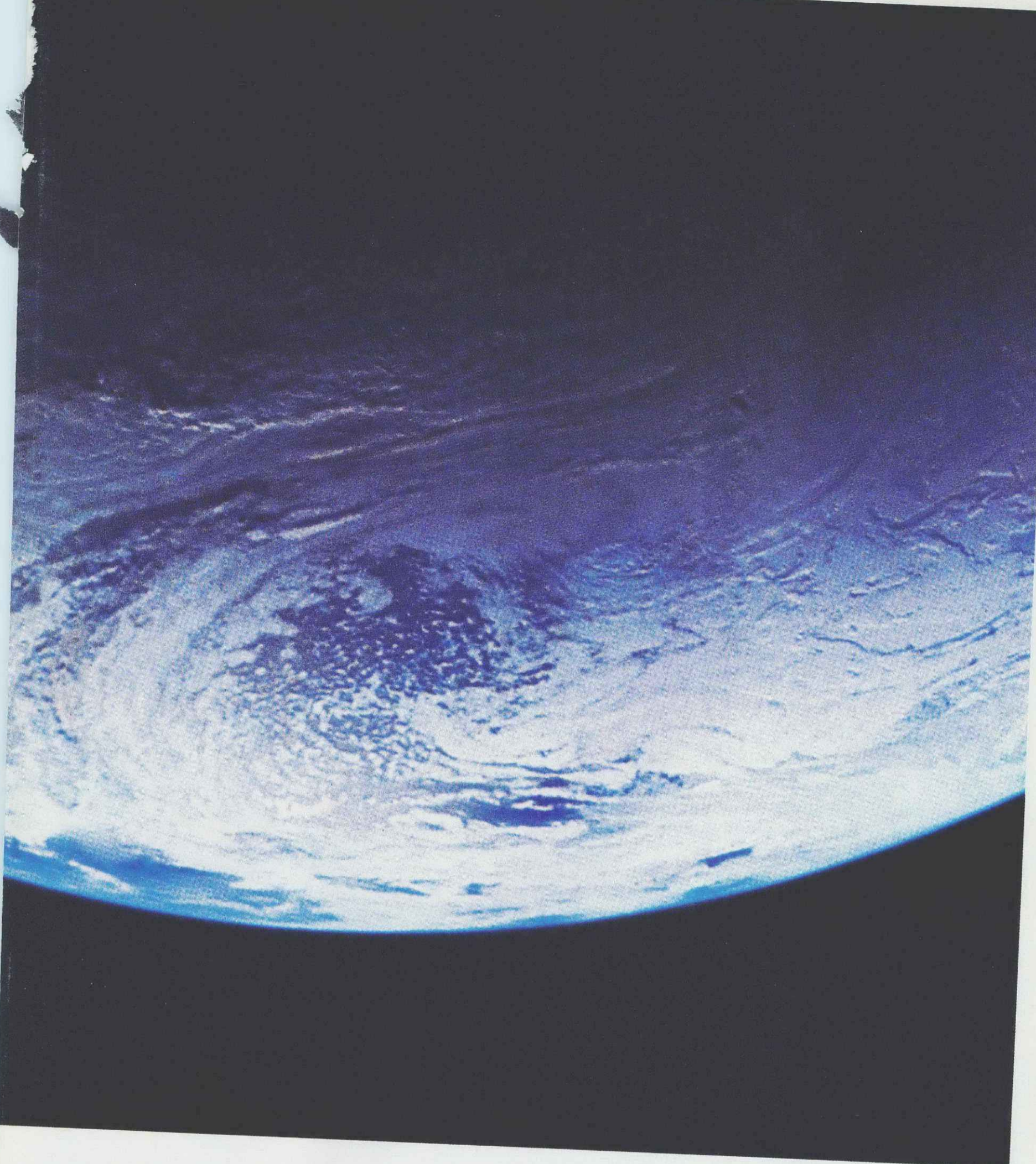
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# New cost control vendor

By Jerry C. Buckley

**A** NEW BREED OF outsourcing vendor is available to provide self-insured entities with a new, effective instrument for containing the escalating medical costs of risk and benefits insurance programs.

The outsourcing vendor—called a benefits integrator—merges the two similar but separated internal organizations within a corporation or a public entity that are given responsibility for administering the organization's major risk and benefits programs:

- The employee benefits department, which has the group health function.
- The risk management department, where workers compensation and property/casualty programs are administered.

The battle to contain medical costs has been raging for several years. While both disciplines have contributed cost-saving measures, the handicap of a divided field of action is clear. Advances made in one discipline are not easily transferred and implemented in the other. Furthermore, efforts are often duplicated, adding to the cost.

Why not simply merge the two operations with an internal reorganization?

It's not easy. They sprang from different needs and sources. Employee benefits developed in the human resources sector, while risk management was spawned in the financial organization. Tradition keeps them apart.

The new strategy of using an outsourcing vendor to merge the risk and benefits functions allows self-insurers to literally tear down the department walls. The best of both efforts are combined. Considerable savings are possible for hard-pressed corporate health budgets.

- **Advantages of outsourcing for benefits and risk programs.**

Outsourcing, simply stated, is the contracting of business support activities to an independent specialty management firm.

But rather than send the company's work to the vendor's site, the outsource vendor dedicates staff and resources to perform the work at the company's site.

This technique is being used by more and more corporations to increase the efficiency and reduce the operating costs of functions as diverse as mail room management and management information system activities.

Take the case of the corporate MIS data center. Rather than invest in in-house computer personnel and resources, a corporation can select an outsource vendor with the required technology, facilities and experts. The vendor often sets up shop at the client's site.

In most cases, the outsourcer also becomes the technology gatekeeper. An MIS outsourcing vendor, for example, purchases the computer hardware, software and communication resources. It directs and manages the MIS operation. It even develops software and applications.

Two incentives motivate corporations to turn to an outsourcer: The outsource vendor provides expert services at lower costs. And, the corporation maintains close ties—and control.

The client-outsource relationship is basically a partnership. The corporation is allowed to leverage the resources of its outsourcing vendor, while maintaining the essential control that is made feasible by having the outsource vendor at the client's location.

- **The benefits integrator vs. the TPA or ASO.**

In the risk and benefits field, a large number of self-insured companies administer their group medical, workers compensation and property/casualty programs with in-house personnel.

But an equally large number choose not to

## Self-insurers hire firms to curb costs in P/C, benefit plans with single approach

self-administer. Instead, they rely on two types of vendors to administer their risk and benefit programs—third party administrators or administrative services only agreements with insurers.

A TPA is an independent firm that provides claims administration, adjusting and auditing services for self-insured companies. These firms usually specialize in workers compensation, property/casualty or employee benefit programs, though a few cover all of them. A TPA is retained by a number of clients—sometimes hundreds.

In an ASO deal, an insurer provides claims administration services for self-insured companies and may also provide the property/casualty or benefits insurance.

Compensation in either arrangement is normally stated as a percentage of the claims volume paid on behalf of each client.

**The handicap of a divided field of action is clear. Advances made in one discipline are not easily transferred. . . Furthermore, efforts are often duplicated, adding to the cost.**

- **How a benefits integrator works.**

A benefits integrator, on the other hand, provides the same claims administration functions as a TPA or ASO, but services only one company and conducts its business at that company's facility. The integrator focuses entirely on one employer's problem, while a TPA or ASO spreads its attention over multiple accounts.

A benefits integrator is compensated to a large extent by the amount of savings achieved in the risk and benefits programs, rather than by the percentage of losses method.

So why use a benefits integrator instead of a TPA or ASO? First, when a corporation turns over its workers compensation or group health tasks to a TPA or ASO, these functions essentially become lost. They are combined with work for all corporate clients. There is little or no differentiation. Every client receives equal treatment, be it good, bad or mediocre.

Second, a TPA or ASO is basically chartered as the corporate steward of a client's funds. But if their revenue is a function of the magnitude of losses, is there an incentive to bear down on losses? Hardly. Cost control would seem to be doomed to fail.

Third, large self-insurers may not even benefit from the supposed economies of scale by engaging in a TPA or ASO arrangement. The only firms that appear to benefit are smaller self-insurers with work volume that does not require a full-time in-house organization.

The key to containing the escalating cost of risk and benefits insurance programs is creating a partnership between management, employees and the vendor.

An outsourcing benefits integrator—under the client's control at the client's site and focused entirely on the host corporation's issues and solutions—is in the best position to accomplish this

alliance. Continual review of performance in accordance with pre-set milestones ensures the success of the partnership.

- **Avoiding and reducing costs.**

Here's how the benefits integrator outsourcing vendor typically works to merge the benefits and risk functions and achieve medical cost containment:

The benefits integrator assembles the necessary technology, people and skills to perform integrated claims processing, cost containment and reporting. Included in the integrator's duties are those normally handled by the risk manager and benefits manager, except for the purchase of insurance.

The integrator brings to the cost-cutting table:

- Integrated claims processing systems, skills, and software.
- Managed care skills and software.
- Medical bill audit skills and software.
- Integrated risk analysis and reporting ability.

Thus armed, the benefits integrator signs up to take on the entire self-insurance infrastructure of the corporate client. Group health care, workers compensation and property/casualty programs all fall within the integrator's purview.

A benefits integrator invokes nearly a dozen proven methods to avoid and reduce costs.

These cost-containment techniques, and their percentage of savings potential, include:

- Managed care, including supervised treatment of all workers compensation injuries—20% to 40%.
- Medical bill audit and review—10% to 15%.

This includes the use of retrospective and prospective review software, claimant review, provider review and fee schedules.

- Use of a common preferred provider organization for employee benefits, workers compensation and property/casualty medical services—10% to 20%.

- Cross-reference of benefits and workers compensation claims to prevent double billing, including using health maintenance organizations—5% to 20%.

- Use of claims-adjudication software for employee benefits, workers compensation and property/casualty claims—5% to 10%.

- Use of risk analysis and reporting software—5% to 10%.

Unlike the TPA or ASO, the benefits integrator has compelling motivation to employ these cost-reduction tools and techniques. Its major source of revenue is a direct function of the savings achieved from these activities.

- **A key technology—the integrated risk information system.**

The critical system technology used by the benefits integrator is an integrated risk information system. The IRIS adjudicates workers compensation, group medical care and bill review subsystems so the data moving between the components is transparent to the operator. It has subcomponents capable of feeding a comprehensive risk analysis and reporting system.

The system consists of products from several vendors. An open systems architecture weaves the products together into a seamless network.

These systems are vitally important because they provide the tools and interconnection capabilities for a benefits integrator to smoothly and easily use these products to reduce medical costs in self-insured risk and benefit programs. ■



Jerry C. Buckley is president of California Interactive Computing Inc., a risk and claims software systems vendor in Northridge, Calif.

# Pruning worker injury rate

## Nursery clips comp claims with better handling of toxic garden products

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the types of questions asked on—and the possible answers to—the three examinations for the ARM designation.

This month's question and answer, taken from a recent national examination in ARM 55-Essentials of Risk Control, illustrate how basic principles of ergonomics and of industrial hygiene can be applied to the delivery operations of a commercial nursery just as effectively as they can be used in a fixed location.

**Q:** Verdant Nurseries sells plants, gardening supplies and related products to commercial and residential customers from its suburban location. Most customers transport their own purchases away from Verdant's premises, using automobiles or small trucks that Verdant's employees often help them load. To serve its regular commercial accounts, however, Verdant operates three trucks. Two trucks are equipped to make large deliveries of merchandise. The third truck is used to spray insecticides, herbicides and fertilizers at customers' premises.

Verdant's employees frequently suffer two types of injuries. First, they suffer back injuries from improper lifting of heavy plants and large bags of fertilizers, insecticides, and other garden products. Second, they suffer illness from inhaling or ingesting toxic chemicals, either gradually from the

### A.R.M. exercises

general atmosphere or suddenly when a large bag of a toxic product bursts or spills.

One approach to controlling the back injuries of employees lifting heavy bags is to teach them an appropriate technique for lifting these bags.

- Identify three rules for proper lifting.
- Other than appropriate lifting techniques, describe two measures for reducing back injuries to employees who transport the bags to customers' premises.

Verdant Nurseries wants to reduce employees' sudden exposures to toxic insecticides and herbicides resulting from broken bags.

- List five general methods of industrial hygiene control, and explain how each could be used to reduce hazards that delivery truck drivers face from this exposure.

**A:** Of the several rules for proper lifting and the many appropriate measures for reducing back injuries, some of the ones most clearly applicable to Verdant Nurseries are given below (other appropriate answers would have earned full credit):

- Three of the most important rules for lifting are: lift mostly with the legs, not the arms or back; stand close to the load so that the lifter is able to exert maximum force on it; and avoid any twisting back motions while lifting.
- Two other measures for reducing back injuries in this setting would include redesigning the lifting job by providing lift trucks and other appropriate mechanical devices, and screening employees so that

those most susceptible to back injuries are not asked to do extensive lifting.

• Five of the approximately 12 widely recognized general methods of industrial hygiene control, together with likely applications of these methods in protecting employees from toxic products that have escaped from broken bags, include:

- ✓ Change of process, such as putting toxic products into solid containers rather than plastic bags.
  - ✓ Substitution, which here could involve using insecticides and herbicides that are less toxic.
  - ✓ Ventilation, such as by installing exhaust ventilation equipment in each of Verdant's three trucks so that employees working with them can breathe less toxic air.
  - ✓ Use of personal protective equipment, which here could include gloves to protect the hands of employees dealing with toxic substances or respiratory protective equipment to safeguard their lungs.
  - ✓ Medical surveillance, such as by regular physical examinations of delivery employees to detect dangerous concentrations of toxic substances in their lungs, blood, bones or other organs.
- Other appropriate answers would have earned full credit. ■

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

# Getting to know the 'enemy'

## Author counts the many ways policyholders and their lawyers can win insurance settlements

"How Insurance Companies Settle Cases"

By Clinton Miller

Published by James Publishing Group, P.O. Box 27670, Santa Ana, Calif. 92799  
\$89.98

By Kevin M. Quinley

JUST OUTSIDE LAS VEGAS lurks a hostile air squadron. At Nellis Air Force Base, fighter pilots dogfight other "top guns" who mimic hostile air tactics and technology. Even with a new world order, the U.S. Air Force continues "Operation Red Flag." The Air Force believes that learning your own weaknesses makes you a better pilot.

Risk managers may not spar with insurers, but they can explore—and correct—their vulnerabilities in collecting on losses by reading "How Insurance Companies Settle Cases" by Clinton Miller. A seasoned claims professional with a law degree, Mr. Miller is an expert witness—for plaintiffs and defendants—on bad-faith issues. If "know your adversary" works for pilots, it applies to risk managers dealing with

### Books & ideas

recalcitrant insurance companies over contested claims.

Make no mistake, though, the plaintiffs' bar—not risk managers—is clearly Mr. Miller's target market. His goal is to facilitate settlements—preferably higher settlements. The book can be an effective how-to manual for attorneys and policyholders looking to "set up" their insurers for bad-faith claims. Mr. Miller may not intend for his book to be used this way, but one could view it as a guidebook for enterprising lawyers to extort higher settlements, driving up the cost of insurance and, ultimately, rendering coverage more unavailable.

For this reason, Mr. Miller won't have many fans among insurers. He gives readers his "inside scoop" on how insurers handle claims. Every insurance claims office should compare its procedures and practices to his suggestions. If companies took this book to heart, they could be impregnable to bad-faith suits.

Mr. Miller presents ideas with ramifications for risk managers

seeking to maximize coverage. Among the ideas are:

- In all coverage question situations, the insurers must offer Cumis counsel, i.e. independent counsel selected by the policyholder but paid for by the insurer.
- Coverage files should be handled by an entirely separate claims office.

Before insurers tack Clinton Miller's snapshot up on a dart board, they should realize that his book gives them a potent weapon—reverse bad faith. When a plaintiffs' lawyer ignores

**Every insurance claims office should compare its procedures and practices to the suggestions made in Mr. Miller's book.**

requests for information on damages and liability, ignores settlement overtures, then disgorges three inches of "documentation" with a demand and gives the insurer a 10-day response limit, an insurer should claim bad faith. Insurers now have a potent retaliatory—even offensive—tactic in the reverse bad-faith letter, of which Mr. Miller gives ample examples.

While policyholders and aggrieved claimants wield bigger slingshots in this arsenal, insurers frustrated by the double standard applied to them and

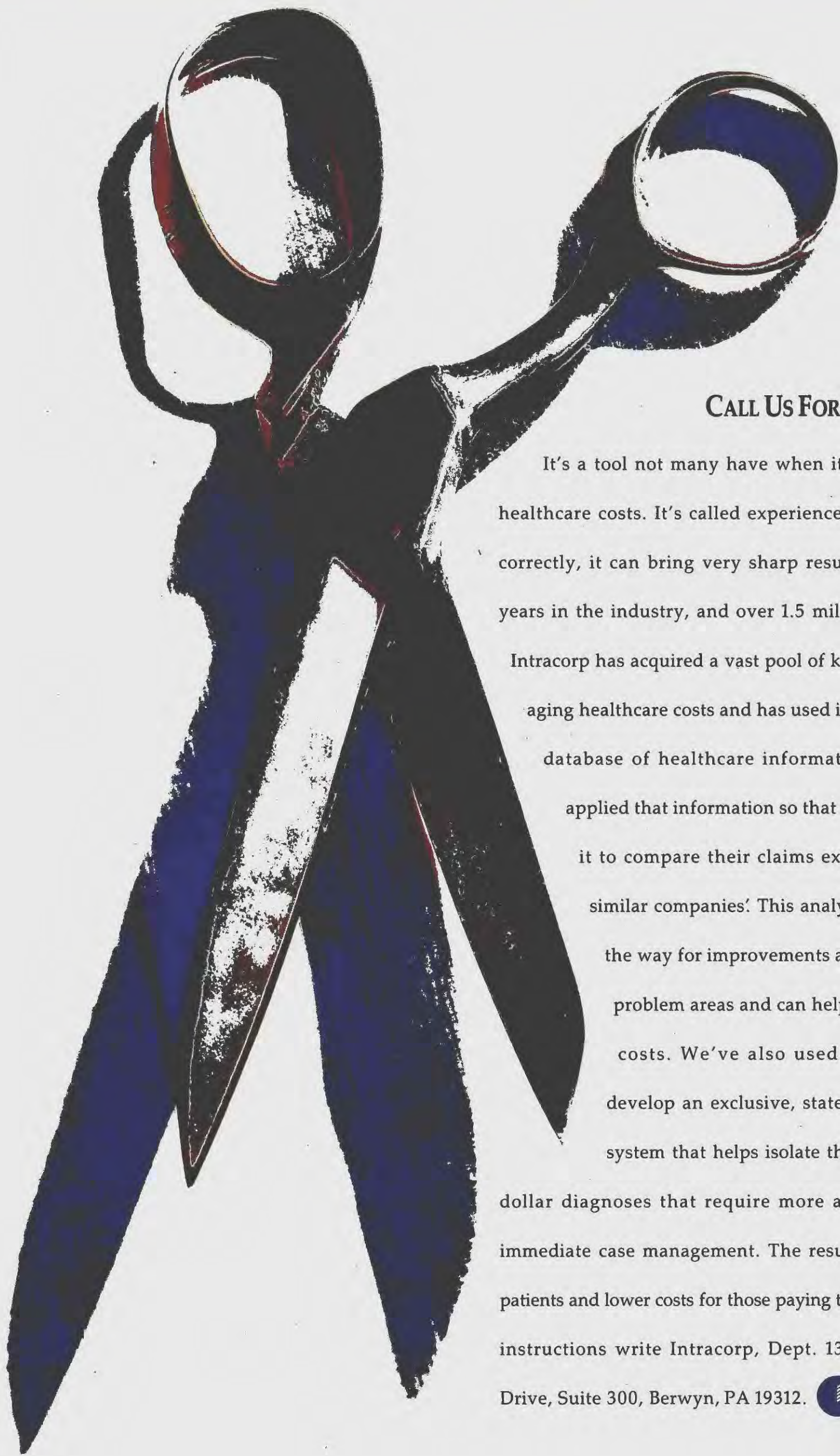
to the claimant's bar can strike back in appropriate cases by sending reverse bad-faith letters to the opposition. Presenting an image of the Poor Little Claimants on one side and a Big Bad Insurance Industry on the other, he views a David and Goliath relationship between consumers and insurers.

Mr. Miller may irritate and alienate, but he won't bore. His book is very readable, broken up into bite-size chunks for quick-hit reading.

The German philosopher Friedrich Nietzsche wrote, "That which does not kill us only makes us stronger." This book will not mortally wound an industry already under heavy fire. In this tight economic time, corporate buyers are looking to squeeze every drop of available coverage from their insurance portfolios. If anything, the book may help insurers bullet proof their claims procedures against bad-faith claims.

"How Insurance Companies Settle Cases" is a mixed blessing to the risk and insurance industry, depending on which lessons are learned. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Risk Retention Group Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.



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# THE FIRST ANNUAL HEALTH CARE MANAGEMENT & COST CONTAINMENT CONFERENCE

*Managed Care, A Changing Industry*

The industry event for all employee benefit managers, human resource executives and health care providers

April 27-28, 1992

The Grand Hyatt Hotel • New York City

## HEALTH CARE MANAGEMENT CONFERENCE AGENDA

### MONDAY, APRIL 27

7:45 a.m. Registration (Coffee & Danish)

8:45 a.m. **OPENING REMARKS FROM THE CHAIR**  
Kathryn J. McIntyre  
Publisher/Editorial Director  
Business Insurance

9:00 a.m. **KEYNOTE ADDRESS**  
Eugene LeBlanc  
Executive Director of Special Assignments  
Ministry of Health  
Government of Ontario

9:30 a.m. **MANAGED CARE: A CHANGING INDUSTRY**

- ▶ Current models of managed care
- ▶ Developing trends that are changing the arena of managed care
- ▶ The next generation of managed care

Charles Jacobs  
President  
InterQual, Inc.

Warren L. Moser  
President  
Advance Benefit Concepts

Roger S. Taylor, M.D.  
National Leader - Health Care  
The Wyatt Company

10:30 a.m. Mid-Morning Refreshments

11:00 a.m. **INNOVATIVE APPROACHES TO CONTAIN HEALTH CARE COSTS: ASSESSING YOUR COMPANY'S PARTICULAR NEEDS**

- ▶ Balancing access, quality and cost in customizing a health care program
- ▶ Designing and implementing an effective communications program to assist employees in making informed decisions

Jay Hague  
Corporate Director of Benefits  
Campbell Soup Company

Jim Norton  
Managing Consultant  
A. Foster Higgins & Co.

12:00 p.m. **GOING DIRECT: PURCHASING DIRECTLY FROM THE SOURCE**

- ▶ Customizing plan design
- ▶ Leasing existing networks
- ▶ Determining and evaluating cost-effectiveness
- ▶ Sharing risk with providers
- ▶ Legal liabilities

Leesa J. Key  
Partner  
Coopers & Lybrand

Paul McAuliffe  
Director - Compensation & Benefits  
Becton, Dickinson & Co.

12:45 p.m. **Luncheon for Attendees & Speakers Sponsored by John Hancock Financial Services**

1:30 p.m. **Luncheon Speaker:**  
William E. Caulfield  
Senior Vice President  
Group Benefit Operations  
John Hancock Financial Services

2:00 p.m. **PREVENTIVE CARE: INTEGRATING PREVENTIVE CARE INTO BENEFIT PROGRAMS**

- ▶ Financial incentives to promote healthy behavior
- ▶ The ingredients of a successful wellness program
- ▶ Effective communication with employees

Lynn Gilfillan  
Community Wellness Development  
Coordinator  
Coors Brewing Company

John Moses  
Consultant  
Hewitt Associates

Sonia Muchnick-Baku  
Director, National Resource Center on  
Worksite Health Promotion  
Washington Business Group on Health

3:00 p.m. Mid-Afternoon Refreshments

3:30 p.m. **Concurrent Session A: THE TOP RISK MANAGEMENT ISSUE OF THE 90s: WORKERS COMPENSATION**

- ▶ Applying managed care techniques to contain workers compensation costs
- ▶ The working model
- ▶ The range of services required
  - case management
  - claims management
  - utilization review

Gary Anderberg, Ph.D.  
Conservco

Douglas Rinaldi  
Risk Manager  
City of Waterbury, CT

Speaker to be announced

3:30 p.m. **Concurrent Session B: FLEXIBLE BENEFITS: HAVE THEY PROVEN EFFECTIVE IN CONTAINING HEALTH CARE COSTS?**

- ▶ Advantages and drawbacks
- ▶ Are employees using them efficiently?
- ▶ Measuring cost-effectiveness

John Hickey  
Partner  
Kwasha Lipton

Andrea L. Schultz  
Vice President & Director -  
Human Resources  
Educational Testing Services

# HEALTH CARE MANAGEMENT CONFERENCE AGENDA

- 4:15 p.m. **MANAGING YOUR MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS: IMPROVING QUALITY WHILE CONTAINING COSTS**
- ▶ The Chrysler Success Story: A managed mental health/substance abuse program with returns
  - ▶ Integrating MH/SA benefits with your current employee assistance program
  - ▶ Scoring points with your union through quality managed MH/SA benefit plan design
  - ▶ Cutting edge concepts for MH/SA benefit plan redesign
- Panel Moderator:**  
Sara Bilik  
Vice President—Marketing  
Preferred Health Care
- Donald Longnecker  
Manager - Finance & Planning  
Health Care Group Insurance  
Chrysler Corporation
- David McDonnell  
President and Chief Executive Officer  
Preferred Health Care

5:15 p.m. **COCKTAIL RECEPTION**  
*Sponsored by Coopers & Lybrand*

## TUESDAY, APRIL 28

- 7:30 -8:45 *Special Working Continental Breakfast*  
*Sponsored by Preferred Health Care*
- PRACTICAL STEPS FOR TAKING CONTROL OF YOUR COMPANY'S MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS**  
*Discussion will focus on state-of-the-art how-to's you can use for:*
- ▶ Cost-effective MH/SA benefit plan design
  - ▶ MH/SA vendor selection, management and evaluation
  - ▶ EAP integration in the new managed environment

Sara Bilik  
Vice President—Marketing  
Preferred Health Care

David Stone  
Corporate Vice President - Marketing  
Preferred Health Care

8:45 a.m. **REMARKS FROM THE CHAIR**

9:00 a.m. **HEALTH CARE REFORM: WHAT IS ON THE HORIZON?**

- ▶ The probability of systemic reform: Is national health insurance a viable option?
- ▶ Proposed bills in Congress
- ▶ Issues being addressed at the State level

**Panel Moderator:**  
Jerry Geisel  
Editor-At-Large  
*Business Insurance*

William Custer, Ph.D.  
Director of Research  
Employee Benefit Research Institute

Ellen Goldstein  
Director of Health Policy & Communications  
Association for Private Pension & Welfare Plans

Frank McArdle  
Partner and Research Consultant  
Hewitt Associates

10:00 a.m. *Mid-Morning Refreshments*

10:30 a.m. **QUALITY OF CARE MANAGEMENT AND COST CONTROL: IS IT A ZERO-SUM GAME?**

- ▶ Assessing cost-effectiveness and quality of care standards of providers
- ▶ How do employers evaluate what they have purchased in the health care marketplace?
- ▶ Techniques for monitoring the quality of care of providers

**Panel Moderator:**  
Joseph Metz  
Director of Governmental Legal Services  
Buck Consultants

John George  
Executive Vice President  
InterGroup Services Corporation

The Honorable Donna Lynne  
First Deputy Commissioner  
Office of Labor Relations  
City of New York

11:30 a.m. **LATEST DEVELOPMENTS IN HEALTH MAINTENANCE AND PREFERRED PROVIDER ORGANIZATIONS**

- ▶ Exclusive provider organizations
- ▶ Open-ended HMOs
- ▶ Managed fee-for-service
- ▶ Utilization review

Art Drechsler  
Vice President  
Martin E. Segal

Larry Goelman  
President and Chief Executive Officer  
Cost Care, Inc.

12:15 p.m. *Luncheon for Attendees & Speakers*

1:00 p.m. **Luncheon Speaker:**  
Gerry Goodrich  
Deputy Commissioner of Health  
State of New Jersey

1:30 p.m. **Concurrent Session A:**  
**EFFICIENT AND COST-EFFECTIVE USES OF TECHNOLOGY IN MANAGING HEALTH CARE COSTS**

- ▶ Evaluating the claims process
- ▶ Monitoring physician costs

**Panel Moderator:**  
Doug Leland  
Vice President  
Intracorp

Jack Romeo  
Director of Health Care Systems  
Bethlehem Steel Corporation

David Rullo, M.D.  
Medical Director  
Health Payment Review

1:30 p.m. **Concurrent Session B:**  
**UNDERSTANDING AND IMPLEMENTING FAS 106**

- ▶ The redesign of retiree health benefits
- ▶ How to fund accrued liability
- ▶ Practical aspects of plan implementation

Lee Launer  
Partner  
Coopers & Lybrand

Lewis M. Borgenicht  
Consulting Actuary  
Actuarial Sciences Associates

2:15 p.m. *Mid-Afternoon Refreshments*

2:45 p.m. **HEALTH CARE COALITIONS: COMPANIES COMING TOGETHER TO REACH COMMON GOALS**

- ▶ Defining the health care coalition
- ▶ What types of strategies are the coalitions implementing
- ▶ Advantages and drawbacks for individual companies

Debra Hubers  
Director of Marketing  
The Alliance

Dorothee Maynard  
President  
Good Neighbor Alliance

3:30 p.m. **END OF CONFERENCE**

▶ **HOW TO REGISTER:** Register for The First Annual Health Care Management & Cost Containment Conference in one of three easy ways:

1. Telephone IBF Conferences at (516) 229-2375, or
2. Fax your registration to us at (516) 229-2386, or
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▶ **FEE:** Your registration fee includes lunches, refreshments, receptions, and the conference workbook. The registration fee is \$795. Early Bird registration fee is \$695 if you register before March 13. You may send a check for your registration fee, charge to your American Express Card, or we will invoice you. Please make checks payable to "IBF Conferences" and print the name(s) of attendee(s) on the face of the check.

▶ **GROUP DISCOUNT:** A group discount of \$100 per person off the registration fee is available for 3 or more registrants from the same company.

▶ **DATES:** April 27 & 28, 1992

▶ **VENUE:** Grand Hyatt New York  
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New York, NY 10017  
(212) 883-1234

▶ **CANCELLATIONS** received in writing by IBF before March 27, 1992 will receive a refund minus a \$100 administrative charge. Thereafter, refunds are not available. Substitutions may be made at any time by calling IBF at (516) 229-2375.

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▶ **TABLETOP EXHIBITORS:** There will be space set aside for tabletop exhibits for companies who target products and services to this market. To access this high-level audience, contact Kim Mascolo at IBF at (516) 229-2375.

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# Paying health club fees is not enough

## Integrate wellness plan with other benefits: Consultants

By JOANNE WOJCIK

ANAHEIM, Calif.—Employers must integrate their wellness programs into their overall benefit plans to ensure their effectiveness, several experts say.

Wellness plans also should give employees a stake in improving their health by offering financial incentives and/or disincentives,

according to the experts.

"If you ask companies if they have a wellness program, they usually say yes," said David R. Anderson, vp-operations at StayWell Health Management Systems Inc. in Eagan, Minn.

For example, 76% of 618 employers surveyed by Hewitt Associates offer at least one health promotion activity, while 91% of

832 firms surveyed by the Hay Group have some type of wellness program.

But doing only one thing, like publishing a monthly wellness periodical or offering to contribute to health club membership fees, "will not have any real impact," said Georgia Casciato, a consultant with Alexander & Alexander Consulting Group Inc.

in Chicago.

"Wellness will have no value or return for the company unless it is integrated" into an overall long-term health care strategy, Ms. Casciato said during a session titled "Wellness: The Only Lasting Cost Containment" last week at the 30th annual Risk & Insurance Management Society conference.

While many innovative employers "experimented" with

wellness during the 1980s, others hesitated because there was no hard data to back up claims that such programs reduce overall health plan costs, said Mr. Anderson.

"People complained there was no data, though everyone intuitively knew that people who took care of themselves were generally healthier," he said. "So we went about collecting data to prove what we already knew."

Some studies compared the experience of employees who participated in wellness programs with those who did not, while others compared the experience of worksites or branches where wellness plans were instituted with the experience of those without such programs.

One commonly cited study was done in 1987 by Milliman & Robertson Inc. for Control Data Corp., a Minneapolis-based computer manufacturer.

The study found that people with high blood pressure are 68% more likely to incur medical claims in excess of \$5,000 per year; people who don't wear seat belts during automobile accidents incur 54% more hospital days; and smokers' overall health care costs are 18% higher than costs for non-smokers.

What the Control Data study

**'Wellness is starting to look a whole lot like risk management,' says David R. Anderson.**

and other studies showed was that "wellness is starting to look a whole lot like risk management," Mr. Anderson said.

Like a corporate risk manager analyzing corporate exposures, benefit managers also must conduct a risk appraisal to identify risks in the employee population, develop intervention programs to target high-risk individuals and monitor their progress over time, Mr. Anderson advised.

"While this may be old hat to risk managers, this is revolutionary thinking in the wellness field," he said.

Taking a risk management approach means incorporating wellness into an overall health care strategy, according to Alexander's Ms. Casciato.

For example, in addition to promoting a healthy lifestyle, employers should use financial incentives and/or disincentives to lure employees into the fold.

"It's important that employees have a buy-in," she said.

Lifestyle-based employee contributions can also help offset the additional cost of instituting a wellness program, according to Mr. Anderson.

"It's a way of taking away on one hand while giving with the other," Ms. Casciato agreed.

"There are all kinds of creative strategies" for integrating wellness into benefit plan design, according to Ms. Casciato.

For example, some companies may provide coverage for preventive health care services as part of employees' core benefit package, she said.

Other employers offer coverage for preventive services as part of a choice or flexible benefits plan. In such arrangements, employees usually can choose the level of coverage they would like to

Continued on next page



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# Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

## Fees to the rescue?

### Offering consulting services appeals to smaller agencies in soft market

By LAURA MAZZUCA

As the commissions and contingencies offered by insurers continue to shrink, more agencies are relying on fee-based consulting services for stable revenues.

Consulting services are nothing new. Many agencies and brokerages—especially larger ones—have been offering their clients loss control, risk management, third party administration of group health programs and other consulting services for 10 years or more.

But in today's soft insurance market, consulting services are becoming more attractive to smaller agencies, many of which can no longer rely on fat commissions and generous contingencies.

Clients expect more service from their agents and brokers, too.

But, there are some drawbacks to offering consulting services, including high start-up costs and a slow return on the investment.

Because of this, mid-sized agencies are better candidates than their smaller counterparts for offering fee-based consulting services.

Fee-based consulting means that the agent or broker places a client's coverage and offers consulting services for a fee rather than commission.

The arrangement is growing more popular with property/casualty clients because businesses want to be sure that "the cost of insurance is related to the services provided," said Edward L. Overmyer, president and chief executive officer of Berwanger Overmyer Associates.

The Columbus, Ohio, agency offers health insurance, pension administration services and property/casualty consulting on both a fee-based and "pure" consulting basis, in which the agency simply provides consulting services without placing insurance, Mr. Overmyer said.

Not only are these consulting-generated revenues more stable than premiums and commissions for the agency, but this arrangement also is better for the client because agencies will not base their decisions on commissions, he explained.

Consulting services are much in demand by

businesses that have been hard hit by the recession. Medium-sized businesses that cannot afford a full-time human resources person—or are seeing a lot of turnover in this area—are

#### CONSULTING SERVICES

turning to their insurance agencies for employee benefits administration and other services, said Donald Reise, president of The Insurance Exchange

Inc., a Rockville, Md., agency with \$35 million in annual premium volume.

And as it becomes increasingly time-consuming for companies to comply with federal pension and welfare plan regulations, agency consulting services will continue to grow, he predicted.

"We've got people begging us to do this, to just take it over for a fee," Mr. Reise said.

Property/casualty business has long accounted for most of the revenues at The Insurance Exchange. But the agency has provided employee benefits administration services for a few clients "when they got into a pinch."

And now, said Mr. Reise, the agency is considering training some of its own employees to start a consulting department on an experimental, six-month basis, "to see if it's something we want to do."

The fees generated by consulting services can make up a substantial chunk of agency revenues.

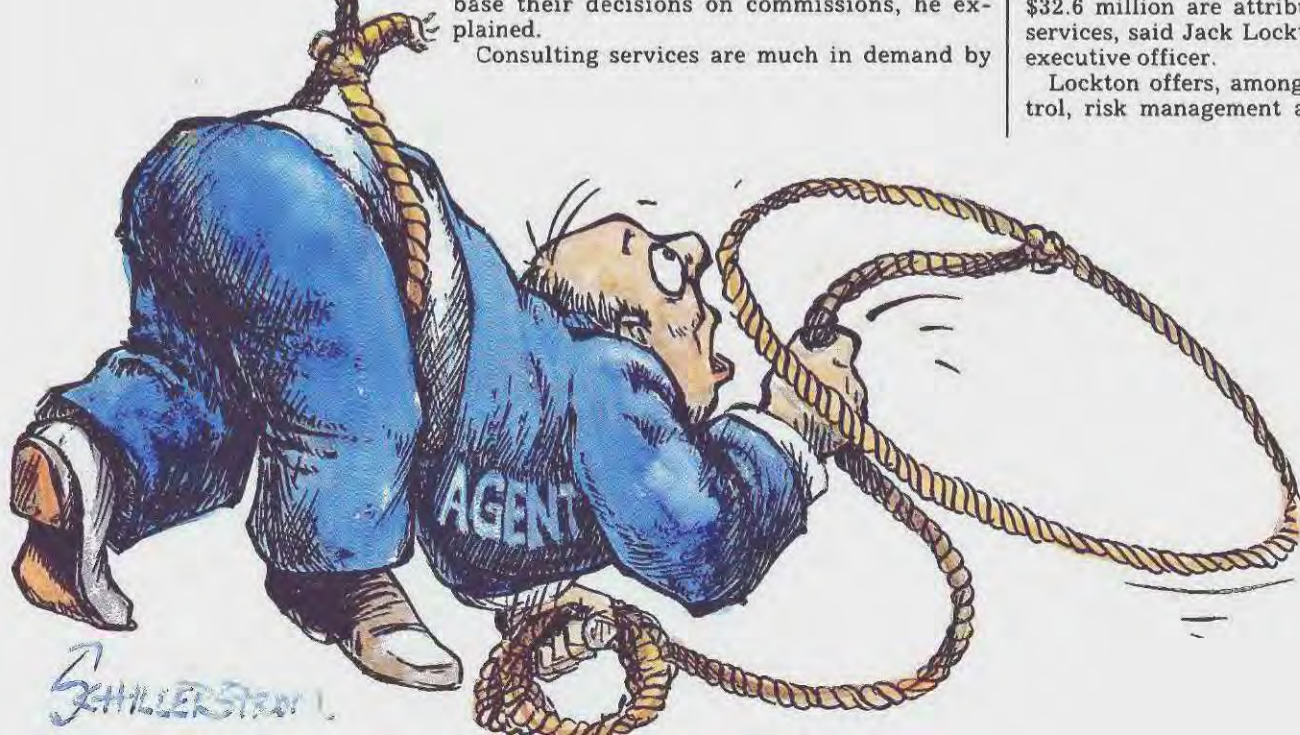
For example, BGS&G Cos., a Cumberland, Md., agency, generates almost 40% of its \$10 million in annual revenues from its financial services division, which specializes in pension administration planning, said Mark Zanger, executive vp.

Revenues and profit margins on the property/casualty side of the business continue to be "flat," he said. In contrast, BGS&G's financial services revenues—which were up 18% last year—grow 15% annually on average.

At The Lockton Group, a Kansas City, Kan., agency, almost 25% of its annual revenues of \$32.6 million are attributable to its consulting services, said Jack Lockton, chairman and chief executive officer.

Lockton offers, among other things, loss control, risk management and claims cost control

*Continued on next page*



SCHILLERSTEIN

## Agent/Broker Topics

## Consulting

Continued from previous page services for a fee.

For claims cost control service, which include loss control advice and consulting on self-administered, self-insured workers compensation plans, Lockton charges annual fees ranging from \$150,000 to \$500,000, Mr. Lockton said.

And Lockton's case management subsidiary, Control Care Inc., which is staffed by a physician and four registered nurses, specializes in workers compensation medical claims.

Hourly rates range from \$85 to \$185 to develop return-to-work programs and to work with other doctors to control the costs of treating clients' injured workers.

The case management unit, which is less than a year old, is expected to generate \$500,000 in revenues in its first year of operation.

An added benefit of offering consulting services is that an agency can use them to retain and attract national accounts, thereby competing with bigger brokers on their own turf, according to Mr. Lockton.

Lockton grew from 20 employees and \$20 million in premium volume in 1980—when it began offering consulting services—to 425 employees and \$450 million in premium volume in 1991 and a projected \$600 million this year, Mr. Lockton said.

Acquisitions do not account for that growth, he said. Instead, it comes from attracting national

accounts with a need for consulting services like Ryder Systems Inc., H&R Block Co., Russell Stover Candies Inc. and Mayflower Group Inc.

These accounts have 2,500 to 50,000 employees; revenues of \$250 million to \$9 billion; and premiums of \$2.5 million to \$100 million.

Another reason to offer clients consulting services is because most standard insurers are "not equipped to do a proper loss control job," said William P. Weible, president at Morency, Weible & Sapa, a Naperville, Ill., agency that offers loss control consulting services.

The agency specializes in heavy manufacturing and commercial construction accounts that generate between \$500,000 to \$2 million in premium volume each.

Although commercial insurers are attracted by such specialty business, most seldom go beyond a "checkbox survey" in their own loss control efforts, Mr. Weible claimed.

Loss control consulting is a service to customers, but it's more a matter of "self-preservation" for the agency in today's soft market, Mr. Weible said.

Morency, Weible & Sapa also uses its loss control consulting program to prequalify new business, which helped it improve its loss ratio 10 points last year—thereby improving its contingencies, Mr. Weible pointed out.

Consulting services, though, have substantial drawbacks.

For example, start-up ex-

penses are high and the paybacks are often a long time coming, said Timothy J. Cunningham, senior consultant at Hales & Associates Inc., a Westchester, Ill.-based agency management consultant.

Most of that expense lies in hiring a specialist for highly technical consulting services, like loss control. These specialists' salaries can start at \$60,000 annually, and many agencies will not realize a profit for a year or more, Mr. Cunningham said.

Lockton, which hires full-time consulting specialists from third-party administrators, insurers and other brokers, pays its consultants salaries and perks "in the six-figure range," Mr. Lockton said.

Morency, Weible & Sapa, which hired a loss control consultant from the ranks of Continental Insurance Co. last year for \$90,000 of annual compensation, is "still in the red" with its consulting revenues, which last year generated less than \$25,000, Mr. Weible said.

In addition, the agency had to retain outside experts for specialized loss control areas like crane inspection and maintenance and fire safety.

Mr. Weible said that he does not expect the program to break even for at least three years. "It's a big-time loser" in the short run, but "our clients and prospects will know we're interested in their welfare."

Automation, too, can be a problem for consultant wannabes.

For example, BGS&G, with its pension administration consulting services, used to turn out 401(k) statements for its clients annually, according to Mr. Zanger.

But today, many clients request monthly statements. To keep up with the demand, BGS&G maintains a separate data automation department, which—at \$25,000—is a costly investment for a small agency.

Identity problems also can arise when agencies begin offering consulting services.

"There's a mindset change that has to take place in an insurance agency that wants to become a consultant," Mr. Zanger said. "There's a big difference between selling a product and sell-

ing an

man, "Especially in the casualty area, whether you are an agent, and some is difficult to draw," Overmyer of BOA.

These complications make it difficult for the smaller agency to get into consulting, Mr. Zanger conceded.

He suggested that they begin by selling products on commission and begin simple fee-based consulting on the side to "get their feet wet."

It also helps to have a sizable base of fairly large customers that could use such services, he added.

## AICPA to discuss accounting change opposed by agents

By SARA J. HARTY

NEW YORK—Agent and broker trade groups will have an opportunity later this month to voice their concerns over a proposed accounting change that would require them to recognize revenues from commissions as they are received, instead of amortizing them over a policy's life.

All agents and brokers who follow generally accepted accounting practices would be affected by the proposal if adopted.

The American Institute of Certified Public Accountants has invited six industry organizations to a meeting in New York April 29 in hopes of coming to a better understanding of industry objections to the proposal, which was initially released for comments late last year.

"We wanted to keep the meeting small so that we could have a good-size working group to address" industry concerns, said Ellise Konigsberg, technical manager of the accounting standards division of New York-based AICPA.

Accounting practices for agents and brokers have "varied" within the industry, and the proposal is intended to bring some consistency to accounting practices, said Ms. Konigsberg, who declined to identify the groups.

The accounting organization has received numerous comments on the draft, "primarily on the issue of revenue recognition," she said.

The draft proposes that agents and brokers recognize their revenue from most commissions on the "revenue recognition date," which is defined by the accounting group as the date when each of the following criteria have been met:

- The insurance policy is in effect.
- The premium due is known or can be reasonably estimated.
- Virtually all required services related to placing the coverage have been rendered.
- No significant obligation exists to perform services after the insurance coverage becomes effective.

"The bottom line is that the

recommendation would result in an acceleration in the way one reports fully earned income," said Patricia Borowski, senior vp of government and industry affairs with the National Assn. of Professional Insurance Agents in Alexandria, Va.

The proposal does not take into account "that when an agent collects a commission, it is not fully earned until the policy matures," even if the whole commission is received up front, Ms. Borowski said.

If the policy is canceled, the unearned portion of the commission must be returned, she pointed out.

But, if the entire commission has already been accounted for, the agent would then be required to adjust in-house records, possibly affecting revenues that had been recorded in the previous fiscal year, she said.

Adjustments in federal taxes that had already been paid also might be necessary, she noted.

"It's crazy," Ms. Borowski said. "Even if the proposal were acceptable to us, which it is not, it allows absolutely no transition period."

In addition, from a practical business standpoint, the proposal is "mechanically impossible" to implement, Ms. Borowski said.

Most producers have automated systems to handle their accounting, and these agency systems are designed to spread the commission out over the life of the policy, she explained. There are no vendors that could currently "accommodate the changes" that would be required by the proposal, she said.

"After we meet with the organizations, we will have to decide if we need to change" the proposal, Ms. Konigsberg said. The proposal would then be further reviewed by two AICPA internal committees: the Insurance Company Committee, followed by the Accounting Standards Executive Committee.

At that point, the Financial Accounting Standards Board would review the proposal. If FASB did not object to the AICPA issuing the standard, it would become a final industry accounting rule, Ms. Konigsberg said.

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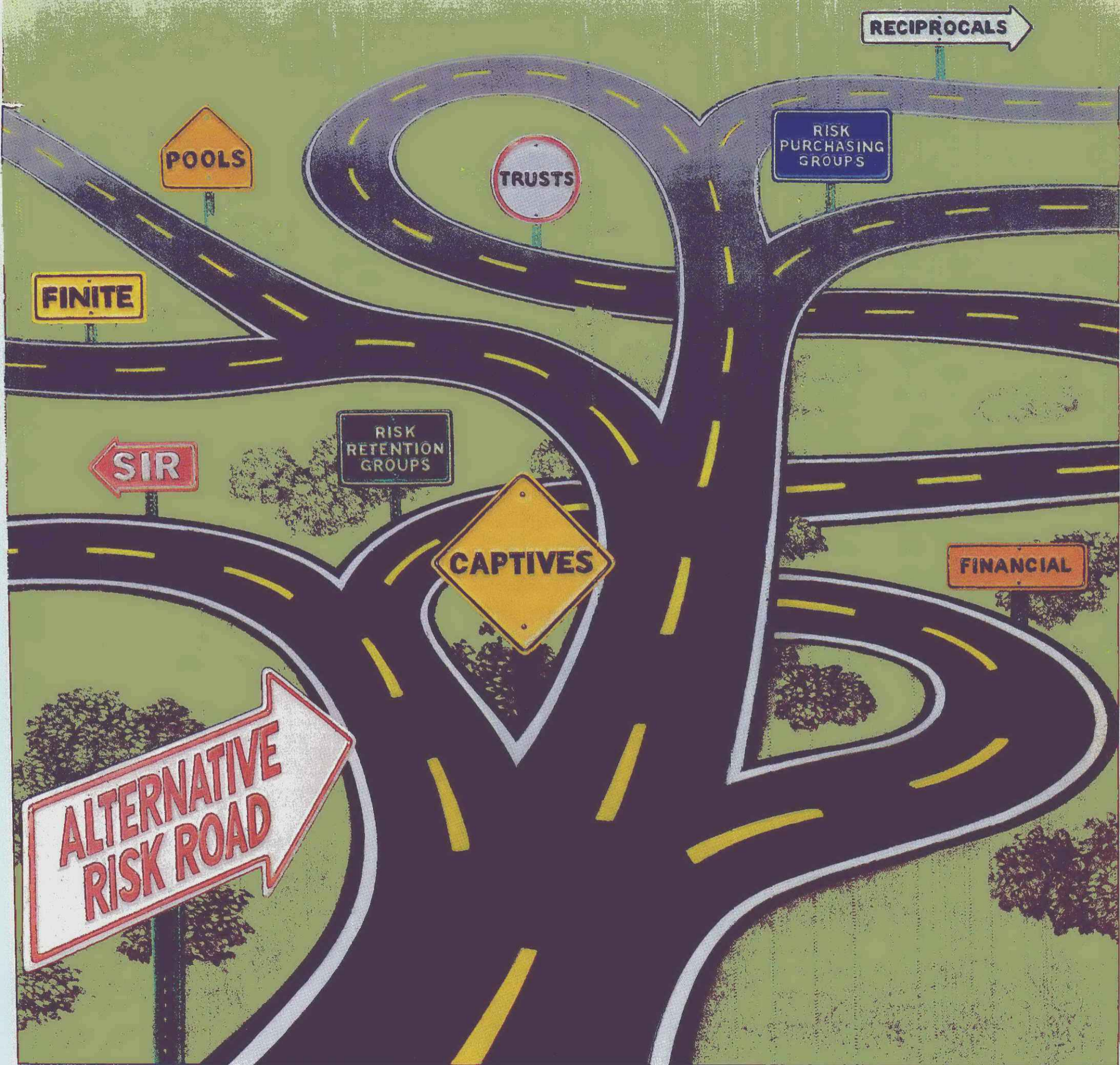
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# Aetna seeks to restore harmony with agents

Insurer's new outlook allays fears of many long-time agents

By LAURA MAZZUCA

Mother Aetna is long gone and few have mourned her passing more than independent agents.

For generations, maternalistic Aetna Life & Casualty Co. had devoted itself to being all things to all people, including legions of loyal independent agents.

Then came the restructuring. Pressed by regulators, competitors and consumer initiatives, Aetna in 1989 began paring its operations by dropping unprofitable lines of business and cutting layers of middle management.

Many independent agents were rapidly alienated by what they saw as erratic marketing decisions, diminishing loyalty to agents and a lack of commitment to personal lines coverages.

But, last month, at its annual "Great Performers" meeting for preferred agents, Aetna Chief Executive Officer Ronald E. Compton and other Aetna executives met with 62 agents, representing an agency force of 3,700.

For some agents at the meeting, Aetna's assurances con-

vinced them that things were changing for the better.

Aetna executives were "loud and clear about not changing their distribution system," said William J. Carroll, president of Merit Insurance Inc. in Bridgeport, Conn.

Now, with its restructuring complete, Aetna has allayed many agents' fears by saying it plans to make agent relations a bigger part of its operations.

Indeed, agents reported that morale was much higher at this meeting than in years past.

"The uncertainty is behind us, and the agents are much more comfortable," said Joseph C. Lukens, president of Insurance Management Associates in Wichita, Kan. "Everyone wants to get on with business."

"I was not very optimistic at first, but I came away from there absolutely convinced that Aetna knows where it's going," Mr. Carroll said. "Agents just have to decide if they want to go with them."

And, the agents did not go easy on Aetna at the meeting. They

came armed with tough questions about service centers, market pullouts, commission structures, and Aetna's commitment not only to agents, but to the independent agency system, said Paul H. Wagener, a senior vp at Frank B. Hall & Co. of California Inc. in Salinas.

"People came there with some real questions," agreed Hank Hubbard, a vp-agency development at Aetna.

But Mr. Compton, along with David A. Kocher, Aetna group executive, and Thomas S. Carpenter, vp-field operations, "were very candid" in answering these questions, Mr. Wagener said.

"The most significant part of the meeting was the time given and commitment shown by senior Aetna management, including Ron Compton," Mr. Lukens agreed. "If you're going to communicate effectively, it needs to be spoken by the top... I compliment Aetna for making those senior officers available."

Mr. Hubbard attributes soured relations with agents over the



From its agent relations staff at headquarters and its chief executive officer, Ronald E. Compton, comes the word: Agent relations are going to be a top priority at a restructured Aetna.

last few years to "lousy communications" by Aetna during the restructuring.

In 1989, when that restructuring began, it was common knowledge that Aetna's expenses were too high and that it was having trouble turning a profit in personal lines, said Walter Fitzgerald, an analyst with RAS Securities in New York.

So it was no surprise, Mr. Fitzgerald added, that Aetna not only canceled many agency contracts, but also changed the commission structure on existing contracts to cut overhead.

"Some of the agents' frustration was part of that sorting-out process. That is done, and we're preparing to be more definitive with our agents," Mr. Hubbard said. "We have acknowledged it and apologized."

To make amends, Aetna has given top priority to strengthening communications with its agents. The insurer is launching a program under which it will establish strategic business units at field offices staffed by representatives of the home office so Aetna's communication with its agents will be more direct, Mr. Hubbard said.

To judge from the complaints of some agents who weren't at the meeting, improvements at Aetna aren't coming a moment too soon.

"Insurance people get used to strange behavior on the part of the carriers from time to time," but Aetna's market changes have been exceptional, said Richard H. Smith Jr., president of Pierson & Smith Inc. in Stamford, Conn. The agency, which has \$5 million in premium volume with Aetna, has represented the insurer since 1946.

"Aetna used to be a bastion of stability. Its place in the sun was always guaranteed because of this tremendous loyalty," Mr. Smith said.

In the past, Aetna met regularly with its agency advisory board, seeking input on issues like marketing decisions and rate changes.

But gradually, these meetings stopped. "We haven't had an advisory board meeting in a long time," Mr. Smith said.

Over the last several years, Aetna's attitude "has been very cavalier," he said. "Communication has been just awful with them, and they're constantly changing course."

Some agents complained that the double whammy of high-priced products and increased

volume demands by Aetna made it impossible for them to retain a contract with Aetna.

For example, Secure C. Ieuter Sr., president of William Feutures Insurance Agency in Des Plaines, Ill., lost his personal lines contract with Aetna last May after 27 years. He blames the high cost of Aetna products, which resulted in little new business. At the time of cancellation, the agency had \$380,000 in premium volume with Aetna.

"I could see it coming," Mr. Ieuter said. "They were changing their whole thought process on personal lines."

Many agents griped that while Aetna wants long-term commitment from its agents, it was unwilling to commit in return. As evidence, they cited personal lines pullbacks, changes in marketing strategy and a disregard for agent opinion.

Aetna was "too bureaucratic" with "layers upon layers of management" before the restructuring, Mr. Ieuter said. "The local branch could not make the decisions they needed to."

The rumblings in Aetna's agency force began with the restructuring program in 1989. The insurer began focusing on niche markets, de-emphasizing personal lines—including pulling out of the auto business in 28 states—canceling agency contracts and tying some commission structures to loss ratios, which often reduced commissions.

Mr. Hubbard said that a partnership to sell homeowners coverage through a Citicorp subsidiary in Florida last year also aroused agent ire, even though only 12 policies are in force as a result of the arrangement (A/BT, Feb. 3).

The plan has since been suspended by the Florida Department of Insurance, which is weighing the question of whether out-of-state banks can sell insurance in the state.

The creation of a service center for Aetna personal lines policies had some agents worried that the company was bypassing them completely.

And recently, a New York Times article depicted Mr. Compton as a take-no-prisoners CEO who will, in his words, "break a little china in and out of the company." That had some agents convinced that Aetna was planning to dump its agency distribution system altogether.

Nothing could be further from

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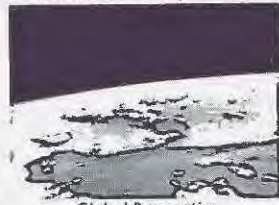
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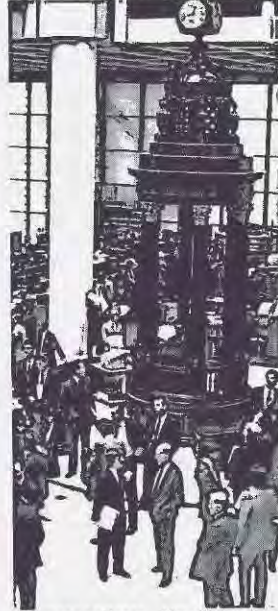
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Continued from previous page  
the truth, Mr. Hubbard said.

"We don't have any other alternatives" than the independent agency system, he said, noting that independent agents placed about \$7 billion in business for Aetna last year. In turn, Aetna paid them about \$730 million in commissions and \$57 million in contingencies. "This is our only source of business, and we understand that, and we intend to build on the strengths of these relationships."

Agents present at the "Great Performers" meeting commended Mr. Compton's straightforwardness and bluntness regarding market conditions and changes within Aetna.

Mr. Compton not only addressed the agents en masse, but he also spent almost two hours in each of the four smaller working groups at the meeting.

"I'd rather have a guy like that than someone who tells me everything is roses," Mr. Carroll said. "This is the first time in years that I felt they were really listening."

"What he said made sense," said Hall's Mr. Wagener. "He was open to all types of questions, and he answered them well."

In talking with *Agent/Broker Topics*, Mr. Hubbard reiterated Aetna's position and addressed many of the issues raised at the agents' meeting:

• **Communications.**

Aetna has pledged to make improved communications with its agency force a top priority, Mr. Hubbard said.

Aetna's agency development department will be represented in the field offices, focusing on the "care and feeding of our agents," rather than marketing he said. The department will provide sales training, producer recruiting assistance, a perpetuation loan program and other help for agents.

Aetna will help agencies' marketing efforts through a so-called strategic business unit format, which will be up and running in 42 Aetna field offices across the country by July, he said. "This tighter integration of Aetna and agency dealings will go beyond the traditional approach of marketing," Mr. Hubbard said.

Over the next several months, Aetna also plans to get feedback from agents on how relations can be further improved.

• **Market withdrawals and contract changes.**

Some agents have complained about the change in Aetna's personal lines auto commission structure, which ties commissions to loss ratios.

"It does not allow you to operate," said Mr. Smith of Pierson & Smith.

Aetna's commission structure, which ranges from 7% to 15%, penalizes agents in Connecticut and other states that have poor auto loss ratios, he said.

According to Mr. Hubbard, Aetna had to choose between reducing commissions across the board or basing them on performance, and the latter choice seemed more equitable. "The problem is you penalize those who are performing well" if overall commission reductions are instituted, he said.

Aetna concedes that personal auto and workers compensation are problem areas for the company and that its attempts "to

grapple with these have caused problems," like market withdrawals.

But, there are other profitable lines of business that Aetna will work with its agents to develop, Mr. Hubbard said.

For example, Mr. Carroll noted that Aetna, in its quest for niche markets, has developed products like a commercial program for food wholesalers that is now being fine-tuned by agents.

• **Contract cancellations.**

In Connecticut, Aetna has canceled contracts with many smaller agents without disclosing its intentions beforehand, Mr. Smith said.

And Mr. Ieuter reported that Aetna cut its agency force in the Chicago area substantially.

But because Aetna already has

lost many agencies through attrition over the last several years, it has no plans to step up cancellations in the future, Mr. Hubbard said. If contracts are canceled, it will continue to be "territory specific" and dependent on individual agents, not "wholesale agency terminations." However, he believes that agency consolidation will continue as they adapt to market conditions.

• **Service centers.**

Nothing strikes fear in agents' hearts more than service centers.

Because service centers allow insurers to process personal policies directly, agents view it as a threat to their relationship with policyholders.

"Our customers don't want to deal with an 800 number—they

want to talk to somebody," said Mr. Ieuter of Secure Futures Insurance.

But agents at the Aetna meeting believe service centers will benefit both themselves and policyholders.

Mr. Carroll, who currently uses a personal lines service center operated by ITT Hartford Group Inc., is pleased with it and is optimistic about Aetna's plans for adding a service center.

But Aetna is only in the initial phases of setting up what it prefers to call "personal lines business centers," and agents will have the option of providing services themselves or turning the duties over to Aetna, Mr. Hubbard said. Until they are available, Aetna's existing personal lines office will remain in place,

with agents for the most part processing claims, he said.

• **Poor automation.**

Some agents gripe that Aetna's computer systems are antiquated and inefficient.

The combination of "average products" and poor personal-lines automation does not encourage agents to place business with Aetna, especially when insurers like St. Paul Cos. Inc. and Chubb Corp. offer better products and top automation, Mr. Smith said.

Mr. Hubbard admitted that Aetna's 22-year-old personal lines automation system could be made more efficient, especially by expanding its data base. But, Aetna is in the initial stages of phasing in a new automation system. ■

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# Recession-busting strategies

Strong regional operations can boost agency growth: Panel

By CHRISTINE WOOLSEY

SAN FRANCISCO—The lingering soft market is haunting national brokers who—like insurance companies—are hard pressed to increase their bottom-line performance.

But there are some strategies that national brokers can put into action to help improve their financial position during tough times, say three brokerage executives.

Beefing up regional operations; focusing on market niches; and hiring, training and compensating the most talented producers all can strengthen a broker's business, they say.

"We all say we are in a growth industry and we are planning for growth, but in reality not too many of us are," said Clark W. Johnson, corporate vp at Arthur J. Gallagher & Co. of Itasca, Ill.

The challenge in the future is to "figure out how to grow despite increased expenses, reduced rates and reduced contingent income," he said.

Mr. Johnson made his comments during a panel discussion at the Russell Miller Inc. National Insurance Symposium Leadership Conference held in San Francisco last month. The session addressed the important role regional operations can play in fueling steady growth for national brokers.

Part of a regional manager's responsibility is to make sure his or her branch offices are bringing in new business, and that the new business is profitable, said Mr. Johnson.

"We are good at budgeting our expenses but not in budgeting new business. We wind up bringing in new business, but we can't increase our pretax profit," he said.

And even when new business is a priority, existing business still

must be nurtured.

Lost business should be a concern to all brokers, Mr. Johnson noted. "In my region, we did \$6 million in billed new business last year, but we lost \$2.5 million, so the net increase was really \$3.5 million," he said.

One approach to generate new business is to focus on niche or specialty business, according to Mr. Johnson and Kevin W. Conboy, Northeastern Regional director for American Business Insurance Inc. in Morristown, N.J.

Gallagher is continuing to develop its niche-oriented business, according to Mr. Johnson. "As I look at which branches have grown over the last few years, it's mostly been branches operating in niches. I try to expand those niche programs to other regions if they are successful."

"We've developed a nice niche in the Northeast," Mr. Conboy said, noting that ABI provides risk management services for many clients in the area.

Another strategy to spur growth in a soft market is to establish target-account teams, Mr. Johnson said. "We aren't as large as some brokers, so when we are going after large accounts, we bring together experts from all areas and from different areas of the country," he explained.

Mergers and acquisitions also can enhance brokers' business.

Gallagher remains interested in merging with or acquiring companies that are a "good fit," Mr. Johnson noted. "We go into cities where we don't operate already. We like companies that bring us expertise and programs that we don't already have.

"When we do acquire a company, we pretty much let it keep its own identity, and we try not to overmanage. Our only requirement is that they grow," he said.

Increasing consolidation in the industry over the past decade has fueled the rapid growth in brokers' regional operations, said Thomas A. McCaffrey, senior vp and western regional manager at Rollins Burdick Hunter Co. in Universal City, Calif. "In 1991, public brokers acquired 41 companies, and regional brokers and agents conducted hundreds of acquisitions," he explained.

National brokers should not underestimate the importance of regional operations, which are growing at record rates, Mr. McCaffrey said. Some regional operations have revenues larger than entire brokers had 10 years ago, he said. And, "some brokers' regional operations are even higher in terms of premium volume than some insurance companies."

Mr. McCaffrey said brokers' regional operations are indispensable. "You can't function if you have 40 or 50 offices reporting to one source," he pointed out. And, because different geographic areas are made up of different markets, societies and industry groups, brokers must have a variety of business strategies, he said.

Brokers can also strengthen their results by strengthening their sales forces, the executive said.

To motivate producers to work most efficiently, Gallagher provides them with a very lucrative compensation package, Mr. Johnson said. But, sometimes a good salary does not guarantee optimum results, he noted.

We sometimes find producers become successful and "then become comfortable and we can't rely on them bringing in new business each year," Mr. Johnson said.

"As we get larger, many of our producers have to be held accountable for their decisions. We

have to direct them some and we have to weed out non-performers."

Nonetheless, brokers should not let the number of their producers dwindle, Mr. Johnson stressed. "If all of us look at our three- or five-year plans, it's mind-boggling how many producers we'll need to hit those targets," he said.

Hiring and training the most effective producers is an integral part of Gallagher's strategy to increase profits, Mr. Johnson pointed out. "Recruiting and training is second in importance only to sales and revenues," he explained.

"Arthur J. Gallagher is committed to college recruiting. We do a good job of recruiting the top college-level people," he said, noting that while it is tempting to expand its recruiting program, doing so wouldn't be wise given the current state of the economy.

Pay is not the only way to motivate employees, said Mr. Conboy. ABI tries to make its workers feel that they are involved, not just employed, by the broker, he said.

"We don't call our people 'employees'; we call them 'associates.' If I call them 'employees,' it implies they are working for me and that they are not part of

the management team. We want them to be participants, and we want to set a career path for them and their families," he said.

Quality regional managers are just as important, Mr. McCaffrey commented, saying that he compares his job as a regional manager to that of Roger Penske, who owns an auto racing team.

"Mr. Penske has a number of drivers he relies on, all of whom have different skills, likes, dislikes and values," he explained. Those "drivers" are akin to the directors in regions, he said.

Mr. McCaffrey continued his analogy by explaining that the different cities where regional brokers have operations are similar to the different racetracks on which Mr. Penske's drivers have to race their cars.

The race cars are akin to the offices regional brokers operate, he said. "All of them need to be slightly different—they need a different type of oil, different tires etc.—to perform at the top level of efficiency."

In addition, all of the drivers need a backer or a sponsor, Mr. McCaffrey said.

"Mr. Penske is the one who has to go out and convince people why there is a need to race," Mr. McCaffrey said. "That's the job of all of us." ■

## Lighthearted advice for keeping firm afloat in difficult economy

By CHRISTINE WOOLSEY

SAN FRANCISCO—A good sense of humor appears to be one of the best attributes a business leader can have when he or she is trying to manage a company in trying economic times.

Donald R. Bell, chairman and chief executive officer of Frank B. Hall & Co. Inc.—the world's

sixth-largest broker (BI, July 1, 1991)—certainly proved he has one during a speech given at the Russell Miller Inc. National Insurance Symposium Leadership Conference held here March 1-3.

"Let's face it, even Communism had a better year than most of us in the insurance industry," Mr. Bell quipped to an audience of more than 150 leading insurance company and brokerage executives.

He let conference attendees in on some of his secrets to managing stress.

"After 35-plus years in the business, I've developed my own fallback tools to deal with stress," Mr. Bell said. "Those tools include Excedrin—I take two tablets whenever I get the urge to hire a management consultant and wait until it passes; Valium—it enables me to relax in a state of euphoria while someone else handles the crises; and Ben & Jerry's Ice Cream," which can make anyone feel better, he said.

Amid the chuckles, however, were nervous glances from insurance industry executives who are searching for ways to improve their businesses despite the moribund economy.

"Many important and respected companies are struggling to keep afloat" these days, Mr. Bell acknowledged. In fact, he said, some companies that are known for their standards of excellence are just trying to keep up with everyone else.

Acknowledging that some of Hall's competitors were present in the audience, Mr. Bell said, "I'll have to limit my ideas." But, he did offer some general advice.

"One fundamental challenge

Continued on next page

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# Rebaters take on insurers over cancellations

By LOUISE KERTESZ

LOS ANGELES—Two independent agents are challenging insurers that terminated sales agreements because the agents rebated portions of their commissions to policyholders in California and Florida.

California and Florida are the only two states where rebating is legal. Rebating became legal in California with the passage of Proposition 103 in 1988. It became legal in Florida in 1986, after the State Supreme Court ruled that laws prohibiting rebating were unconstitutional.

One agent has filed a lawsuit

against the insurers seeking reinstatement of the agreements and compensatory and punitive damages, while the other agent has complained to state regulators, who have completed an investigation and are considering whether to file suit against the insurers.

Rick K. Nelson, president of Rick K. Nelson & Associates, an independent life insurance agent in Northbrook, Ill., filed suit against Metropolitan Life Insurance Co., Prudential Insurance Co. of America and Transamerica Occidental Life Insurance Co.

The suit, filed in Cook County

Chancery Court in Chicago last May, alleges that the insurance companies violated their sales agreements with Mr. Nelson by canceling the agreements in 1990 on the grounds that he offered rebates to policyholders.

The lawsuit seeks reinstatement of sales agreements with all three insurers, as well as unspecified damages for lost business and \$10 million in punitive damages against each company. It seeks an additional \$1 million in punitive damages from Prudential because it terminated its agreement "just as I was getting ready to consummate a sale, so I lost \$75,000 in commission,"

Mr. Nelson said.

Last November, MetLife and Prudential filed a motion to dismiss Mr. Nelson's suit, according to his lawyer, Burt Weinstein, a partner with Baskin, Server, Berke & Weinstein in Chicago.

Transamerica is awaiting the outcome of the motion to dismiss before deciding on its own response, according to Mr. Weinstein.

A spokesman for MetLife in New York said that the insurer had no comment on the court proceeding or on the rebating issue in general.

A spokesman for Prudential in Newark, N.J., said the insurer

had no comment on the court proceeding. But, he said that "we do not want to do business with an agent who uses rebates. We do not believe in rebating. It's harmful to the industry as well as to the consumer," since it focuses the insurance transaction on "who offers the biggest discount" and masks the "true price" of insurance.

Prudential believes it has the right to terminate an agreement with an agent because it is "not a contract or a license. They are not employees of the company," the spokesman said.

Alan Cunningham, vp and dep-  
Continued on next page

## Recession advice

Continued from previous page  
management faces" in these times is promoting "the obsolescence of platitudes," Mr. Bell said. Companies that insist they are dedicated to their employees and customers—yet do not treat either with respect—are particularly insidious.

"In the last few years, you could pick up any annual report and read 'Our people are our greatest assets,'" Mr. Bell explained. But workers are not always treated that way, he said, citing the recent spate of layoffs.

"I'm not suggesting a socialistic system. I think recessions are necessary... (to rid organizations) of the waste and deadwood that limits their vitality," Mr. Bell said. However, "I question our methodology for showing people sensitivity," he said.

Faced with today's economic realities, companies may have to cut staff or "downsize" or "rightsize," as some firms prefer to call it, Mr. Bell said.

Unfortunately, "everyone wants to be Santa Claus and no one wants to be the Grinch," he said.

"The fact is, cuts may have to be made" and management should begin explaining to employees the true reasons behind those cuts, he advised. "People want to know what's going on," and management should not hide behind glossy public relations messages, he said.

Motivating the employees that remain after a staff cut can be difficult, Mr. Bell admitted. But, "there are two tools to motivate people any time—not just during difficult times: a common goal and a common enemy," he said.

Superficial dedication to customers is another irksome platitude, Mr. Bell continued.

"The customer alone casts a vote about how successful our businesses will be," he said, noting that only the companies that truly serve their customers will get ahead. Mr. Bell pointed to well-known retailer Nordstrom Inc., which is known for its customer service.

"Nordstrom's sales have increased about 50% since 1986, compared with its industry's sales increase of 12%," he noted.

Mr. Bell also stressed the importance of being able to quickly adapt to change.

"Fast adapters will be the winners. We must learn to embrace new technology and get to know what we don't as fast as possible. Our three goals as an organization are to be fast, fluid and flexible."

## MAY

### Mergers/Acquisitions/Divestitures

Issue: May 4

Ad Closing: April 22

Reality: there are fewer agencies today than 5 years ago; smaller agencies had trouble surviving as larger competitors gobbled them up, and in the throes of a recession the numbers are dwindling still. *BI's Agent/Broker Topics* section will look at what small to medium-sized agencies can do to hang on... merge with similar sized agencies, buy books of business handled by smaller firms, groom themselves for acquisition by a bigger operation. Editors will examine how agencies can improve their financial management in a sluggish market.

## JUNE

### Legislative Issues; NAIB Report

Issue: June 1

Ad Closing: May 19

The role of lobbyists and political action committees takes on new importance during an election year. *BI's Agent/Broker Topics* section will look at the role insurance lobbyists and PACs will be playing in this year's campaign. Are legislators shunning insurance PAC money for fear of being branded as a tool of big business? In addition, editors will report on developments from the National Association of Insurance Brokers meeting in Pebble Beach, California.

## JULY

### Compensation & Incentives

Issue: July 6

Ad Closing: June 24

Can employee compensation at independent agencies continue to increase faster than revenues during the current recession and soft market? *BI's Agent/Broker Topics* section will focus on this critical issue, reporting on how agencies can attract and keep qualified personnel without going overboard on compensation. What perks and benefits are being offered as an alternative to big raises?

## Agent/Broker Topics

*Agent/Broker Topics* is a monthly demographic section published within the pages of *Business Insurance* and sent exclusively to *BI's* agent/broker subscribers. Advertisers in *Agent/Broker Topics* are positioned within an unparalleled editorial environment and reach an undiluted audience representing a wealth of purchasing power for insurance products and services. With an average premium volume of \$14.91\* million, 94%\* of these influential readers take action as a direct result of the articles or advertisements they read in *Business Insurance*.

\* An Audience Profile of the Business Insurance 'Agent/Broker' Subscriber, 1990.

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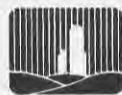
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## Agent/Broker Topics

### Rebates

*Continued from previous page*  
uty general counsel for Transamerica Occidental in Los Angeles, said Mr. Nelson was not terminated for rebating but, rather, for low production. In addition, he had solicited business outside his approved territory, Mr. Cunningham said.

Transamerica Occidental does not endorse rebating, he said.

Mr. Nelson said he began rebating a percentage of commissions to clients in California and Florida in 1990, but had for some time earlier been engaged in so-called "internal discounting," resulting in policies with lower premiums.

Mr. Nelson said he gives life insurance and annuity buyers a rebate equal to between 40% to 70% of the selling agent's first-year commission, with the higher rebates going to buyers paying higher premiums and commissions. His firm has rebated as much as \$50,000 and as little as \$50, and still does business with a number of other insurers, he said.

"I offer insurance buyers a

discount, just as Wal-Mart (Stores Inc.) discounts name brands or Charles Schwab (& Co. Inc.) discounts stocks," Mr. Nelson said. The insurers "don't want discount insurance brokers and they want to prevent savings from reaching the consumer," he argued.

Those sentiments were echoed by Mark White, president of Direct Insurance Services of San Diego.

"Most insurance companies don't want the public to know rebating is possible," he said.

The insurance companies are guilty of "intimidation and coercion and are in violation of rules of fair business practice," he asserted.

Mr. White, who offers a minimum rebate of 50% of the selling agent's commission, saw his agreements with the same three insurers canceled "over the course of the last year and a half." He complained to the California Department of Insurance, which investigated his complaint and is currently deciding whether to sue the insurers, according to a department spokesman.

"Efforts on the part of insurance companies, brokers or agents to prevent (rebating) or to punish those who do offer discounts, will not be tolerated. . . . I will vigorously enforce the provisions of Proposition 103 that facilitate reductions, including the rebating section," Insurance Commissioner John Garamendi said last year.

Every insurance buyer in California—including the commercial insurance buyer—is entitled to a rebate under Proposition 103, asserted Mr. White of Direct Insurance Services.

But rebating is not such a burning issue in the commercial arena, he said, because "generally, commissions are negotiated" for larger commercial premiums.

Direct Insurance Services' main lines of business are life insurance, annuities and disability insurance. The agency, which has agreements with 83 companies, can also provide quotations for group health care coverage, "but we're very cautious about group health," according to Mr. White, because "the whole issue is in turmoil." ■

## Court denies pension obligation

WASHINGTON—Insurance agents who participate in insurer pension plans are independent contractors—not employees—and thus are not protected by the Employee Retirement Income Security Act, the Supreme Court has ruled.

In a unanimous decision, the justices said that if independent contractors were considered employees it would compromise employers' ability to determine their pension obligations.

The decision overturns a 4th U.S. Circuit Court of Appeals ruling that said workers would be considered employees if they had a "reasonable expectation" of receiving benefits.

The case involved an agent under contract with Nationwide Mutual Insurance Co. who participated in a Nationwide pension plan. Nationwide terminated the contract and dropped the agent from the pension plan. The agent later sued, arguing that the vesting provisions of ERISA gave him a non-forfeitable right to the benefits.

As a result of the decision, employers can determine with certainty which employees the act protects, said George Ragsdale, a senior partner in the Raleigh, N.C., office of LeBoeuf, Lamb, Leiby & MacRae, which represented Nationwide.

### Bank annuity sales

MOUNT VERNON, N.Y.—A coalition of New York agents and brokers is battling bank annuity sales in state court.

Recently, the New York State Supreme Court granted the coalition—a group of agent and insurer trade groups that calls itself Bank Regulation: Agents Committee Effort, or BRACE—the right to argue against allowing state-chartered commercial banks to sell annuities in the state.

The state Supreme Court, a trial court, held that the group has standing to bring suit against the New York State Banking Department, which last January issued an opinion stating that

banks could sell annuities.

In granting standing, the trial court signified that BRACE could potentially suffer injury, making the case worthy of hearing.

Last month, an appellate court denied a subsequent appeal by the Banking Department to overturn the lower court decision. The issue will go back to the trial court for arguments and a decision on its merits, scheduled for sometime next month.

The agent/broker coalition expects a final ruling on the bank annuity sales two to four months after that.

### A/BT briefs

### Merger in Missouri

JEFFERSON CITY, Mo.—Members of the Independent Insurance Agents of Missouri and the Missouri Assn. of Professional Insurance Agents have unanimously approved the consolidation of the two groups.

The new organization is now known as the Professional Independent Insurance Agents of Missouri.

Staffs of the two Jefferson City-based groups were consolidated in the current IIAM headquarters and began using the new name last month, though the merger legally takes effect July 1.

The PIAM will have a membership of about 750 independent agencies and brokerages. ■

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**Business  
Insurance**

Continued from previous page have in such areas as preventive care, acute care, intermediate care or emergency care.

"For example, someone with diabetes might choose to have higher acute care benefits," she explained.

Among the "carrots" employers usually offer their employees to participate in wellness programs are:

- Rebates on premium contributions for good health or health improvement.

- Accomplishment awards, such as bonuses for employees who have not smoked for at least six months.

- Discounted life, health and/or disability rates for those who pledge to maintain a healthy lifestyle.

Among the "sticks," or financial disincentives, employers use are increased life, health and/or disability rates for those who have unhealthy lifestyles, such as smokers.

"It doesn't say you can't smoke, but if you do, you'll pay more for your benefits," Ms. Casciato said.

Another financial incentive with which employers are experimenting is the establishment of risk-related benefit plan contributions.

Such contributions are usually calculated based on a point system using information collected from a health risk appraisal conducted of each employee.

The risk factors that usually are taken into account are smoking, blood pressure, cholesterol level, obesity and whether an employee exercises regularly.

Some employers are more flexible than others, according to Ms. Casciato.

For example, Southern California Edison Co. rewards employees' willingness to try to reduce their risk factors, said Mary Schmitz, manager of health care customer services for the Rosemead, Calif.-based utility.

"This way they can have a disease and still get a rebate," said Ms. Schmitz, who also spoke during the session.

Under SCE's good health rebate program, employees and their spouses can get a rebate of up to \$10 per month on their health plan contributions if they pass the tests for five risk factors—obesity, blood pressure, high cholesterol, smoking and diabetes—or are under a doctor's care for one of these factors.

Flexibility enables employers to avoid the appearance of discriminating against one group of individuals who may argue that their high blood pressure or diabetes are disabilities covered under the Americans with Disabilities Act, all three speakers agreed.

In fact, some employees may argue that their smoking is a disability since Dr. C. Everett Koop, the former Surgeon General, said that nicotine is as addictive as heroin.

In general, under the ADA, employers no longer can refuse to hire workers predisposed to work-related or non-work-related injuries and illnesses. And employers cannot exclude applicants because their conditions will probably deteriorate in the future or because workers compensation or health insurance premiums will probably increase once they are hired (BI, Jan. 27).

Each company's approach to integrating wellness into its health benefit plan will vary depending on its corporate philoso-

phy and culture, financial objectives, plan design and workforce demographics, Alexander's Ms. Casciato explained.

"It's always important to look at the corporate culture and see what actually fits in terms of wellness," she said.

An integrated wellness program also "needs to be inclusive, from primary prevention to rehabilitation, including cost, volume and quality considerations," she said.

Above all, a program should reward behavior change that makes employees healthier, thus reducing their overall health care costs, Ms. Casciato concluded.

Robert D. Jensen, insurance/risk manager for the Minneapolis/St. Paul Metropolitan Airports Commission, moderated the session. ■

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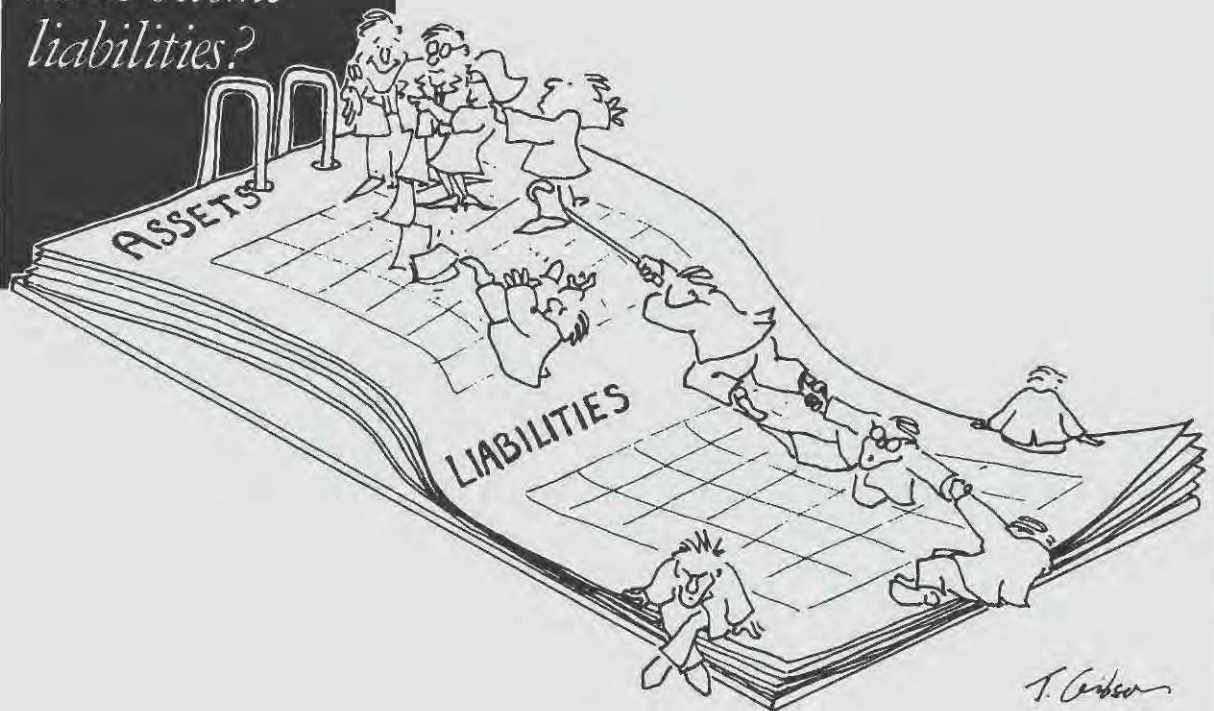
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# Courts and Congress fill in gaps left by COBRA law

By **JERRY GEISEL**

*Consultant details where continuation coverage is heading*

ANAHEIM, Calif.—Six years after COBRA was enacted, the landmark statute continues to evolve.

Through a slew of rulings, federal courts are filling in the blanks left by COBRA's many ambiguous provisions.

At the same time, Congress continues to add new health insurance continuation requirements, with even more changes on the horizon, said Pamela Sande, assistant vp and manager of applied research in the Newburyport, Mass., office of Alexander & Alexander Consulting Group Inc.

While no legislative changes are likely during the current congressional session, the pending proposals provide a good idea of the direction future changes will take, Ms. Sande said last week at the 30th annual Risk & Insurance Management Society Conference in Anaheim, Calif.

Since President Reagan signed it into law on April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 has been a major headache to employers.

Almost overnight, employers had to extend health insurance to millions of former employees and dependents.

Former employees can receive group health care coverage for up to 18 months, while dependents, like widows or divorced spouses, can take coverage for up

to 36 months.

But, employers can charge COBRA beneficiaries a maximum premium equal to only 102% of the group rate for the coverage. Several studies have found these premiums fall well short of covering claims payments because of adverse selection.

COBRA imposes penalties of \$100 for each day coverage has not been extended to a qualified beneficiary. However, employers say, the law and proposed Internal Revenue Service regulations provide little guidance to help them determine whether they have properly extended COBRA benefits.

But courts now are providing answers to many of the questions and problems that have cropped up for employers in administering COBRA, Ms. Sande said.

Among those is that the act does not specify how employers must notify beneficiaries that they are eligible for COBRA coverage, she said. For example, she said, the law does not specify whether sending a notice by first-class mail, as opposed to certified mail, is sufficient.

But courts have ruled that using first-class mail will meet the notification requirement as long as an employer also could prove it followed sound administrative practices.

For example, a federal court in Washington, D.C., ruled last year

that an employer complied with COBRA's notice requirements by sending a coverage election notice and election forms to a former employee's last known mailing address.

While the employee claimed not to have received the notice, the court ruled that the employer provided proper notification because its administrative practices were careful and that it relied on information provided by the former employee.

"The bottom line is that distribution (of COBRA notices) by first-class mail probably is okay if you have good documentation," Ms. Sande said.

But some employers also may want to send a follow-up letter if the first notice gets no response, she said.

Employers say they have also been confused by the so-called gross misconduct exception. Under COBRA, coverage must be offered to all former employees except those fired for gross misconduct, a term the law does not define.

Some courts are adopting the definitions of gross misconduct in state unemployment statutes, Ms. Sande said, advising employers to check state law definitions.

In other issues, courts have required employers to pay the beneficiaries' claims incurred after their COBRA coverage expired. For example, a federal appeals

court ruled last year that because an employer continued to accept COBRA premium payments from beneficiaries after coverage expired, the employer was, in fact, continuing to extend coverage.

"You want to be sure to monitor premium payments" to ensure that none are accepted after coverage expires, she said.

Meanwhile, as courts interpret COBRA, Congress continues to expand its requirements, Ms. Sande said.

For example, Congress in 1989 included several new COBRA provisions as part of a budget law. Among other things, the 1989 law said former employees who were considered disabled could receive coverage for 29 months, not 18 months. During the first 18 months of coverage, a disabled former employee would pay the 102% premium. For the remaining 11 months, the employer could charge a premium equal to 150% of the group rate.

The 1989 law also amended a basic COBRA provision that said COBRA benefits cease when the beneficiary becomes covered under another employer's health care plan. Under the 1989 change a beneficiary could retain COBRA coverage if his or her new employer's plan excluded coverage for pre-existing medical conditions.

These new provisions also have triggered confusion.

For example, some employers

may incorrectly believe that the COBRA extension applies only to claims that were denied under a new employer's pre-existing medical condition exclusion.

In fact, the employer would have to continue full COBRA coverage since the beneficiary with the pre-existing medical condition would continue to pay the full COBRA premium, Ms. Sande said.

Legislators also are considering a new round of COBRA changes, she said. For example, legislation, S. 281, introduced by Sen. Edward Kennedy, D-Mass., would codify an IRS notice—issued during the Persian Gulf War—that employers extend COBRA coverage to employees called up from the military reserves for active duty.

This legislation also would require the Defense Department to pick up the COBRA premium.

Another proposal, H.R. 1161, introduced by Rep. Patricia Schroeder, D-Colo., would require employers to extend COBRA coverage for up to 15 years—five times longer than the current requirement—for a spouse age 50 or older at the time of an employee's death, divorce or marital separation.

The session was moderated by Barbara Bass, corporate risk manager at Acme Holdings Inc. in Irvine, Calif.

It was coordinated by W. Lee Carter III, director of research and development with Alexander & Alexander Inc. in Dallas. ■



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# Close screening needed when employers evaluate case management firms

*Selection will impact quality of care*

By MICHAEL BRADFORD

ANAHEIM, Calif.—Employee benefits managers have to ask tough questions to ensure they are getting professional services when evaluating or choosing a case management firm, benefits experts advise.

"As more and more corporations are forced to face the fact that health care costs are eroding profits, the search for a more proactive approach to containing these costs is intensifying," said Maddy Bowling, regional vp in the Lisle, Ill., office of Intracorp, a provider of case management services.

Case management is a tool that can be used to achieve dramatic health care cost savings while providing appropriate health care for patients and support services for relatives and friends, Ms. Bowling said.

Martin Brown, corporate manager-employee benefits at The Clorox Co. in Oakland, Calif., agreed.

"Working with a patient, family and physicians, a case management nurse can coordinate a comprehensive treatment plan to provide not only good cost-effective health care, but also the most appropriate care for a person who has a catastrophic illness or injury," he said.

Case management, commonly used when catastrophic illnesses or injuries occur, provides an alternative to expensive hospital care. A patient, generally treated at some other facility or at home, works closely with a health care professional who coordinates the care through a network of local physicians, support groups, vendors of health care products and other care-providers.

But, a benefits manager must consider many factors before selecting a case manager, Ms. Bowling said at the 30th annual Risk & Insurance Management Society conference held here last week.

For example, benefits managers must ask whether the case management vendor offers services both on-site and over the telephone, she said.

And, the firm should be able to answer questions about cost savings and an employer's return on investment, Ms. Bowling commented.

How the case management firm pinpoints cases that are appropriate for management also should be evaluated, she said. "Leading case management companies have turned away from identification based solely on diagnosis, and they have progressed to sophisticated technological processes, specifically expert systems," she said.

Benefits managers also should ask case managers about their philosophy on timely intervention, she said.

"Since significant impact on the quality of care and health care dollars expended depends on many different factors, intervention on a serious injury case must occur at just the right time," Ms. Bowling told the group.

The initial screening process that identifies medical cases that could benefit from management is a critical part of the process, she said.

Certain illnesses and injuries are generally good candidates for case management: terminal cancer, severe head injuries, acquired immune deficiency syndrome and others that over time can lead to significant health

*Continued on next page*

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## Case management

Continued from previous page  
care expenditure, she said.

Once the screening process is examined, benefit managers should make sure that case management personnel are qualified to do their jobs, Ms. Bowling noted.

"The case manager should be a trained medical professional who holds a nursing degree or a master's degree in behavioral sciences," Ms. Bowling said. "All case managers must have clinical experience and are usually assigned on the basis of a professional specialty in areas like AIDS, oncology or high-risk pregnancy."

Using "specialty nurses for specialty cases" is critical to the program's success, Ms. Bowling emphasized. "If cutting costs is their only concern, you'll know that as soon as they tell you they don't need specialty nurses to get results."

And, "the case manager must be a super communicator," she said. "They have to interact with the patient, the family, the medical provider and the insurer."

The case manager also must be

compassionate while educating a patient and his or her family about the patient's injury or illness and its treatment, Ms. Bowling said.

"Also, the case manager must work with the doctor and other medical providers on a professional level," she noted. "Together they agree upon an appropriate short- and long-term treatment plan."

A case manager also must have "good working knowledge of medical benefits coverage" and the financial acumen to develop a cost-effective program that provides high quality care, she said.

Ms. Bowling urged benefit managers to "look for a program with on-site capability using nurses from the local area. Local case managers have an in-depth knowledge base of which providers or facilities to avoid and which offer quality care cost-effectively."

A case manager has to be a "strong negotiator, who seeks the very best prices for health equipment and services. The bottom line is, it's up to the case manager to keep the costs in line. When managed properly, thou-

### 'The case manager must be a super communicator,' says Intracorp's Ms. Bowling.

sands of dollars can be saved."

International Business Machines, which implemented a case management program in 1989, is learning how the approach can save money while providing better quality health care, according to Patricia A. Mullane, program manager of IBM's health and wellness programs division in Purchase, N.Y.

A survey conducted after cases were completed showed that 85% of those involved were "very satisfied" with the case management process, Ms. Mullane said.

Another benefit of the case management program for IBM was health care cost savings of about \$4 million, something "we really didn't drive for, but were very glad to see," she said.

The company chose to attack mental health and catastrophic

cases with case management, partly because those areas were eating up most of the company's health care dollars, she said.

The programs for both areas contain similar features.

"We didn't want to change anything that was traditional in the IBM environment. We wanted to be very sensitive to employee needs, we wanted it to be cost-effective. But at the same time, we wanted it to be of the highest quality and to have the greatest flexibility," Ms. Mullane said.

The IBM plan was set up as a voluntary plan that featured patient involvement like a self-referral line for patients to call and discuss an illness or injury to determine if they qualified for case management.

IBM knew it needed help with provider negotiations and called on Intracorp to handle that when establishing the plan, Ms. Mullane explained.

"Despite all the things that we will negotiate for," like a car and a house, "people are very, very leery of talking to a doctor down and dirty" about prices and what is bought for those prices, she said. "So we wanted the help of

professionals."

Ms. Mullane and Ms. Bowling agreed that benefit managers cannot ignore employees when a case management program is being considered as a benefit offering.

"Successful case management requires informing employees that the case managers are there to help them. Employees have to understand how case management can have a 'positive effect on them or their families' well-being in the event of a catastrophic illness or injury," Ms. Bowling said.

Case management is particularly important for companies smaller than the Fortune 500, she noted. For these companies, particularly those that are self-insured, two or three catastrophic cases that run into hundreds of thousands or millions of dollars can lead to "economic disaster" if they are not managed, she said.

And even a Fortune 500 company could be hurt by several significant cases, she added.

Mr. Brown moderated the session. It was coordinated by Sue Fazo, director of corporate communications at Intracorp. ■

## BI benefits survey

Continued from page 3

In a strong reversal of last year's survey, 54.6% of respondents favored requiring employers to offer a health plan or pay a new tax, while 45.4% were opposed. Last year, 53% of respondents opposed a "play or pay" health care system.

But opposition remained

strong to the adoption of Canadian-style national health insurance in the United States. Of the 345 people surveyed, 60.9% opposed a Canadian-style, single-payer health insurance program, while 39.1% favored it. Last year's results were almost identical (BI, May 6, 1991).

Opinion was far more evenly

divided on whether a single-payer health care program would do a better job of keeping costs under control than the current system: 165 respondents said a single-payer program would not do a better job, while 164 thought it would. Last year's survey did not include a similar question.

An overwhelming majority of those surveyed said the states do not do a very good job of regulating insurance companies.

Of the 343 people responding, 54.5% said the states did only a fair job of regulating insurers and 26.5% said the states did a poor job.

Slightly more than 18% said the states did a good job of regulation and just 1%—only three respondents—said the states did an excellent job. Last year's survey did not include a similar question.

But respondents were closely split on whether the federal government would do a better job of insurer solvency regulation.

Of the 348 people responding, 50.9% did not think the federal government would do a better job than the states of regulating insurer solvency and 49.1% thought it would.

Other survey findings include:  
• Lawyers, doctors and malingering claimants continue to receive the greatest share of blame for rising workers compensation costs.

Of the 348 people who responded to the question, "Whom do you blame for rising workers compensation costs," 79.3% blamed lawyers, up from 74% last year; 56.9% cited doctors, up from 48.6%; and 53.2% blamed malingering and fraudulent employees, up from 40%.

Other parties that were blamed include state legislators, cited by 32.5%, down from 36.3%; state workers compensation administrators, named by 27%, down from 52%; and insurers, 15.2%, down from 18.4%.

Interestingly, 15.8% of the respondents said employers should receive at least some of the blame for rising workers comp costs.

A similar question was not asked last year.

Respondents were allowed to name more than one category.

• Risk and benefit professionals favor combining workers compensation and group health insurance into a single 24-hour program funded by employers. Of 339 respondents, about two-thirds favor 24-hour coverage and one-third oppose it. Last year, 52.4% were in favor, and 47.5% opposed.

• Of 359 respondents, 71.9% said employers should not be al-

lowed to cut health care benefits for employees with AIDS, while 28.1% said they should be allowed to do so.

The 5th U.S. Circuit Court of Appeals has ruled that the Employee Retirement Income Security Act of 1974 does not bar employers with self-funded health plans from reducing benefits for people with AIDS (BI, Aug. 6, 1990). The ruling is now being appealed to the U.S. Supreme Court (see update, page 2). ■

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Business Insurance

## HMO costs

Continued from page 2

increased at a much slower rate in 1991 due to a number of factors, including higher deductibles and maximum out-of-pocket expenses paid by employees, Mr. Erb said.

The "1991 Managed Care Survey," which will be released today, is the largest survey of its kind, querying 2,409 employers about HMOs, PPOs and, for the first time, point-of-service plans (see stories, pages 42 and 43).

While the survey demonstrates that HMOs are the lowest-cost method of delivering health care, it also reveals employers are less satisfied with HMOs, compared to other health care options.

For example, only 61% of the employers were satisfied or very satisfied with the quality of care at HMOs, compared with 80% who expressed satisfaction with the quality of care at PPOs, and 77% who expressed satisfaction with the quality of care in point-of-service plans.

Employers also expressed lower satisfaction with the ability of HMO plans to control costs, compared with the performance of other types of managed care plans.

Only 49% of the employers reported they were satisfied or very satisfied with the ability of their HMOs to control costs, compared with 57% who expressed satisfaction with both the ability of PPOs and point-of-service plans to control costs.

And, only 17% of the employers were satisfied or very satisfied with HMOs' ability to provide utilization data, compared with 40% for PPOs and 38% for point-of-service plans.

Comparable questions about plan satisfaction were not asked in the 1990 survey.

The lower satisfaction levels partly stem from the fact that many HMOs are not offered by an employer by choice; rather, if a federally qualified HMO properly approaches a company it has to be made available as an option to employees.

HMOs and employers "have been unwilling partners in many cases," Mr. Erb noted.

Another factor, he said, is that "employers intuitively know that HMOs are going to be the primary way health care is going to be delivered in this century, but they are skeptical about their performance to date. They realize there are good HMOs and bad HMOs."

The survey found wide differences in the average costs of HMOs in different regions of the country.

HMO costs were the highest in the New England region at \$3,261 per employee on average, and lowest in the Pacific region at \$2,894.

"In the Pacific, there are a number of very mature HMOs, and these HMOs are often staff-modeled—the model that should produce the greatest savings," explained Mr. Erb. "In contrast, in the New England area the cost of HMOs is high in areas like Boston because many of the HMOs are affiliated with teaching hospitals, which often have higher charges."

HMO costs also varied by size of employer.

The smallest employers—those with fewer than 500 employees—paid the most for HMO premiums at \$3,104 per employee on average. Large employers—those with 20,000 to 39,999 employees—paid the lowest premiums at

\$2,844 on average.

"Smaller employers don't have as much choice in plan design as large employers because they are often in community rating," Mr. Erb noted. Also, large employers may have more leverage to negotiate better deals than smaller employers, he said.

There were also dramatic HMO cost differences by type of industry.

HMO costs at mining and construction companies—\$4,035 per employee on average—were higher than at other industries. Wholesale and retail trade companies had the lowest cost on average, \$2,409. The disparity between the two industries' premiums is 67.5%.

"There are many factors that can account for this discrepancy," said Mr. Erb. "Mining companies offer rich benefits, in part because they are unionized.

In contrast, retail companies tend to have very skinny benefits. They often employ minimum-wage workers."

Another factor may be that in mining companies, almost all employees select family coverage, whereas in retail companies many employees select individual coverage, he said.

Overall, Foster Higgins reported that nearly three-fourths of employers offer employees a choice of at least one type of managed care plan in addition to an indemnity plan. Only 23% offer a managed care plan without also offering a traditional indemnity plan.

The most common arrangement—reported by 31% of employers—is to offer indemnity coverage and one or more HMOs.

When an option was available, the survey found that more than half of the respondents' employ-

ees—55%—chose to be covered by a traditional indemnity plan rather than a managed care plan. The next most popular choices among employees were: HMOs, 23% of employees; PPOs, 17%; and point-of-service plans, only 5%.

The survey suggested, though, that the presence of an HMO option drives up the cost of the traditional indemnity plans.

Where an HMO is also offered, average indemnity plan costs were \$3,814, 16.4% higher than the \$3,276 average cost when no HMO is offered.

This is partly due to adverse selection, in which an employer's better risks join the HMO, but poorer risks stay in the traditional indemnity plan, driving up its costs.

The cost difference also reflects that larger employers, which are most likely to also

offer HMOs, also tend to provide richer and more expensive medical benefits, raising the average premium, the survey said.

This phenomenon offsets some of the savings an employer may receive from the HMO, said Mr. Erb.

Meanwhile, several trends evident in the 1990 survey were reversed in 1991, Foster Higgins found.

For example, the survey found a reduction in the number of employers with HMOs that set premiums based on individual companies' experience rather than the experience of the entire community for which an HMO provides coverage.

Thirty-eight percent of employers said they offered an HMO that used experience rating in 1991, which is down from 44% in 1990. However, 1990 levels

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### HMO costs

Continued from previous page had been up sharply from 1989, when 35% of employers had experience-rated premiums (BI, Aug. 13, 1991). In addition, employers in 1991 offered an average of nine HMOs, which was up from eight in 1990, but down from 10 in 1989.

"The attrition in the number of HMOs will continue," Mr. Erb predicted. "If for no other reason than national networks will cause employers to choose fewer HMOs."

In 1991, 66% of employers required employees to pay a portion of HMO premiums for individual coverage, down from 69% in 1990. And 82% required employees to pay at least part of the HMO premium for family coverage, down from 85% the previous year.

Employees paid an average of \$36 a month toward the HMO premium for individual coverage last year, up from \$30 in 1990. The monthly premium contribution for family coverage averaged \$107, up from \$89 in 1990.

But, employees' average HMO premium contribution for individual coverage—as a percent of total premiums—declined to 22% in 1991, from 29% in 1990.

Similarly, employees' premium contribution for family coverage also dipped to 30% of total premiums on average, from 32% in 1990.

Copies of the "1991 Managed Care Survey" are available for \$100 from Sheila Lynn, A. Foster Higgins & Co. Inc., Research and Survey Services, 212 Carnegie Center, CN 5323, Princeton, N.J., 08543-5323; 609-520-2695.

# Stalled growth in PPOs in second year: Study

For the second year in a row, preferred provider organizations were stalled in 1991, although more employers are expected to offer PPOs this year, according to a new survey.

Since 1989, about 31% of employers have had PPOs, according to the "1991 Managed Care Survey" from A. Foster Higgins & Co. Inc. of New York.

However, 7% of the employers surveyed indicated that they would be introducing a PPO by 1993.

The lack of growth in PPOs "is very significant," said John Erb, a Foster Higgins managing consultant in New York.

"The PPO has been seen as a transitional vehicle away from indemnity plans and into more restrictive forms of managed care," he explained.

The stalled growth in PPOs may indicate that employers are moving employees directly into more restrictive managed care plans, like health maintenance organizations, he said.

Although more employers are not rushing to offer PPOs, a majority of employers that offer the plans believe they are effective in reducing health care costs.

Sixty percent of the surveyed employers believe their PPO led to lower medical plan costs in 1990, while 25% said it had no effect and 15% said it increased costs. More recent figures were

not yet available. The average savings generated by PPOs in 1990 was 3.5%, respondents reported.

"PPOs' ability to offer provider discounts is the most significant factor in PPOs' ability to reduce health care costs," said Mr. Erb.

The cost of indemnity coverage with a PPO option, including services rendered inside and outside the network, was \$3,355 per employee on average in 1991. That is 6.1% lower than the \$3,573 average cost for traditional indemnity coverage, but 10.1% higher than HMO premiums, which averaged \$3,046 in 1991.

The cost of PPO premiums increased 13.7% last year, up from \$2,952 in 1990. That is about even with the 13.5% increase in HMO premiums and higher than the 13% increase in indemnity premiums (see story, page 2).

Although inclusion of out-of-network charges raises the overall cost of PPOs in this survey, this is the best way to view PPOs, said Mr. Erb.

"It is fair to include out-of-network charges, because it's the bottom line to the employer that matters," he said.

Employers in the survey reported that even though they offer their employees financial incentives to use network providers, on average 38% of the

claims payments are from outside doctors and hospitals.

"Imagine if employers could reduce this to 5%," said Mr. Erb. "Employers could maximize their savings from PPOs."

Furthermore, once 95% of the employees were using network providers, employers could easily transform their plans into HMOs, since "for all intents and purposes, employees have abandoned choice," he said.

While only 38% of employees used network providers last year, this is a significant change from 1990, when 54% of employees went to outside doctors, said Mr. Erb.

He attributes the change to the increase in stiff incentives to use network providers.

Twenty percent of employers said they impose a 20% coinsurance requirement for inpatient hospital care performed outside the PPO, but waive it for services rendered within the network.

And, 15% of employers impose a 10% coinsurance requirement for inpatient hospital services in the network, raising it to 30% for non-network services.

But, 24% of employers impose only a 10 percentage point difference between the coinsurance requirement on network and non-network inpatient care: 10% vs. 20%.

Another 9% provide the same coinsurance requirement for inpatient care—20%—regardless of whether the employee uses network providers.

Thirty-two percent of the employers set other coinsurance differentials for inpatient hospital services.

Some 80% of the employers said they were satisfied or highly satisfied with both the quality of care and provider accessibility at PPOs.

And, 71% of the employers said they were satisfied or highly satisfied with employees' acceptance of the PPOs.

Overall, it appears that employers were more satisfied with PPOs than with other forms of managed care, said Mr. Erb.

"PPOs have evolved as an indemnity alternative to HMO, which is what employers wanted to achieve," he said.

Other survey findings include:  
• The average employee contribution to a PPO for employee-only coverage was 18% of the premium, or \$35 per month.

• The average employee contribution to a PPO for family coverage was 29% of the premium, or \$108.

• 37% of the employers said their PPOs were organized by a commercial insurer; 21% by Blue Cross/Blue Shield plans; and 18% by a third-party administrator. In addition, 10% of employer said they contracted with the PPO directly and another 7% said their PPOs were organized by hospitals. Seven percent reported other arrangements.

• Premiums varied by the size of the employer. The smallest employers—those with fewer than 500 employees—had the highest average PPO costs in 1991—\$3,415 per employee. Large employers—those with 20,000 to 39,999 employees—had the lowest, 2,760.

—By Stacy Gordon

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# Growth stands out for point-of-service plans, study says

The prevalence of point-of-service plans nearly doubled from 1989 to 1991, according to a new survey.

Eleven percent of employers offered the plans in 1991, up from only 6% of employers two years earlier, reports Foster Higgins' "1991 Managed Care Survey."

Growth was flat among the more established managed care options, HMOs and PPOs, during the same period, according to the Foster Higgins employer survey.

This is the first year the consulting firm was able to survey enough employers with point-of-service plans to generate meaningful data, said John Erb, a managing consultant with A. Foster Higgins & Co. Inc. in New York.

The 1991 survey questioned 250 employers with point-of-service plans.

A point-of-service plan is a hybrid between a traditional health maintenance organization and a preferred provider organization.

In a point-of-service plan, each employee has a primary care physician who acts as a gatekeeper.

**'In many ways, a point-of-service plan is more like an HMO than a PPO,' says John Erb.**

This physician participates in the decision whether the employee should be treated by a doctor or hospital in the network or a doctor or hospital that is outside the network.

"In many ways, a point-of-service plan is more like an HMO than a PPO," explained Foster Higgins' Mr. Erb.

The average premium for a point-of-service plan in 1991 was \$3,291 per employee.

That is 7.9% lower than the \$3,573 average premium for coverage from a traditional indemnity plan, but it is 8% higher than the average HMO premium of \$3,046.

Large employers are more likely to offer a point-of-service plan than other size companies, the survey found.

Among employers with 40,000 or more employees, 20% offer their employers a point-of-service plan.

This compares to only 9% of employers with fewer than 500 employees.

In many cases, the point-of-service plan replaces the traditional indemnity plans, the survey found.

Of the employers with a point-of-service plan, 57% also offer an indemnity plan.

Other findings include:

- 66% of point-of-service plans require employee contributions for employee-only coverage. The average monthly contribution is \$33.

- 84% of the surveyed employers require an employee contribution for family coverage. The average contribution per em-

ployee is \$101 per month.

- 78% of the employers with point-of-service plans say they expect to increase or add employee contributions by the end of 1992.

- 41% of point-of-service plans are self-funded, while 59% are insured.

Of the surveyed point-of-service plans that are insured, 44.1% are experience-rated, 37.3% are community-rated and 18.6% use a minimum premium arrangement.

—By Stacy Gordon

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# Summary of major property/casualty insurers' 1991 results

Ranked by change in net income. All amounts in thousands of dollars.

Rank 1991	Corporate					Property/casualty operations								
	Consolidated revenues 1991	Net income 1991	Percent increase (decline) 1990-1991	Combined <sup>1</sup> ratio 1991	Combined <sup>1</sup> ratio 1990	Net premiums written 1991	Percent increase (decrease) 1990-1991	Pretax underwriting income (loss) 1991	Percent increase (decline) 1990-1991	Pretax investment income 1991	Percent increase (decrease) 1990-1991	Policyholders surplus 1991	Percent increase (decrease) 1990-1991	
1	Travelers Corp.	11,376,900	317,800	278.1	112.4	115.9	4,182,800	(1.7)	(532,500)	21.8	757,300	(1.2)	1,843,200	(3.2)
2	Royal Group (U.S. subs.) <sup>2</sup>	N/A	67,000	245.7	122.1 <sup>3</sup>	126.9 <sup>3</sup>	1,528,000	(16.7)	(326,000)	33.5	344,000	0.6	911,000	10.7
3	Home Insurance Co.	2,317,000	128,000	164.0	109.5 <sup>2</sup>	109.7 <sup>2</sup>	1,750,000	(10.6)	(191,000)	11.2	292,000	(9.0)	901,000	14.6
4	USF&G Corp.	4,134,000	(176,000)	69.1	117.7 <sup>2</sup>	115.3 <sup>2</sup>	3,032,000 <sup>2</sup>	(16.5)	(505,000)	5.3	498,000	(13.5)	1,404,000	3.8
5	CNA Financial Corp.	11,131,000	612,500	67.1	116.5 <sup>2</sup>	115.0 <sup>2</sup>	6,620,000 <sup>2</sup>	0.6	(1,091,000) <sup>2</sup>	(7.5)	1,258,000 <sup>2</sup>	8.2	3,928,000	24.8
6	Hartford Insurance Group	9,242,000	413,000	41.9	111.3	109.7	6,157,000	1.2	(710,000)	(7.3)	1,122,000	19.6	3,059,000	11.7
7	CIGNA Corp.	18,750,000	449,000	36.1	117.3	115.9	5,462,000	(7.9)	(973,000)	(1.5)	845,000	(1.5)	2,030,000	3.2
8	Ohio Casualty Corp.	1,714,218	107,854	28.2	104.9 <sup>2</sup>	105.3 <sup>2</sup>	1,492,279 <sup>2</sup>	1.6	(74,518)	6.1	191,563	8.4	643,415	38.1
9	Old Republic Int'l	1,374,524	131,027	25.2	107.1	105.7	744,053 <sup>2</sup>	8.7	(68,277) <sup>2</sup>	(4.7)	171,143 <sup>2</sup>	8.1	917,334	18.1
10	Fremont General Corp.	581,174	31,167	16.2	106.0	105.0	413,571	0.9	(24,936)	(22.2)	64,202	(15.2)	158,512	(2.0)
11	Argonaut Insurance Co.	456,414	89,803	9.3	108.0 <sup>2</sup>	104.8 <sup>2</sup>	334,636 <sup>2</sup>	(20.1)	(28,546) <sup>2</sup>	(24.4)	121,667 <sup>2</sup>	(8.8)	462,602	16.4
12	Lincoln National Corp.	9,169,000	208,400	8.9	111.9 <sup>2</sup>	109.2 <sup>2</sup>	2,242,700	(4.8)	(256,300)	(23.3)	276,500	(3.5)	1,377,600	10.6
13	American International Group	16,883,911	1,553,009	7.7	100.5 <sup>2</sup>	99.6 <sup>2</sup>	9,146,394	(1.3)	(4,809)	(106.4)	1,163,461	9.8	6,156,899	18.6
14	General Re Corp.	3,206,600	656,700	7.0	107.2 <sup>2</sup>	99.0 <sup>2</sup>	2,249,100	4.6	(41,500)	(319.2)	751,600	6.4	3,363,100	15.9
15	Sentry Insurance Cos. <sup>2</sup>	1,530,651	63,461	6.4	102.4 <sup>2</sup>	100.6 <sup>2</sup>	1,147,310	5.4	(83,797)	(11.0)	164,736	8.1	760,299	14.5
16	Chubb Corp.	4,513,100	552,000	5.7	99.5 <sup>2</sup>	99.7 <sup>2</sup>	3,112,300	6.6	15,900	1,235.7	515,100	4.1	1,673,300	19.1
17	Crum & Forster Inc.	3,762,400	163,000	3.8	117.0	114.2	2,442,000	(22.9)	(413,700)	11.1	605,800	1.4	1,535,800	20.8
18	The St. Paul Cos. Inc.	4,351,700	405,062	3.5	105.0 <sup>2</sup>	104.2 <sup>2</sup>	3,233,729	6.0	(163,782)	(35.7)	640,856	1.8	1,685,836	14.9
19	Transamerica Ins. Group	2,153,005	62,709	2.6	111.3	111.8	1,842,623	1.3	(214,280)	3.2	255,743	1.2	1,112,519	6.3
20	Hartford Steam Boiler	630,433	73,868	(6.2)	93.9	88.0	329,913	7.6	19,609	(45.3)	41,449	(2.2)	409,321	15.2
21	SAFECO Corp.	3,349,229	259,578	(6.8)	108.6	107.2	1,629,710	(3.5)	(141,121)	(18.4)	286,073	1.0	1,193,750	16.3
22	Aetna Life & Casualty Co.	19,195,600	505,200	(17.7)	115.4	113.4	5,810,600	(7.6)	(966,700)	(14.4)	1,080,600	(0.3)	2,412,300	(10.9)
23	Berkshire Hathaway Group	1,108,259	207,944	(22.3)	115.4	104.5	802,522	39.7	(119,593)	(348.8)	331,846	1.5	8,700,000	38.1
24	Continental Corp.	5,425,400	56,400	(60.0)	116.0 <sup>2</sup>	114.3 <sup>2</sup>	4,364,400 <sup>2</sup>	(3.5)	(705,200) <sup>2</sup>	(10.9)	718,100	(3.0)	1,936,000	(0.3)
25	Reliance Ins. Co. & subs.	3,391,876	(145,614)	(239.4)	121.0 <sup>2</sup>	110.0 <sup>2</sup>	1,611,044	(4.9)	(313,180)	(134.2)	179,624	(9.7)	840,538	(0.7)
—	Nationwide Mutual Ins. Co. <sup>2</sup>	N/A	N/A	N/A	105.2	111.6	6,207,592	10.9	(405,790)	17.0	812,437	9.9	3,782,921	22.7
—	Commercial Union Ins. (U.S.)	N/A	N/A	N/A	111.4 <sup>2</sup>	110.7 <sup>2</sup>	1,341,700	4.1	(162,500)	(7.8)	179,000	12.3	724,900	24.0
—	Liberty Mutual Ins. Co. <sup>2</sup>	N/A	N/A	N/A	114.6	114.1	6,260,607	(0.1)	(772,308)	(13.9)	1,113,180	4.0	2,846,692	10.8
—	Kemper National P/C Cos. <sup>2</sup>	N/A	N/A	N/A	115.0	115.9	3,164,522	5.6	(476,850)	1.6	355,049	10.7	1,873,467	30.8
	<b>Cumulative</b>	<b>139,748,394</b>	<b>6,792,868</b>	<b>30.3</b>	<b>111.0</b>	<b>110.5</b>	<b>88,655,105</b>	<b>(1.8)</b>	<b>(5,730,678)</b>	<b>(4.7)</b>	<b>15,136,029</b>	<b>3.9</b>	<b>58,643,305</b>	<b>16.4</b>

<sup>1</sup> After dividends

<sup>2</sup> Statutory

<sup>3</sup> Before dividends

N/A—Company did not provide data

## P/C insurers

Continued from page 1  
billion in 1991 from \$5.21 billion in 1990.

Year-to-year net income comparisons for the group were

boosted by results from Travelers Corp. and Royal Group, all of which reported profits in 1991 compared with losses in 1990. USF&G Corp. also cut its losses to \$176 million last year from \$569 million in 1990.

An increase in realized capital gains was also a factor in the improved profits.

Thanks to a strong equity and bond market last year, the property/casualty insurance industry's realized capital gains increased 55.9% to \$4.49 billion in 1991 from \$2.88 billion in 1990, according to figures released by the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

But once factors such as realized gains, companies' failure to increase reserves and 1991 catastrophe losses are taken into account, "operating earnings were either flat or down for most companies," according to Marvin Shulman, an analyst for rating agency Moody's Investors Service Inc. in New York.

Other results of BI's survey of 29 major commercial property/casualty insurers' year-end results reflect a static market:

- Underwriting losses increased 4.7% to \$9.73 billion in 1991 from \$9.3 billion in 1990. This compares with a 6.5% increase for the nine months ended Sept. 30 (BI, Dec. 9, 1991), and a 6.9% increase for 1991's first half (BI, Sept. 9, 1991).

- Net written premiums fell 1.8% to \$88.66 billion in 1991 from \$90.3 billion in 1990. This compares with a 1.5% decline for the first nine months of 1991, and a 1.8% decline for the first half.

- Combined income grew 3.9% to \$15.14 billion in 1991 from \$14.56 billion the previous year. This is a slight improvement from a 3.7% increase for the nine months, but lower than the 4.3% increase for the first half of last year.

- The aggregate combined ratio deteriorated to 111% in 1991 from 110.5% in 1990. This compares with a 111.1% combined ratio for both the nine-month period and

Continued on next page

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## P/C insurers

Continued from previous page the first half.

• Policyholder surplus increased 16.4% to \$58.64 billion from \$50.4 billion. A 13.8% improvement was reported for the nine-month period, compared with only a 5.4% improvement in the first half.

Year-end results do not reflect Fireman's Fund Insurance Cos., which declined to participate in the survey.

Observers say there is little new to report about insurers' 1991 results.

"The earnings just reflect a competitive grinding away at the industry's margins, and there is no reason to expect this to not continue indefinitely," said Barbara Stewart, president of Stewart Economics in Chapel Hill, N.C.

"The results were not surprising. There's been no significant change in the pricing environment," said Walter Fitzgerald, an analyst with RAS Securities Corp. in New York.

"I call the results lackluster, but not bad enough" to turn the market, said Steven A. Gaviols, an analyst with Kidder, Peabody & Co. in New York.

"It was another consistently mundane quarter," summed up Jamie Guenther, assistant vp at Duff & Phelps Credit Rating Co. in Chicago.

Although the fourth quarter is the traditional period in which companies boost their reserves, some observers contend that companies are underreserving in order to raise their bottom lines.

According to ISO and the NAI, loss reserves grew by 6.2% in 1991, which was the lowest rate of growth in at least 20 years. In the 1980s, loss reserves grew at an average annual rate of 12.1%.

"I wouldn't be surprised at all that reserves were pretty much being managed to produce the best earnings the company can (produce)," said Ms. Stewart.

"I think they've been fueling profits to a degree from reserves," agreed David Wells, an analyst with rating agency Fitch Investors Service in New York.

"Reserve strengthening is much less than I and other analysts would have expected," said Kidder, Peabody's Mr. Gaviols. "That's the source of any strength in earnings."

However, not all analysts agree that insurers are drastically underreserving.

RAS Securities' Mr. Fitzgerald contends that although the industry "will be adding to reserves forever" for certain lines, particularly for long-tail liability business, the industry in general is only marginally underreserved, if at all.

"It does not appear as if the industry showed significant deterioration from where we were a year ago, and that's a manageable deficiency," said Harry Fong, director of research at Conning & Co. in Hartford, Conn.

Meanwhile, despite big realized gains stemming from last year's strong equity and bond markets, lower premium income combined with low interest rates produced only modest increases in investment income at year-end.

"Investment income has clearly slowed, and we would not expect any meaningful changes in the current trends," said Mr. Fong.

In fact, in the first three

months of this year, insurers lost about one-third of their year-end unrealized bond profits, said David Seifer of Donaldson, Lufkin & Jenrette in New York.

Upheavals in the junk bond market and continuing concerns about commercial real estate investments have made insurers cautious about their investments.

"Obviously, there's been a more conservative bent" on investments, said Mr. Lewis of Dean Witter.

Insurers are unwilling to assume more risk for higher yields, said Moody's Mr. Shulman. "There's enough risk in the insurance underwriting part of the operation."

Mr. Shulman also noted that as fixed-income investments mature, insurers are forced to reinvest them at the lower prevailing interest rates.

"There's nothing dramatically different in our investment philosophy," said Sentry's Mr. Hlavac. "We're conservative in equity investments and we're still investing in high-quality bonds," he said.

Sentry posted an 8.1% increase in pretax investment income last year.

Ohio Casualty Corp. is continuing to invest in instruments maturing in the five- to 10-year range, said C. David Mencer, controller. "We have reconciled ourselves to the fact that rates are going to be lower for a while," he said. Ohio Casualty saw pretax investment income rise 8.4%.

Better rates can be obtained with longer maturities, he said, but "from a liquidity standpoint, it doesn't make sense for us."

With changes introduced with the 1986 tax act, insurers can no longer invest in 30-year municipal bonds, said Mr. Mencer.

Meanwhile, catastrophes, including the fourth-quarter fire in Oakland, Calif., affected some insurers' results last year as well, observers note.

Catastrophes caused an estimated \$4.22 billion in insured property damages last year, making 1991 the second-worst year on record for catastrophes after 1989, when catastrophes produced \$7.64 billion in insured damages (BI, Jan. 27). The most costly single catastrophe in 1991 was the Oakland, Calif., wildfire, which caused an estimated \$1.2 billion in insured damages (BI, Oct. 28, 1991).

"There were significant catastrophe hits during the year, although it didn't seem to hit the companies as badly as catastrophes in prior years did," said Moody's Mr. Shulman. "I think it's just because of the kinds of catastrophes" that were prevalent last year—storms and fires, he said.

The 1991 catastrophes hit certain companies that did business in certain areas, but not others, he noted, explaining that there were not big storms like Hurricane Hugo that had a widespread impact on the industry.

Among the insurers affected by the Oakland fire, for instance, was SAFECO Corp., which reported net losses from the fire of \$20 million, according to Assistant Comptroller George Yonker.

On the other hand, Sentry had no exposure to the fire, said Mr. Hlavac.

Catastrophe losses "were clearly a factor for some companies, but it wasn't sufficient enough to cause any meaningful change in the way the affected companies are going to conduct

business," said Conning's Mr. Fong.

Meanwhile, after witnessing trends during the first quarter of a new year, industry analysts say 1992 is going to look essentially like 1991.

"On the property/casualty side of the equation, '92 seems to be shaping up as a repeat of '91," with soft market conditions, growing underwriting pressures, slow investment income growth, and companies continuing to drag on their reserve increases, said Mr. Lewis of Dean Witter.

"This year may be a little worse as one more year in a tough pricing environment," but basically it will not be different from 1991, agreed Kidder Peabody's Mr. Gaviols.

"There is no way we're going to see a change" in 1992, said Joanne Morrissey, a principal of Firemark Consultants Inc. in Morristown, N.J. "Surplus is going to have to go down before we see a change."

Observers disagree as to when the market is likely to turn, with the most optimistic putting it at late 1992, and others setting the date at 1993 at the earliest. Some are reluctant to make any prediction at all.

"It's a difficult situation to call," summed up Dean Witter's Mr. Lewis.

There are no real signs of any hardening now, and nothing on the horizon to indicate it will harden, he explained.

"I think it's going to be difficult to turn the insurance market without a change in the economy," said Ohio Casualty's Mr. Mencer.

But Donaldson, Lufkin's Mr. Seifer said, "I think '92 is a pivotal year on the property/casualty side. There's little growth in premium volume for most property/casualty companies, little growth in pretax investment income, tax rates are rising, underwriting losses are rising, and my feeling is that cash flows will be really pinched."

As a result, he said, "my feeling is without cash flow, good things can happen, so I'm hoping it'll be soon."

RAS' Mr. Fitzgerald also focused on cash flow as the critical factor in a market turn. "I think the earliest you could see it is sometime late in the year," he said. The industry now collectively has a negative cash flow, he said. Historically, that has triggered a change in the pricing environment, he added.

This year has the potential to be transitional, said Duff & Phelps' Mr. Guenther, noting that investment income's failure to offset increasing underwriting losses will depress earnings. Management is going to have to look at improving their underwriting results "because the investment results won't be there for them," he said.

However, it will still take several quarters and perhaps another year before changes become apparent, he said.

"I haven't seen anything that leads us to believe '92 is going to be a good year, and unless something of biblical proportions happens later in the year, I don't hold any optimism that prices are going to go up until '93," said Fitch's Mr. Wells.

The market could turn sometime in 1993, said Moody's Mr. Shulman. Right now, he said, "you don't see any real signs of rate increases" and it would take half a year for rate increases to work their way into earned premium.

## Health insurers

Continued from page 1

said the insurers' results partly reflect the fact that they've "gotten a little ahead of the trend factors. They're not playing catch-up."

As a result, while rates continue to rise, they are rising in direct proportion to medical inflation, "which is still substantial," Ms. Vogel noted.

Ed Freedman, managing director-national health and welfare practice for the Alexander & Alexander Consulting Group Inc. in Lyndhurst, N.J., concurs that the trend is slightly lower than it has been.

But, health care inflation "is still running three to five times the consumer price index," he noted.

"We're seeing the underlying cost trends to be in the range of

10% to 15%," hovering closer to 15%, said Fred Cue, senior vp of finance for the Blue Cross & Blue Shield Assn. in Chicago. "It's certainly better than the opposite direction, but the trend is still too high for everyone."

The trend has "been very stable for the past couple of years, which is unlike the '80s," observed Jim Galasso, a vp and actuary with Metropolitan Life Insurance Co. of New York. "Predictability has gone up considerably."

Richard H. Neil, the senior vp-group for The Principal Financial Group in Des Moines, Iowa, agreed.

Principal stumbled some last year, after reporting a record-setting gain in 1990. Statutory earnings from its group life and health insurance business fell 16.5% to \$142 million from \$170

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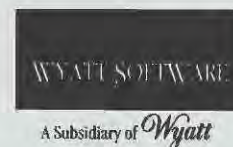
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## Health insurers

Continued from previous page million in 1990.

Mr. Neil predicted similar results in 1992.

But, he said 1990 was somewhat of an aberration, because the insurer was "strongly priced," based on the assumption that the trend was going to be higher than it was.

Mr. Neil projected that the 1992 medical trend will hover around 18% for indemnity plans and range between 12% and 14% for HMO business.

Combined with heightened competition, rate hikes will be slightly smaller in 1992, he said. But, "I really don't see a lot of change" in 1992.

However, Lowell Robinson, vp of finance and chief financial officer for the managed care and employee benefits business of the

Travelers Corp. in Hartford, Conn., predicts that rate increases will begin "ticking up" in the latter part of 1992.

He bases his prediction on an anticipated "pent-up demand" from employers, whom he expects to expand their workforces as the economy emerges from the recession, and from employees, whom he expects will seek medical services they put off while unemployed.

Mr. Robinson also expects that inflation will be higher during the second half of the year as the country leaves the recession behind.

But for now, "rate increases are pretty competitive," Mr. Robinson said.

Charles T. Bell, senior vp of health plans for Aetna Life & Casualty Co. in Hartford, Conn., said buyers that are "still stuck" in an "unmanaged indemnity

plan" will experience a trend greater than 20%, while "those people who have moved into managed care will see less than that."

He expects that buyers with managed care plans will see a 12% to 15% increase, depending on how "aggressive" the managed care plan is.

Buyers are not necessarily looking to move from one insurer to another, but "they are looking at how (their current) insurer can help them deliver managed care," said John Kosciusko, a consultant with The Wyatt Co. in Washington, D.C.

Travelers' Mr. Robinson noted that while buyers may not be changing insurers more frequently, they are "shopping the business more," due to the continued recession. "There's a lot more bidding going on."

"Given the significant compe-

tion in the marketplace," Travelers is satisfied with its performance last year, Mr. Robinson said.

Travelers reported an 8% decline in profits as its group life and health operating profits fell to \$96.3 million from \$104 million in 1990.

But, premium volume and premium equivalents rose 6.5% in 1991, which indicates that its "core operating business continues to be strong," he said.

Mr. Robinson partly attributed the decline to the bankruptcy of a major account, Pan American World Airways, which put the Travelers "on the hook" for the airlines' claims even though it could not collect further premiums from the airline.

Another significant factor in the drop in profits was due to poor claims results in its long-term disability business, he said.

Profitability should rebound in 1992 since the events that lowered profits last year were "one-time occurrences," Mr. Robinson said. "One of the key focuses" for the company in 1992 will be "to continue to maintain revenue growth" while operating more efficiently, he said.

"The market is getting a little more competitive," agreed Mr. Cue of Blue Cross/Blue Shield.

The result of this competition is an increased willingness on the part of BC/BS members to "give a little on certain key accounts," he said.

Last year, BC/BS plans reported combined earnings of \$1.62 billion, a 15.8% decline from \$1.9 billion in 1990.

Mr. Cue predicts that the BC/BS Assn. will experience another drop in operating income this year, perhaps to \$1.3 billion, as the non-profit insurer competes more on price.

The goal of holding the line on pricing "inevitably has to weaken in the face of competition," Mr. Cue said.

Aetna also expects that it will face more competition, particularly over point-of-service plans. Because these plans generally are designed to replace an employer's current health plan, "as each employer gets ready to convert, the competition gets very intense," Mr. Bell said.

He added that the level of interest buyers are showing for managed care programs is sparking battles among insurers.

However, Mr. Bell predicted a stable year for 1992.

Aetna reported a 31.4% increase in group health and life profits in 1991 to \$349 million from \$265.7 million in 1990. But, \$50 million of last year's increase was attributed to a non-recurring gain.

A "major driver" behind the gain "is the continued turnaround in our HMO operations," Mr. Bell noted.

MetLife also expects to match its 1991 "bottom-line" results, while pursuing sales more aggressively Mr. Galasso said.

MetLife in 1991 saw its "best year ever," Mr. Galasso said. It was the first time MetLife "ever broke \$200 million for our group operations."

MetLife led the group of insurers with a 40.8% boost in profits, which climbed to \$214 million from \$152 million in 1990.

Mr. Galasso attributed the insurer's results to a "good underwriting year" and "trends that were managed effectively."

Also, the performance of its HMO operations held steady while its point-of-service results improved.

CIGNA Corp. reported its group life and health operating earnings increased 7.5% last year to \$301 million from \$280 million in 1990.

"We had respectable underwriting results in a difficult economic environment," said Joe Fitzgerald, the chief financial officer in CIGNA's employee benefits division.

And, CIGNA's HMO business, which is part of the insurer's specialty health care operations, continued to improve, he said. This segment, which also includes CIGNA's substance abuse facilities and dental HMOs, reported a 13.7% gain to climb to \$67 million in 1991.

"Our outlook at this point is that we expect to have improvements in both our indemnity earnings and our health care earnings" this year as compared with 1991, Mr. Fitzgerald said. ■



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## INTERNATIONAL

## Lloyd's 1989 loss forecast at \$3.09 billion

By STACY SHAPIRO

## LONDON

LONDON—The latest prediction of Lloyd's of London's overall market loss for 1989, which closed at year-end, has risen to 1.65 billion pounds (\$3.09 billion at appropriate exchange rate) based on information from managing agents.

However, that dire forecast excludes additions to reserves for asbestosis and pollution losses, which helped plunge the 1988 account deep into the red last year.

Nor does the latest forecast from the Assn. of Lloyd's Members include losses from open syndicate accounts that are being run off.

Lloyd's 1989 account closed Dec. 31, 1991, under the market's three-year accounting system and is now being audited. Lloyd's will publish

its official 1989 global results in June.

The ALM data, which was distributed to its 9,000 members last week, is based on a survey of 96% of the market undertaken on behalf of the Lloyd's Underwriting Agents' Assn.

To get an early idea of losses, the LUAA in January asked managing agents to forecast "bottom line" 1989 results. Last year, most expected the market's 1988 account to have fewer losses and were shocked when Lloyd's announced a 1988 loss of 509.7 million pounds (\$983.7 million at appropriate exchange rate) (*BI*, July 1, 1991).

In fact, independent syndicate analyst Chatset Ltd. had predicted last May that the 1988 loss would be about 278 million pounds (\$536.4 million) (*BI*, May 27, 1991).

Lloyd's already has indicated that 1989 losses would be more than 1 billion pounds (\$1.87 billion). And Chatset has projected losses of about 1.5 billion pounds (\$2.7 billion).

However, based on the LUAA survey, the ALM projects that Lloyd's will post an overall loss of 1.65 billion pounds (\$3.09 billion) in losses for 1989. At best, says the ALM, overall losses will be 1.06 billion pounds (\$2 billion).

A Lloyd's spokesman last week said that these predictions are in line with what the market has predicted centrally.

The ALM's predictions, however,

do not include reserving for asbestosis and pollution losses because the syndicates are only now being audited and calculating their reinsurance-to-close premiums into their 1990 accounts.

Lloyd's pure underwriting results in 1988 produced a small profit of 68 million pounds (\$131.2 million), but this additional reserving of 577.7 million pounds (\$1.11 billion) is what put the market into the red.

Lloyd's members have already been asked to pay cash calls totaling 700 million pounds (\$1.22 billion at current exchange rates) for 1989 losses, of which 500 million pounds (\$870 million) has been paid, said Roger Pascall, the ALM's administrator. It is not known, however, how much more in cash calls will be sought—or paid vol-

untarily—he confirmed.

At least 820 members continue to fight to stop Lloyd's from drawing down on their deposits to pay for cash calls already made. Their action is expected to be heard in a closed court today.

Meanwhile, syndicate 475, formerly managed by R.J. Bromley (Underwriting Agencies) P.L.C., announced last week that the 1989 underwriting year will remain open, and the cash call will be 50% of the 25 million pounds (\$43.5 million) amount they underwrote rather than 10% which they were told last December. The syndicate's 1989 capacity is not known. The call, due to losses on excess-of-loss reinsurance claims from Hurricane Hugo, is due to be paid in July.

Lloyd's syndicate 932, managed  
*Continued on next page*

## Aneco creditors get update on reinsurer

By ROGER SCOTTON

## BERMUDA

HAMILTON, Bermuda—London brokers have collected more than \$5 million for the account of Aneco Reinsurance Underwriting Ltd., but the funds are now frozen.

However, the funds are subject to an injunction that has frozen all of Aneco's assets in the United Kingdom, creditors of the insolvent Bermuda company were told at a March 26 meeting.

In opening the creditor meeting, Aneco's provisional liquidator, Malcolm Butterfield, said he expects that permanent liquidators will want to "discuss the lifting of the (injunction) so that these funds

may be entered into the estate."

In an earlier report, Mr. Butterfield had noted that the funds are being held pending the outcome of an action in the London High Court in which Lloyd's of London managing agent Colin W. Spreckley is seeking a declaration that certain funds in the United Kingdom be held in trust for London market creditors of Aneco. Mr. Spreckley represents Lloyd's syndicate 1007, which he claims is owed \$6 million by Aneco.

Mr. Butterfield said permanent

liquidators also may want to consider the circumstances in which \$2.1 million had been drawn down against Aneco letters of credit since the start of the liquidation on Dec. 12, 1991 (*BI*, Dec. 23, 1991).

Mr. Butterfield told creditors that in his capacity as Bermuda's registrar of companies, he had initially petitioned for Aneco's winding up last July "in order to protect the assets of the company from further erosion."

Though he said he was not in a position to report conclusively on the causes of Aneco's failure, he told the meeting that it "was affected by heavy underwriting losses and liquidity problems from

its property book," caused mainly by Hurricane Hugo and the European windstorms of 1989.

Following an aborted management buyout of the company in mid-1990, the company ceased underwriting new or renewal business in September 1990.

"It was about this time that Aneco commuted the majority of its reinsurance on the captive program," Mr. Butterfield told creditors. "The remaining reinsurers of this line of business are largely those from the New York and Miami insurance exchanges, whose ability to meet their obligations is, for the most part, seriously impaired."

Mr. Butterfield said that various proposals for the restructuring of Aneco were put forward "but were dependent on the collectibility of the reinsurance protections remaining in force."

The provisional liquidator released figures at the meeting showing that as of June 30, 1991, Aneco had a \$6.2 million underwriting loss, an \$18.5 million net loss, and that outstanding loss reserves of \$17.2 million at that time were "net of approximately \$29 million recoverable from reinsurers."

"By far, the greatest proportion of this amount relates to discontinued captive lines," he said, "And,  
*Continued on next page*

## British companies stick by brokers

By GAVIN SOUTER

## But competition high to keep accounts: Survey

LONDON—Nearly all of Britain's major companies still use a broker to arrange coverage for their exposures, despite the increase in alternative risk financing arrangements and the rise of other intermediaries, a recent survey finds.

But brokers must stay innovative and keep themselves well preened at the so-called beauty parades, or broker reviews, if they want to maintain the business, the survey found.

The Manchester Business School's "Buyer Attitude Survey" also found that brokers are generating additional business with risk management and captive management services.

A separate study by consulting firm Datamonitor shows, among other things, that Willis Corroon P.L.C. has the biggest share of Britain's large commercial insurance market.

"The rise of alternative funding arrangements, the participation of new entrants (such as) accountants, management consultants, banks and other financial intermediaries, together with increased buyer sophistication, has forced brokers to look at their costs, structures and strategies," the MBS survey states.

But brokers are still used by most large companies, the survey found.

Only three companies said that they did not use an insurance broker at all. Nine did not use a broker for their British exposures, and eight did not use a broker to place their global programs, the survey states.

Where brokers were used to place overseas coverage, they placed the majority of the program, MBS found.

"This was possibly because of logistical problems, including the need for local servicing," the survey states.

Some kind of global program was used by 48% of the respondents. The use of a broker is directly related to the size of the program, the report states.

"The smaller the company, the more likely the broker is to place all classes and be the sole broker," MBS said.

Direct placing and the use of multiple brokers is more often seen in global and large domestic programs, the survey says.

For domestic risks, 31% of the respondents used more than one broker.

Where brokers are only used to purchase part of a program, they are more likely to be used to buy liability and excess-of-loss coverage than other coverages, the survey indicates.

London is the main insurance market used, with 38% of risks placed there.

The person responsible for arranging the coverage varies from company to company.

Of the respondents, 41.5% had an insurance department, 36% placed through the company secretary, 18% through the finance director, and 4.5% through other departments.

And although the risk manager, company secretary or finance director influences which brokers should pitch for the account, the board generally has the final say in the selection of the brokers.

Broker presentations figure largely in the selection process. The MBS survey states, "97% of the respondents had received broker presentations in the previous five years,

either as part of a holding broker's review, or in a competitive environment where the business was being fully marketed."

As a result of the so-called beauty parades, 35% of the respondents had changed brokers.

None of the companies had appointed one of the top 15 brokers in Britain as a direct result of an approach by a broker, according to the MBS survey.

"This emphasizes the importance of long-term wooing... and of the beauty parades which lead to a group board decision to appoint," the survey states.

Over the past five years, the top 15 brokers made a total of 1,051 presentations to the respondents, the survey found.

Clients changed brokers 117 times as a result of the presentations. The best hit rate of the top 15 was obtained by Willis Corroon, which secured one extra client for every 4.8 presentations. The worst rate was that of Bain Clarkson P.L.C. which secured one extra client for every 16.5 presentations.

When clients changed brokers, 24.8% did so because of poor service, 18.9% changed because of the broker's lack of innovation, and 15.8% changed because of premium costs, the survey shows.

In addition to insurance services, 36% of the respondents bought non-insurance risk management services through their broker, the survey indicates.

Brokers also play a large role in captive management, the survey found.

Twenty-four percent of the respondents had a captive. Brokers were captive manag-

ers for 63% of the captives, and of these, 78% also acted as broker for the client's commercial insurance needs.

Meanwhile, the study by Datamonitor, "U.K. Insurance Broking," covered all types of insurance brokers.

That study is based on trade interviews, available data bases, annual reports, Datamonitor surveys and company returns to the Department of Trade and Industry.

British brokers currently earn around 3.1 billion pounds (\$5.34 billion at current exchange rates) a year in commission from the global insurance coverage of British companies. Property damage insurance commission is the biggest earner, generating 1.3 billion pounds (\$2.24 billion) annually.

British-based risks generated 977 million pounds (\$1.68 billion) in commercial insurance commissions, the report said.

The profitability of the brokerage sector is directly related to the insurance cycle, according to Datamonitor.

"Industry profitability rose by 3% in 1989 and by 14% in 1990 after falling in 1987 and 1988. Datamonitor expects profits to continue to increase in 1991 and 1992 before tailing off in 1993, and the insurance cycle progresses," the study states.

An analysis of the top 1,000 companies in Britain shows that Willis Corroon has the highest market share of their business, Datamonitor found.

Willis Corroon has a market share of 18%; Sedgwick has 13%; C.T. Bowring & Co. Ltd. has 10%; Alexander Stenhouse Ltd. has 9%; and Bain Clarkson has 4%.

"U.K. Insurance Broking" is available for 500 pounds (\$862), from Datamonitor, 106 Baker St., London W1M 1LA.

# Risk managers bump glass ceiling: Survey

By JOANNE WOJCIK

Many risk managers believe they will not advance in their careers if they remain with their present employers, a new survey finds.

In fact, most risk managers achieved their present position by changing employers, the survey shows.

A stumbling block for risk managers may be the lack of upper management's understanding of what risk management is all about, according to the survey.

"The corporate hierarchy is still not looking at the risk manager as promotable into other parts of the organization," observed Bill Perry, president of Logic Associates Inc., a New York executive search firm that conducted the survey.

The "Glass Ceiling" survey, which was included in Logic's annual risk management salary survey, was designed to provide insight into where risk management careers may be heading.

The annual risk management survey provides an important guide to employers creating risk management positions and to risk

managers who want to compare their situation with those of their counterparts at other companies (BI, March 30).

The "Glass Ceiling" survey found that the overwhelming majority—72%—of the 1,189 surveyed risk managers feel they have hit the figurative glass ceiling in their current jobs.

In fact only 35% of them were promoted into their present positions by their present employer.

"This indicates that 65% achieved their present position by changing employers," Logic noted.

"Some companies with vision see risk management as a stepping stone to the treasury or finance function," said Barry Citron, a vp with Logic.

"But this survey shows that's the minority of companies," he said.

"A lot of times risk managers have to move on in order to move up," he observed.

To further illustrate that many risk managers have peaked in their current positions, Mr. Citron pointed out that only 25% of those surveyed said they have discussed succession planning with their

employers.

"This indicates that only 25% of the companies have growth plans for the risk manager," he said.

"There is a great deal of ignorance about what risk management is all about," Mr. Citron said.

In fact, 79% of those surveyed said they and their bosses have different views of risk management.

However, 70% also said their bosses are committed to risk management.

To become more promotable, a risk manager "has to be a good internal salesman," Mr. Citron advised. "The risk manager has to constantly sell upper management about the value of the risk management program."

In addition, risk managers should become more involved in other aspects of their corporations' business, like acquisitions or expansion planning, according to Mr. Citron.

Mitchel Kent, another Logic vp, agreed: "You can't be myopic. A good risk manager sees the big picture."

For example, risk managers have to see environmental exposures as an ineliminable part of their discipline, he said.

But only 67% of surveyed risk managers said they believe en-

vironmental issues will open new opportunities for them in the future.

That percentage, though, will grow over the next 10 years "as more environmental liabilities rear their heads," Mr. Kent predicted.

Mr. Citron also advises risk managers to pursue continuing education to enhance their promotability.

For example, a risk manager in the No. 2 or No. 3 spot in his or her department who plans to become the director of risk management should pursue the Chartered Property & Casualty Underwriter designation, he suggested.

And risk managers already in the No. 1 position should consider obtaining a master of business administration degree in finance, he said.

Indeed, an MBA in finance is the most appropriate degree for a risk manager with higher aspirations, Mr. Citron said. That is because 97% of those surveyed believe that their next step up on the career ladder would most likely be related to the corporate treasury function.

In addition, "when placing risk managers, we find an MBA carries more weight than a CPCU," he said.

But only 43% of risk managers

surveyed felt that the most highly regarded professional designation is the MBA, while 42% cited the CPCU and 15% the Associate in Risk Management designation.

Surveyed risk managers were also split on which MBA program is the most desirable. Half said finance and 33% said risk management.

Among other "Glass Ceiling" survey findings:

- The average number of years that a risk manager's company employed a professional corporate insurance/risk management specialist was 14 years.

- The average number of years that risk managers have been in their present position is 5.6 years.

- Fifty-seven percent believe there is equal pay for equal responsibility for men and women in the top risk management position.

- Sixty-four percent believe employee benefits should be part of the risk management function, while only 33% are actually responsible for benefits placement and/or administration.

Copies of the complete survey are available for \$60 each from Logic Associates Inc., 170 Broadway, Suite 814, New York, N.Y. 10038; 212-227-8000.

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## INTERNATIONAL

### LONDON

Continued from previous page  
by Janson Green Ltd. also will leave open its 1989 year following the amalgamation last year of the capacity of the syndicate with two other marine syndicates and two non-marine syndicates into syndicate 79 (BI, Sept. 2, 1991; July 22, 1991). Overall losses for the syndicate, once one of the largest at Lloyd's, will be about 17.5 million pounds (\$32.7 million), the ALM says.

Lloyd's Deputy Chairman Richard Hazell said last week that he has not decided whether to keep his syndicate 190 open for the 1989 underwriting year.

Members agents say, however, that syndicate 190's 1989 account could remain open. According to ALM figures, syndicate 190 expects a worst-case pure underwriting loss in 1989 of 5 million pounds (\$9.4 million), but has not

yet specified its liabilities for prior underwriting years.

### LUC reviews leases

The London Underwriting Centre may ask the Institute of London Underwriters to move into its new building following the major contraction in the London market and the fire that swept through the LUC's new headquarters last year.

In fact, it would be ideal if all three London markets—the LUC, the ILU and Lloyd's—were in one large building to cut costs, said Victor Blake, chairman of the LUC.

Following the 125 million pound (\$217.5 million at current exchange rates) fire last year at the LUC's new offices under construction at 3 Minster Court, the LUC has moved its expected opening date back from last month to October 1993.

As a result, 48 out of the 72 non-marine underwriting companies that planned to move into LUC have had their signed subtenancy agreements declared null and void, said Mr. Blake. The other 24 companies belong to Market Building Ltd., which leases the building, and are still liable for the full rent, he said. Prudential Corp. P.L.C. owns the building.

Last week, Mr. Blake sweetened lease terms to lure non-marine underwriters next year. Rents have been cut for the first two years and an initial rent-free period extended to six months from four, with no rent due before March 25, 1994.

If the LUC can't rent all the space to non-marine underwriters as first intended, "there might be enough space to house the ILU," Mr. Blake said. The LUC has tendered the idea to ILU executives "as a sensible idea, but no more."

Lloyd's syndicates have also approached company underwriters like Mr. Blake to see if they want to rent space in the Lloyd's building, but he doubts many company underwriters will do so.

### BERMUDA

Continued from previous page  
as I have already stated, the potential recoveries on the captive side are seriously impaired."

He said the recoverables include contracts with Chairman Mark Hardy's Turks & Caicos company, Channel Reinsurance Co. Ltd., into which Aneco's discontinued lines of reinsurance were novated. But, he said that no adequate security arrangements for Channel's obligations had been put in place, which was challenged by Mr. Hardy's attorney, Delroy Duncan.

The attorney said that it is Mr. Hardy's contention that security arrangements were in place as of Dec. 12, 1991, when the court issued the winding up order.

The creditors at the meeting voted overwhelmingly to appoint Coopers & Lybrand partners Peter Mitchell in Bermuda and Christopher Hughes in London as Aneco's joint liquidators.

The vote, which is almost certain to be upheld by the Bermuda Supreme Court, came after creditors rejected a motion initiated by Mr. Hardy to oppose Coopers & Lybrand's involvement. Mr. Hardy had argued that the firm's appointment would constitute a conflict of interest because Coopers & Lybrand liquidators already are winding up two other companies formerly controlled by Mr. Hardy: Focus Insurance Co. Ltd. and Forum Reinsurance Co. Ltd. (BI, March 18, 1991; Dec. 31, 1990).

He also argued that a conflict could arise because Coopers & Lybrand is the auditor for Sphere Drake Underwriting Management (Bermuda) Ltd., which is now headed by former Aneco executive Jonathan Crawley.

Mr. Hardy said after the meeting that he was disappointed the creditors had failed to recognize the liquidators' conflict of interest.

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# More women in profession

## But few large firms hiring women risk managers: Survey

One of every four risk managers is a woman, and companies increasingly are seeking out women to fill risk management positions, a new survey shows.

But women have yet to break into the upper ranks in risk management at the Fortune 50 companies, according to Logic Associates Inc. of New York, a recruiting firm that did the survey.

"In corporations with \$1 billion or less in annual sales, we're finding more women risk managers than ever before," said Bill Perry, president of Logic.

"It's always been harder for women to break into top management in larger corporations, but women have a better chance of rising to the top in small companies," he added.

Logic Vp Barry Citron says as a recruiter he's witnessing firsthand the surge in the hiring of women risk managers.

"Many companies let us know up-front that they want to interview women candidates, and we've had many women placements," he said.

He agreed with Mr. Perry that women tend to fare better at small companies than larger ones. "A risk manager of a Fortune 50 company has control of \$50 million to \$70 million in premiums. Some companies may not feel comfortable handing that over to a woman executive," he said.

"It's a sexist thought," he admitted. "But the stereotypes are not going away that easily."

Women risk managers also are more prevalent in the financial services industry, the survey showed.

For example, 50% of risk managers at financial services firms with \$501 million to \$1 billion in assets are women, compared with 25% of all other companies with sales of \$501 million to \$1 billion.

And the percentage of women risk managers in all financial services firms remained almost flat—27% in 1991, compared with 28% a year earlier.

Overall, though, the ranks of women risk managers are growing. Twenty-four percent, or 323 out of 1,366, of the risk managers in the 1991 survey are women, compared with 20% in 1990.

Risk managers at smaller companies are more likely to be women, the survey found.

Among the 318 respondents from companies with \$201 million to \$500 million in sales, 31%, or 99, were women. At companies where annual sales exceeded \$7 billion, there was only one—or 2% out of the 43.

This breakdown shows where women stood in risk management in 1991 and 1990:

- At companies with less than \$200 million in annual sales, 26% of risk managers were women, up from 24% in 1990.
- At companies with \$201 million to \$500 million in annual sales, 31% were women, up from 28% in 1990.
- At companies with \$501 mil-

lion to \$1 billion in annual sales, 25% were women, up from 20% in 1990.

- At companies with \$1 billion to \$2 billion in sales, 17% were women, up from 16% in 1990.
- At companies with \$2 billion to \$4 billion in annual sales, 14% were women, up from 13% in 1990.
- At companies with \$4 billion to \$7 billion in sales, 14% were women, up from 9% in 1990.
- At companies with more than \$7 billion in annual sales, 2% were women, unchanged from 1990.

—By Joanne Wojcik

### IN THE MATTER OF THE INSOLVENCY ACT 1986 AND MENTOR INSURANCE COMPANY (UK) LIMITED (IN LIQUIDATION)

Notice is hereby given pursuant to Section 105 of the Insolvency Act 1986 that annual meeting of creditors of the above named company will be held at the offices of Touche Ross & Co. at Friary Court, Crutched Friars, London EC4 at 11:00 on Thursday 16th April 1992 for the purpose of receiving an account of the Liquidator's Acts and Dealings and of the conduct of the winding-up to 18th March 1992.

A creditor entitled to attend and vote at the above meeting may appoint a proxy to attend and vote in his place. It is not necessary for the proxy to be a creditor.

Proxy forms must be returned to the office of Touche Ross & Co., Friary Court, Crutched Friars, London EC3 not later than 12 noon Tuesday 14th April 1992.

Dated this day 18th March 1992 — C. Morris, Liquidator

#### APRIL CLOSINGS

- issue: April 20
- closing: April 8
- demographic section: Insurer Topics: Automation: Underwriting
- issue: April 27 — Reader Service
- closing: April 14
- editorial feature: Benefits: Plan Design & Administration  
Directory: Employee Benefits Information Systems
- issue: May 4 — Bonus Distribution: NAIB
- closing: April 22
- demographic section: Agent/Broker Topics: Mergers/Acquisitions/Financial Management
- issue: May 11
- closing: April 29

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# INFORMATION SYSTEMS

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## Computer literate risk managers in demand: Logic

Risk management departments are becoming increasingly automated, although larger firms are still the most likely to have computer-based risk management information systems, a new survey finds.

Ninety-six percent of risk management departments at companies with more than \$7 billion in annual sales had an RMIS in 1991, up from 92% in 1990, according to the survey by Logic Associates Inc.

In contrast, only 44% of risk management departments at companies with less than \$200 million in annual sales had an RMIS last year, up from 41% in 1990.

Smaller companies are less likely to have an RMIS because many are unable or unwilling to make the financial commitment necessary, explained Abe Altschuel, vp of the New York-based executive search firm.

Still, computer use is growing at more companies, and risk managers increasingly are expected to know or learn how to operate them, according to

Mr. Altschuel.

"Nine out of 10 job orders for No. 2 people in a risk management department seek people who know computer programs," he said.

"Lotus 1-2-3 is far and away the major software package" with which companies request familiarity, Mr. Altschuel said. In addition, he said, many companies seek risk managers who are familiar with the CRIS system, a popular RMIS from CIGNA Corp. (BI, July 29, 1991).

Following is a breakdown of computerization by company size, comparing 1991 with 1990:

- Companies with less than \$200 million in annual sales: 44% were computerized in 1991, up from 41% in 1990.
- \$201 million to \$500 million: 57%, up from 53%.
- \$501 million to \$1 billion: 68%, up from 65%.
- \$1 billion to \$2 billion: 72%, up from 71%.
- \$2 billion to \$4 billion: 85%, up from 83%.
- \$4 billion to \$7 billion: 90%, up from 89%.
- More than \$7 billion: 96%, up from 92%.

—By Joanne Wojcik

## Recession is cited for job upheavals in risk management

Risk managers are working harder than ever before as the recession continues to force staff and budget cuts, a new survey shows.

Risk managers at smaller companies—those with annual sales of less than \$500 million—are more likely than risk managers at larger companies to have hands-on responsibility for most tasks, the survey found.

Even though they are being forced to do more with less, risk managers today are not complaining because they are grate-

ful to be working during the recession, according to Bill Perry, president of Logic Associates Inc. of New York, the executive search firm that did the survey.

"The recession continues to cause staff reductions that are forcing risk managers to work harder than ever before, especially at small companies," he said.

But while the areas of responsibility haven't changed, "the workloads are larger," he said.

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*Continued on next page*

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<b>Risk/Employee Benefits:</b>	
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/employer relations	11,995
<b>Sub-total</b>	<b>25,683</b>
<b>Associations</b>	442
Government, Unions and Educational Institutions	1,261
<b>Commercial Consumers</b>	
<b>Sub-total</b>	<b>27,386</b>
Insurance Agents and Brokers	9,090
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Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,529
Others Allied to the Field	1,580
Single Copies	46
<b>TOTAL</b>	<b>51,099</b>

\* Source Business/Occupational breakdown of qualified circulation, November 25, 1991 issue, as submitted to BPA for December 1991 BPA Publisher's Statement.

Continued from previous page  
 risk management and employee benefits, Mr. Perry has found that few of these overworked risk managers are looking for employment elsewhere.

"They're happy they have a job," he explained.  
 Indeed, many risk managers are out of work, he said.

But the employment picture isn't all that bleak, according to Mr. Perry.

"There is a tremendous dichotomy in the market today: A lot of risk managers are getting laid off, but there are also a lot of risk managers getting hired," he said.

Among the reasons for risk management staff reductions are the enduring soft market, overall corporate budget cuts, mergers and acquisitions or "the normal going out of business," Mr. Perry said.

"A lot of companies got into risk management in the go-go years" when they were profitable and the market was hard, he explained.

"But when times got hard and the market softened, risk management was often seen as a luxury rather than as a necessity.

"Instead of fully appreciating what a risk manager can do, they're giving up the department," he said.

Risk managers at large companies are less likely than their counterparts at smaller firms to have responsibility for pension or benefits administration, according to the survey.

For example, at companies with more than \$7 billion in annual sales, only 4% of risk managers had hands-on responsibility for pension/profit sharing administration, compared with 27% of those at companies with less than \$200 million in annual sales.

Likewise, only 4% of risk managers at companies with more than \$7 billion in annual sales had hands-on responsibility for benefits administration, compared with 50% of those at companies

with less than \$200 million in annual sales.

Risk financing and negotiation of coverage placement continue to be the domain of most risk managers, the Logic survey found.

But in the areas of claims handling, safety/fire loss engineering and data security, small company risk managers are more likely to have hands-on responsibility for those tasks, while large company risk managers are more likely to have supervisory or advisory responsibility.

For example, 57% of risk managers at companies with less than \$200 million in annual sales had hands-on responsibility for safety/fire loss control engineering, while only 14% of risk managers at companies with more than \$7 billion had that type of responsibility.

For a further breakdown of risk managers' areas of responsibility by company size, see chart.

—By Joanne Wojcik

### Risk managers' areas of responsibility

By company sales in millions of dollars

Legend:	Direct, hands-on responsibility						
	Supervisory/advisory responsibility						
	\$0-200	\$201-500	\$501-1,000	\$1,001-2,000	\$2,001-4,000	\$4,001-7,000	More than \$7,000
Risk financing	53% 32%	74% 19%	56% 25%	89% 9%	63% 19%	49% 18%	26% 47%
Negotiation of coverage placement	56 32	59 24	62 27	72 16	75 17	51 33	35 44
Claims handling	46 33	60 23	66 31	49 50	41 59	31 45	23 47
Safety/fire loss engineering	55 35	68 21	39 27	37 41	26 58	27 41	30 44
Data security	53 35	19 56	13 29	8 45	8 48	12 61	26 42
Benefits administration	50 32	41 27	15 25	13 25	11 34	10 55	19 47
Pension/profit-sharing administration	23 35	32 36	10 19	14 12	4 22	8 37	14 49

Source: Logic Associates

GRAPHIC BY CYNTHIA WATSON

## Offset ruling

Continued from page 1  
 offset statutes at the time the cases were filed (BI, Feb. 3; Sept. 16, 1991).

Missouri has since adopted an offset statute that goes into effect in July.

The New York high court ruling "is an extraordinary decision that confirms what the industry has said all along regarding the common law right of offset," observed Ronald Gass, assistant general counsel with the American Insurance Assn. in Washington, D.C.

"It dismisses the argument that offset is a preference in a liquidation setting," said Debra Anderson, vp and general counsel of the Reinsurance Assn. of America in Washington, D.C.

The New York high court ruling also will have a significant impact beyond the state's borders, several reinsurance lawyers predict.

"I think the decision effectively puts an end to the offset controversy in the major states," said David Spector of Mayer, Brown & Platt in Chicago, who represented the reinsurance subsidiary of Long Grove, Ill.-based Kemper Corp.

"Most of the country tends to follow New York in insurance regulatory decisions," Mr. Spector said.

The ruling could influence the California Supreme Court's review of a 1989 state appellate ruling allowing Prudential Reinsurance Co. to offset amounts it owed to the defunct Mission Insurance Co. against amounts Mission owed Prudential.

"It's highly significant because the New York statute has served as a model for insolvency codes in most other jurisdictions, including California," observed Peter Chaffetz, a lawyer with Sidley & Austin in Los Angeles, who represents two reinsurers in litigation with Mission's liquidator.

"This is a prestigious court interpreting the statute which was the source for our statute. I see no reason our court would reach a different conclusion," Mr. Chaffetz said.

"This is a very clear-cut and definitive rejection of (liquidators') positions, and I would think it has to be very influential," he added.

"This will have strong precedential value in many other states," agreed Dean Hansell of Leboeuf, Lamb, Leiby & MacRae  
 Continued on next page

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# Offset ruling

Continued from previous page in Los Angeles, who also represents Mission reinsurers.

However, some liquidator representatives question how much weight the ruling will have as precedent and whether it will put an end to litigation on the offset issue.

"This will certainly clarify the point in New York," said Jonathan Bank, a lawyer with Buchalter, Nemer, Fields & Younger in Los Angeles, which has represented Mission's liquidator.

But "whether other state courts will be influenced by this opinion is open to conjecture. I doubt, however, that those state insurance departments and liquidators already opposed to offset will be swayed by this decision," Mr. Bank said.

Midland, a New York-based insurer that was ordered into liquidation in April 1986, ceded business to Kemper Re under two agreements: a 1979 treaty; and a 1984 facultative agreement under which Kemper Re reinsured 75% of the excess product liability risk Midland had written for International

**'Liquidation cannot place the liquidator in a better position than the insolvent company he takes over, authorizing him to demand that which the company would not have been entitled to prior to liquidation,' the New York Court of Appeals says.**

Playtex Inc.

After Midland entered liquidation, Kemper Re tried to offset the roughly \$750,000 in loss payments it owed Midland under the Playtex facultative agreement against premiums Midland owed

it under the treaty, allegedly in excess of that amount.

The New York Insurance Department objected, though, and Kemper Re filed suit.

A state judge granted the Insurance Department's motion for

summary judgment, but an intermediate appellate court reversed the decision, finding in Kemper Re's favor.

The seven-judge Court of Appeals, which is New York's highest court, affirmed the appellate decision in a unanimous March 26 ruling.

The appeals court rejected the liquidator's arguments that the credits and debts were not "mutual" because they did not arise out of the same contract and that allowing the offsets would constitute an unlawful preference of the reinsurer over Midland policyholders.

Debts and credits are mutual when they are "due to and from the same person in the same capacity," and the legislative history of the insurance law and previous New York court rulings suggest they need not arise from the same transaction, the court found.

The panel also rejected the argument that public policy considerations justify disallowing offsets to protect policyholders and discourage insolvencies.

"An important reason offset has been recognized as desirable is that it provides a form of security to insurers," the panel noted, citing the conclusion in the 7th Circuit's offset ruling that "offsetting debts in a reinsurance pool not only spreads risk but also acts as mutual security for performance."

The New York department also had argued that Kemper Re's offsets are barred by the insolvency clause in the Playtex facultative agreement, which required Kemper Re to pay losses to Midland or its liquidator "without diminution because of such insolvency."

But, the appeals panel concluded that the insolvency clause does not bar offsets but simply obligates a reinsurer to pay losses to a liquidator regardless of whether the liquidator has first paid the claims of the insolvent company's policyholders.

"Were we to adopt (the New York department's) construction of the insolvency clause, the reinsurer's right to offset... would be nullified in every liquidation proceeding where a ceding company elected to include the clause in its reinsurance contract."

The appeals court also threw out the Insurance Department's contention that Midland's insolvency made Kemper Re's obligations payable directly to the liquidator, thereby destroying Midland's mutual debtor/creditor relationship with Kemper Re.

State insurance law "was not intended to create a special category of obligation owed directly to the liquidator," the court concluded. "Moreover, liquidation cannot place the liquidator in a better position than the insolvent company he takes over, authorizing him to demand that which the company would not have been entitled to prior to liquidation."

The court also noted that the New York department has conceded that the Midland/Kemper Re offsets would have been allowed before Midland became insolvent.

"Those rights were not altered merely because a liquidation order was entered," the court found.

*Kemper Reinsurance Co. vs. James P. Corcoran as Superintendent of Insurance of the State of New York, New York Court of Appeals, No. 35.*

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said. "For example, a few years ago, IRI's account team helped to put together an all risk policy and program that was designed specifically to meet our needs as a specialty chemical company. At that time, the program included more than 50 locations in the U.S. and Canada."

"As IRI's account team reviewed the insurance plans for the various properties and occupancies, its willingness to be flexible made all the difference," he said. "Too often, insurance companies operate strictly by the book and resist alternative points of view. That's not the case with IRI. They're willing to listen." That's part of The IRI Difference.

"Our people, especially those on the safety and engineering staff, welcome interaction with IRI's representatives," Mr. Dietz said. "Their loss prevention recommendations have been invaluable and have helped Nalco achieve a low loss history over our business relationship, which spans more than half a century."

"I wish all my programs worked as smoothly as the one with IRI," Mr. Dietz said.



Fred R. Dietz,  
Nalco Chemical Company



can make a difference

## Pollution exclusion

Continued from page 1  
Greaney.

Until the highest court in each state rules on the pollution exclusion clause, this area of the law will remain in turmoil, attorneys agree.

The Massachusetts Supreme Court is one of seven state supreme courts to address this issue, making relief from this uncertainty a distant hope, they say. Georgia, Wisconsin and Colorado have interpreted the exclusion in favor of policyholders. North Carolina, New York, Michigan and Massachusetts have ruled in favor of insurers. The issue is pending before four state supreme courts: Illinois, Ohio, Florida and Montana.

In the absence of state guidelines, federal courts are interpreting state laws and adding to the patchwork of decisions.

In the most recent decision interpreting New Jersey's stance, the 1st U.S. Circuit Court of Appeals on March 24 ruled that under New Jersey law the pollution exclusion, which bars coverage for all pollution that is not "sudden and accidental," is ambiguous.

Because the exclusion is capable of more than one reasonable interpretation, the court interpreted the exclusion in favor of policyholders, ruling that it bars coverage only for events that are unexpected and unintended.

Insurers had argued that the pollution exclusion is not ambiguous and bars coverage for pollution that does not occur abruptly.

As a result of the ruling, CPC International Inc., an Englewood, N.J.-based food and chemical manufacturer, can tap \$25 million in excess liability coverage written in 1979 by Northbrook Excess & Surplus Insurance Co., a unit of Allstate Insurance Co., to pay for a massive pollution cleanup.

The pollution stemmed from the leaching of hazardous chemicals into the Blackstone River in Cumberland, R.I. The U.S. Environ-

mental Protection Agency says the pollution, which Rhode Island authorities discovered in 1979, was caused by a CPC subsidiary, Peterson/Puritan Inc., which manufactured flea repellent, hair spray, spot remover and oven cleaner at the Cumberland site from the 1960s through the 1980s.

Residents of a nearby town, Lincoln, sued CPC in 1982, alleging that pollution at the site had contaminated their drinking water. This lawsuit was settled in 1984 for \$780,000. CPC's primary general liability insurer, Northwestern National Life Insurance Co. of Milwaukee, paid the settlement under its 1979 \$1 million policy.

Since its primary layer was largely exhausted, CPC turned to Northbrook Excess & Surplus when the EPA in 1982 ordered it to clean up the Cumberland site.

CPC has agreed to pay an undetermined sum to clean up the site under a 1987 consent decree with the EPA.

However, Northbrook denied coverage for the cleanup costs, prompting litigation. The U.S. District Court for the District of Rhode Island ruled in favor of Northbrook on March 15, 1991.

In reversing the lower court, the 1st Circuit examined how state courts in New Jersey, where CPC is based, had ruled on the exclusion.

Specifically, the 1st Circuit looked at an intermediate appellate court decision in New Jersey, which had found the pollution exclusion ambiguous and interpreted it in favor of policyholders, and said this was the best indication of how the New Jersey Supreme Court would rule.

In that case, *Broadwell Realty Services Inc. vs. Fidelity & Casualty Co. of New York*, the state appeals court ordered Fidelity & Casualty, a unit of Continental Corp., to indemnify Broadwell, which leased property to a gas station whose underground tanks later leaked. The court said Broadwell could not have expected the leak to occur (BI, July 27, 1987).

"When a federal court is advised

that the intermediate appellate court of the relevant state has found the pollution exclusion to be ambiguous and that there are no reported cases in that state to the contrary, the federal court has no warrant to reject the teaching of the intermediate appellate court," said the 1st Circuit.

But rejecting the teaching of the Broadwell decision is exactly what the 4th Circuit did when it interpreted New Jersey law in a March 2 decision (BI, March 16).

The 4th Circuit said the New Jersey Supreme Court would not follow the existing precedent in the state on the pollution exclusion, but rather would follow the reasoning of pro-insurer decisions in other jurisdictions.

The New Jersey Supreme Court would "not have concurred with the (Broadwell) opinion," the 4th Circuit concluded.

"It is totally bizarre" that two federal appellate courts each interpreting New Jersey law could reach such opposite results, said policyholder attorney Robert Johnson of Anderson, Kill, Olick & Oshinsky in New York.

He said the 4th Circuit refused to follow existing New Jersey precedent because the 4th Circuit "has an anti-policyholder bent."

Mr. Greaney agreed: "The 4th Circuit had no basis to out of whole cloth determine that the New Jersey Supreme Court would not follow 17 years of New Jersey precedent. The only reason they did this is because the 4th Circuit imported its own notions of public policy that insurers should not be forced to pay for pollution cleanups."

Attorneys expressed hope that the confusion over how the pollution exclusion should be interpreted under New Jersey law will be resolved soon.

The New Jersey Supreme Court has agreed to review a dispute between Chicago-based Morton International Inc. and its liability insurers that addresses this very issue. The New Jersey Department of Environmental Protection has

## Routine pollution bars duty to defend

By STACY GORDON

BOSTON—The pollution exclusion clause in comprehensive general liability policies bars a duty to defend when a policyholder is accused of long-term dumping of hazardous materials, the highest court of Massachusetts ruled.

On March 26, the Massachusetts Supreme Judicial Court said allegations in the underlying complaint against a policyholder determine whether the pollution exclusion, which bars coverage for pollution that is not "sudden and accidental," can relieve insurers of their duty to defend.

The court said when an underlying lawsuit against the policyholder alleges pollution as a result of "routine business activity lasting over several months," the pollution exclusion bars coverage.

This same court in 1990 interpreted the word "sudden" in the pollution exclusion to mean "abrupt" (BI, June 25, 1990).

In this case the court found that four insurance companies owed no duty to defend SCA Services Inc., a private sanitation company that transported industrial and chemical waste to a landfill in Tusten, N.Y., between 1973 and 1974. SCA is now owned by Laidlaw Waste Systems of Rowley, Mass.

The insurers involved in the case are Liberty Mutual Insurance Co. in Boston; ITT Hartford Group Inc. in Hartford, Conn.; CNA Insurance Cos. in Chicago; and CIGNA Corp. in Philadelphia, which each wrote \$500,000 in primary liability coverage for SCA in the 1970s.

The state of New York sued SCA in a Massachusetts trial court, accusing the company of "routine business activity lasting over several months in which the toxic contents of the barrels brought by SCA to the landfills were either emptied into open trenches or dumped into trenches and flattened with a bulldozer," according to the court.

The court said this type of allegation is "within the pollution exclusion because it is not 'sudden and accidental.'"

SCA argued that the court should consider whether the opening of each barrel was a "sudden" event. But the court said this is a "strained interpretation" of the policy.

"The court properly refused to look at each frame of a months-long movie as a separate event," said insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C.

"This decision makes it clear that 'sudden' applies to the duration of the polluting event, not just to when the pollution begins," agreed Michael F. Aylward of Morrison, Mahoney & Miller in Boston, who represented CNA unit Transportation Insurance Co.

*Liberty Mutual Insurance Co. vs. SCA Services Inc., Massachusetts Supreme Judicial Court, No. S-5775.*

sued Morton Thiokol, a predecessor company, for cleanup of mercury contamination at a site in Woodridge, N.J. (BI, Oct. 21, 1991)

"Once the New Jersey Supreme Court rules, the federal appellate courts won't be able to guess wrong anymore," said Mr. Harris,

who represented CPC in the 1st Circuit case.

*CPC International Inc. vs. Northbrook Excess & Surplus Insurance Co., U.S. Court of Appeals for the 1st Circuit, No. 91-1580, No. 91-1734.*

## NAIC proposal

Continued from page 2

said Ronald S. Gass, associate general counsel with the American Insurance Assn. in Washington, D.C.

"They are not rushing to judgment. I think they finally heard us," said Lenore S. Marema, vp-legal and regulatory affairs for the Alliance of American Insurers in Schaumburg, Ill.

The proposed "Limitations on Reinsurance Activities of Insurers Act" would restrict fronting arrangements that regulators blame for threatening the financial solvency of some ceding insurers.

Among other things, the proposal would establish minimum standards for some reinsurance agreements (BI, March 16; Dec. 16, 1991; April 15, 1991).

Mr. Brown told the task force at the meeting that the latest draft of the proposed model law includes three provisions that are of concern to RIMS. RIMS' concerns are that the draft proposal would:

- Exclude from some model law requirements only group captives that write coverage for companies "engaged in businesses or activities similar or related with regard to the risks being insured."

Captive Resources Inc., a Schaumburg, Ill.-based captive consulting firm, joined RIMS in saying it wants to broaden the definition so that group captives insuring a variety of businesses are also protected by the exclusions.

In response, Vincent Lauren-

ziano, chief of the New York Insurance Department's Property Companies Bureau and chairman of the working group, said he opposes exempting a group captive insuring heterogeneous risks. He said such a captive "smacks more of a commercial enterprise than a captive."

- Allow a regulator in a state other than where a fronting insurer is licensed to void or interfere with a national insurance program, even if the program had been approved by the regulator in the state where the ceding insurer is domiciled.

But, Mr. Laurenzano called this concern a "red herring," because the proposal allows a non-domiciliary regulator to act only under limited circumstances.

- Require a ceding insurer to obtain annually an independent actuarial opinion that the premium rates applicable to the policies are adequate.

However, Mr. Brown said it would be difficult to obtain an actuarial opinion in cases when a state regulator approves an inadequate rate for a line of coverage like workers compensation.

Mr. Laurenzano said he thought the model could be changed to eliminate actuarial certification in those states where a regulator formally approved the rate used by the fronting insurer.

However, he and other regulators took umbrage at Mr. Brown's comment about states approving inadequate rates.

"For them to admit the problem would be politically troublesome for regulators," Mr. Brown said later.

While RIMS and licensed insurance companies are more optimistic that they can hammer out a compromise with regulators, the insurance industry still faces some obstacles.

For example, New Hampshire Insurance Department Chief Deputy Director Robert M. Solitro, a task force member, gave "fair warning" that he wants to expand the proposal to regulate reinsurance ceded by surplus lines insurers to unlicensed reinsurers, instead of applying the proposal only to admitted ceding companies.

Regulating fronting arrangements involving only admitted insurers creates "a loophole" that would allow most insurers with surplus lines affiliates to avoid the proposed model law in states that allow surplus lines insurers to act as fronting insurers.

Those insurers could transfer their fronting business to their surplus lines affiliates, Mr. Solitro explained.

Another potential obstacle for risk managers is that Mr. Foster is a stronger advocate of fronting limitations than was Illinois Chief Deputy Director James W. Schacht, who previously represented Illinois as the chairman of the task force now considering the fronting proposal.

"It's critical that we have a

model act in place," Mr. Foster said last week.

Mr. Schacht has questioned the working group's activities and its conclusions.

The change in chairmen, though, should not have a dramatic impact on the discussion, because the ultimate decision depends on the majority of all regulators, emphasized Robert L. Zeman, assistant vp and assistant general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill.

In addition, an Illinois regulator is now vice chairman of the task force.

Illinois abstained from recommending the working group's draft to the task force. Regulators from the other four states represented on the working group—Florida, Missouri, New York and Virginia—supported recommending the draft to the task force, Mr. Laurenzano said.

Mr. Foster said the task force intends to recommend the draft, including any changes, to the NAIC's Special Issues Committee, which oversees the task force, in June.

Besides Illinois, New Hampshire, New York and Virginia, other states on the task force are Colorado, Georgia, Iowa, North Carolina, Ohio, Utah and Vermont.

If the Special Issues Committee, chaired by New York, approves the draft, the full NAIC would vote on the proposal. That vote will come no earlier than September, Mr.

Foster said.

In other NAIC action last week:

- The Examination Oversight Task Force approved testing of a risk-based capital formula for life insurers. The NAIC already is testing a similar formula for property/casualty insurers.

The NAIC "remains on track toward its goal of final adoption of risk-based capital formulas for both life and property/casualty companies in 1992," the NAIC said.

- The Property/Casualty Reinsurance Study Group, which is redrafting Schedule F of the NAIC's annual convention statement, is expected to study two significant changes in the way property/casualty insurers report overdue reinsurance, according to Mr. Solitro of New Hampshire, which chairs the Blanks Task Force.

He suggests that insurers be given 120 days from the date a claim is paid to collect reinsurance proceeds or pay a 20% penalty on overdue amounts. Currently, insurers are given 90 days, but there is some confusion about when the clock starts.

In addition, Mr. Solitro recommends that insurers pay a new 10% penalty on overdue recoveries in dispute, which are currently not penalized.

"We are concerned that many items may have been moved into the disputed category to avoid the aging penalty," according to Mr. Solitro.

## Point of service

Continued from page 2

ject of benefit management," Mr. George said.

"It also works to replace multiple (health plan) options, and thus will eventually hold down administration costs to the level of your standard HMO."

"Gatekeeper-driven plans seem to be saving employers about 6.5% on average, and top management at all of the major insurers is really supporting point-of-service. Network usage among these plans is now at about 85%, so they appear to be working. I think these plans will see a doubling in enrollment by 1995 and will further erode the indemnity market and eventually displace PPOs," Mr. George said.

And, as more quantified data becomes available on the savings health care gatekeepers are producing for plan sponsors, point-of-service products will be on a rapid growth path through the '90s, he predicted.

Up to 11% of all employers now offer employees a point-of-service option, nearly twice the number that offered such programs two years ago.

A recent study by A. Foster Higgins & Co. Inc. reported similar findings (see story, page 43).

And, enrollment at HMOs offering a point-of-service or open-ended option is booming.

Mr. George cited a recent study by managed care research organization Interstudy of Excelsior, Minn., that reported a 38.8% growth in membership among HMOs offering a point-of-service option, compared with only 3% membership growth among HMOs overall.

Point-of-service products are well-positioned in today's health care market primarily because they balance cost containment and choice, Mr. George said.

For example, the rate of hospital admissions among enrollees in point-of-service plans is lower than the rate among enrollees in PPOs, managed indemnity plans

## Provider networks

Continued from page 3  
Corp. in Los Angeles.

These plans are hybrids of HMOs and PPOs that allow employees to opt out of the network, but with fewer benefits.

Security Pacific evaluated five point-of-service proposals and in 1991 implemented two.

"Our per employee per month medical cost in 1990 was \$307," Mr. Martinez said. "We projected that if we did nothing, that cost would increase to \$369 per employee per month in 1991."

After implementing the plans in two locations, Security Pacific estimated its per employee per month medical costs would be \$306, Mr. Martinez said. But the costs were lower than expected:

## Lackluster year in review

Continued from page 55

occurs, clients may become increasingly mindful of the need for continuity of relationships when capacity shrinkage makes the going more difficult.

Analyst: What is your feeling about the ongoing impact of the economy?

Contact: The economy has hurt us in certain regions such as New England and Southern California. Some lines have also suffered, such as energy with the deep decline in oil and natural gas drilling activity here in the United States. We also experi-

and traditional indemnity plans, Mr. George said.

Due to gatekeepers and aggressive plan design that promotes the use of network-affiliated hospitals and physicians, the average number of inpatient days per 1,000 for point-of-service plans is about 350 to 400, according to Mr. George.

In comparison, the inpatient rate is about 425 days per 1,000 PPO enrollees; 450 days per 1,000 managed indemnity plan enrollees; and as much as 800 days per 1,000 unmanaged indemnity plan enrollees, he said.

"And, these are pretty early figures, too. I believe managed

**Eventually, point-of-service plans could move to only catastrophic coverage, 'depending on how aggressive the employer wants to be,' says Mr. George. 'But I just don't see employers becoming completely insensitive to employee choice.'**

care's control of out-of-network utilization will only improve," Mr. George said.

In addition, "maintaining a level of choice is very important to many employers, especially larger employers that are attempting to gain or maintain a reputation of being an employee-friendly company," he said.

However, there is a school of skeptics that cites several reasons why the point-of-service movement will not last, Mr. George acknowledged.

"Many people feel our ultimate destiny is HMOs—and HMOs only. Some feel employee choice is a luxury employers will eventually not be able to provide," he said. "Others say point-of-service is simply a transitional marketing strategy designed to provide a quick fix."

But, "I don't quite see this," Mr. George said. "Employers with sizable workforces at multiple locations will continue to want to offer employees a choice,

\$184 in one location and \$199 in the other. Those costs include the expense of additional administration that is typically associated with setting up such plans, he said.

"Point-of-service programs do work and they do save money, but they are complicated and difficult to administer," said Eric C. Sohlgren, manager of group insurance for Times Mirror Co. The Los Angeles-based publishing company is looking into implementing the plans.

Times Mirror has already saved significant amounts with a carved out mental health and substance abuse program for its 26,000 U.S. employees, Mr. Sohlgren said.

After seeking several requests for proposals, it chose Human Af-

airs International, a subsidiary of Aetna Life & Casualty Co., to administer the plan.

Times Mirror recently assessed the savings associated with the new plan, implemented in 1990. Comparing its 1989 utilization data to utilization between July 1990 and June 1991, the company found its mental health admissions decreased about 35%, Mr. Sohlgren said.

Also during that period, Times Mirror found its bed days per 1,000 members decreased 44%, and the average length of stay decreased about 13.5%, he said.

Lea Sirota, risk manager for Elixir Industries in Gardena, Calif., served as moderator. Mr. Richter was coordinator.

treatment.

"These plans entail a limited amount of hassle, offer quality care and give the employee a choice by event. They really do offer the best of all worlds," Mr. George said.

Those insisting that point-of-service is a fad also say out-of-network benefit levels are still too high for most employers.

But, even though most plans cover out-of-network care at 70% to 80% above deductibles, coverage for out-of-network care could be even further restricted without making it prohibitively expensive.

"Eventually, I could see point-of-service benefit designs moving from 20% to 30% out-of-network disincentives to only catastrophic level coverage, depending on how aggressive the employer wants to be," Mr. George said.

"But I just don't see employers becoming completely insensitive to employee choice." ■

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Lea Sirota, risk manager for Elixir Industries in Gardena, Calif., served as moderator. Mr. Richter was coordinator.

Contact: Our crystal ball is no better than most. We are not counting on any change through the balance of this year. If the stock market continues to advance and bolsters underwriters' surplus, the soft market could be prolonged beyond 1992. We are sure of one thing. We have learned more about managing costs over the past several years. When the prices finally firm, we should be in a very advantageous position to realize the leverage of faster top line growth. Maybe that qualifies as encouragement. ■

## Update

### Coal miner retiree fund ruling

WASHINGTON—Members of the Bituminous Coal Operators' Assn. must increase contributions to two struggling multiemployer retiree health care funds by nearly 50%, a federal judge has ruled.

Approximately 300 members of the BCOA must immediately begin contributing \$3.67 per man-hour of production to the 1950 and 1974 United Mine Workers of America Health and Retirement Benefit Funds. The coal companies had been contributing \$2.50 per man-hour to the funds under terms of the 1988 wage agreement between the union and the BCOA. However, the funds had fallen into debt by about \$100 million, forcing trustees of the funds to sue the BCOA for an increase in contributions to \$5.42 per man-hour (BI, Feb. 10).

The BCOA hopes that legislation will resolve the problem of providing health benefits to nearly 120,000 retired coal miners. However, a proposal passed by Congress was killed because it was tacked onto the tax bill that President Bush later vetoed.

### Fibreboard, Chubb unit settle

CONCORD, Calif.—Fibreboard Corp. and Pacific Indemnity Co. have reached a new agreement to settle their dispute over coverage for asbestos bodily injury and property damage claims.

Under the new agreement, which replaces a March 1991 agreement, Pacific Indemnity, a unit of Chubb Corp., will provide the former asbestos producer \$30 million in coverage over the next 12 months to pay asbestos claims and defense costs. Unlike the old agreement, the new pact requires no court approval (BI, Jan. 20; March 11, 1991).

Additional coverage under the Pacific Indemnity policy will hinge on how California courts interpret the policy. The insurer could be forced to pay an additional \$105 million under its 1956-1957 policy, or Fibreboard could be forced to repay the insurer amounts it has received under the policy.

The agreement also provides that if Concord, Calif.-based Fibreboard can win litigation that would bar its other insurers from seeking contributions from Pacific Indemnity, then Pacific Indemnity will provide an additional \$140 million to \$225 million in coverage.

Pacific Indemnity will pay the money into an irrevocable trust established to pay asbestos claims.

Separately, a California state court jury found that Fibreboard proved the existence of a policy written by Employers Surplus Lines Insurance Co., now part of Commercial Union Assurance Co. P.L.C., between 1959 and 1962. The jury also found the policy had no aggregate limits.

### Berkle pleads guilty to fraud

NEWARK, N.J.—Maryland insurance executive Warren H. Berkle Jr. has pleaded guilty to a charge of conspiring to use Preferred Indemnity Insurance Co. of Old Bridge, N.J., to defraud buyers of high-risk liability coverages.

Mr. Berkle was indicted on conspiracy, fraud and money laundering charges last year with Martin Bramson and Leonard Allen Bramson. The Bramsons still face a variety of criminal charges stemming from their operation of Preferred Indemnity and Trans-Pacific Insurance Co. (F.S.M.) of Micronesia (BI, Sept. 16, 1991).

Mr. Berkle last week also pleaded guilty in U.S. District Court in Newark, N.J., to two separate mail fraud charges accusing him of writing fraudulent surety bonds and insurance policies. He faces a maximum of 15 years in prison and \$750,000 in fines.

Mr. Berkle also has agreed to testify against the Bramsons and two other defendants named in a superseding indictment, according to the U.S. Attorney's office.

Martin Bramson jumped bail after his arrest last year and is still a fugitive (BI, Nov. 4, 1991). Split trials for Leonard Bramson and the two other defendants are scheduled for April and May.

No date has been set for Mr. Berkle's sentencing.

### Briefly noted

Lloyd's of London has begun an investigation into "irregularities" recently discovered in syndicates formerly managed by Gooda Walker Ltd. Allegations of improper accounting for time-and-distance policies for syndicate 290 and transactions among Gooda Walker syndicates were contained in an affidavit filed last week by Lloyd's in ongoing litigation over members' challenge to cash calls (BI, March 9). . . CIGNA Corp. says its potential problem mortgage loan and bond holdings more than doubled last year to \$1.35 billion from \$640 million in 1990, not including reserves CIGNA set aside for possible losses. . . Standard & Poor's Corp. has lowered the claims-paying ability rating of The Travelers Indemnity Co. property/casualty intercompany pool to AA- from AA. But, S&P affirmed the A+ life/health claims-paying ability rating of Travelers Insurance Co. and Travelers Corp.'s A+ senior debt rating. . . The Commodity Futures Trading Commission has approved a Chicago Board of Trade plan to sell homeowners and health insurance futures and options. Sales of homeowners insurance futures and options are scheduled to begin Sept. 25, but no trading date has been set for health insurance futures and options (BI, March 23). . . Moody's Investors Service Inc. has assigned Metropolitan Property & Casualty Insurance Co. a first-time financial strength rating of Aa2. . . A Louisiana judge has placed North American Indemnity Co., a Baton Rouge-based liability and workers comp insurer, into Louisiana Insurance Department-supervised 'conservation'. . . The National Council on Compensation Insurance last week filed for a 27.8% overall workers comp rate increase in Virginia, effective Aug. 1.

# A lackluster year in review

By LEONARD M. WILSON

Special to Business Insurance

THE YEAR 1991 IS NOW history for the insurance brokers. Not especially good history, but at least history. Results for the year reflected the soft market, the pressure on profit margins and the absence of any contracyclical activities that might have mitigated the adverse effect of sliding insurance brokerage. Investors in brokerage stocks share the pain of managements.

Fourth-quarter reports, the latest window on operating activities, can only be described as continuing the lackluster trends of the year's prior reporting periods. Earnings comparisons were generally negative. Special charges also marred results for several brokers.

Analyst contacts with company managements elicited the following observations and comments:

Analyst: Why don't we start with premium rates? Everyone I speak to indicates that conditions haven't changed in the mainstream lines. Do you see even a glimmer of hope?

Contact: We previously estimated that rates declined about 5% in the third quarter. Not much has changed. Competition is keen, but on the positive side, we are not in what some people might call a raging soft market. It is more like water torture.

Analyst: Can you give me an estimate of the increase in insurance brokerage commissions for the fourth quarter? My feeling is that domestic brokerage probably rose only 2% year over year in the quarter.

Contact: You are pretty much on the mark. If we eliminate any distortions from acquisitions, or special factors, domestic commissions increased around 2%. Not particularly robust, and clearly victimized by the impact of soft rates. We are more or less resigned to this glacial rate of gain as long as the current soft market prevails.

Analyst: Some observers of the industry are placing their bets on a firming in reinsurance rates to lead the primary markets away from price competition. How did the fourth quarter stack up in reinsurance brokerage?

Contact: At the risk of sounding like a

broken record, reinsurance rates again can be characterized as stable to down modestly. We see ample capacity in reinsurance, and as long as the demand side of the equation—that is, the level of retentions by primary companies—shows no signs of shifting, we would expect reinsurance rates to parallel the pattern of the primary markets.

Analyst: Are you experiencing any acceleration in benefit consulting after the slowdown of the past few quarters?

Contact: We used to believe that benefit consulting was largely unaffected by the economy. Benefit consulting thrives on escalation in medical costs and change in pension plans. There is plenty of action in the area of medical cost containment for corporations, as everyone knows from reading just about any newspaper. Nevertheless, companies can defer benefits projects, and we are feeling the impact. Benefit consulting revenues increased about 3% to 4% in the fourth quarter. We are hopeful that currently deferrals mean considerable pent-up demand that will accelerate the growth of benefit consulting once clients feel more comfortable about the course of the economy.

Analyst: International brokerage seems to be a bit stronger than the domestic side. Are we correct in this judgment?

Contact: Insurance brokerage outside the United States typically is a country-by-country affair. As a generalization, international revenues are running somewhat stronger than U.S. revenues. We estimate overall an advance in the fourth quarter, year over year, of 4% to 5% with a narrowly adverse effect from appreciation of the dollar against sterling. Markets abroad are perhaps less competitive than here, but there is still plenty of capacity worldwide. Of course, rates are moving up in marine, aviation and in catastrophe coverages. Capacity is tight in the catastrophe area.

Analyst: Investment income took a plunge in the quarter for almost all the public insurance brokers. How did you fare?

Contact: Our investment income slid by roughly 25% from the previous year's fourth quarter. Throughput was up only slightly as you might expect, but the drop in short-term interest rates was pretty steep. The fourth quarter is likely to be the worst in terms of

the decline in investment income. Upcoming quarters in 1992, though, will feel the effects of lower short-term interest rates.

Analyst: Now it is our turn to sound like a broken record. Total revenues are still advancing only in the low single-digit area. Profit margins were still under pressure in the fourth quarter. What does the expense situation look like, and can you sustain your cost restraint initiatives?

Contact: We believe that our cost control programs are working. Headcounts are not rising, and in some instances we have been able to prune without impairing our service levels. We are looking closely at all of our costs and are optimistic that we can hold the line as long as the soft market continues. The fourth quarter gave evidence of this, despite the margin pressures that you cite.

Analyst: New business is always a subject that interests us. What were the new business trends in the fourth quarter?

Contact: Production is going along quite well. In the fourth quarter, we reckon new business at 10% to 11% of commissions. This range would also apply for the full year. We think that we are at least holding our own in terms of market penetration.

Analyst: The corollary to new business is lost business.

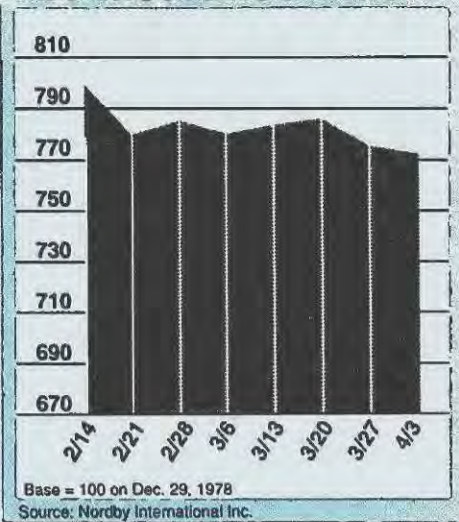
Contact: Lost business has remained at 4% to 5% for the quarter and for the full year. This means that our new business came in at roughly 5% for the quarter and the year. Programs to retain clients are working. In addition, as you have pointed out, given the duration of the soft market, there is less incentive for clients to shift their allegiance as a result of price alone. Moreover, as we get closer to a hard market, whenever that

Continued on page 54



Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

## BI Insurance Index



Insurance industry stocks slid last week, as the Business Insurance Index fell 4.5 points to 772.2 on April 3 from 776.7 on March 27. Advancing issues were led by U.S. Healthcare, up 13.1%; United Fire & Casualty, up 8.3%; and Phoenix RE Corp., up 5.0%. Declining issues followed Frank B. Hall, down 10.8%; Fremont General Corp., down 10.8%; and Gainsco Inc., down 9.7%. The most active issue was U.S. Healthcare, 5.2 million shares traded. The BI Index was down 0.6%; the New York Stock Exchange Composite was down 0.7%; the Standard & Poor's 500 was down 0.5%; and the Dow Jones 30 Industrials rose 0.6%.

## British Issues

April 2 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm Union	413	N/M	31.5	7.6	413	408
Genl Accident	385	N/M	35.7	9.3	403	385
Gdn Royal Exch	119	N/M	10.0	8.4	122	119
Royal	178	N/M	15.0	8.4	187	178
Sun Alliance	250	N/M	19.0	7.6	270	250
<b>Brokers</b>						
Bradstock	150	17.0	6.3	4.2	156	150
CE Health	364	24.1	34.5	9.5	389	364
Hogg Group	167	11.1	10.9	6.5	186	167
JIB Group	175	12.9	10.0	5.7	177	175
Lloyd Thompson	225	22.5	6.0	2.7	235	225
Lowndes Lambt	313	13.1	17.3	5.5	321	313
PWS Holdings	49	5.3	5.3	10.8	60	49
Sedgwick Grp	204	15.9	16.0	7.8	206	204
Steel Brl Jones	277	13.9	17.7	6.3	301	277
Willis Coroon	233	14.7	17.6	7.6	233	225

Source: Philip Olsen, Insurance Industry Analyst, London

## BI Industry Stock Report

MARCH 30, 1992 THROUGH APRIL 3, 1992

BROKERS	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			
				High	Low										High	Low									
Alexander & Alexander	NYS	19.00	-8.43	-7.32	27.50	18.00	406	1.00	5.26	-76	9.77	1.94	26.75	-5.31	21.59	28.25	14.00	40	0.00	0.00	13	3.22	8.31		
Gallagher Arthur J. & Co	NYS	23.63	-4.55	5.59	27.63	19.00	65	0.64	2.71	18	5.88	4.02	34.25	-2.84	-2.49	37.75	17.00	18	0.12	0.35	25	13.52	3.16		
Frank B. Hall	NYS	4.13	-10.81	-2.94	5.50	3.13	150	0.00	0.00	-3	-5.24	-0.79	18.50	-0.67	N/A	23.63	18.50	96	0.12	0.65	8	N/A	N/A		
Hib. Rogal & Hamilton	OTC	12.00	-4.00	-9.43	17.50	11.25	200	0.40	3.33	20	3.56	3.37	42.75	-2.84	4.27	48.25	29.50	40	0.00	0.00	25	13.52	3.16		
Marsh & McLennan	NYS	74.88	-0.99	-7.99	86.00	70.00	444	2.60	3.47	18	14.77	5.07	5.38	-2.27	34.38	6.00	3.38	23	0.00	0.00	4	7.76	0.69		
Poe & Associates	OTC	15.88	4.10	32.29	15.88	7.25	37	0.40	2.52	17	2.52	6.30	33.25	-3.97	6.83	38.50	18.63	141	1.40	4.21	12	42.73	0.78		
BROKERS AVERAGE			-4.1	1.7									52.75	-5.80	6.57	58.25	42.25	154	2.68	5.08	9	36.38	1.45		
<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>																									
Berkley W R Corp.	OTC	34.13	1.11	11.89	36.25	23.50	97	0.36	1.05	13	23.89	1.43	41.63	4.06	17.25	41.88	27.50	204	0.72	1.73	8	33.09	1.26		
Berkshire Hathaway Inc.	NYS	8900.00	-0.56	-1.66	9125.00	7760.00	0	0.00	0.00	-33	4612.00	1.93	30.50	-1.21	-3.56	34.25	24.13	111	0.92	3.02	5	20.42	1.49		
ITT (Hartford Group)	NYS	64.50	-1.34	11.69	70.63	50.00	991	1.84	2.85	10	64.01	1.01	10.50	5.00	0.00	11.75	8.50	64	0.20	1.90	42	13.30	0.79		
Sears (Allstate)	NYS	45.25	-0.28	19.47	47.88	32.50	4118	2.00	4.42	14	37.98	1.21	21.88	-2.78	-5.91	24.25	16.75	164	1.00	4.57	9	25.88	0.85		
CONGLOMERATES AVERAGE			-0.3	10.3									16.25	2.36	13.04	18.63	13.13	6	0.24	1.48	13	15.05	1.08		
<b>INSURERS/REINSURERS</b>																									
AEGON N.V.	NYS	69.50	-1.94	-0.71	71.75	54.75	9	2.30	3.31	7	N/A	N/A	4.25	-5.56	3.03	6.25	3.50	68	0.32	7.53	3	5.61	0.76		
Aetna Life & Casualty	NYS	42.75	2.09	-2.84	49.13	31.88	1181	2.76	6.46	9	64.23	0.67	19.38	0.65	17.42	20.38	11.88	20	0.48	2.48	9	14.41	1.34		
Allied Group Inc.	OTC	21.75	1.16	27.94	22.25	16.00	111	0.64	2.94	8	11.50	1.89	70.00	-0.53	-3.95	75.75	57.13	479	2.72	3.89	7	52.00	1.35		
American General	NYS	41.38	0.61	-7.02	44.75	36.38	821	2.08	5.03	10	37.14	1.11	50.00	0.28	-7.44	50.00	35.50	918	1.48	3.28	11	31.50	1.43		
American Indemnity/Fin'l	OTC	7.00	1.82	47.37	9.25	4.50	2	0.08	1.14	6	12.93	0.54	17.50	-2.78	13.82	18.88	11.63	16	0.28	1.60	10	11.19	1.56		
American International	NYS	85.88	0.00	-12.71	102.00	78.63	1257	0.48	0.56	12	45.34	1.89	5.50	0.00	0.00	8.88	4.00	190	0.36	6.55	-2	7.35	0.75		
Aon Corp.	NYS	40.00	-3.90	0.95	45.25	34.75	217	1.80	4.00	11	18.50	2.16	19.25	0.00	14.93	19.75	13.75	126	1.04	5.40	9	18.91	1.02		
Argonaut Group	OTC	27.00	0.00	13.68	33.38	21.75	101	0.88	2.52	9	48.26	0.56	5.50	2.33	-4.35	6.88	2.31	174	0.00	0.00	3	2.48	2.22		
AVEMCO Corp.	NYS	24.50	-3.92	-2.00	28.00	19.63	22	0.40	1.63	18	9.55	2.57	35.88	-5.28	-30.34	55.25	35.88	14	0.00	0.00		70.93	0.51		
Baldwin & Lyons Inc.	OTC	27.00	0.93	4.85	28.00	21.50	1	0.28	1.04	8	24.29	1.11	55.75	-3.46	-3.67	61.50	46.50	250	1.60	2.87	12	16.70	3.34		
Belvedere Corp.	ASE	5.38	0.00	65.38	6.13	2.75	40	0.04	0.74	15	7.65	0.70	40.13	-5.59	0.63	43.88	31.25	350	2.00	4.98	34	36.56	1.10		
Chandler Insurance	OTC	5.00	-2.44	53.85	5.50	2.13	195	0.00	0.00	63	5.95	0.84	35.25	-2.08	-9.32	39.63	29.00	47	0.24	0.68	11	18.38	1.92		
Chubb Corp.	NYS	64.75	-1.89	-15.91	78.00	60.75	758	1.60	2.47	10	35.19	1.84	20.00	-0.62	-7.51	25.13	17.25	1071	1.60	8.00	7	41.44	0.48		
CIGNA Corp.	NYS	50.25	-4.96	-17.79	61.75	41.25	769	3.04	6.05	11	73.15	0.69	30.75	3.00	-0.44	30.75	23.00	52	0.72	2.54	10	21.71	1.31		
CNA Financial Corp.	NYS	81.63	2.03	-16.71	104.50	75.50	89	0.00	0.00	8	70.23	1.16	59.00	8.26	31.11	59.00	42.00	5	1.32	2.24	12	35.39	1.67		
Continental Corp.	NYS	26.63	0.00	-3.62	30.38	23.25	471	2.60	9.77	27	37.83	0.70	8.25	-1.49	13.79	12.50	5.63	975	0.20	2.42	-4	11.96	0.69		
EXEL Ltd.	NYS	34.38	1.48	-8.33	40.25	27.38	582	0.92	2.68	7	N/A	N/A	UNLIM Corp.	NYS	33.63	-9.43	-16.98	40.63	28.81	900	0.52	1.55	11	37.25	0.90
Fund American Corp.	NYS	66.25	0.76	-5.19	70.25	62.00	111	0.88	1.03	15	36.11	1.83	45.38	0.00	-5.22	47.88	37.50	378	1.64	3.61	9	60.34	0.75		
Fremont General Corp.	OTC	18.75	-10.18	-23.08	26.00	18.00	501	0.88	4.69	5	19.13	0.98	41.50	-3.00	-7.69	41.50	31.00	340	1.00	3.03	13	30.70	1.07		
Frontier Insurance Group	NYS	30.38	-1.22	12.50	31.25	19.22	63	0.60	1.98	11	11.20	2.71	UNLIFE Corp.	NYS	45.38	0.00	-5.22	47.88	37.50	378	1.64	3.61	9	60.34	0.75
Gainsco Inc.	ASE	12.75	-9.73	-8.93	15.00	6.38	49	0.04	0.31	15	3.37	3.78	OTC	33.00	-3.00	-7.69	41.50	31.00	340	1.00	3.03	13	30.70	1.07	
General RE Corp.	NYS	90.00	-2.96	-11.66	104.75	85.00	811	1.80	2.00	12	37.50	2.40	USLCO Corp.	NYS	18.13	-1.36	-2.03	21.00	17.00	23	1.00	5.52	-18	29.44	0.62
Guaranty National Corp.	NYS	15.50	1.64	6.90	17.00	12.63	37	0.44	3.10	11	N/A	N/A	Washington National	NYS	17.25	0.73	8.66	19.25	13.38	11	1.08	6.26	-8	26.86	0.64
Hanover Insurance Co.	OTC	36.75	-2.00	2.80	42.75	27.13	32	0.48	1.20	16	37.														

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